amedisys

HOME HEALTH · HOSPICE · PERSONAL CARE

APPLICATION FOR CERTIFICATE OF NEED

TO EXPAND HOME HEALTH AGENCY SERVICES TO FREDERICK COUNTY, MARYLAND

FILED BY AMEDISYS MARYLAND, LLC, D/B/A AMEDISYS HOME HEALTH

May 5, 2017

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APPLICATION

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. APPLICANT. *If the application has a co-applicant, provide the following information for that party in an attachment.*

Legal Name of Project Applicant (Licensee or Proposed Licensee):
Amedisys Maryland, LLC, d/b/a Amedisys Home Health

Address:				
511 Jernor Lane #206	Westminster	21157-6151	MD	Carroll County
Street	City	Zip	State	County

Telephone: (410) 751-9904

Name of Owner/Chief Executive: Amedisys Maryland, LLC
Paul B. Kusserow, CEO

2. Name of Owner

If Owner is a Corporation, Partnership, or Limited Liability Company, attach a description of the ownership structure identifying all individuals that have or will have at least a 5% ownership share in the applicant and any related parent entities. Attach a chart that completely delineates this ownership structure.

Applicant Response:

The Owner is Amedisys Maryland, LLC. Please refer to **Exhibit 1** for the requested information regarding ownership structure.

3. FACILITY

Name of HHA provider: Amedisys Home Health

Address:			
511 Jernor Lane #206	Westminster	21157	Carroll
Street	City	Zip	County

Name of Owner (if differs from applicant):

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from the applicant:

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5. LEGAL STRUCTURE OF APPLICANT (and LICENSEE, if different from applicant).

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☐	
	(2) For-profit	☐	
	(3) Close	☐	State & Date of Incorporation ☐
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited Liability Partnership	☐	
	Limited Liability Limited Partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☑	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☑	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Geoffrey L. Abraskin, PT, DPT, DWS, Vice President of Operations, Northeast South Region, Amedisys Home Health and Hospice Services

Mailing Address:

3603 Southside Ave	Phoenix	MD	21131
Street	City	Zip	State

Telephone: 855-214-2989

E-mail Address (required): geoffrey.abraskin@amedisys.com

Fax:

B. Additional or alternate contact:

Marta D. Harting, Esquire, Venable LLP

Mailing Address:

750 E. Pratt Street Suite 900	Baltimore	21202	MD
Street	City	Zip	State

Telephone: 410-244-7542

E-mail Address (required): mdharting@venable.com

Fax:

B. Additional or alternate contact:

Name and Title:

Company Name

Mailing Address:

Street	City	Zip	State

Telephone:

E-mail Address (required):

Fax:

If company name is different than applicant briefly describe the relationship

7. Proposed Agency Type: ☑

a. Health Department ___
b. Hospital-Based ___
c. Nursing Home-Based ___
d. Continuing Care Retirement Community-Based ___
e. HMO-Based ___
f. Freestanding ☑
g. Other ___
(Please Specify.) _____

8. **Agency Services (Please check ☑ all applicable.)**

Service	Currently Provided	Proposed to be Provided in the Jurisdiction(s) that are the subject of this Application*
Skilled Nursing Services	☑	☑
Home Health Aide	☑	☑
Occupational Therapy	☑	☑
Speech, Language Therapy	☑	☑
Physical Therapy	☑	☑
Medical Social Services	☑	☑

* If proposing different services in different jurisdictions, note that accordingly.

9. Offices

Identify the address of all existing main office, subunit office, and branch office locations and identify the location (city and county) of all proposed main office, subunit office, and branch offices, as applicable. (Add rows as needed.)

Applicant Response:

The Applicant (Amedisys Maryland, LLC d/b/a Amedisys Home Health, License Number HH7048) is a parent home health agency with one office location (see completed table below). The Applicant currently has no subunits or branch offices. Through this Application, the Applicant seeks to expand to Frederick County, establishing a branch office there. The specific address of the branch office has not yet been determined, but the Applicant plans to locate the office in the City of Frederick. Including the Applicant, there are seven home health agency parent offices and one branch office in Maryland within Amedisys Maryland, LLC or its affiliate Tender Loving Care Health Care Services Southeast, LLC. See **Exhibit 2** for a list of those HHAs.

	Street	City	County	State	Zip Code	Telephone
Existing Main Office	511 Jernor Lane Suite 200	Westminster	Carroll	Maryland	21157	410-751-9904
Existing Subunit Offices						
Existing Branch Offices						
Locations of Proposed HHA Main Office						
Locations of Proposed HHA Subunit Office						
Locations of Proposed Branch Office	To be determined	City of Frederick	Frederick	Maryland	21701	To be determined

10. Project Implementation Target Dates

A. Licensure: Within 9 months from CON approval date.
B. Medicare Certification: Within 9 months from CON approval date.

NOTE: in completing this question, please note that Commission regulations at COMAR 10.24.01.12 state that "home health agencies have up to 18 months from the date of the certificate of need to: (i) become licensed and Medicare certified; and (ii) begin operations in the jurisdiction for which the certificate of need was granted."

11. Project Description:

Provide a summary description of the project immediately below. At minimum, include the jurisdictions to be served and all of the types of home health agency services to be established, expanded, or otherwise affected if the project receives approval.

Applicant Response:

a. *Overview*

The Applicant, Amedisys Maryland, LLC d/b/a Amedisys Home Health, is a parent home health agency located in in Westminster, Maryland, that has been providing home health

services in Carroll, Howard and Baltimore Counties since 2007. Through this CON application, the Applicant seeks authorization to expand its home health agency services into Frederick County, establishing a branch office in that jurisdiction. The The Applicant has a proven track record with exceptional quality scores and HHCAPS. Currently, the Applicant is a 4 STAR care center with multiple metrics being 4.5 STARs as well as 5 STARs. CMS's 3-month preview of the Applicant's scoring for July 2017 showed the Applicant at 4.5 STARs.

The Applicant is a subsidiary of Amedisys, Inc., a leading national home health and hospice provider, providing health care to patients in 36 states through more than 400 Medicare-certified home health and hospice agencies (including 328 parent home health agencies, subunits and branch offices). Our care teams deliver personalized home health care and hospice services to approximately 380,000 patients each year, and partner with more than 2,000 hospitals and nearly 62,000 physicians across the country. With regard to Maryland specifically, Amedisys Home Health and other Amedisys affiliates operate seven parent home health agencies and one branch agency that provide home health care in 14 Maryland jurisdictions.

The experience of the Applicant and its corporate family in providing high quality home health care in Maryland and throughout the country make the Applicant well-suited to meet the demonstrated need for additional home health agencies to offer high quality home health care services to residents of Frederick County.

Amedisys Home Health provides experienced, compassionate health care. We provide customized care to suit the unique situation of each patient, while focusing on empowerment, recovery, and maximizing independence. We help patients and their families to understand the patient's condition, how to manage it and how to live life to the fullest with a chronic disease or other health condition. Our clinicians are trained to understand the whole patient, not just their medical diagnosis.

b. *Services and Health Care Conditions*

We will provide home health care services in Frederick County by providing medical treatment to patients recovering from an illness or injury, with the goal of helping patients to regain independence and become as self-sufficient as possible. Specific services to be offered include:

- Skilled nursing
- Care transitions
- Patient education and training
- Medication management
- Pain management
- Physical therapy
- Occupational therapy
- Speech therapy
- Infusion therapy
- Social worker support
- Certified wound care tele-consult
- Nutritional consult
- Home health aide

We will also offer specialized chronic care programs that focus on actively involving the patient in the health care process, addressing conditions including:

- Heart disease
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Pain management
- Wound care
- Infusion therapy
- Oncology
- Chronic kidney disease
- Psychiatric services

c. *Care Transitions Program to Reduce Avoidable Hospitalizations*

With the depth of experience that comes from being part of a leading national home health care company, the Applicant can offer several evidence-based clinical programs. The Amedisys Care Transitions Program is an important example of one of these programs that has been proven effective in reducing unnecessary hospitalizations. Amedisys understands that preparing for a successful transition from the hospital back home is crucial to the patient's recovery and avoiding readmissions. It designed the Care Transitions Program based on work by Eric Coleman, MD, MPH, University of Colorado, and Mary Naylor, PhD, FAAN, RN, University of Pennsylvania School of Nursing. The program incorporates each of Coleman's four pillars and Naylor's recommended based practices early in the transition process including:

- Utilization of a Care Transitions Coordinator
- Early engagement of the patient, caregiver and family with condition specific coaching
- Physician engagement

Through coordination of services, in-home risk assessment and education on self-care, we help patients move home safely, helping to reduce 30-day readmissions and empowering patients to take control of their own health. Care Transition Coordinator interventions include:

- Coaching patients on effective communication with physicians
- Connecting to the community
- Teaching self-assessment, identification of symptoms and preventing exacerbations
- Setting goals and building action plans
- Promoting medication compliance with education and medication reconciliation
- Guiding medication reconciliations
- Assisting in making physician appointments

The benefits of the Amedisys Care Transition Program include:

- Reduction in emergent care and acute care hospitalization rates
- Improved quality of care
- Active patient engagement
- Self-management education
- Partnering with physicians
- Coordination across the healthcare continuum
- Application of evidence-based guidelines
- Measurement of clinical outcomes
- Recognition of early warning signs

Please refer to **Exhibit 3** for additional information about the Care Transitions Program.

In 2010, the Amedisys Care Centers where Care Transitions was first deployed were able to collectively reduce their acute care hospitalization rate by 7.9%.

d. *Additional Evidence-Based Clinical Programs*

Additional Amedisys evidenced based programs involving skilled medical services, supportive services for patients and their caregivers and education on self-management skills include the following programs (which are described further in **Exhibit 4).**

- ***Balanced for Life***® (balance training and assessment to help reduce the need for emergency care due to falls)
- ***Chronic Kidney Disease @ Home*** (provides early assessment, intervention and education on risk factors, diet and medication management)
- ***COPD @ Home*** (helps improve the quality of life for patients living with COPD, including help with oxygen therapy, medication management and monitoring of vitals)
- ***Diabetes @ Home*** (supports patients with Type 1 and Type 2 diabetes; recognized for excellence by the American Diabetes Association™)
- ***Empowered for Life*** ® (supports patients under psychiatric care including Alzheimer's and depression, including skilled assessments of the patient's condition, administering injectable medications, crisis intervention and individual or family counselling)
- ***Heart @ Home*** (supports patients with heart disease, including assessment and education, medication management, symptoms, mobility and other aspects of care)
- ***Orthopedic Recovery @ Home*** (combination of skilled nursing care and therapeutic rehabilitation to support recovery after an orthopedic surgery or injury)
- ***Pain Management @ Home*** (helps patients manage chronic pain by empowering them through education and techniques)
- ***Rehab Therapy @ Home*** (comprehensive rehabilitation therapy services to help patients improve their strength, mobility, balance and swallowing to function safely)
- ***Stroke Recovery @ Home*** (our clinicians help patients manage pain, bladder issues, depression and stress, impaired judgment balance and coordination and memory issues, and educate patients and caregivers to recognize the warning signs for stroke and prevention of future strokes)

- ***Surgical Recovery @ Home*** (multidisciplinary approach to meet post-operative care needs by highly skilled nurses and therapists accordance with the physician's plan of care)
- ***Partners in Wound Care*** ® (implements the most current evidence-based practices, incorporates the most current techniques, and uses the most advanced products to improve healing

PART II - CONSISTENCY WITH REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. These criteria follow, 10.24.01.08G(3)(a) through 10.24.01.08G(3)(f).

10.24.01.08G(3)(a). "The State Health Plan" Review Criterion
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria. (Note: In this case it is the standards at COMAR 10.24.16.08 – and in the case of comparative reviews, at COMAR 10.24.16.09.)

10.24.16.08 Certificate of Need Review Standards for Home Health Agency Services.
The Commission shall use the following standards, as applicable, to review an application for a Certificate of Need to establish a new home health agency in Maryland or expand the services of an existing Maryland home health agency to one or more additional jurisdictions.

The following standards must be addressed by all home health agency CON applicants, as applicable. Provide a direct, concise response explaining the proposed project's consistency with each standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

10.24.16.08A. Service Area.
An applicant shall:

(1) Designate the jurisdiction or jurisdictions in which it proposes to provide home health agency services; and

Applicant Response:

The Applicant proposes to provide home health agency services in Frederick County.

(2) Provide an overall description of the configuration of the parent home health agency and its interrelationships, including the designation and location of its main office, each subunit, and each branch, as defined in this Chapter, or other major administrative offices recognized by Medicare.

Applicant Response:

The Applicant (Amedisys Maryland, LLC d/b/a Amedisys Home Health, License Number HH7048) is a parent HHA located in Westminster, Maryland. The Applicant currently has no subunits or branch offices. Through this Application,

the Applicant seeks to expand its services into Frederick County, establishing a branch office there. Including the Applicant, there are seven Amedisys home health parent offices and one branch office in Maryland. See **Exhibit 2**

10.24.16.08B. Populations and Services.

An applicant shall describe the population to be served and the specific services it will provide.

Applicant Response:

The Applicant will provide home health services to the population of Frederick County ages 18 and above.

The Applicant will provide home health care services providing medical treatment to patients recovering from an illness or injury, with the goal of helping patients to regain independence and become as self-sufficient as possible. Specific services to be offered include:

- Skilled nursing
- Care transitions
- Patient education and training
- Medication management
- Pain management
- Physical therapy
- Occupational therapy
- Speech therapy
- Infusion therapy
- Social worker support
- Certified wound care tele-consult
- Nutritional consult
- Home health aide

The Applicant will also offer specialized chronic care programs the focus on actively involving the patient in the health care process, addressing conditions including:

- Heart disease
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Pain management
- Wound care
- Infusion therapy
- Oncology
- Chronic kidney disease
- Psychiatric services

Please also refer to the Project Description (Part 1, Question 11) for a description of additional clinical programs that the Applicant will provide.

10.24.16.08C. Financial Accessibility.
An applicant shall be or agree to become licensed and Medicare- and Medicaid-certified, and agree to maintain Medicare and Medicaid certification and to accept clients whose expected primary source of payment is either or both of these programs.

Applicant Response:

The Applicant is and agrees to remain licensed and Medicare- and Medicaid-certified and to continue to accept clients whose expected primary source of payment is either or both of these programs. Please refer to **Exhibit 5** for the Applicant's current license and **Exhibit 6** for its Medicare certification and Medicaid participation documentation.

The Applicant's payer mix in calendar year 2016 is set forth in Table 1 below, which reflects 96% Medicare/Medicare Advantage, 3% private PPS and commercial, and 0.5% Medicaid.

Table 1
2016 Payer Mix

Payor	# of Admissions
Medicare	543
PPS Private	12
Episodic Admits Total	547
Medicaid	3
Medicare Advantage	20
Private Commercial	8
Non-Episodic Admits Total	31
Total Admissions	586

10.24.16.08D. Fees and Time Payment Plan.
An applicant shall make its fees known to prospective clients and their families at time of patient assessment before services are provided and shall:

(1) Describe its special time payment plans for an individual who is unable to make full payment at the time services are rendered; and

(2) Submit to the Commission and to each client a written copy of its policy detailing time payment options and mechanisms for clients to arrange for time payment.

Applicant Response:

The Applicant will make its fees known to prospective clients and their families at the time of patient assessment before services are provided. The Applicant will offer a time payment plan for individuals who are unable to make full payment at

the time services are rendered. Please refer to **Exhibit 7** for the Applicant's time payment plan policy. A copy of this policy will be provided to clients and their families at the time of patient assessment.

10.24.16.08 E. Charity Care and Sliding Fee Scale.
Each applicant for home health agency services shall have a written policy for the provision of charity care for indigent and uninsured patients to ensure access to home health agency services regardless of an individual's ability to pay and shall provide home health agency services on a charitable basis to qualified indigent and low income persons consistent with this policy. The policy shall include provisions for, at a minimum, the following:

(1) Determination of Eligibility for Charity Care and Reduced Fees. Within two business days following a client's initial request for charity care services, application for medical assistance, or both, the home health agency shall make a determination of probable eligibility for medical assistance, charity care, and reduced fees, and communicate this probable eligibility determination to the client.

Applicant Response:

Please refer to **Exhibit 7** for the Applicant's charity care policy which contains this Maryland specific provision.

(2) Notice of Charity Care and Sliding Fee Scale Policies. Public notice and information regarding the home health agency's charity care and sliding fee scale policies shall be disseminated, on an annual basis, through methods designed to best reach the population in the HHA's service area, and in a format understandable by the service area population. Notices regarding the HHA's charity care and sliding fee scale policies shall be posted in the business office of the HHA and on the HHA's website, if such a site is maintained. Prior to the provision of HHA services, a HHA shall address clients' or clients' families concerns with payment for HHA services, and provide individual notice regarding the HHA's charity care and sliding fee scale policies to the client and family.

Applicant Response:

The Applicant will publish annual notice of its charity care policy in publications available to residents of Frederick Count. Please refer to **Exhibit 8** for a sample notice. The Applicant will also distribute its policy to the Frederick County Health Department and other agencies responsible for providing social services and other services to Frederick County residents. The Applicant will also make its charity care policy (**Exhibit 7**) available to prospective clients and their families and the general public in its business office in Frederick County. The Applicant will also make the policy available on its website.

(3) Discounted Care Based on a Sliding Fee Scale and Time Payment Plan Policy. Each HHA's charity care policy shall include provisions for a sliding fee scale and time payment plans for low-income clients who do not qualify for full charity care, but are unable to bear the full cost of services.

Applicant Response:

Please refer to **Exhibit 7** for the Applicant's charity care policy which contains a discounted fee schedule and time payment plan policy.

(4) Policy Provisions. An applicant proposing to establish a home health agency or expand home health agency services to a previously unauthorized jurisdiction shall make a commitment to, at a minimum, provide an amount of charity care equivalent to the average amount of charity care provided by home health agencies in the jurisdiction or multi-jurisdictional region it proposes to serve during the most recent year for which data is available. The applicant shall demonstrate that:

(a) Its track record in the provision of charity care services, if any, supports the credibility of its commitment; and
(b) It has a specific plan for achieving the level of charity care to which it is committed.

Applicant Response:

The Applicant commits to provide an amount of charity care equal to or greater than the average amount of charity care provided by home health agencies in Frederick County in 2014, the most recent year for which data is available in the Commission's Public Use Data Set. In that year, the cumulative percentage of charity care provided by Frederick County HHAs (measured as number of charity care visits over total HHA visits) was 0.1%. The Applicant's financial projections assume 6 charity care patients (or 96 visits) in each year. This equates to 2% of projected visits in Year 1, 1% in in Year 2, and 0.8% in Year 3.

In 2012, the Applicant provided 0.5% in charity care visits, exceeding the average amount of charity care provided by home health agencies in Frederick County in 2014 (0.1%) required by this standard. In order to meet at least the 0.1% level going forward, the Applicant will use the 23-person sales team of Amedisys in Maryland to actively market to all of our referral sources about the availability of charity care. We will incorporate this message into all of our daily sales calls.

We will also work with the Frederick County Department of Health and the local social services office to make them aware of the availability of charity home health care from Amedisys. The Applicant also intends to develop a relationship with the Frederick County-owned nursing home (Citizens Care) and assisted living facility (Montevue) for which providing care for the indigent population is part of its mission.

We will also publish notices of the availability of charity care in local newspapers and other publications.

Notice of the availability of charity care will also be displayed on our website.

10.24.16.08 F. Financial Feasibility.
An applicant shall submit financial projections for its proposed project that must be accompanied by a statement containing the assumptions used to develop projections for its operating revenues and costs. Each applicant must document that:

(1) Utilization projections are consistent with observed historic trends of HHAs in each jurisdiction for which the applicant seeks authority to provide home health agency services;

(2) Projected revenue estimates are consistent with current or anticipated charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving each proposed jurisdiction; and

(3) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant if an existing HHA or, if a proposed new HHA, consistent with the recent experience of other Maryland HHAs serving the each proposed jurisdiction.

Applicant Response:

The historic utilization trends in Frederick County through 2014 (the most recent year for which Public Use Data Set information is available) are set forth in Table 2 below.

Table 2
Historic Trends in Utilization

Year	Total Visits	% Increase over prior year
2010	62,715	
2011	73,817	17%
2012	76,306	3.8%
2013	82,045	7.5%
2014	90,974	11%

This is a 45% increase during this period, with an average increase of nearly 10% per year. Continuing at a 10% rate of growth would yield total visits of approximately 134,000 in 2018.

The Applicant's projections achieve projected full utilization in its fourth year, at 11,244 total visits (ramping up from 2,324 visits in year 1, 6,299 in year 2, and 9,338 in year 3). These projections are based on its experience in Carroll County in terms of number of lives age 65+, number of home health competitors, and home health utilization. The Applicant has 12,970 total visits in 2016, virtually all of which were in Carroll County which has a significantly smaller population overall and a smaller 65+ population than Frederick County. Further, as described in the Need section below, Carroll County is already at a high home health utilization rate relative to the state and other counties, whereas Frederick County continues to have a low utilization rate (even while it experienced 45% growth in visits between 2010 and 2014) and has significant growth potential.

During the ramp up period, the Applicant intends to earn the trust of referral sources in the County and employ staff at the appropriately to meet the need. The Applicant will also utilize a substantial Amedisys sales team to educate referral sources on the benefits of home health as well as the cost savings by reducing hospital admissions during the ramp up period and beyond.

As an existing HHA, the Applicant's projected revenue estimates are based on its current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt and charity care. The applicant is projecting slow and steady growth to ensure quality patient care is consistent to all patients under care. In order to qualify the revenue projections, the Applicant considered its historical average revenue per episode on episodic patients as well as private patients and projected based on the anticipated admission growth.

The Applicant's staffing and overall expense projections are based on its utilization projections and current expenditure levels and reasonable anticipated future staffing levels as experienced by the Applicant as an existing HHA.

10.24.16.08G. Impact.
An applicant shall address the impact of its proposed home health agency service on each existing home health agency authorized to serve each jurisdiction or regional service area affected by the proposed project. This shall include impact on existing HHAs' caseloads, staffing and payor mix.

Applicant Response:

Please refer to the Response to COMAR 10.24.01.08G(3)(f) (Impact on Existing Providers Review Criterion).

10.24.16.08H. Financial Solvency.
An applicant shall document the availability of financial resources necessary to sustain the project. Documentation shall demonstrate an applicant's ability to comply with the capital reserve and other solvency requirements specified by CMS for a Medicare-certified home health agency.

Applicant Response:

The Applicant is a wholly owned subsidiary of Amedisys Holding, LLC (which is 100% owned by Amedisys, Inc.) that supports and provides cash flow for all of its subsidiaries' operations. Please refer to the Amedisys, Inc. Annual Report (**Exhibit 15**) that demonstrates the availability of financial resources necessary to sustain this project. The corporate organizational chart of Amedisys, Inc. is attached as **Exhibit 1**

With regard to the CMS capitalization requirement (42 C.F.R §489.28), the Applicant does not propose to establish a new HHA with a new Medicare provider number, but rather proposes to expand an existing HHA into Frederick County by establishing a branch office that will operate under the same Medicare provider number as the parent HHA in Westminster. Accordingly, the capital reserve requirements specified by CMS hat apply to HHAs entering the Medicare program after January 1, 1998 do not apply to the Applicant.

10.24.16.08I. Linkages with Other Service Providers.
An applicant shall document its links with hospitals, nursing homes, continuing care retirement communities, hospice programs, assisted living providers, Adult Evaluation and Review Services, adult day care programs, the local Department of Social Services and home delivered meal programs located within its proposed service area.

(1) A new home health agency shall provide this documentation when it requests first use approval.

(2) A Maryland home health agency already licensed and operating shall provide documentation of these linkages in its existing service area and document its work in forming such linkages before beginning operation in each new jurisdiction it is authorized to serve.

Applicant Response:

As an existing HHA, the Applicant has linkages with all of these types of health care providers and service providers in its existing service area. Please refer to **Exhibit 9** for a complete list of all of the Applicant's referrals in 2015 and 2016. The Applicant expects that many of these linkages with health care providers in Carroll County will carry over into adjacent Frederick County. In addition, the Applicant has already begun to work on forming additional linkages in Frederick County. Please refer to **Exhibit 10** for documentation of these efforts to date.

10.24.16.08J. Discharge Planning.
An applicant shall document that it has a formal discharge planning process including the ability to provide appropriate referrals to maintain continuity of care. It will identify all the valid reasons upon which it may discharge clients or transfer clients to another health care facility or program.

Applicant Response:

Please refer to **Exhibit 11** for a copy of the Applicant's Discharge Planning policy in accordance with this standard.

10.24.16.08K. Data Collection and Submission.
An applicant shall demonstrate ongoing compliance or ability to comply with all applicable federal and State data collection and reporting requirements including, but not limited to, the Commission's Home Health Agency Annual Survey, CMS' Outcome and Assessment Information Set (OASIS), and CMS' Home Health Consumer Assessment of Healthcare Providers (HHCAHPS).

Applicant Response:

The Applicant submits the Commission's Home Health Agency Annual Survey on an annual basis, including required information about operations, ownership, license and organization, certification and accreditation, services, provided, staffing, financial information, utilization, and client distribution.

The Applicant complies with all CMS data collection and reporting requirements, including the Outcome and Assessment Information Set (OASIS), and CMS' Home Health Consumer Assessment of Healthcare Providers (HHCAHPS) survey. OASIS is CMS's comprehensive quality assessment tool that must be completed for each patient, and at specified points in the care process. Working with approved CMS vendor Strategic Healthcare Partners (SHP), the Applicant transmits the required OASIS data weekly to CMS and receives verification from CASPER (Certification and Survey Provider Enhanced Reports). Please refer to **Exhibit 12** for quality reports from SHP based on the Applicant's OASIS data submissions in 2016.

HHCAHPS is designed by CMS to measure the experiences of people receiving home health care from Medicare-certified home health agencies. The HHCAHPS is conducted for home health agencies by approved HHCAHPS Survey vendors. The Applicant participates in the HHCAHPS Survey through SHP, an approved Survey vendor. Attached as **Exhibit 12** is the record from SHP of all of the Applicant's survey submissions under HHCAHPS.

10.24.16.09 Certificate of Need Preference Rules in Comparative Reviews. Consistent with COMAR 10.24.01.09A(4)(b), the Commission shall use the following preferences, in the order listed, to limit the number of CON applications approved in a comparative review.

10.24.16.09A. Performance on Quality Measures.
Higher levels of performance will be given preference over lower levels of performance.

Applicant Response:

Because this review is not a comparative review, this standard is not applicable.

10.24.16.09B. Maintained or Improved Performance.
An applicant that demonstrates maintenance or improvement in its level of performance on the selected process and outcome measures during the most recent three-year reporting period will be given preference over an applicant that did not maintain or improve its performance.

Applicant Response:

Because this review is not a comparative review, this standard is not applicable.

10.24.16.09C. Proven Track Record in Serving all Payor Types, the Indigent and Low Income Persons.
An applicant that served a broader range of payor types and the indigent will be given preference over an applicant that served a narrower range of payor types and provided less service to the indigent and low income persons.

Applicant Response:

Because this review is not a comparative review, this standard is not applicable.

10.24.16.09D. Proven Track Record in Providing a Comprehensive Array of Services.
An applicant that provided a broader range of services will be given preference over an applicant that provided a narrower range of services.

Applicant Response:

Because this review is not a comparative review, this standard is not applicable.

10.24.16.09E. These preferences will only be used in a comparative review of applications when it is determined that approval of all applications that fully comply with standards in Regulation .08 of this Chapter would exceed the permitted number of additional HHAs provided for in a jurisdiction or multi-jurisdictional region as provided in Regulation .10.

Applicant Response:

Because this review is not a comparative review, this standard is not applicable.

10.24.01.08G(3)(b). The "Need" Review Criterion

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Please discuss the need of the population served or to be served by the Project. Recognizing that the State Health Plan has identified need to establish an opportunity for review of CON applications in certain jurisdictions based on the determination that the identified jurisdiction(s) has insufficient consumer choice of HHAs, a highly concentrated HHA service market, or an insufficient choice of HHAs with high quality performance (COMAR 10.24.16.04), applicants are expected to provide a quantitative analysis that, at a minimum, describes the Project's expected service area; population size, characteristics, and projected growth; and, projected home health services utilization.

Applicant Response:

The State Health Plan for Home Health Agency Services (COMAR 10.24.16) defines need for the development and expansion of HHA services based on ensuring consumer choice of high quality providers Where previous HHA chapters attempted to define the need for HHA services by focusing on rates of population demand for services and changes in population, this Chapter "identifies need for new HHA service providers on whether there is reasonable consumer choice of quality performing HHA providers in a jurisdiction, and takes the position that more good quality choices should be encouraged when a market is dominated by a small number of providers." COMAR 10.24.16.03C. It emphasizes the "importance of providing consumers with meaningful choices for obtaining high quality services, in which one HHA or a small number of HHAs do not command overwhelming dominance." COMAR 10.24.16.03B. As noted in COMAR 10.24.16.03C, this approach benefits consumers because research indicates that quality and performance scores improve over time in more competitive markets."

The Commission has made the determination that the Western Maryland region, including Frederick County, needs new HHA providers based on the criteria outlined in COMAR 10.24.15.04A, which include insufficient consumer choice of HHAs, a highly concentrated HHA service market, or an insufficient choice of HHAs with high quality performance.

The service area for this project will be all of Frederick County.



The historical and projected total population for Frederick County is shown in Table 3.

Table 3
Historical and Projected Total Population for Frederick County[1]

Year	Population
2010 (Census)	233,385
2015	245,600
2020	265,650
2025	285,950
2030	304,050
2035	319,800
2040	334,100

The U.S. Census Bureau estimates that, as of July 1, 2016, Frederick County had a population of 247,591, a 6.1% increase since 2010, as compared to a 4.2% increase in Statewide population in the same period.

The annualized growth rate in Frederick County is projected to outpace the annualized growth rate for the State as a whole through 2040.

[1]Maryland Department of Planning data (July 2014)

Table 4
Projected Annualized Growth Rates (Frederick County and Maryland)[2]

Period	Frederick County	Maryland
2015-2020	1.58%	0.70%
2020-2025	1.48%	0.65%
2025-2030	1.24%	0.56%
2030-2035	1.02%	0.45%
2035-2040	0.88%	0.37%

Further, its growth rate is projected to be one of the highest in the State. In the 2015-2020 time period, Frederick County's projected annual growth rate of 1.58% is projected to be the third highest in the state (following Charles County and St. Mary's County). In the 2020-2025 time period, Frederick County's projected annual growth rate of 1.48% is projected to be the fourth highest in the state (following St. Mary's County, Charles County and Cecil County). [3]

Older residents make up a significant part of the County's population growth. According to Census Bureau data, the population aged 65 and older in Frederick County increased from 11.1% to 13.3% between 2010 and 2015, an increase of nearly 20%. This is higher than the State-wide growth in this population in the same period. The population aged 65 and older State-wide grew from 12.3% to 14.1% in the same period, an increase of 15%.

According to population data from Tetrad, in 2014, Frederick County had the 8th highest 65+ population and this population is projected to increase by 2019 at a compound annual growth rate of 5.3%, the 6th highest projected growth rate for this population in the state. (See Table 5 below).

As shown in Table 5, 2014 Medicare claims data shows that Frederick County had a home health utilization rate of 8.0% in 2014, the 9th lowest in the State, less than the State as a whole (8.6%) and its neighbor Montgomery County (8.4%) and significantly less than Carroll County (9.1%) and Allegany County (9.9%).

[2]Maryland Department of Planning data (July 2014)
[3]Maryland Department of Planning data (July 2014)

Table 5

Medicare Claims Data and Population Data[4]

File Year	County	No. of Providers	Episodes	Visits	Medicare Population	MA Enrolled	MA %	2014 65+ Pop.	65+ 5yr. CAGR	HH Utilization Rate
2014	ALLEGANY	2	1,684	24,094	16,455	668	4.1%	14,374	5.5%	9.9%
2014	ANNE ARUNDEL	14	8,504	136,673	83,723	4,460	5.3%	76,447	5.6%	7.7%
2014	BALTIMORE	26	15,882	246,136	146,690	12,609	8.6%	130,048	3.7%	9.6%
2014	BALTIMORE CITY	19	11,009	162,590	96,671	11,653	12.1%	79,318	3.3%	10.4%
2014	CALVERT	6	1,013	14,623	13,354	384	2.9%	11,591	5.6%	6.2%
2014	CAROLINE	2	723	11,322	6,073	41	0.7%	5,021	6.8%	8.4%
2014	CARROLL	14	3,410	51,050	29,065	987	3.4%	25,130	4.7%	9.1%
2014	CECIL	4	1,778	25,297	16,896	302	1.8%	14,061	5.3%	8.2%
2014	CHARLES	6	1,667	22,998	19,563	1,088	5.6%	16,895	4.0%	6.9%
2014	DORCHESTER	3	1,062	17,225	7,460	65	0.9%	6,581	3.2%	9.2%
2014	FREDERICK	8	3,774	61,392	35,443	2,080	5.9%	30,921	5.7%	8.0%
2014	GARRETT	2	452	5,658	6,585	402	6.1%	6,003	2.0%	6.4%
2014	HARFORD	13	4,289	61,793	41,775	2,395	5.7%	35,951	3.1%	8.8%
2014	HOWARD	15	3,093	48,588	39,269	2,934	7.5%	36,800	4.6%	6.7%
2014	KENT	1	523	6,898	5,280	92	1.7%	5,008	2.8%	8.8%
2014	MONTGOMERY	23	13,026	180,799	141,847	14,140	10.0%	139,892	5.6%	8.4%
2014	PRINCE GEORGES	23	10,628	162,630	112,913	15,714	13.9%	98,824	5.2%	8.2%
2014	QUEEN ANNES	4	704	9,869	9,162	180	2.0%	8,439	3.1%	5.9%
2014	SAINT MARYS	5	1,235	18,152	14,208	244	1.7%	12,997	4.8%	6.8%
2014	SOMERSET	3	610	9,177	4,523	36	0.8%	4,097	3.3%	10.1%
2014	TALBOT	3	1,108	16,607	10,275	253	2.5%	10,353	3.5%	8.1%
2014	WASHINGTON	4	2,468	35,019	27,907	2,396	8.6%	23,331	2.7%	7.4%
2014	WICOMICO	4	2,513	39,903	17,290	173	1.0%	14,287	3.0%	11.1%
2014	WORCESTER	4	1,946	29,872	13,942	283	2.0%	14,004	2.8%	11.1%
MD Totals		208	93,112	1,398,519	916,369	73,579	8.0%	820,373	4.6%	8.6%

Although Frederick County's utilization rate is lower than the Statewide rate and most other counties, it has improved since 2012, when it had a home health utilization of 7.2% for people aged 65+ (again lower than the Statewide rate and nearby counties). The need for home health services in Frederick County will continue to increase as its utilization rate increases towards the statewide average.

As Table 5 also shows, the Medicare Advantage penetration in Frederick County (5.9%) is significantly lower than the State-wide rate of 8.0%. As Medicare Advantage plans gain penetration, home health utilization and the need for home health services will increase because it is a lower cost alternative to facility-based care. Additionally, as technology advances, more acute level services will be available in the home as opposed to facility-based post-acute settings, which will help drive utilization of home health services.

As shown in the response to 10.24.16.08 F (Financial Feasibility) above, the number of home health visits in Frederick County increased between 2010 and 2014 by 45%, or an average growth of 10% per year -- even while the County had one of the lowest home health utilization rates in the State and a low Medicare Advantage penetration rate. With the continued projected growth in the County's 65+ population and the increasing pressures to avoid unnecessary hospitalizations in favor of high quality, lower cost alternatives for care, it is reasonable to expect this high rate of growth in utilization to continue for the forseeable future.

The State Health Plan Chapter takes the approach of regulating HHA services by emphasizing

[4]Source: 2014 Medicare Data provided by Healthcare Market Resources (healthmr.com); 2015 Medicare population data from CMS.gov; 2014 65+ population data and 2019 estimates from Tetrad.

the importance of providing consumers with meaningful choices for obtaining high quality services, in which one HHA or a small number of HHAs do not command overwhelming dominance. The Chapter recognizes the great flexibility home health agencies have to expand or contract their service capacity and production expenses to fit the level of demand they are experiencing, but rejects this as an approach to determine whether to open up new HHA and HHA expansion opportunities in a jurisdiction in favor of an approach based on ensuring consumer choice of high quality providers in which better performance by HHAs is encouraged by development and expansion opportunities. Ensuring consumer choice and better performance through competition in Frederick County is even more important as the need for and utilization of HHA services continue to grow.

10.24.01.08G(3)(c). The "Availability of More Cost-Effective Alternatives" Review Criterion

The Commission shall compare the cost-effectiveness of the proposed project with the cost-effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly and/or a more effective alternative for meeting the needs identified than other types of projects or approaches that could be developed for meeting those same needs or most of the needs.

A clear statement of project objectives should be outlined. Alternative approaches to meeting these objectives should be fully described. The effectiveness of each alternative in meeting the project objectives should be evaluated and the cost of each alternative should be estimated.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project that will assure the quality of care to be provided. These may include, but are not limited to: meeting quality measures and performance benchmarks established by the Commission; meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics the Commission should take into account.

Applicant Response:

This project involves expanding the home health agency services of the Applicant, an existing parent home health agency located in Carroll County, into Frederick County and establishing a branch office there. The State Health Plan methodology recognizes a need for additional HHA competition in Frederick County in order to provide consumers with "meaningful choices for obtaining high quality services in which one HHA or a small number of HHAs do not command overwhelming dominance." COMAR 10.24.16.03B. The only way to accomplish this objective is to authorize additional high quality HHAs in Frederick County that meet the other requirements of the Chapter, as the Applicant believes that it does.

Further, this project involves a branch office that will operate under the Applicant's Medicare provider number and share administration, supervision and services with the parent, so it represents a more efficient, cost effective approach to providing consumers with additional

choices in Frederick County as compared to establishing a parent HHA or subunit.

Home health care is a highly cost effective care setting as compared to facility-based care, such as skilled nursing facilities, long term acute facilities and emergency departments. For example, according to Medicare claims data from 2014, the average Medicare expense per case in a skilled nursing facility was more than twice the average Medicare expense per case in the home health setting ($11,695 vs. $5,301). As described in the Need section above, Frederick County has one of the lowest home health utilization rates in the State. With this project, the Applicant has a 23-person marketing team in the State with which it will actively educate and market in the Frederick County community to increase the home health utilization rate and thereby reduce health care costs.

Through this project, Amedisys seeks to expand its footprint in the state of Maryland in order to generate increased organic growth and enhance its recognition and stability in the Maryland market as a provider of high quality home health services. The Applicant identified Frederick County for expansion based on the market potential associated with (1) its low home health utilization rate, and (2) the projected growth in its 65+ population outpacing most of the rest of the state. Additionally, the limited competition that currently exists in Frederick County enhances its market potential, particularly for high quality providers like the Applicant since limited competition lowers quality. As evidence that limited competition is associated with lower quality, 2012 Medicare claims data indicate that Frederick County had the second highest home care hospitalization rate in the State. As the State Health Plan recognizes, performance and quality improve in more competitive markets. The proposed project is a cost effective way to introduce additional HHA competition in Frederick County to increase home health utilization, drive down health care costs, and improve quality.

Home health care can reduce hospital admissions and improve population health and independence. Being that the hospitalization rate for Frederick Country was the second worst in the state of Maryland in 2012, the Applicant plans to use its substantial, experienced marketing team to increase the knowledge of the community as well as potential referral sources that home health is a cost effective level of care and alternative to higher cost settings including, but not limited to skilled nursing facilities (SNFs), long term acute care facilities (LTACs), and emergency departments (EDs). Through these efforts, the Applicant intends to increase home health utilization and ultimately decrease the cost of health care for Frederick County residents.

The Applicant is accredited by the Accreditation Commission for Health Care (ACHC),which found that the Applicant operates at a level of "quality, integrity and effectiveness" consistent with its high standards. **See Exhibit 21**. Further, the Applicant has a proven quality track record with exceptional quality scores and HHCAPS. Currently, the Applicant is a 4 STAR care center with multiple metrics being 4.5 STARs as well as 5 STARs. CMS's 3-month preview of the Applicant's scoring for July 2017 showed the Applicant at 4.5 STARs.

Further, as described above, with the depth of experience and resources that come from being part of a leading national home health care company, we are able to offer several evidence-based clinical programs to our clients that can help to improve outcomes and reduce hospital admissions. These evidence-based clinical programs are described in Part 1 above in the Project Description, which is incorporated herein by reference.

10.24.01.08G(3)(d). The "Viability of the Proposal" Review Criterion.
The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part IV, Table 1 B. Sources of Funds for Project, must be documented.

Applicant Response:

Please refer to **Exhibit 14** and **Exhibit 15** for the 2015 and 2016 Annual Reports of Amedisys, Inc. (the Applicant's ultimate parent company) which includes its audited financial statements for those years.

b. **Existing home health agencies shall provide an analysis of the probable impact of the project on its costs and charges for the services it provides**. Non-home health agency applicants should address the probable impact of the project on the costs and charges for core services they provide.

Applicant Response:

The impact of the project on the Applicant's costs are shown in Table 3. No impact on the Applicant's charges are expected because the charges for home health services are largely driven by Medicare payment rates and commercial payer contracting.

c. A discussion of the probable impact of the project on the cost and charges for similar services provided by other home health agencies in the area.

Applicant Response:

The project is not expected to have any impact on the cost and charges provided by other home health agencies in the area. As stated above, the charges for home health services are largely driven by Medicare and commercial payer contracting.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

Applicant Response:

Please refer to **Exhibit 16**.

e. A discussion of the staffing and workforce implications of this proposed project, including:

- An assessment of the sources available for recruiting additional personnel;
- A description of your plans for recruitment and retention of personnel believed to be in short supply;
- A report on the average vacancy rate and turnover rates for affected positions in the last year.
- Completion of Table 5 in the *Charts and Tables Supplement (Part IV)*.

Applicant Response:

- Recruitment efforts to fill the clinical openings projected in this Application will be handled by the Applicant. Sources available for recruiting personnel include, but ar not limited to:

  Newspaper and magazine advertising
  Attendance at job fairs and career days
  Open Houses
  Direct mailings
  Education affiliations
  Internship programs
  Word of mouth and professional relationships
  On-line professional recruitment sources

  Currently, none of the positions to be filled by the Applicant for this project are considered to be in short supply. The Applicant utilizes an internal recruitment team that utilizes market data and trends on staffing through a third party software called Liquid Compass. Through the analysis, the Applicant believes that there are enough clinicians within the market to staff the new branch effectively. The Applicant does not anticipate difficulty in recruiting new staff members or shortages in any position that would be needed for the expanded program.

- The average vacancy rate and turnover rates experienced by the Applicant in Maryland in the last year are 17%.

- Table 5 is included in Part IV.

10.24.01.08G(3)(e). The "Compliance with Conditions of Previous Certificates of Need" Review Criterion.

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

List all prior Certificates of Need that have been issued since 1990 to the project applicant or to any entity which included, as principals, persons with ownership or control interest in the project applicant. Identify the terms and conditions, if any, associated with these CON approvals and any commitments made that earned preferences in obtaining any of the CON approvals. Report on the status of the approved projects, compliance with terms and conditions of the CON approvals and commitments made.

Applicant Response:

The Applicant has not received a certificate of need (CON) in the past. However, Amedisys Maryland, LLC d/b/a Home Health Care of America (HHCA) received a CON to expand its general home health agency services into Talbot County on June 24, 2011 (Docket No, 10.20-2312). The CON was subject to a condition that HHCA provide charitable home health agency services to indigent persons in need of such services equivalent in value to 0.4% of total expenses and to document its compliance with this condition within 6 months of the close of each fiscal year. HHCA was also required to undertake outreach and public notification of the availability of charitable services. HHCA has complied with the outreach and public notification requirements as well as the annual reporting requirement. In 2013, HHCA met the 0.4% requirement, but has not met the requirement since that time. While HHCA provided charitable care in each year, it has not been able to reach the 0.4% requirement (except in 2013) in spite of its public outreach efforts, which is believed to be a result of the ACA's expansion of insurance coverage. Attached as **Exhibit 17** are the letters that HHCA submitted with its last report to the Commission demonstrating that it continues to make outreach in the community for charity care referrals.

10.24.01.08G(3)(f). The "Impact on Existing Providers" Review Criterion.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project. Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, payer mix, access to service and cost to the health care delivery system including relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions. Provide an analysis of the following impacts:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project;

b) On the payer mix of all other existing health care providers that are likely to experience some impact on payer mix as a result of this project. If an applicant for a new nursing home claims no impact on payer mix, the applicant must identify the likely source of any expected increase in patients by payer.

c) On access to health care services for the service area population that will be served by the project. (State and support the assumptions used in this analysis of the impact on access);

d) On costs to the health care delivery system.

If the applicant is an existing provider, submit a summary description of the impact of the proposed project on the applicant's costs and charges, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

a) According to the Commission's Public Use Data Set, there were 91,000 total visits in 2014 provided by 11 HHAs in Frederick County, with 86% of those visits provided by two HHAs. The approach to regulating the development of new or expanded HHAs in the State Health Plan is premised on providing consumers with "meaningful choices for obtaining high quality services in which one HHA or a small number of HHAs do not command overwhelming dominance." COMAR 10.24.16.03B The Chapter finds that consumers benefit from additional competition because "quality and performance scores improve over time in more competitive markets." COMAR 10.24.16.03B This approach to regulation not only recognizes that creating development and expansion opportunities in a jurisdiction may cause some amount of volume to shift, but has as its goal to eliminate "overwhelming dominance" by a small number of HHAs. The State Health Plan further recognizes that "since the delivery of home health agency services does not require a resource base of buildings or equipment, agencies have great flexibility in expanding or contracting their service capacity and production expenses to fit the level of demand they are experiencing." Accordingly, volume shifts in the HHA market do not raise the concerns that are raised for health care facilities with a large level of fixed costs.

The Applicant projects volume of 11,244 total visits in Frederick County in its fourth year (the first year of projected full utilization). This projected full utilization is modest and, while it would not be inconsistent with the purpose of opening up Frederick County to additional HHA competition, it is not expected to have a material impact on any existing HHAs. This expectation is reasonable in light of the large and growing 65+ population and low home health utilization rate in Frederick County, growth potential for which the existing and new HHAs can compete to develop and serve. As discussed in the Need section above, Frederick County has the 8th highest county population 65+, with the 6th highest growth rate in 65+ in the state, and has the 9th lowest home health utilization in the State.

Further, because quality and performance scores improve over time in more competitive markets, the additional competition this project would represent can benefit existing HHAs by incentivizing better performance and quality.

b) No impact on payer mix of other home health agencies is expected as a result of this project.

c) This project will positively impact access to home health care services by increasing the number of "meaningful choices for obtaining high quality services" available to home health care consumers in Frederick County. The Applicant has a proven track record with exceptional quality scores and HHCAPS. Currently, the Applicant is a 4 STAR care center with multiple metrics being 4.5 STARs or even 5 STARs. SHP, the CMS approved vendor with which the Applicant works on quality reporting, has provided a preview of the July, 2017 scoring of the Applicant at 4.5 STARs. As noted in COMAR 10.24.16.03C, competition amongst HHAs benefits consumers because research indicates that quality

and performance scores improve over time in more competitive markets.

d) The project will have a positive impact on costs to the health care delivery system. Home health care is a lower cost alternative to facility-settings including skilled nursing facilities (SNFs), long term acute care facilities (LTACs), and hospital emergency departments (EDs). As described in the Need section above, Frederick County currently underutilizes home health care services in comparison to the State as a whole and most counties; in 2014, it had the 9th lowest utilization rate, even with a growing 65+ population. The Applicant, through its marketing team, will educate the community as well as health care facilities and health care providers, about home health care as a cost effective level of care and alternative to higher cost settings in order to increase home health utilization and ultimately decrease the cost of health care for Frederick County residents.

No impact on the Applicant's charges is expected. The impact on the Applicant's costs are shown in Table 3.

PART III - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND SIGNATURE

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identity and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

Applicant Response:

Amedisys Maryland, LLC will be the owner of the project and the entity responsible for its implementation. The principal office of Amedisys Maryland, LLC is 15118 Liberty Grove, Burtonsville MD 20866. Amedisys Maryland, LLC was formed under the laws of the State of Maryland on January 1, 2005. Amedisys Maryland, LLC is 100% owned by Amedisys Holding, LLC, which is 100% owned by Amedisys, Inc. A corporate organizational chart is attached as **Exhibit 1**.

The individual who will be responsible for the implementation of the project is:

Geoffrey L. Abraskin, PT, DPT, CWS
Vice President of Operations
Northeast South Region (MD, DE, DC, VA, KY, IN, PA, WV)
Amedisys Home Health and Hospice Services
3603 Southside Ave.
Phoenix, MD 21131
(855) 214-2989
Geoffrey.abraskin@amedisys.com

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility or program? If yes, provide a listing of each facility or program, including facility name, address, and dates of involvement.

Applicant Response:

The health care facilities owned and operated by Amedisys Maryland, LLC in Maryland are listed in **Exhibit 2**.

Additionally, please refer to **Exhibit 18** for a list of all the health care facilities in the Amedisys, Inc. corporate family.

3. Has the Maryland license or certification of the applicant home health agency, or any of the facilities or programs listed in response to Questions 1 and 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on

admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owner or other person responsible for implementation of the Project was not involved with the facility or program at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

Applicant Response:

No.

4. Is any facility or program with which the applicant is involved, or has any facility or program with which the applicant or other person or entity listed in Questions 1 & 2, above, ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to an action to suspend, revoke or limit the licensure or certification at any facility or program. If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility or program, and any final disposition reached by the applicable governmental authority.

Applicant Response:

No.

Please refer to **Exhibit 19** for a description of certain matters involving Amedisys, Inc. (the Applicant's ultimate parent company). Although these matters are not responsive to this question, the Applicant is disclosing them for the Commission's information.

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or program or any health care facility or program listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

Applicant Response:

No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or authorized agent of the applicant for the proposed home health agency service.

Applicant Response:

Please refer to **Exhibit 20** for this authorization.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

5/5/2017
Date

PT, DPT, CWS
Geoffrey L. Abraskin, PT, DPT, CWS
Vice President of Operations
Northeast South Region
Amedisys Home Health and Hospice Services

Part IV: Home Health Agency Application: Charts and Tables Supplement

TABLE 1 - PROJECT BUDGET

TABLE 2A: STATISTICAL PROJECTIONS – FOR HHA SERVICES IN MARYLAND

TABLE 2B: STATISTICAL PROJECTIONS – FOR PROPOSED JURISDICTIONS

TABLE 3: REVENUES AND EXPENSES - FOR HHA SERVICES IN MARYLAND

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

TABLE 5: STAFFING INFORMATION

Existing Operations				New CON			
2015	1/1/2015	12/31/2015	Filed				
2016	1/1/2016	12/31/2016	Filed				
2017	1/1/2017	12/31/2017	current year estimated	2017	1/1/2017	12/31/2017	no activity
2018	1/1/2018	12/31/2018	estimated	2018	1/1/2018	12/31/2018	6 months pre-cert/6 months activity
2019	1/1/2019	12/31/2019	estimated	2019	1/1/2019	12/31/2019	Month 7-18 of operations
2020	1/1/2020	12/31/2020	estimated	2020	1/1/2020	12/31/2020	Month 19-30 of operations
2021	1/1/2021	12/31/2021	estimated	2021	1/1/2021	12/31/2021	Month 31-42 of operations

Assume green light for CON 1/1/2018
Certification from 1/1/2018 - 6/30/2018
Certified 7/1/2018

TABLE 1: Project Budget

A. USE OF FUNDS	
1. CAPITAL COSTS (if applicable):	
New Construction	
• Building	$
• Fixed Equipment (not included in construction)	
• Land Purchase	
• Site Preparation	
• Architect/Engineering Fees	
• Permits, (Building, Utilities, Etc)	
a. SUBTOTAL	$ -
Renovations	
• Building	$
• Fixed Equipment (not included in construction)	
• Architect/Engineering Fees	
• Permits, (Building, Utilities, Etc.)	
b. SUBTOTAL	$ -
Other Capital Costs	
• Major Movable Equipment	
• Minor Movable Equipment	
• Contingencies	
• Other (Specify)	
c. SUBTOTAL	$ -
TOTAL CURRENT CAPITAL COSTS (sum of a - c)	$ -
Non Current Capital Cost	
• Interest (Gross)	
• Inflation (state all assumptions, including time period and rate	
d. SUBTOTAL	$ -
TOTAL PROPOSED CAPITAL COSTS (sum of a - d)	$ -
2. FINANCING COST AND OTHER CASH REQUIREMENTS	
a. Loan Placement Fees	
b. Bond Discount	
c. Legal Fees (CON Related)	$ 40,000
d. Legal Fees (Other)	
e. Printing	
f. Consultant Fees CON Application Assistance	
Other (Specify)	
g. Liquidation of Existing Debt	
h. Debt Service Reserve Fund	
i. Principal Amortization Reserve Fund	

j. Other (Specify)	
TOTAL (a - j)	$ 40,000
3. WORKING CAPITAL STARTUP COSTS	$ 40,000
TOTAL USES OF FUNDS (sum of 1 - 3)	**$**
B. SOURCES OF FUNDS FOR PROJECT	
1. Cash	$ 40,000
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 (sum of 1-9)	**$ 40,000**
ANNUAL LEASE COSTS (if applicable)	
• Land	
• Building	$ 36,000.00
• Major Moveable equipment	
• Minor moveable equipment	$ 3,600.00
• Other (specify)	

TABLE 2A: STATISTICAL PROJECTIONS – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND

	Two Most Current Actual		Projected years – ending with first year at full utilization			
CY or FY (circle)	2015	2016	2017	2018	2019	2020
Client Visits						
Billable	8402	12285	14995	17284	21101	24193
Non-Billable	88	255	228	263	321	368
TOTAL	8490	12970	15223	17547	21422	24561
# of Clients and Visits by Discipline						
Total Clients (Unduplicated Count)	426	590	708	808	1065	1257
Skilled Nursing Visits	3459	5014	6015	7045	8745	10124
Home Health Aide Visits	212	1247	1301	1451	1724	1945
Physical Therapy Visits	3604	4358	5257	6092	7494	8629
Occupational Therapy Visits	1102	1942	2237	2471	2847	3153
Speech Therapy Visits	79	348	341	395	483	555
----------Medical Social Services Visits	34	61	72	93	127	155
Other Visits (Please Specify)	0	0	0	0	0	0

TABLE 2B: STATISTICAL PROJECTIONS - PROJECTED HOME HEALTH AGENCY SERVICES IN THE PROPOSED PROJECT

	Projected years – ending with first year at full utilization			
CY or FY (circle)	2018	2019	2020	2021
Client Visits				
Billable	2289	6106	9198	11075
Non-Billable	35	93	140	169
TOTAL	2324	6199	9338	11244
# of Clients and Visits by Discipline				
Total Clients (Unduplicated Count)	100	357	549	685
Skilled Nursing Visits	1030	2730	4109	4943
Home Health Aide Visits	150	423	644	782
Physical Therapy Visits	835	2237	3372	4063
Occupational Therapy Visits	234	610	916	1099
Speech Therapy Visits	54	142	214	257
----------Medical Social Services Visits	21	55	83	100
Other Visits (Please Specify)				

TABLE 3: REVENUES AND EXPENSES – HISTORIC AND PROJECTED HOME HEALTH AGENCY SERVICES IN MARYLAND (including proposed project)

	Two Most Recent Years - Actual		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2015	2016	2017	2018	2019	2020	2021
1. Revenue							
Gross Patient Service Revenue	1,655,618	2,299,024	2,664,602	2,963,425	3,770,658	4,330,535	4,837,956
Allowance for Bad Debt	-29,650	-22,263	-13,382	-16,214	-23,866	-29,173	-33,983
Contractual Allowance	-93,347	-128,298	-97,446	-110,192	-144,624	-168,505	-190,148
Charity Care	0	0	0	0	0	0	0
Net Patient Services Revenue	1,532,621	2,148,463	2,553,774	2,849,764	3,649,346	4,203,916	4,706,527
Other Operating Revenues (Specify)	0	0	0	0	0	0	0
Net Operating Revenue	1,532,621	2,148,463	2,553,774	2,837,018	3,602,168	4,132,857	4,613,825
2. Expenses							
Salaries, Wages, and Professional Fees, (including fringe benefits)	1,364,012	1,721,003	1,963,099	2,488,711	2,801,538	3,173,809	3,427,583
Contractual Services (skilled nursing)	2,360	0	0	0	0	0	0
Contractual Services (physical therapy)	108,423	215,592	307,247	315,176	331,242	344,188	352,562
Contractual Services (occupational therapy)	9,650	0	0	0	0	0	0
Contractual Services (speech therapy)	1,379	13,625	17,994	17,994	17,994	17,994	17,994
Interest on Current Debt	0	0	0	0	0	0	0
Interest on Project Debt	0	0	0	0	0	0	0
Current Depreciation	12,553	14,665	12,129	15,443	12,129	12,129	12,129
Project Depreciation	0	0	0	0	0	0	0
Current Amortization	0	0	0	0	0	0	0
Project Amortization	0	0	0	0	0	0	0
Supplies	16,455	26,455	35,645	43,198	53,788	63,221	69,106
Other Expenses (Specify)	0	0	0	0	0	0	0
- Rent/Facilities	61,852	66,452	60,943	120,483	100,717	103,038	107,100
- Advertising	5,373	10,234	10,500	12,616	13,365	14,828	15,723
- Travel/Training	20,012	27,994	28,112	36,912	39,728	45,577	49,105
- Office Supplies	9,031	12,501	13,068	16,978	18,274	20,909	22,507
- Other (phones, IT work, etc)	23,444	48,061	76,913	116,736	139,301	172,604	193,619
	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
Total Operating Expenses	1,634,544	2,156,582	2,525,650	3,184,246	3,528,077	3,968,297	4,267,429
3. Income							
Income from Operation	-101,923	-8,119	28,124	-347,228	74,091	164,560	346,396
Non-Operating Income	0	0	0	0	0	0	0
Subtotal	-101,923	-8,119	28,124	-347,228	74,091	164,560	346,396
Income Taxes	n/a – taxes paid at the corporate level and not allocated to individual agencies						
Net Income (Loss)	-101,923	-8,119	28,124	-347,228	74,091	164,560	346,396
Table 3 Cont.	**Two Most Actual Ended Recent Years**		**Current Year Projected**	**Projected Years (ending with first full year at full**			
CY or FY (Circle)	2015	2016	2017	2018	2019	2020	2021
4A. - Payor Mix as Percent of Total Revenue							

Medicare	93%	95%	92%	93%	93%	94%	94%
Medicaid/Private	5%	3%	5%	4%	4%	4%	4%
Blue Cross							
Commercial Insurance							
Self-Pay							
PPS Episodic	2%	2%	3%	3%	3%	2%	2%
TOTAL REVENUE	100%	100%	100%	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits							
Medicare	89%	93%	92%	92%	93%	93%	93%
Medicaid	2%	1%	1%	1%	1%	1%	1%
Blue Cross	Do not track for Individual Payers						
Other Commercial Insurance	7%	4%	5%	5%	4%	4%	4%
Self-Pay							
PPS Episodic	2%	2%	2%	2%	2%	2%	2%
TOTAL VISITS	100%	100%	100%	100%	100%	100%	100%

TABLE 4: REVENUES AND EXPENSES – PROJECTED HOME HEALTH AGENCY SERVICES FOR PROPOSED PROJECT

	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2018	2019	2020	2021
1. Revenue				
Gross Patient Service Revenue	298,823	1,106,056	1,665,933	2,173,354
Allowance for Bad Debt	-2,832	-10,484	-15,791	-20,601
Contractual Allowance	-12,746	-47,178	-71,059	-92,702
Charity Care				
Net Patient Services Revenue	295,990	1,095,572	1,650,142	2,152,753
Other Operating Revenues (Specify)				
Net Operating Revenue	**283,244**	**1,048,394**	**1,579,083**	**2,060,051**
2. Expenses				
Salaries, Wages, and Professional Fees, (including fringe benefits)	525,612	838,439	1,210,710	1,464,484
Contractual Services (skilled nursing)				
Contractual Services (physical therapy)	7,929	23,995	36,941	45,315
Contractual Services (occupational therapy)				
Contractual Services (speech therapy)				
Interest on Current Debt				
Interest on Project Debt				
Current Depreciation	3,314			
Project Depreciation				
Current Amortization				
Project Amortization				
Supplies	7,553	18,143	27,576	33,461
Other Expenses (Specify)				
- Rent/Facilities	59,540	39,774	42,095	46,157
- Advertising	2,116	2,865	4,328	5,223

- Travel/Training	8,800	11,616	17,465	20,993
- Office Supplies	3,910	5,206	7,841	9,439
- Other (phones, IT work, etc)	39,823	62,388	95,691	116,706
Total Operating Expenses	**658,596**	**1,002,427**	**1,442,647**	**1,741,779**
3. Income				
Income from Operation	-375,352	45,967	136,436	318,272
Non-Operating Income				
Subtotal	-375,352	45,967	136,436	318,272
Income Taxes	n/a – taxes paid at the corporate level and not allocated to individual agencies			
Net Income (Loss)	-375,352	45,967	136,436	318,272

Table 4 Cont.	**Projected Years (ending with first full year at full utilization)**			
CY or FY (Circle)	2018	2019	2020	2021
4A. - Payor Mix as Percent of Total Revenue				
Medicare	94%	94%	94%	94%
Medicaid/Private	4%	4%	4%	4%
Blue Cross				
Other Commercial Insurance				
PPS Episodic	2%	2%	2%	2%
TOTAL	100%	100%	100%	100%
4B. Payor Mix as Percent of Total Visits				
Medicare	93%	93%	93%	93%
Medicaid	1%	1%	1%	1%
Blue Cross	Do not track for individual payers			
Other Commercial Insurance	5%	4%	4%	4%
Self-Pay				
PPS Episodic	1%	2%	2%	2%
TOTAL	100%	100%	100%	100%

TABLE 5. STAFFING INFORMATION

Position Title	Current No. of FTEs		Change in FTEs (+/-)		Average Salary		TOTAL SALARY EXPENSE	
	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff	Agency Staff	Contract Staff
Administrative Personnel	3	0	0	0	$15, 339	0	$99,221	$11,609
Registered Nurse	2	0	2	0	$32,999	0		
Licensed Practical Nurse	1	0	1	0	$2,761	0		
Physical Therapist	2	1	1	0	$17,579	$11,110		
Occupational Therapist	2	0	1	0	$17,177	0		
Speech Therapist	0	0	1	0	$1,456	$499		
Home Health Aide	1	0	1	0	$1,910	0		
Medical Social Worker	0	0	1	0	0	0		
Other (Please specify.)								
						Benefits	$14,040	-
						TOTAL	$113,261	$11,609

AFFIRMATIONS

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need to expand Home Health Agency Services to Frederick County, Maryland filed by Amedisys Maryland, LLC d/b/a Amedisys Home Health, and its attachments are true and correct to the best of my knowledge, information and belief.

Dated: May 5, 2017

Loraine Bryan RN

Name:

Title:

Loraine Bryan RN
Area Vice President of
Business Development.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need to expand Home Health Agency Services to Frederick County, Maryland filed by Amedisys Maryland, LLC d/b/a Amedisys Home Health, and its attachments are true and correct to the best of my knowledge, information and belief.

Dated: May 5, 2017

Brenda Dile

Name: Brenda Dile
Title: Vice President Clinical Practice, Amedisys Home Health

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need to expand Home Health Agency Services to Frederick County, Maryland filed by Amedisys Maryland, LLC d/b/a Amedisys Home Health, and its attachments are true and correct to the best of my knowledge, information and belief.

Dated: May 5, 2017

Name: Anessa Johnson
Title: Vice President Business Development

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Application for Certificate of Need to expand Home Health Agency Services to Frederick County, Maryland filed by Amedisys Maryland, LLC d/b/a Amedisys Home Health, and its attachments are true and correct to the best of my knowledge, information and belief.

Dated: May 5, 2017

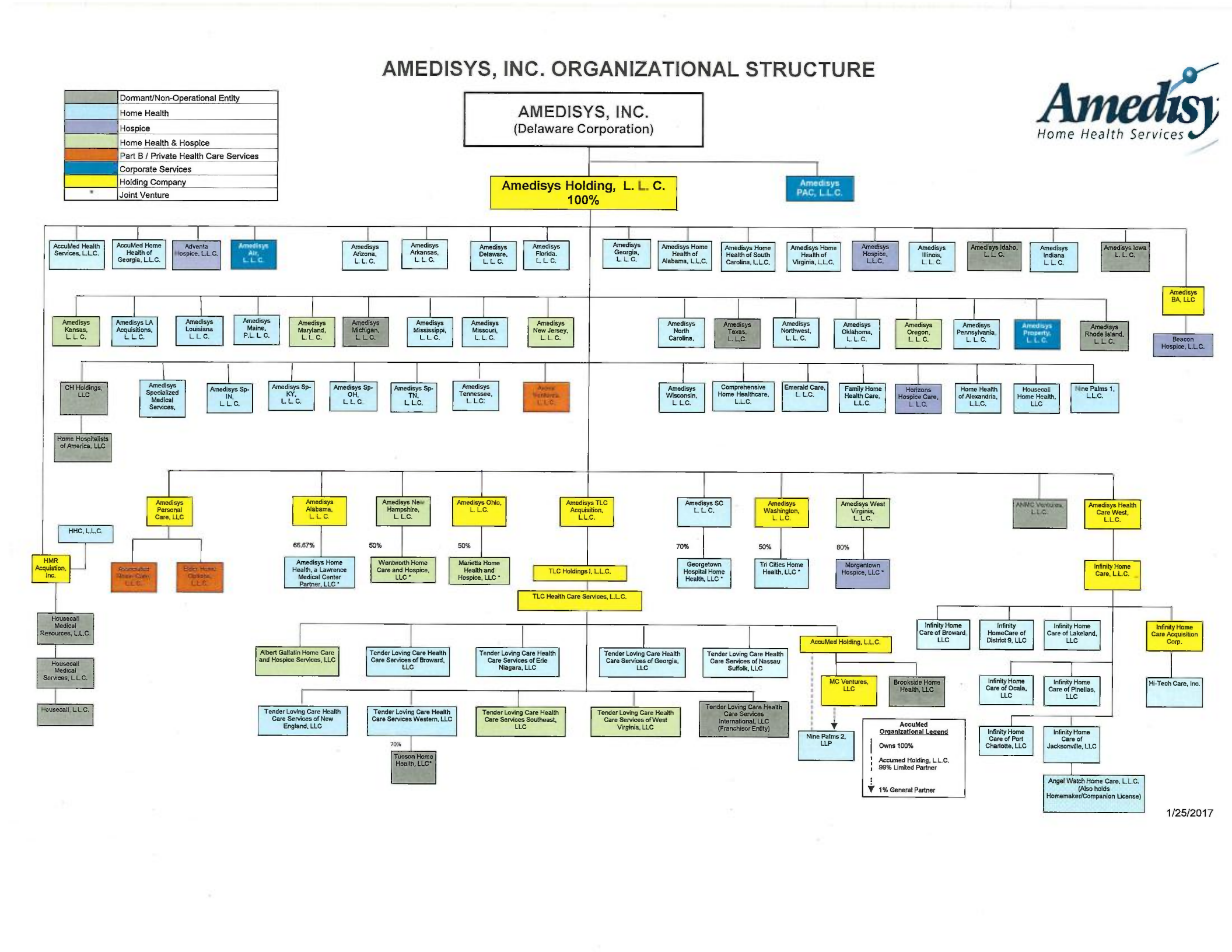
/Michelle B. Gee

Name: Michelle Gee
Title: Regional Director of Financial Operations

EXHIBITS

EXHIBIT 1

AMEDISYS, INC. ORGANIZATIONAL STRUCTURE



1/25/2017

EXHIBIT 2

Amedisys, Inc. - Active Locations

5/3/2017

Tax ID #	Status	Legal Entity Name d/b/a Agency Name Agency Address	Home Care or Hospice License #	Medicare # & Branch ID	Medicaid # & Other Provider #'s
20-1032665	*Parent	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health Care 19 Newport Drive, Suite 201 Forest Hill, MD 21050-1622 County: Harford *Relocated from Baltimore 09/09/2011*	HH7045	21-7045	Medicaid: 420716501
20-1032665	*Parent	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health Care 1401 Mercantile Lane, Suite 351 Largo, MD 20774-4315 County: Largo *(Relocated from Silver Spring eff 04/28/14 to Largo's branch's address and assumed Largo's loc code)	HH7149	21-7149	Medicaid: 420716500
20-2222985	*Parent	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 511 Jermor Lane, Suite 200 Westminster, MD 21157-6151 County: Carroll	HH7048	21-7048	Medicaid 414978500
20-2222985	*Parent	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 7106 Ridge Road, Suite 110 Rosedale, MD 21237-3876 County: Baltimore *Relocated from Baltimore, MD 10/18/11*	HH7094	21-7094A	Medicaid: 4169654 00
20-2222985	*Parent	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 811 Cromwell Park Drive, Suite 109 Glen Burnie, MD 21061-2538 County: Anne Arundel	HH7108	21-7108	Medicaid 407725300
20-2222985	*Parent	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 6512 Deer Pointe Drive, Suite B Salisbury, MD 21804-1669 County: Wicomico	HH7111	21-7111A	415927600 DE Mcd: 000045714
20-2222985	Branch	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 204 Cedar Street, Suite 101 Cambridge, MD 21613-2312 County: Dorchester	HH7111	21-7111A Branch ID: 21Q7111001	Medicaid: 415927600
20-2222985	*Parent	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 107 Chesapeake Boulevard, Suite 114 Elkton, MD 21921-6390 County: Cecil	HH7151	21-7151	Medicaid: 415928400

EXHIBIT 3

DESCRIPTION OF AMEDISYS CARE TRANSITIONS PROGRAM

Amedisys places Care Transitions Coordinators (CTCs) in acute care facilities, Senior Living Communities, and physician practices who work to ensure patients transition safely home from their prior care setting. The initial few days post-discharge are the most vulnerable for patients, particularly for the frail elderly. To guard against adverse events related to care fragmentation, the CTC becomes the patient's "touch point" for any issues between the time of discharge and the time when our nurse visits the patient's home. Once the initial connection with the patient and caregiver is made, the CTC utilizes an Amedisys proprietary tool, the *Bridge to Healthy Living* guide, to begin the process of early engagement, education and coaching. This bound notebook is personalized for each patient, with the CTC's name and 24-hour phone contact information.

The CTC identifies the patient's diagnoses, as well as social and/or economic barriers that may affect the patient's outcomes. These diagnoses are written in the tool along with a list of the patient's medications, describing what each is for and the exact dosage and instructions for each drug. Coaching focuses on the diagnoses and patient capabilities, discussing diet and lifestyle needs, as well as "red flags" about each condition.

Physician and caregiver engagement in the process of transitions is critical to reducing avoidable re-hospitalizations. Unlike prior attempts to systematically manage chronically ill patients, this health care at home, care transitions initiative is a relationship-based care delivery model, which elevates the roles of the family and informal caregivers as well as the patient.

This relationship is possible because of the clinical coordination provided by the Care Transitions Coordinator who serves as the funnel for information sharing among all providers engaged with the specific patient.

At the time of hospital discharge the care transitions initiative directs the CTC to arrange the patient's appointment with the primary care physician. The date and time for the patient's first home nursing visit would also be arranged and recorded, allowing the patient and caregiver to know exactly when to expect that visit.

On the first home nursing visit, typically carried out within 24 hours of hospital discharge, the nurse reviews the *Bridge to Healthy Living* tool and uses it to guide care in partnership with the patient, enhancing adherence to the care plan.

As part of the initial home nursing visit, an environmental assessment is completed, observing for hazards that could increase the risk for falls or other injury. Medications are reviewed and checked against the list from the hospital discharge. The home care nurse would then ask about any other medications that might be in the cabinet or the refrigerator that the patient might be taking.

At each subsequent visit, the nurse will review that medication list and adjust if physicians have changed any medication. If there has been a change, this is communicated by the Amedisys care team to all physicians caring for the patient. The home care nurse will then reinforce coaching on medications, red flags and dietary or lifestyle issues that was begun by the CTC in the hospital.

EXHIBIT 4

Comprehensive Health Care at Home.

We offer several evidence-based clinical programs that include skilled medical services, supportive services for the patient and their caregivers, and education on self-management skills.

Balanced for Life® – Falls are one of the greatest risks to people age 60 years plus. The Amedisys® Balanced for Life program is designed to provide balance training, environmental assessments for risk factors and several advanced medical assessments to help reduce the need for emergency care due to falls.

Chronic Kidney Disease @ Home – Millions of Americans have chronic kidney disease (CKD) and are not aware of it. Our Chronic Kidney Disease @ Home program provides early assessment, intervention and education on risk factors including management of high blood pressure, which is often present with CKD, diet and medication management.

COPD @ Home – This program has been carefully designed to help improve the quality of life for patients living with COPD. Our skilled home care clinicians can help with oxygen therapy, medication management and monitoring of vitals, all essential to managing COPD effectively.

Diabetes @ Home – Our Diabetes @ Home program is designed to support patients with Type 1 and Type 2 diabetes and has been recognized for excellence by the American Diabetes Association.™ Our goal is to help prevent diabetes related complications such as blindness and heart disease. Our skilled nurses help monitor and record glucose levels, advise on diet and exercise as well as help you manage insulin injections and other medications.

Empowered for Life® – Patients with psychiatric conditions have special needs. Frequently, psychiatric illness exists in tandem with physical illness requiring nursing care that is specific to both conditions. Our Empowered for Life program supports patients under psychiatric care including Alzheimer's and depression. Amedisys can provide skilled assessments of a patient's condition, administer injectable medications, provide crisis interventions and individual or family counseling.

Heart @ Home – Long-term complications from heart disease can be prevented if the patient is willing to make healthier lifestyle choices and adhere to their physician's guidance. Amedisys Home Health Care can support patients with congestive heart failure, hypertension, coronary artery disease and other heart conditions in the comfort of home. Detailed assessment and education are provided on management of medication, symptoms, mobility and other aspects of care.

Orthopedic Recovery @ Home – A combination of skilled nursing care and therapeutic rehabilitation in the home creates an excellent environment for recovery after an orthopedic surgery or injury. Our clinicians are skilled in the care of joint replacements, orthopedic injuries, and complex orthopedic disease patients. Our goal is to assist the patient in reaching the highest possible level of independence in the comfort of their home.

Pain Management @ Home – Common types of chronic pain include back pain, headaches, arthritis, cancer pain and pain resulting from injury to nerves. Pain can diminish the ability to concentrate, work, exercise, socialize and sleep, which can lead to depression, a sense of isolation and loss of self-esteem. Amedisys can help manage pain and help patients have a greater quality of life by empowering them through education and techniques.

Rehab Therapy @ Home – Amedisys has comprehensive rehabilitation therapy services including physical therapy, occupational therapy and speech therapy. Our goal is to help our patients improve their strength, mobility, balance and swallowing so they can function safely. Our rehabilitation care is often prescribed for patients with diabetes, osteoporosis, arthritis, post-operative care for hip and knee surgeries as well as other chronic conditions.

Stroke Recovery @ Home – Our stroke program focuses on rehabilitation from a stroke, managing stroke related disorders such as weakness, paralysis or dysphagia (difficulty in swallowing). Amedisys has caring clinicians who can help patients manage pain, bladder issues, depression and stress, impaired judgment, balance and coordination and memory issues. We also coach the patient and their caregivers to recognize early warning signs for stroke and how to help prevent future strokes.

Surgical Recovery @ Home – Amedisys takes a multidisciplinary approach to recovering from surgery at home. Patients can recover at home with the reassurance that their post operative care needs are being met by highly professional and skilled nurses and therapists in accordance with their physicians plan of care.

Partners in Wound Care® – Sometimes it takes more than cleansing and dressing a wound for it to heal. Wound care is frequently complicated by multiple disease conditions, making it even more significant that Amedisys implements the most current evidence-based practices, incorporates the most current techniques and uses the most advanced products to improve healing.

Not all programs available in all areas

Amedisys®
Bringing Home the Continuum of Care

For more information about Amedisys Home Health Care, please visit us at www.amedisys.com and find a Care Center near you or your loved one.

EXHIBIT 5

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

April 14, 2016

Ms. Cindy Kingsbury, Administrator
Amedisys Home Health
511 Jermor Lane, Suite 200
Westminster, MD 21157-6153

RE: HOME HEATH AGENCY LICENSE

Dear Ms. Kingsbury:

This is to acknowledge receipt of a licensure fee of $350.00 and an application to license your facility as a Home Health Agency.

The enclosed license will be in effect until June 1, 2017, unless revoked. It is your authority to operate a Home Health Agency under the Department of Health and Mental Hygiene regulations, COMAR 10.07.

This license is to be displayed in a conspicuous place, at or near the entrance, plainly visible and easily read by the public. If question arise, please contact our Office by calling (410) 402-8038.

Sincerely,

Marilyn T. Johnson for

Roslyn S. Tyson, Program Coordinator
Ambulatory Care Programs Unit
Office of Health Care Quality

cc: Ms. Cathy S. Weiss

Enclosure: **License No. HH7048**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY
SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. **HH7048**

Issued to: **Amedisys Home Health**
511 Jermor Lane, Suite 200
Westminster, MD 21157-6153

Type of Facility or Community Program: **HOME HEALTH AGENCY**

Date Issued: **June 1, 2016**

SERVICES PROVIDED:

SKILLED NURSING, HOME HEALTH AIDES, PHYSICAL & OCCUPATIONAL THERAPY, SPEECH LANGUAGE PATHOLOGY, MEDICAL SOCIAL SERVICES AND INFUSION SERVICES

AREAS SERVED:

ANNE ARUNDEL, BALTIMORE, CARROLL, HARFORD, HOWARD COUNTIES, AND BALTIMORE CITY

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: **June 1, 2017**

Patricia Tomasko May, MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 6

received
06/18/2008
MLG

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
The Public Ledger Building, Suite 216
150 S. Independence Mall West
Philadelphia, PA 19106-3499

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Northeast Consortium/ Division of Survey & Certification

June 16, 2008

Laura Hughes, Administrator
Amedisys Home Health of Westminster
511 Jermor Lane; Suite 206
Westminster, Maryland 21157-6153

Dear Ms. Hughes:

Re: CMS Certification Number: **21-7048**

This is to acknowledge the change of ownership for Amedisys Home Health of Westminster effective **June 1, 2007**. In that regard, enclosed is the fully-executed Health Insurance Benefit Agreement (CMS-1561) for this Maryland free-standing Home Health Agency (HHA).

Regulation 42 CFR 489.18 permits the existing Provider Agreement to be automatically assigned to the new ownership subject to all the terms and conditions under which it was issued.

Palmetto GBA (FI # 00380) continues to be the HHA's fiscal intermediary.

The Office for Civil Rights (OCR) will be contacting you to determine the HHA's compliance with civil rights requirements. (*Note that refusal to submit information that OCR requests from the HHA would be a basis for terminating the HHA's Provider Agreement*).

Should there be any questions, please contact *Dan Feld* of our staff at (215) 861-4279.

Sincerely,

Timothy J. Hock, Manager
Certification & Enforcement Branch

Enclosure

Monica Guidroz

From: Monica Guidroz
Sent: Tuesday, November 18, 2008 9:40 AM
To: ~Westminster5005; Laura Hughes; Teresa Ledgerwood; Jill Cannon
Cc: ~Corporate Department Supervisors; 'bdedmond@dhmh.state.md.us'; 'ccraig@dhmh.state.md.us'; Traci Rea; Tina Snyder; 'Jim Brodmerkel'; Eric Mohring; Jamie Seghers; Sherry Dukes; Charles Shipman; Andy Davis; Julie Wilson; Misty Purdom; Allison Speaks; Shannen Rouse; Brandi Jarreau; Tracy Darby; Erica Craig; Jeremy Rogers; Pat Jones; Richard Hall; Cheryl Vanhorn; Eric Bright; Dawn DeLeo; Chelsea Santone; Kim Riordan; Margie Stevens; ~Regulatory_Clinical Services; ' (fay.plofsky@HSSGLOBAL.COM)'; carwri@ocsys.com; karsmi@ocsys.com; support@hssonline.com
Subject: Medicaid Approval Received - Westminster, MD (#5005)
Attachments: 21-7048.Wesminster.McdApproval.11-18-08.pdf

Please be advised that Regulatory Services has received the attached Medicaid Approval for the Change of Ownership of the Westminster, MD home health agency effective **08/07/2008.**

Please note OASIS information is as follows **effective 08/07/2008:**

Westminster, MD

M0010 **21-7048 (Unchanged)**

M0012 **414978500**

M0016 **N (Unchanged)**

NPI **1699934968**

If you have any questions, do not hesitate to contact me. Thanks! Have a great day! ☺

Monica L. Guidroz
Director, Regulatory/Clinical Services
Acquisition Division
Amedisys, Inc.
(225) 292-2031 Ext. 3693
mguidroz@amedisys.com

"We do not stop playing because we grow old;
we grow old because we stop playing."

Tracking:

MARYLAND MEDICAL ASSISTANCE PROGRAM

NOTIFICATION OF PROVIDER / VENDOR NUMBER

DATE OF ISSUE 11/12/08

4149785000
PROVIDER / VENDOR NUMBER

Home Health
TYPE PROVIDER / SPECIALTY

Amedisys Home Hlth of Westminster
5959 S. Sherwood Forest BLVD
Baton Rouge, LA 708160038
PROVIDER RECORD NAME / ADDRESS

08-07-08
SERVICE BEGIN DATE

REMARKS: ATTN: Monica Guidroz

MH-2655

EXHIBIT 7

Policy: FM-008	Date(s) Revised:	05/2017
Subject: ***Indigent and Charity***		
Applicable Service(s): Home Health	**Page:**	Page 1 of 5

PURPOSE:

- To provide a mechanism for obtaining fair reimbursement for services rendered to all patients. To provide guidelines to be considered when establishing patient eligibility for uncompensated or discounted services for uninsured or underinsured indigent and charity patients.
- To establish a framework in which uncompensated or discounted services can be given consideration and mechanisms for approval of such 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 2014, 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.

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. Approval for Indigent Care:
   - Patients meeting guidelines for consideration for indigent or charity care may be prospectively approved by the care center Director of Operations for care up to $1,000.
   - If the amount of services exceeds $5,000, the approval of the corporate office or the Senior Vice-President of Operations, or her designee, should be obtained.
   - A log of pre-approved indigent or charity patients and amount of charges for discounted services to such patient shall be maintained.
   - Indigent or charity patients are setup in HCHB with the payer code of Private INDIGENT/Charity. HCHB will automatically mark any visits as non-billable.
   - Separate accounts should be maintained for indigent or charity patients and a patient should not be included in one of these accounts and also in a bad debt accounting category. A patient whose accounts have been placed in a bad debt category or other accounting classification may have his or her charges moved to an indigent or charity account if his income level is determined to qualify for such status at any time prior to legal action being taken against such person.
   - 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.
   - Changes in billing or payment practices by an insurer or governmental payer that render a patient ineligible for coverage by such payer may be considered in determining if a patient qualifies for a full or partial discount under this policy.
7. Reporting of Indigent/Charity Care:
   - Where Amedisys has made a minimum indigent/charity care commitment as part of a certificate of need application, indigent and charity care provided by the Company should be credited to the various, respective commitments and reported to the applicable state regulatory agency.
   - In the event that indigent/charity care provided by Amedisys, has not been previously allocated or reported, it may be carried over and applied to subsequent commitment periods.

   Income Document Verification

   Income Document Attestation

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:
A determination of probable eligibility for charity care and/or reduced fees will be made within two business days after the request is made.

Maryland Sliding Fee Scale
The charitable patient must have an income level less 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%

Maryland Time Payment Plan
A patient who qualifies for a discounted fee under this policy may request to pay billed charges over time. We ask for a minimum of $25 per month with the balance being resolved within 1 year from start-of-care.

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 8

[AMEDISYS HOME HEALTH LOGO]

FINANCIAL ASSISTANCE POLICY

Amedisys Home Health provides home health care to residents of Frederick County. Amedisys Home Health is committed to providing accessible home health care to its community. Home health care is available to all patients regardless of their race, color, national origin, gender or ability to pay. Amedisys offers financial assistance to qualified residents of Frederick County who are unable to pay for its services and who apply for financial assistance under the program. Eligibility for financial assistance is determined on an individual basis based on income, as explained in the Financial Assistance Policy. If you have any questions about Amedisys' Financial Assistance Policy, please contact us at _____ or visit our website to review the Financial Assistance Policy at: _____.

EXHIBIT 9

Referral Source Name		2015	2016
Brinton Woods Nursing and Rehab Br0022147	Episodic	30	29
	Non-Episodic	4	2
Brinton Woods Nursing and Rehab Br0022147 Total		**34**	**31**
Carroll Hospital Center Ca0000750	Episodic	25	43
	Non-Episodic	2	2
Carroll Hospital Center Ca0000750 Total		**27**	**45**
Lorien Taneytown, Inc Lo0000379	Episodic	19	46
	Non-Episodic	0	1
Lorien Taneytown, Inc Lo0000379 Total		**19**	**47**
Carroll Lutheran Village Ca0000754	Episodic	10	24
	Non-Episodic	0	2
Carroll Lutheran Village Ca0000754 Total		**10**	**26**
Future Care Cherrywood Fu0000023	Episodic	1	26
	Non-Episodic	1	2
Future Care Cherrywood Fu0000023 Total		**2**	**28**
Howard County General Hospital Ho0112047	Episodic	7	14
	Non-Episodic	6	1
Howard County General Hospital Ho0112047 Total		**13**	**15**
Fairhaven, Inc. Fa0011140	Episodic	14	14
	Non-Episodic	1	0
Fairhaven, Inc. Fa0011140 Total		**15**	**14**
Ellicott City Health and Rehab Center Acccca001fzi	Episodic	0	10
	Non-Episodic	0	2
Ellicott City Health and Rehab Center Acccca001fzi Total		**0**	**12**
Oakwood Manor Acccca005v40	Episodic	11	16
	Non-Episodic	1	1
Oakwood Manor Acccca005v40 Total		**12**	**17**
Baltimore Va Medical Center Ba0040576	Episodic	8	14
	Non-Episodic	0	3
Baltimore Va Medical Center Ba0040576 Total		**8**	**17**
Saint Agnes Hospital Sa0011436	Episodic	10	4
	Non-Episodic	4	0
Saint Agnes Hospital Sa0011436 Total		**14**	**4**
Transitions Healthcare At Sykesvill Tr0001239	Episodic	9	10
	Non-Episodic	1	1
Transitions Healthcare At Sykesvill Tr0001239 Total		**10**	**11**
Charlestown Care Center Ch0013577	Episodic	12	6
Charlestown Care Center Ch0013577 Total		**12**	**6**
Baltimore Washington Medical Cente Ba0040422	Episodic	8	8
Baltimore Washington Medical Cente Ba0040422 Total		**8**	**8**
Lorien Elkridge Rehab Lo0000457	Episodic	1	8
Lorien Elkridge Rehab Lo0000457 Total		**1**	**8**
Mahmood, Tariq	Episodic	1	6
Mahmood, Tariq Total		**1**	**6**

Sinai Hospital of Baltimore Si0000113	Episodic	8	5
Sinai Hospital of Baltimore Si0000113 Total		**8**	**5**
Keswick Multi-Care Center Ke0011201	Episodic	7	4
	Non-Episodic	1	0
Keswick Multi-Care Center Ke0011201 Total		**8**	**4**
Copper Ridge Co0011673	Episodic	2	10
Copper Ridge Co0011673 Total		**2**	**10**
Golden Living Center- Westminster Go0000332	Episodic	3	3
	Non-Episodic	2	0
Golden Living Center- Westminster Go0000332 Total		**5**	**3**
Envoy Of Pikesville En0000029	Episodic	5	6
Envoy Of Pikesville En0000029 Total		**5**	**6**
Manorcare Health Services - Ruxton Ma0010521	Episodic	4	7
Manorcare Health Services - Ruxton Ma0010521 Total		**4**	**7**
Johns Hopkins Hospital	Episodic	0	1
	Non-Episodic	0	1
Johns Hopkins Hospital Total		**0**	**2**
Kuo, Wilbur	Episodic	2	6
Kuo, Wilbur Total		**2**	**6**
Lazris, Andrew	Episodic	0	5
Lazris, Andrew Total		**0**	**5**
Mercy Medical Center Inc Me0012794	Episodic	3	4
	Non-Episodic	1	1
Mercy Medical Center Inc Me0012794 Total		**4**	**5**
Lorien Mt Airy Acccca001fzu	Episodic	0	6
Lorien Mt Airy Acccca001fzu Total		**0**	**6**
Middleton, John	Episodic	3	6
Middleton, John Total		**3**	**6**
Golden Crest Assisted Living-Albert Rill Acccca005	Episodic	4	3
	Non-Episodic	1	0
Golden Crest Assisted Living-Albert Rill Acccca005 Total		**5**	**3**
Holmes, Kharia J	Episodic	7	1
Holmes, Kharia J Total		**7**	**1**
Greater Baltimore Medical Center Gr0003055	Episodic	4	2
Greater Baltimore Medical Center Gr0003055 Total		**4**	**2**
The Johns Hopkins Hospital Th0011829	Episodic	4	1
	Non-Episodic	2	1
The Johns Hopkins Hospital Th0011829 Total		**6**	**2**
Johns Hopkins Bayview Medical Cente Jo0000375	Episodic	1	5
	Non-Episodic	1	1
Johns Hopkins Bayview Medical Cente Jo0000375 Total		**2**	**6**
Augsburg Lutheran Home Au0001180	Episodic	6	1
Augsburg Lutheran Home Au0001180 Total		**6**	**1**
University of Maryland Medical Cent Un0021324	Episodic	1	2
	Non-Episodic	0	1
University of Maryland Medical Cent Un0021324 Total		**1**	**3**
Vento, Thomas J	Episodic	3	3

Vento, Thomas J Total		**3**	**3**
Gunawardane, Ruwani	Episodic	1	4
Gunawardane, Ruwani Total		**1**	**4**
Ryberg, Tracie L	Episodic	5	1
Ryberg, Tracie L Total		**5**	**1**
Golden Living Center - Frederick Go0000331	Episodic	0	4
Golden Living Center - Frederick Go0000331 Total		**0**	**4**
Northwest Hospital Center No0011343	Episodic	1	4
Northwest Hospital Center No0011343 Total		**1**	**4**
Shangri La Alf Acccca001fzc	Episodic	0	3
Shangri La Alf Acccca001fzc Total		**0**	**3**
Longview Nsg. Home Lo0000371	Episodic	3	3
Longview Nsg. Home Lo0000371 Total		**3**	**3**
Northwest Hosp. Ctr. Sub. Unit No0011346	Episodic	3	3
Northwest Hosp. Ctr. Sub. Unit No0011346 Total		**3**	**3**
Kernan Hospital Ke0011249	Episodic	4	2
Kernan Hospital Ke0011249 Total		**4**	**2**
Va Medical Center Va0000557	Episodic	4	0
	Non-Episodic	0	1
Va Medical Center Va0000557 Total		**4**	**1**
Country Companions Assisted Living	Episodic	4	1
Country Companions Assisted Living Total		**4**	**1**
Adu-Sarkodie, Nana Yaw	Episodic	0	3
	Non-Episodic	0	1
Adu-Sarkodie, Nana Yaw Total		**0**	**4**
Kass, Robert	Episodic	1	4
Kass, Robert Total		**1**	**4**
Freiji, Khalil	Episodic	1	3
Freiji, Khalil Total		**1**	**3**
New Life Alf Acccca004ze4	Episodic	0	1
New Life Alf Acccca004ze4 Total		**0**	**1**
ALMOST HOME ASSISTED LIVING - MAIN	Episodic	5	0
ALMOST HOME ASSISTED LIVING - MAIN Total		**5**	**0**
Ali Khan, Abeda	Episodic	2	2
Ali Khan, Abeda Total		**2**	**2**
Pansuriya, Maganbhai	Episodic	1	2
Pansuriya, Maganbhai Total		**1**	**2**
Mendoza, Ernesto	Episodic	0	2
Mendoza, Ernesto Total		**0**	**2**
Brewster, Kevin	Episodic	1	1
Brewster, Kevin Total		**1**	**1**
Ellicott City Health & Rehabilitati	Episodic	0	4
Ellicott City Health & Rehabilitati Total		**0**	**4**
Saint Joseph Medical Center Sa0011435	Episodic	1	3
Saint Joseph Medical Center Sa0011435 Total		**1**	**3**
Levine, Jerry	Episodic	4	0
Levine, Jerry Total		**4**	**0**

Walter Reed Army Medical Center Wa0022429	Episodic	4	0
Walter Reed Army Medical Center Wa0022429 Total		**4**	**0**
Bogdaschewskyi, Alexander	Episodic	1	3
Bogdaschewskyi, Alexander Total		**1**	**3**
Goedeke, Rebecca	Episodic	1	0
Goedeke, Rebecca Total		**1**	**0**
Wah, John	Episodic	0	3
Wah, John Total		**0**	**3**
Union Memorial Hospital Un0021325	Episodic	1	2
Union Memorial Hospital Un0021325 Total		**1**	**2**
Friends Nursing Home Fr0001242	Episodic	2	1
Friends Nursing Home Fr0001242 Total		**2**	**1**
Shapiro, Andrew	Episodic	1	2
Shapiro, Andrew Total		**1**	**2**
Kim, Soon	Episodic	0	2
Kim, Soon Total		**0**	**2**
Prada, Gary	Episodic	1	0
	Non-Episodic	1	1
Prada, Gary Total		**2**	**1**
Holly Hill Nursing And Rehabilitati Ho0112050	Episodic	3	0
Holly Hill Nursing And Rehabilitati Ho0112050 Total		**3**	**0**
Upper Chesapeake Medical Center Up0000023	Episodic	2	1
Upper Chesapeake Medical Center Up0000023 Total		**2**	**1**
Ruzbarsky, Philip	Episodic	1	1
	Non-Episodic	0	0
Ruzbarsky, Philip Total		**1**	**1**
St Elizabeth Rehab & Nsg Ce St0111909	Episodic	2	0
St Elizabeth Rehab & Nsg Ce St0111909 Total		**2**	**0**
Schiffman, Amy	Episodic	0	2
Schiffman, Amy Total		**0**	**2**
University of Maryland Rehab & Ortho Inst	Episodic	0	0
University of Maryland Rehab & Ortho Inst Total		**0**	**0**
Patuxent River Health and Rehabilit Pa0100422	Episodic	0	1
Patuxent River Health and Rehabilit Pa0100422 Total		**0**	**1**
Geller, Steven	Episodic	0	2
Geller, Steven Total		**0**	**2**
GOLDEN CREST ASSISTED LIVING-NELSON	Episodic	0	1
GOLDEN CREST ASSISTED LIVING-NELSON Total		**0**	**1**
Gorbaty, Elliott	Episodic	1	2
Gorbaty, Elliott Total		**1**	**2**
Brockington Iii, Mcneal	Episodic	1	2
Brockington Iii, Mcneal Total		**1**	**2**
Waugh Chapel Wa0022437	Episodic	0	2
Waugh Chapel Wa0022437 Total		**0**	**2**
Hidden Treasures Assisted Living	Episodic	2	1
Hidden Treasures Assisted Living Total		**2**	**1**
Shady Grove Adventist Hospital Sh0011247	Non-Episodic	2	1

Shady Grove Adventist Hospital Sh0011247 Total		**2**	**1**
McConnell, William	Episodic	3	0
McConnell, William Total		**3**	**0**
Suburban Hospital Su0000436	Episodic	2	0
Suburban Hospital Su0000436 Total		**2**	**0**
U, Nilar	Episodic	0	2
U, Nilar Total		**0**	**2**
Sabapathi, Ramesh	Episodic	2	0
Sabapathi, Ramesh Total		**2**	**0**
Sinai	Episodic	1	1
Sinai Total		**1**	**1**
Kaplan, Harry	Episodic	1	1
Kaplan, Harry Total		**1**	**1**
Linthicum, William	Episodic	0	0
Linthicum, William Total		**0**	**0**
Hammond, Jason	Episodic	0	1
	Non-Episodic	0	1
Hammond, Jason Total		**0**	**2**
Dua, Rajiv	Episodic	0	1
	Non-Episodic	0	0
Dua, Rajiv Total		**0**	**1**
Golden Crest Assisted Living	Episodic	0	2
Golden Crest Assisted Living Total		**0**	**2**
Rothstein, Jeffrey	Episodic	1	1
Rothstein, Jeffrey Total		**1**	**1**
Robins, William	Episodic	0	2
Robins, William Total		**0**	**2**
Good Samaritan Hospital Go0000329	Episodic	0	2
Good Samaritan Hospital Go0000329 Total		**0**	**2**
Gentiva	Episodic	1	1
Gentiva Total		**1**	**1**
Diener, Steven	Episodic	0	1
Diener, Steven Total		**0**	**1**
Abel, John	Episodic	0	1
Abel, John Total		**0**	**1**
Babkes, Richard R	Episodic	1	1
Babkes, Richard R Total		**1**	**1**
Forest Hill Fo0001182	Episodic	1	1
Forest Hill Fo0001182 Total		**1**	**1**
Ghiaur, Elena D	Episodic	0	2
Ghiaur, Elena D Total		**0**	**2**
Leichtling, David	Episodic	0	2
Leichtling, David Total		**0**	**2**
Gu, Jin	Episodic	0	2
Gu, Jin Total		**0**	**2**
Cherry Lane Nursing Center Acccca001f3j	Episodic	0	1
Cherry Lane Nursing Center Acccca001f3j Total		**0**	**1**

Tampus, Greg	Episodic	0	2
Tampus, Greg Total		**0**	**2**
Sun Valley Assisted Living Acccca005i3b	Episodic	0	1
Sun Valley Assisted Living Acccca005i3b Total		**0**	**1**
Oh, Sangjin	Episodic	1	1
Oh, Sangjin Total		**1**	**1**
Lorien Health Systems - Columb Lo0000373	Episodic	1	1
Lorien Health Systems - Columb Lo0000373 Total		**1**	**1**
Levindale Hebrew Ger Ctr Snf Le0000770	Episodic	1	1
Levindale Hebrew Ger Ctr Snf Le0000770 Total		**1**	**1**
Kroopnick, Robert B	Episodic	2	0
Kroopnick, Robert B Total		**2**	**0**
McEvoy, Michael	Episodic	1	0
McEvoy, Michael Total		**1**	**0**
Pallan, Elizabeth	Episodic	0	2
Pallan, Elizabeth Total		**0**	**2**
Bel Air Health and Rehabilitation Be0001278	Episodic	0	2
Bel Air Health and Rehabilitation Be0001278 Total		**0**	**2**
Heartlands At Ellicott City Alf	Episodic	0	2
Heartlands At Ellicott City Alf Total		**0**	**2**
Bayleigh Chase	Episodic	2	0
Bayleigh Chase Total		**2**	**0**
Tate, Jason	Episodic	1	0
Tate, Jason Total		**1**	**0**
Walter Reed Military Medical Center Wa0022431	Episodic	1	1
Walter Reed Military Medical Center Wa0022431 Total		**1**	**1**
Frederick Villa Nursing Center Fr0001241	Episodic	0	1
Frederick Villa Nursing Center Fr0001241 Total		**0**	**1**
Summit Park Health and Rehabilitati Su0000437	Episodic	0	1
Summit Park Health and Rehabilitati Su0000437 Total		**0**	**1**
Future Care Old Court Fu0000019	Episodic	0	2
Future Care Old Court Fu0000019 Total		**0**	**2**
Gupta, Devika P	Episodic	1	0
	Non-Episodic	1	0
Gupta, Devika P Total		**2**	**0**
Maragakis, Nicholas John	Episodic	2	0
Maragakis, Nicholas John Total		**2**	**0**
Layhill Center La0011536	Episodic	1	1
Layhill Center La0011536 Total		**1**	**1**
Atlantic General Hospital At0000176	Episodic	1	1
Atlantic General Hospital At0000176 Total		**1**	**1**
Manorcare Health Services -Towson Ma0010514	Episodic	1	1
Manorcare Health Services -Towson Ma0010514 Total		**1**	**1**
George Washington Univ Hospital Ge0123328	Episodic	0	1
George Washington Univ Hospital Ge0123328 Total		**0**	**1**
Weiss, Howard D	Episodic	0	1
Weiss, Howard D Total		**0**	**1**

Silber, David A	Episodic	0	1
Silber, David A Total		**0**	**1**
Deborja, Christopher	Episodic	0	0
Deborja, Christopher Total		**0**	**0**
Multi-Medical Center Mu0000036	Episodic	0	1
Multi-Medical Center Mu0000036 Total		**0**	**1**
Eren, Fer	Episodic	0	1
Eren, Fer Total		**0**	**1**
Rahnama, Mohammad	Episodic	0	1
Rahnama, Mohammad Total		**0**	**1**
Izzi, Stephan	Episodic	0	1
Izzi, Stephan Total		**0**	**1**
SUN VALLEY ASSISTED LIVING-THE MEADOWS	Episodic	0	1
SUN VALLEY ASSISTED LIVING-THE MEADOWS Total		**0**	**1**
Kennedy Kreiger Institute Adult Outpatient Clinic	Episodic	0	1
Kennedy Kreiger Institute Adult Outpatient Clinic Total		**0**	**1**
Jari, Rajesh	Episodic	1	0
Jari, Rajesh Total		**1**	**0**
Chacko, Binu	Episodic	1	0
Chacko, Binu Total		**1**	**0**
Margolis, John	Episodic	1	0
Margolis, John Total		**1**	**0**
Cranberry Cottage 4 Acccca001i13	Episodic	0	0
Cranberry Cottage 4 Acccca001i13 Total		**0**	**0**
Spa Creek Center Sp0000276	Episodic	0	1
Spa Creek Center Sp0000276 Total		**0**	**1**
Mehta, Piyush	Episodic	1	0
Mehta, Piyush Total		**1**	**0**
Providence Hospital Pr0022166	Non-Episodic	0	1
Providence Hospital Pr0022166 Total		**0**	**1**
Hosain, Syed	Episodic	1	0
Hosain, Syed Total		**1**	**0**
Hashmi, Zeenat	Episodic	0	0
Hashmi, Zeenat Total		**0**	**0**
Rudikoff, Michael	Episodic	1	0
Rudikoff, Michael Total		**1**	**0**
Fairland Center Fa0011139	Episodic	1	0
Fairland Center Fa0011139 Total		**1**	**0**
Perez-Mera, Rafael	Episodic	0	1
Perez-Mera, Rafael Total		**0**	**1**
Ochaney, Mahesh	Episodic	0	1
Ochaney, Mahesh Total		**0**	**1**
Awan, Mateen	Episodic	0	1
Awan, Mateen Total		**0**	**1**
Genesis Healthcare - Heritage Center	Non-Episodic	1	0
Genesis Healthcare - Heritage Center Total		**1**	**0**
Jackson, Mercy P	Episodic	0	1

Jackson, Mercy P Total		**0**	**1**
Overlea Health and Rehabilitation C Ov0000011	Episodic	1	0
Overlea Health and Rehabilitation C Ov0000011 Total		**1**	**0**
Forthman, Christopher L	Episodic	1	0
Forthman, Christopher L Total		**1**	**0**
Saway, William	Episodic	1	0
Saway, William Total		**1**	**0**
Eversley, Steven	Episodic	0	0
Eversley, Steven Total		**0**	**0**
Moore, Parry	Episodic	0	0
Moore, Parry Total		**0**	**0**
Kushner, Jonathan	Episodic	1	0
Kushner, Jonathan Total		**1**	**0**
Lorien Nursing & Rehab Belair - 223353	Episodic	0	0
Lorien Nursing & Rehab Belair - 223353 Total		**0**	**0**
Veterans Administration Baltimore Acccca002kn4	Episodic	0	1
Veterans Administration Baltimore Acccca002kn4 Total		**0**	**1**
Williams, Kenneth	Episodic	1	0
Williams, Kenneth Total		**1**	**0**
Cheng, Peter	Episodic	0	1
Cheng, Peter Total		**0**	**1**
Nelms, Justin	Episodic	1	0
Nelms, Justin Total		**1**	**0**
Moss, Robert	Episodic	0	0
Moss, Robert Total		**0**	**0**
Arden Courts of Pikesville	Episodic	2	0
Arden Courts of Pikesville Total		**2**	**0**
Reddy, Anuradha	Episodic	1	0
Reddy, Anuradha Total		**1**	**0**
Greenway Manor - ALF	Episodic	1	0
Greenway Manor - ALF Total		**1**	**0**
Mackrell, Peter J	Episodic	0	1
Mackrell, Peter J Total		**0**	**1**
SUN VALLEY ASSISTED LIVING-HOMESTEAD	Episodic	1	0
SUN VALLEY ASSISTED LIVING-HOMESTEAD Total		**1**	**0**
Desai, Ujwala	Episodic	1	0
Desai, Ujwala Total		**1**	**0**
Randallstown Center Ra0000098	Episodic	1	0
Randallstown Center Ra0000098 Total		**1**	**0**
Bullock, Eddye J	Episodic	1	0
Bullock, Eddye J Total		**1**	**0**
Holy Cross Hospital Ho0112046	Episodic	0	1
Holy Cross Hospital Ho0112046 Total		**0**	**1**
Oakleaf Manor North Acccca002z7d	Episodic	0	1
Oakleaf Manor North Acccca002z7d Total		**0**	**1**
Naganna, Gourishankar C	Episodic	1	0
Naganna, Gourishankar C Total		**1**	**0**

Price, Michelle	Episodic	0	1
Price, Michelle Total		**0**	**1**
Durry, Michael	Episodic	0	0
Durry, Michael Total		**0**	**0**
Manor Care Health Services Pike Creek Acccca0031dg	Episodic	1	0
Manor Care Health Services Pike Creek Acccca0031dg Total		**1**	**0**
Messiah Village Me0012994	Episodic	0	1
Messiah Village Me0012994 Total		**0**	**1**
Papoi, Benjamin F	Episodic	1	0
Papoi, Benjamin F Total		**1**	**0**
Thakor, Ruchira N	Episodic	0	1
Thakor, Ruchira N Total		**0**	**1**
Dlhosh, Sharon	Episodic	0	1
Dlhosh, Sharon Total		**0**	**1**
Rockville Nursing Home Ro0011343	Episodic	0	1
Rockville Nursing Home Ro0011343 Total		**0**	**1**
Panikar, Mini	Episodic	0	0
Panikar, Mini Total		**0**	**0**
Transitional Care Services At Mercy Tr0001241	Episodic	0	1
Transitional Care Services At Mercy Tr0001241 Total		**0**	**1**
Bustillo, Jorge	Episodic	1	0
Bustillo, Jorge Total		**1**	**0**
Kheterpal, Pankaj	Episodic	1	0
Kheterpal, Pankaj Total		**1**	**0**
Badder, Elliott M	Episodic	1	0
Badder, Elliott M Total		**1**	**0**
Laiken, Stephen	Episodic	0	1
Laiken, Stephen Total		**0**	**1**
Manorcare Health Services - Woodbri Ma0010527	Episodic	0	1
Manorcare Health Services - Woodbri Ma0010527 Total		**0**	**1**
Stahl, Alan	Episodic	0	1
Stahl, Alan Total		**0**	**1**
Peninsula Regional Medical Ctr Snf Pe0012439	Episodic	0	1
Peninsula Regional Medical Ctr Snf Pe0012439 Total		**0**	**1**
Vaughn, Julie	Episodic	0	1
Vaughn, Julie Total		**0**	**1**
Powerback Rehab Br0022146	Episodic	1	0
Powerback Rehab Br0022146 Total		**1**	**0**
Reaven, Laura	Episodic	1	0
Reaven, Laura Total		**1**	**0**
Patel, Alkesh	Episodic	0	0
Patel, Alkesh Total		**0**	**0**
Eyer, Michael	Episodic	0	1
Eyer, Michael Total		**0**	**1**
Caton Manor Ca0000752	Non-Episodic	0	1
Caton Manor Ca0000752 Total		**0**	**1**
Mathew, Abraham	Episodic	1	0

Mathew, Abraham Total		**1**	**0**
Wright, Ernestine	Episodic	1	0
Wright, Ernestine Total		**1**	**0**
Rollo, Vincent J	Episodic	0	1
Rollo, Vincent J Total		**0**	**1**
Courtland Gardens Nursing & Rehab Co0011671	Episodic	0	1
Courtland Gardens Nursing & Rehab Co0011671 Total		**0**	**1**
Zooker, Chad	Episodic	0	1
Zooker, Chad Total		**0**	**1**
Magnolia Center Ma0010522	Episodic	1	0
Magnolia Center Ma0010522 Total		**1**	**0**
Gold, Craig L	Episodic	1	0
Gold, Craig L Total		**1**	**0**
Fairfield Nursing & Rehabilitation Fi0000026	Episodic	0	1
Fairfield Nursing & Rehabilitation Fi0000026 Total		**0**	**1**
Schneider, Jeffrey A	Episodic	1	0
Schneider, Jeffrey A Total		**1**	**0**
Michelson, Elyse L	Episodic	0	1
Michelson, Elyse L Total		**0**	**1**
Lorien Bulle Rock Lo0000458	Non-Episodic	0	1
Lorien Bulle Rock Lo0000458 Total		**0**	**1**
Cadbury At Lewes	Episodic	1	0
Cadbury At Lewes Total		**1**	**0**
Thaker, Nilay B	Episodic	0	1
Thaker, Nilay B Total		**0**	**1**
Lancaster Rehabilitation Hospital La0011688	Episodic	0	1
Lancaster Rehabilitation Hospital La0011688 Total		**0**	**1**
Sheehan Iii, Charles E	Episodic	1	0
Sheehan Iii, Charles E Total		**1**	**0**
Anne Arundel Medical Center An0000205	Episodic	1	0
Anne Arundel Medical Center An0000205 Total		**1**	**0**
Holy Cross Rehab and Nursing Ho0112052	Episodic	0	1
Holy Cross Rehab and Nursing Ho0112052 Total		**0**	**1**
Manko, Gary	Episodic	0	0
Manko, Gary Total		**0**	**0**
Consagra, Genine	Episodic	0	1
Consagra, Genine Total		**0**	**1**
Harbor Hospital Ha0001430	Non-Episodic	0	1
Harbor Hospital Ha0001430 Total		**0**	**1**
Syed, Farhana	Episodic	1	0
Syed, Farhana Total		**1**	**0**
Harford Memorial Hospital Ha0001431	Episodic	0	1
Harford Memorial Hospital Ha0001431 Total		**0**	**1**
Munir, Kashif M	Episodic	0	1
Munir, Kashif M Total		**0**	**1**
Thomas, Lizy	Episodic	0	0
Thomas, Lizy Total		**0**	**0**

Serlemitsos, John	Episodic	0	1
Serlemitsos, John Total		**0**	**1**
Gunawardane, Vajira R	Episodic	1	0
Gunawardane, Vajira R Total		**1**	**0**
Mills, Kelly A	Episodic	1	0
Mills, Kelly A Total		**1**	**0**
Kramer, Risa	Episodic	0	0
Kramer, Risa Total		**0**	**0**
Inova Mount Vernon Hospital In0011313	Non-Episodic	0	1
Inova Mount Vernon Hospital In0011313 Total		**0**	**1**
Wilson, Robin K	Episodic	1	0
Wilson, Robin K Total		**1**	**0**
Hussain, Azher	Episodic	0	1
Hussain, Azher Total		**0**	**1**
Future Care Irvington, Llc Fu0000027	Episodic	0	1
Future Care Irvington, Llc Fu0000027 Total		**0**	**1**
Stella Maris, Inc. St0111910	Episodic	1	0
Stella Maris, Inc. St0111910 Total		**1**	**0**
Eng, Samuel	Non-Episodic	1	0
Eng, Samuel Total		**1**	**0**
Levindale Hebrew Hospital Le0000771	Episodic	0	1
Levindale Hebrew Hospital Le0000771 Total		**0**	**1**
Westgate Hills Rehab & Healthcare We0010605	Episodic	0	1
Westgate Hills Rehab & Healthcare We0010605 Total		**0**	**1**
Bridgepark Healthcare Center Li0001426	Episodic	0	0
Bridgepark Healthcare Center Li0001426 Total		**0**	**0**
Frederick Villa- Catonsville	Episodic	0	1
Frederick Villa- Catonsville Total		**0**	**1**
Lorien Mays Chapel Lo0000376	Episodic	0	1
Lorien Mays Chapel Lo0000376 Total		**0**	**1**
Mellis, Nicholas	Episodic	0	1
Mellis, Nicholas Total		**0**	**1**
Lorien Health Systems Mt Airy Lo0000377	Episodic	0	1
Lorien Health Systems Mt Airy Lo0000377 Total		**0**	**1**
Trent-Mims, Karen Y	Episodic	0	1
Trent-Mims, Karen Y Total		**0**	**1**
Harbor Hospital Acccca001i0g	Non-Episodic	1	0
Harbor Hospital Acccca001i0g Total		**1**	**0**
Maryland Masonic Homes Ma0010951	Episodic	1	0
Maryland Masonic Homes Ma0010951 Total		**1**	**0**
Naganna, Hemalatha	Episodic	1	0
Naganna, Hemalatha Total		**1**	**0**
Faustino, Deogracias V	Episodic	1	0
Faustino, Deogracias V Total		**1**	**0**
Sawhney, Daljit	Episodic	1	0
Sawhney, Daljit Total		**1**	**0**

EXHIBIT 10



- Home Oxygen
- Respiratory Equipment and Services
- Home Medical Equipment
- CPAP Supply Program

Dear Sir or Madam:

The purpose of my letter is to support Amedisys Home Health and the services provided by their clinicians. My Agency has used Amedisys Home Health services in Carroll County and Quality care is top priority at Amedisys and their clinicians exemplify clinical excellence with each patient encounter. If my patients need Nursing or Therapy services Amedisys is staffed and ready to meet their needs at any time. The referral process is accommodating to my practice and their clinicians are easily accessible around the clock.

My Agency as well as my patients have confidence in and trust Amedisys home health. With their focus on Clinical excellence and improving outcomes I support Amedisys Home Health. Amedisys provides patient updates and works with me to reduce unnecessary readmits to the hospital. Amedisys works to improve the quality of life with their patients and provides services that allows patients to heal and recover in the comfort of their homes. I do feel there is a need for another Home Health provider in Frederick County. Amedisys offers SN, PT, OT, ST, MSW, and HHA services which would benefit my patient population. Due to their strong commitment to clinical excellence which reflects in their patient outcomes (or low ACH rates), I'm asking for the state to approve them in being able to expand their services in Frederick county.

Sincerely,

Bradley Klein
Account Executive (Frederick and Baltimore County)
Americoast Mid-Atlantic
Cell: (410) 463-5112

Right at Home
In Home Care & Assistance

PHYLLIS GREEN BUILDING
826 WASHINGTON ROAD, SUITE 103
WESTMINSTER, MD 21157

P 410.871.9804
F 410.871.9807

www.rightathome.net/centralmdcarroll
info2@rahmd.net

Dear Sir or Madam:

The purpose of my letter is to support Amedisys Home Health and the services provided by their clinicians. Our agency Right at Home In-Home Care & Assistance has used Amedisys Home Health services in Carroll County and Quality care is top priority at Amedisys and their clinicians exemplify clinical excellence with each patient encounter. If our clients need Nursing or Therapy services Amedisys is staffed and ready to meet their needs at any time. The referral process is accommodating to our agency and their clinicians are easily accessible around the clock.

Our Agency as well as our clients have confidence in and trust Amedisys home health. With their focus on Clinical excellence and improving outcomes we support Amedisys Home Health. Amedisys provides patient updates to out Agency and works with us to reduce unnecessary readmits to the hospital. Amedisys works to improve the quality of life with their patients and provides a service that allows patients to heal and recover in the comfort of their homes. We do feel there is a need for another Home Health provider in Frederick County. Amedisys offers SN, PT, OT, ST, MSW and HHA services which would benefit our client population. Due to their strong commitment to clinical excellence which reflects in their patient outcomes (or low ACH rates), we are asking for the state to approve them in being able to expand their services in Frederick county.

Thank you for the consideration, and please feel free to contact me if you have any further questions.

Sincerely,

Lauren Hickey

Lauren Hickey
Community Relations
Right at Home in-Home Care & Assistance
826 Washington Road
Suite 103
Westminster, Maryland 21157
410-871-9804
Lhickey@rahmd.net

Visiting Angels
LIVING ASSISTANCE SERVICES

Phone: 410-549-8002
Fax: 410-549-2909

6505 Ridenour Way E, Unit 1B
Eldersburg, MD 21784
info@mdvisitingangels.com
www.visitingangels.com/eldersburg

May 1, 2017

To whom it may concern:

The purpose of my letter is to support Amedisys Home Health and the services provided by their clinicians. My Agency has used Amedisys Home Health services in Carroll County and quality care is top priority at Amedisys and their clinicians exemplify clinical excellence with each patient encounter. If my clients need Nursing or Therapy services Amedisys is staffed and ready to meet their needs at any time. The referral process is accommodating to my practice and their clinicians are easily accessible around the clock.

My Agency as well as my clients have confidence in and trust Amedisys home health. With their focus on Clinical excellence and improving outcomes I support Amedisys Home Health. Amedisys provides patient updates and works with me to reduce unnecessary readmits to the hospital. Amedisys works to improve the quality of life with their patients and provides services that allows patients to heal and recover in the comfort of their homes. I do feel there is a need for another Home Health provider in Frederick County. Amedisys offers SN, PT, OT, ST, MSW, and HHA services which would benefit my patient population. Due to their strong commitment to clinical excellence which reflects in their patient outcomes (or low ACH rates), I'm asking for the state to approve them in being able to expand their services in Frederick county.

Sincerely,

D'Alan Baugh

D'Alan Baugh, President

Daljaco, Inc

dba "Visiting Angels"

Brinton Woods
Health & Rehabilitation Center
at Winfield

Dear Sir or Madam:

The purpose of my letter is to support Amedisys Home Health and the services provided by their clinicians. My Agency has used Amedisys Home Health services in Carroll County and Quality care is top priority at Amedisys and their clinicians exemplify clinical excellence with each patient encounter. If my patients need Nursing or Therapy services Amedisys is staffed and ready to meet their needs at any time. The referral process is accommodating to my practice and their clinicians are easily accessible around the clock.

My Agency as well as my patients have confidence in and trust Amedisys home health. With their focus on Clinical excellence and Improving outcomes I support Amedisys Home Health. Amedisys provides patient updates and works with me to reduce unnecessary readmits to the hospital. Amedisys works to improve the quality of life with their patients and provides services that allows patients to heal and recover in the comfort of their homes. I do feel there is a need for another Home Health provider in Frederick County. Amedisys offers SN, PT, OT, ST, MSW, and HHA services which would benefit my patient population. Due to their strong commitment to clinical excellence which reflects in their patient outcomes (or low ACH rates), I'm asking for the state to approve them in being able to expand their services in Frederick county.

Sincerely,

Kelly Kincaid
Director of Social Services

1442 Buckhorn Road • Sykesville, MD 21784 • Phone 410-795-2737 • Fax 410-795-5501

EXHIBIT 11

Policy: AA-016	Date(s) Revised:	02/2017
Subject: ***Discharge of Patients***		
Applicable Service(s): Home Health	**Page:**	Page 1 of 20

PURPOSE:

- The process for discontinuing home health services will be subject to the guidelines as outlined below and as mandated by appropriate state regulatory entities.
- To have a discharge process to ensure the patient is being discharged appropriately and arrangements have been made to address any ongoing health care needs the patient may have at the time of discharge.

REGULATORY GUIDANCE:

§484.48 Condition of Participation: Clinical Records: The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient's medical and health status at discharge. The regulation does not dictate the frequency with which progress notes must be written. If necessary, review the HHA's policies and procedures concerning the frequency of preparing progress notes. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary reports already furnished to the physician.

Agencies must adhere to the most stringent regulations (state, federal, accreditation, professional practice, etc.); see also the state specific regulations located behind this policy for additional reference.

PROCEDURE:

The agency may decline to continue services under any of the following circumstances:

1. The patient fails to continue to meet criteria for eligibility of services established by the patient's payor sources. (Examples – failure to comply with face-to-face and homebound requirements).
2. Threats of violence or actual violence to agency staff members, and conditions in or around home, which pose safety risk to staff.
3. The goals of the patient's plan of care have been attained or are no longer attainable.
4. The patient's home environment will not support the provision of home health services.
5. The agency has not been/will not be compensated for care provided.
6. The patient cannot care for him/herself in between visits from Agency personnel and no reliable paid or voluntary primary caregiver is available to meet all of the needs of the patient between visits by Agency staff.
7. A caregiver has been prepared and is capable of assuming responsibility for care.
8. In the event of a natural disaster when the client's health and safety is at risk.
9. The patient and/or primary caregiver are noncompliant or have a documented history of noncompliance in cooperating to attain the objectives of home care.
10. There is suspected illegal activity in the patient's home. i.e. drug abuse or history of drug abuse.
11. Agency staff members are subject to sexual harassment or verbal abuse when they provide services to the patient.

12. Agency staff members are subject to racial discrimination when they provide services to the patient.

13. The agency can no longer provide appropriate staffing.

14. The patient moves to a location outside of the licensed geographic service area of the agency.

15. The patient or his/her legally authorized representative chooses another provider.

16. The patient or the patient's legally authorized representative terminates services by the Agency or refuses care.

17. No signed orders from appropriately licensed practitioners (doctors of medicine, osteopathy or podiatry) are in effect upon which to base services.

18. If the patient is found to be ineligible for home care services, all attempts will be made by the agency to direct the individual to the appropriate community resource and notification will be made to the patient's attending physician and/or referral agency.

19. The agency will no longer provide a particular service needed by patients or is closing.

20. The Director of Office Operations is the sole determiner of the decision to discharge the patient considering the above criteria.

DISCHARGES (see also Medicare Choice/Expedited Review policy - TX 007)

1. Discharge planning will begin during the initial admission evaluation and continues throughout the length of service. The patient, or his/her representative if any, shall be informed of and participate in discharge planning.

2. The Plan of Care will identify problems and goals that need to be met for discharge. Goals and discharge planning are discussed with patient and caregiver.

3. When a patient is discharged prior to the end of the episode's treatment orders due to:
   a. The patient's goals have been met.
   b. Patient is no longer homebound.
   c. Patient has relocated out of the agency's geographical area.
   d. The patient is no longer compliant with their treatment plan.
   e. The patient refuses further home health services.

   The physician will be notified of the patient's discharge from the home health agency. Documentation of physician notification will be evident in the patient's medical record. Only when required by state regulations will a discharge order be generated.

4. When a skilled discipline discharges the patient from their service, the discipline will complete a discharge summary that will be available to the physician upon request. ***Note Exceptions:***
   - ***When a therapist (PT, OT, ST, and MSW) completes an evaluation only, provides no subsequent therapy/care, the therapist will document communication/ notification to the physician and a discharge summary is not required.***
   - ***When SN completes an assessment only or provides a one-time only visit (venipuncture for lab, etc.) for a patient receiving another skilled service and no subsequent Skilled Nursing services are ordered, the nurse will document***

communication/notification to the physician and a discharge summary is not required.

5. The discipline will also provide the patient with discharge instructions pertaining to that discipline, if applicable.

6. Discharge criteria:
   a. Physician's request
   b. Patient no longer meets eligibility requirements
   c. Patient has met expected goals
   d. Patient death
   e. Patient request
   f. Patient relocates outside of service area
   g. Services ordered are not provided by agency
   h. Patient refusal of services
   i. Non-compliance with treatment plan
   j. Patient residence deemed unsafe environment for employee. Threatened violence by patient or caregiver.
   k. Patient is still in hospital on Day 60 (unless the patient is discharged from inpatient facility on Day 60 and requires a skilled visit for day of discharge (intravenous therapy or other qualifying skilled service).

7. The clinician assigned to supervise and coordinate care for a particular patient must complete a discharge summary when services are terminated. The Discharge Summary includes:
   a. Reason for Homecare admission
   b. Summary of Care and Services provided and progress towards goals
   c. Symptoms needing continued management
   d. Instructions given to patient and family

8. A Discharge OASIS is completed within 48 hours for applicable patients.

9. The patient's discharge date is the date of discontinuation of services, patient death, transfer out of the service area or when the agency becomes aware of the discharge.

10. The discharge chart is completed and audited after the discharge date or documented discharge notification.

When patients already admitted to the agency meet one (1) or more of the criteria listed to discontinue services, the agency may take the following actions:

1. Hold a case conference to determine whether to discontinue services and if so, whether immediate termination is warranted or what constitutes a reasonable notice period taking into account facts and circumstances relevant to individual patients and applicable state and/or federal requirements. The results of this case conference will be documented in the patient's chart, including:
   a. The date and time of termination
   b. The reason(s) for termination
   c. In appropriate circumstances such as violence or an admission to an institutional provider, services may be discontinued immediately.

2. If a decision is made to terminate services, staff will normally verbally notify non-institutionalized patients and their attending physicians at least 2 days prior to discharge of the date and time of termination of services and the reason(s) for termination within a reasonable period of time prior to discharge, or within a specified time frame according to state regulation. These verbal communications will be documented in the patient's chart. When patient's who are admitted to hospitals or other institutions are discharged, the Agency will normally notify the discharge planning staff at the hospital or other institution that the patient cannot be readmitted to the agency.

3. Verbal notification to non-institutionalized patients not in jeopardy will normally be immediately followed by written notice (Notice of Medicare Non-Coverage) Written notice will also include any additional information that may be required by state and/or federal requirements. A copy of this written notice shall be placed in the patient's chart.

4. Agency staff will report to adult and child protective services as appropriate and in accordance with applicable requirements of state law and regulation.

Discharge Dates:

What is the appropriate date to document on the Discharge summary?

The patient's discharge date on the Discharge Summary, and MO906 of the Discharge OASIS assessment should be the date the agency becomes aware of the patient's discharge or discontinuation of services, patient death, or transfer out of service area.

For example: The patient was transferred to the hospital on 3/02/08 but the agency was notified on 3/8/08, the patient would not be returning to the home care agency. The date of discharge will be 3/8/08, not 3/2/087 and **not the last billable visit**.

Discharge Order Requirements per State

Please see the following table listing the different states and the specific requirements.

****See State Specific section for regs***

STATE	DC orders required if pt is discharged prior to end of episode
Alabama	No
Alaska	No
Arkansas	No
Arizona	Yes
California	No
Colorado	No
Connecticut	No
Delaware	No
District of Columbia	No
Florida	No
Georgia	YES
Idaho	No
Illinois	Yes*
Indiana	No
Iowa	No
Kansas	No
Kentucky	No
Louisiana	Yes*
Maine	Yes
Maryland	No
Massachusetts	No
Michigan	No
Minnesota	No
Mississippi	Yes

STATE	DC orders required if pt is discharged prior to end of episode
Missouri	No
Nebraska	No
Nevada	Yes
New Hampshire	No
New Jersey	No
New Mexico	No
New York	No
North Carolina	No
North Dakota	No
Ohio	No
Oklahoma	No
Oregon	No
Pennsylvania	No
Puerto Rico	No
Rhode Island	No
South Carolina	No
South Dakota	No
Tennessee	No
Texas	No
Utah	Yes
Virginia	No
Washington	No
West Virginia	No
Wisconsin	No
Wyoming	No

State Specific Requirements

NOTE: *Expedited Review requirements for Medicare or individual Managed Care contracts also apply. Agency is subject to the most stringent requirements.*

Alabama:
Discharge/ Orders/Summary: Follows Medicare Conditions of Participation

Alaska:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Arizona:
At the time of a Scheduled Discharge the CC must ensure a D/C plan, D/C Instructions and a D/C Summary and have available to the physician upon request. A D/C order is required for non-scheduled Discharges.

R9-10-1101. Definitions

5. "Discharge summary" means a brief review of service, patient status, and reasons for discharge.

R9-10-1106. Plan of Care

C. Staff shall document, in the medical record, any verbal order for either the initiation or modification to the plan of care and shall include in the record the physician's verifying signature which shall be obtained within 30 days of the order.

R9-10-1108. Medical Records

B. Each agency shall maintain a medical record for each patient which contains the following:

13. Patient transfer or discharge plan and discharge summary.

Arkansas:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

SECTION XI. GENERAL REQUIREMENTS

O. Discharge Planning

1. There shall be a specific plan for discharge in the clinical record and there must be ongoing discharge planning with the patient.

California:
Discharge/Orders/Summary: The discharge statement shall include the date of discharge, reason for termination of services and condition upon discharge. All health records of discharged patients shall be completed within 30 days after the discharge.

§ 74735. Patient Health Records.

(a) The agency shall establish and maintain for each patient accepted for care a health record which shall include the following information:

(9) Discharge statement. The discharge statement shall include the date of discharge, reason for termination of services, and condition upon discharge

§ 74731. Patients' Health Records Availability.

(c) All health records of discharged patients shall be completed within 30 days after their discharge date.

(d) Health records of each discharged adult patient shall be kept for a minimum of seven years following discharge of the patient. The health record of a discharged minor shall be kept for at least one year after the minor has reached the age of 18 years and in all cases not less than seven years.

Colorado:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation
CHAPTER XXVI – HOME CARE AGENCIES
6.6 Discharge planning
(A) There shall be a specific plan for discharge in the consumer record and there shall be ongoing discharge planning with the consumer.
(B) If no improvement or no discharge is expected, the agency shall document in the consumer record this assessment.
(C) The HCA shall assist each consumer or authorized representative to find an appropriate placement with another agency if the consumer continues to require care and/or services upon discharge. The HCA shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the consumer's safety and welfare.
(D) Once admitted, an HCA shall not discontinue or refuse services to a consumer unless documented efforts have been made to resolve the situation that triggered such discontinuation or refusal to provide services.
(1) The consumer or authorized representative shall be notified verbally and in writing of the agency's intent to discharge and the reasons for the discharge.

Connecticut:
Discharge/Orders/Summary: The physician must be notified each time one or more services are terminated and upon discharge. No discharge order is required.
Discharge from Service:
(A) Agency policies shall define categories for discharge of patients. These categories shall include but not be limited to:
(i) Routine discharge--termination of service(s) when goals of care have been met and patient no longer requires home health care services;
(ii) Emergency discharge--termination of service(s) due to the presence of safety issues which place the patient and/or agency staff in immediate jeopardy and prevent the agency from delivering home health care services;
(iii) Premature discharge--termination of service(s) when goals of care have not been met and patient continues to require home health care services;
(iv) Financial discharge--termination of service(s) when the patient's insurance benefits and/or financial resources have been exhausted.
(B) In the case of a routine discharge the agency shall provide:
(i) pre-discharge planning by the primary care nurse, attending physician, or dentist and other agency staff involved in patient's care, which shall be documented in patient's clinical record;
(ii) A procedure through which the patient's physician or dentist is notified each time one or more services are terminated, and when the patient is discharged.
(C) In the case of an emergency discharge the agency shall immediately take all measures deemed appropriate to the situation to ensure patient safety. In addition, the agency shall immediately notify the patient, the patient's physician, and any other persons or agencies involved in the provision of home health care services. Written notification of action taken, including date and reason for emergency discharge, shall be forwarded to the patient and/or family, patient's physician, and any other agencies involved in the provision of home health care services within five (5) calendar days.
(D) In the case of a premature discharge the agency shall document that prior to the decision to

discharge a case review was conducted which included patient care staff, supervisory and administrative staff, patient's physician, patient and/or patient representative, and representation from any other agencies involved in the plan of care.

(i) Decision to continue service: If the decision of the case review is to continue to provide service, a written agreement shall be developed between the agency and the patient or his/her representative to identify the responsibilities of both in the continued delivery of care for the patient. This agreement shall be signed by the agency administrator and the patient or his representative. A copy shall be placed in the patient's clinical record with copies sent to the patient and his or her physician.

(ii) Decision to discharge from service: If the case review results in an administrative decision to discharge the patient from agency services, the administrator shall notify the patient and/or family and the patient's physician that services shall be discontinued in ten (10) days and the patient shall be discharged from the agency. Services shall continue in accordance with the patient's plan of care to ensure patient safety until the effective day of discharge. The agency shall inform the patient of other resources available to provide health care services.

(E) In the case of a financial discharge the agency shall conduct a:

(i) Pre-termination Review: Whenever one or more home health services are to be terminated because of exhaustion of insurance benefits or financial resources, at least ten (10) days prior to such termination there shall be a review of need for continuing home health care by the patient, his family, the supervisor of clinical services, the patient's physician or dentist, primary care nurse and other staff involved in the patient's care. This determination and, when indicated, the plan developed for continuing care shall be documented in the patient's clinical record.

(ii) Post-termination Review: The clinical records of each patient discharged because of exhaustion of insurance benefits or financial resources shall be reviewed by the professional advisory committee or the clinical record review committee at the next regularly scheduled meeting following the discharge. The committee reviewing the record shall ensure that adequate post-discharge plans have been made for any patient with continuing home health care needs.

Delaware:

Title 16, 4410 Skilled Home Health Agencies (Licensure)

6.8 Discharge

6.8.1 The patient, or her/his representative if any, shall be informed of and participate in discharge planning.

6.8.2 The home health agency shall develop a written plan of discharge which includes a summary of services provided and outlines the services needed by the patient upon discharge.

6.8.3 When discharging a patient who does not wish to be discharged, a minimum of two (2) week notice will be provided to permit the patient to obtain an alternate service provider. Exceptions to the two (2) week notice provision would include:

6.8.3.1 The discharge of patients when care goals have been met.

6.8.3.2 The discharge of patients when care needs undergo a change which necessitates transfer to a higher level of care and for whom a new discharge plan needs to be developed.

6.8.3.3 The discharge of patients when there is documented non-compliance with the plan of care or the admission agreement (including, but not limited to, nonpayment of justified charges).

6.8.3.4 The discharge of patients when activities or circumstances in the home jeopardize the welfare and safety of the home health agency caregiver.

District of Columbia:

Each home care agency shall have written policies that describe transfer, discharge, and referral criteria

and procedures.
Each patient shall receive written notice of discharge or referral no less than seven (7) calendar days prior to the action. The seven (7) day written notice shall not be required, and oral notice may be given at any time, if the transfer, referral or discharge is the result of:

a) A medical or social emergency;
b) A physician's order to admit the patient to an in-patient facility;
c) A determination by the home care agency that the referral or discharge is necessary to protect the health, safety or welfare of agency staff;
d) A determination, made or concurred in by a physician, that the condition that necessitated the provision of services no longer exists; or
e) The refusal of further services by the patient or the patient's representative.

Each home care agency shall document activities related to discharge planning for each patient in the patient's record

Florida:
Discharge/Orders/ Summary: When an agency terminates services for a patient needing continuing home health care, as determined by the physician, for patients receiving care under a physician's order, or as determined by the patient or caregiver, for patients receiving care without a physicians order, a plan must be developed and a referral made by home health agency staff to another home health agency or service provider prior to termination. The patient must be notified in writing of the date of termination, the reason for termination, and the plan for continued services by the agency or service provider to which the patient has been referred. This requirement does not apply to patients paying through personal funds or private insurance who default on their contract through non-payment. The home health agency should provide social work assistance to patients to help them determine their eligibility for assistance from government funded programs if their private funds have been depleted or will be depleted.

Georgia:
Discharge/ Orders/ Summary: Clarification from the GA DOH Jennifer Oetzel, Home Health Agency Program Manager of the Office of Regulatory Services at the Georgia Department of Human Resources: the discipline specific discharge does not need to be sent to the physician; the Agency Discharge Summary must be sent.
290-5-38-.08 (e) Coordination of Patient Services. All personnel providing services shall maintain a liaison with the Home Health Agency to assure that their efforts effectively complement one another and support the objectives outlined in the plan of treatment. The clinical record shall contain dated minutes of case conferences verifying that effective interchange, reporting, and coordinated patient evaluation does occur. A written summary report of clinical and progress notes for each patient shall be sent to the attending physician at least every sixty (60) days and upon discharge. A copy of these reports shall become a permanent part of the patient's clinical record.
01/29/2016: Clarification from GA Nancy Holz-Scott who stated that in addition to sending the D/C summary to the physician, the Discipline D/C summary must show evidence of MD notification.

Idaho:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Illinois:
Section 245.200 Services – Home Health
d) Acceptance of Patients. Patient acceptance and discharge policies shall include, but not be limited to, the following:

5) When services are to be terminated by the home health agency, the patient is to be notified three working days in advance of the date of termination, stating the reason for termination. This information shall be documented in the clinical record. When indicated, a plan shall be developed or a referral made for any continuing care.
6) Services shall not be terminated until such time as the registered nurse, or the appropriate therapist, or both, in consultation with the patient's physician or podiatrist, deem it appropriate or arrangements are made for continuing care.

f) Consultation with the patient's physician or podiatrist on any modifications in the plan of treatment deemed necessary shall be documented, and the patient's physician's or podiatrist's signature shall be obtained within 30 days after any modification of the medical plan of treatment.

1) The home health services team shall review the plan every 62 days, or more often if the patient's condition warrants.

2) An updated plan of treatment shall be given to the patient's physician or podiatrist for review, for any necessary revisions, and for signature every 62 days, or more often as indicated.

h) Clinical Records
M) A discharge summary giving a brief review of service, patient status, reason for discharge, and plans for post-discharge needs of the patient. A discharge summary may suffice as documentation to close the patient record for one-time visits and short-term or event-focused or diagnoses-focused interventions. The discharge summary need not be a separate piece of paper and may be incorporated into the routine summary of reports already furnished to the physician.

Indiana:
Discharge/Orders/Summary: The patient, the patient's legal representative or other individual responsible for the patient's care shall be given notice of discharge at least five (5) calendar days before the services are stopped. The Agency must continue, in good faith, to provide services during the 5-day period. If the Agency cannot provide such services during that period, its continuing attempts to provide services must be documented. The five (5) day period does not apply in the following circumstances:

- The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.
- The patient refuses the home health agency's services.
- The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following the discharge; or
- The patient no longer meet applicable regulatory criteria, such as lack of physician's order and the home health agency informs the patient of community resources to assist the patient following discharge.

Iowa:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Kansas:
Discharge/Orders/Summary: A discharge summary report is a concise statement signed by a qualified health professional, reflecting the care, treatment and response of the patient in accordance with the

patient' s plan of care and the final disposition at the time of discharge.

Kentucky:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Louisiana:
Discharge/Orders/Summary: Per Marion Tate – LA Health Standards – DOH 2.22.16, "If the HHA has completed the ordered frequency – a discharge order is not necessary, however there should be documentation in the medical record of communication with the physician. If the HHA did not complete the ordered frequency for whatever reason – patient improved, patient refuses, etc., a discharge order is needed since the HHA would no longer be providing services according to the physician's plan of care.

§9123. Patient Care Standards
G. Discharge Policy and Procedures
1. The patient may be discharged from an agency when any of the following occur:
   a. the patient care goals of home care have been attained or are no longer attainable;
   b. a caregiver has been prepared and is capable of assuming responsibility for care;
   c. the patient moves from the geographic service area served by the agency;
   d. the patient and/or caregiver refuses or discontinues care;
   e. the patient and/or caregiver refuses to cooperate in attaining the objectives of home care;
   f. conditions in the home are no longer safe for the patient or agency personnel. The agency shall make every effort to satisfactorily resolve problems before discharging the patient;
   g. the patient's physician fails to renew orders for the patient;
   h. the patient, family, or third-party payor refuses to meet financial obligations to agency;
   i. the patient no longer meets the criteria for services established by the payor source;
   j. the agency is closing out a particular service or any of its services;
   k. death of the patient.
2. The agency must have discharge procedures that include, but are not limited to:
   a. notification of the patient's physician;
   b. documentation of discharge planning in the patient's record;
   c. documentation of a discharge summary in the patient's record; and
   d. forwarding of the discharge summary to the physician, if requested.
3. The following procedures shall be followed in the event of the death of a patient in the home:
   a. the proper authorities shall be notified immediately in accordance with state and local ordinances;
   b. the home health agency parent office shall be notified;
   c. the home health agency personnel in attendance shall offer whatever assistance they can to the family and others present at scene; and
   d. progress notes shall be completed in detail and must include observations of the patient, any treatment provided, individuals notified, and time of death, if established by the physician.

F. Medical Social Services
f. submit a written assessment and summary of services provided when medical social work services are discontinued, including an assessment of the patient's current status that will be retained in the patient's clinical record.
G. Nutritional Guidance Services
i. prepare a written discharge summary and ensure that a copy is retained in patient's clinical record and a copy is forwarded to the attending physician;
H. Occupational Therapy
f. when occupational therapy services are discontinued, submit a written summary of services provided, including an assessment of patient's current status, for retention in the patient's clinical record;

J. Physical Therapy.
f. when physical therapy services are discontinued, prepare a written discharge summary and ensure that a copy is retained in the patient's clinical record and a copy is forwarded to the attending physician;
M. Speech Pathology Services
f. submit a written summary of the services provided when speech therapy services are discontinued including an assessment of the patient's current status, which shall be retained in the patient's clinical record.

Maine:
7.F. **Patient/Client Records**

7.F.1. Each Home Health Care Services Provider's patient/client shall have an identifiable clinical record initiated and maintained by the Home Health Care Services Provider in accordance with accepted professional standards. Patient/client records shall contain but not be limited to:

m. Where appropriate, a dated and signed discharge summary giving a brief review of service, patient/client status, reason(s) for discharge, and plans for post-discharge needs of the patient/client;

7.G. **Patient/Client Transfer and Discharge**

7.G.1 Each Home Health Care Services Provider must have written criteria for the transfer, referral and/or discharge of patients/clients. At the time of transfer, referral and/or discharge, the patient/client must meet at least one of the following criteria. Criteria must, but are not limited to:

a. The patient's/client's welfare and/or medical needs cannot be met by the Home Health Care Services Provider,
b. The patient's/client's health and/or functional abilities have improved so that the patient/client no longer needs the services provided by the Home Health Care Services Provider, as ordered by the patient's/client's physician, with agreement from all parties involved;
c. The health and safety of individuals providing services is endangered.

7.G.2. A written notice of discharge or transfer must be sent to patients/clients at least fourteen(14)days before services are terminated. A written notification of patients/clients' appeal rights must be included in this notice and must follow State and Federal requirements. The only written exceptions to this regulation are Chapter 7.G.1.b. and Chapter 7.G.1.c.

7.G.3. Each patient's/client's clinical record must contain documentation describing the criteria that necessitated the transfer, referral and/or discharge. Documentation must include, but is not limited to:

a. Signed and dated physician's orders for transfer, referral or discharge,
b. Multidisciplinary interventions that have been tried and failed to meet the patient's needs if applicable;
c. Notation of the cessation of operation of the Home Health Care Services Provider, if applicable, and Incidents and/or circumstances where agency staffs' health and safety are endangered if applicable.

Maryland:
Discharge/Orders/Summary: Records of discharged patients must be completed no later than 30 days after the date of discharge.

Massachusetts:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

Michigan:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

Minnesota: (4668.0050)
4668.0050 ACCEPTANCE, RETENTION, DISCONTINUATION OF SERVICES, AND DISCHARGE OF CLIENTS.
Subp. 2. **Assistance upon discontinuance of services.** If the licensee discontinues a home care service to a client for any reason and the client continues to need the home care service, the licensee shall provide to the client a list of home care providers that provide similar services in the client's geographic area. This subpart does not apply to a licensee that discontinues a service to a client because of the client's failure to pay for the service.

Mississippi:
130 PATIENTS' RIGHTS
130.01 General. The agency shall maintain written policies and procedures regarding the rights and responsibilities of patients. These written policies and procedures shall be established in consultation with the Professional Advisory Committee. Written policies regarding patients' rights shall be made available to patients and/or their guardian, next of kin, sponsoring agency or agencies, or lawful representative and to the public. There shall be documented evidence that the staff of the agency is trained and involved in the implementation of these policies and procedures. In-service on patient's rights and responsibilities shall be conducted annually. The patients' rights policies and procedures ensure that each patient admitted to the agency:
4. Is transferred or discharged only for medical reasons, or for his welfare, or for non-payment (except as prohibited by Titles XVIII or XIX of the Social Security Act), or on the event of an unsafe environment, or should the patient refuse treatment, and is given advance notice to ensure orderly transfer to discharge, and such actions are documented in his clinical record;
101.15 **Discharge Summary** shall mean the written report of condition of patient, services rendered, pertinent goals achieved during the entire service provided and final disposition at the time of discharge from the service.
124 POLICY AND PROCEDURE MANUAL
124.01 **Manual**.
c. When services are to be terminated by the home health agency, the patient and the physician or podiatrist are to be notified in advance of the date of termination stating the reason and a plan shall be developed or a referral made for any continuing care.
d. Services shall not be terminated without an order by the physician or podiatrist in consultation with the registered nurse and/or the appropriate therapist. Except in cases of non-payment, where the specific and approved plan of care has been documented as completed, where the patient refuses treatment, in the event of an unsafe environment, or should the patient require the services beyond the capability of the agency. In any event, the physician or podiatrist shall be notified of the termination of services. Arrangements shall be made for continuing care when deemed appropriate.

Missouri:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Nevada:
NAC 449.797 Contents of clinical records.

10. A record of the termination of services, including the date and reason for termination and the time when the physician was notified of the termination.

New Hampshire:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

New Mexico:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation
7.28.2.34 PATIENT/CLIENT RECORDS: Each agency licensed pursuant to these regulations must maintain the original record for each patient/client receiving services. Patient/client records shall be made available for review upon request of the licensing authority. Every record must be accurate, legible, promptly completed and consistently organized. A patient/client record must meet the following criteria:
B. If the patient/client is discharged or transferred to another provider of health care, upon receipt of a signed request from the patient/client, a copy of the original record or an abstract of the same must be made available to the receiving facility, within twenty-four (24) hours.

New York:
Discharge/Orders/Summary: A patient may be discharged by the agency only after consultation, as appropriate, with the patient's authorized practitioner, the patient, the patient's family or informal supports, any legally designated patient representative, and any other professional personnel including any other case management entity involved in the plan of care. If the agency determines that the patient's health care needs can no longer be met safely at home, the agency must continue to provide home health services only to the extent necessary to address minimally essential patient health and safety needs until such time as an alternative placement becomes available and such placement is made or the patient or the patient's legal representative, who has the authority to make health care decisions on behalf of the patient, makes an informed choice to refuse such placement. As appropriate, the patient and family or informal supports, any legally designated patient representative and any other professional personnel including any case management entity involved, shall be fully informed of the agency's intent to discharge the patient to an alternate service, when available, and shall be consulted in the development of an interim plan of care.

North Carolina:
Discharge/Orders/Summary: A discharge summary is completed and the physician is notified of the discharge. An advance notification to patient or responsible party of at least 48 hours is required, except in cases where the patient agrees with discharge.

Ohio:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Oklahoma:
Discharge/Orders/Summary: The physician is notified of discharge.

Oregon:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Pennsylvania:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Puerto Rico:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation
Rhode Island:
Discharge/Orders/Summary: Discharge summary required.
Section 15.0 ***Admission and Discharge Policies***
15.1 Providers shall establish policies pertaining to eligibility for admission to and discharge from home nursing care provider or home care provider services. Such policies shall be based on the following criteria:
(a) Pre-admission assessment of patient care needs;
(b) Reasonable expectations of the home nursing care provider's or home care provider's capability to respond to the medical and nursing needs of the patient;
(c) Plan of care;
(d) Constraints imposed by limitation of services, family conditions;
(e) Community or other resources to ensure continuity of patient care; and
(f) Such other criteria as may be deemed appropriate.

(i) Discharge summaries.
16.1.1 Home nursing care provider or home care provider personnel involved in the care of patients shall participate, to the extent possible, in developing care plans. When practical, designated home nursing care provider or home care provider personnel shall complete a "Continuity of Care" form as approved by the Director for each patient who is discharged to another health care facility, such as a hospital or nursing facility, or other facility licensed under the provisions of RIGL Chapter 23-17 [Reference 1]. Said form shall be provided to the receiving facility, agency, or provider prior to, upon transfer, or discharge of the patient. (See the Department's website for the approved form: www.healthri.org).

Medical Services
21.8 Patients admitted for medical services shall be under the care of a licensed physician responsible for the development of the plan of care.
(a) A care plan prescribed by the attending physician, if appropriate, shall contain no less than the following:
(1) Pertinent diagnosis, including mental status, level of consciousness, ability to communicate including language, speech and hearing;
(2) Types of services and equipment required, frequency of visits, prognosis, rehabilitative potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, safety measures (if any), instructions for continuing care, referral or discharge; dates/times of any follow-up appointment(s), when known; and

South Carolina:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Tennessee:
Discharge/Orders/Summary: The discharge summary shall be dated and signed within 7 days of discharge. A copy of the discharge summary is available to the physician upon request. The discharge summary must include medical and health status at discharge.
For patients receiving services through the Division of Mental Retardation Services (DMRS): if the agency determines that they are no longer willing or able to provide services they must comply with the following:

1. Prior to discontinuation of authorized services, the agency will obtain approval from DMRS;
2. The agency will notify the consumer, their conservator or guardian and DMRS no less than 60 days prior to the planned discharge;
3. If the consumer or his/her representative request a hearing in accordance with T.C.A 33-1-202, the discharge will not occur prior to the final agency decision and resolution of the administrative appeal unless ordered by a court and approved by the state;
4. The agency shall continue to provide service until the consumer is provided with other services that are acceptable and appropriate quality in order to maintain the continuity of care
5. If the consumer or his/her representative request to be discharged from the agency, the agency will follow the steps outlined above and provide transfer documentation to new provider, if requested, in order to maintain continuity of care and facilitate transfer.

Texas:

§97.295 Client Transfer or Discharge Notification Requirements

(a) Except as provided in subsection (e) of this section, an agency intending to transfer or discharge a client must:
   (1) Provide written notification to the client or the client's parent, family, spouse, significant other or legal representative; and
   (2) Notify the client's attending physician or practitioner if he is involved in the agency's care of the client.

(b) An agency must ensure delivery of the written notification no later than five days before the date on which the client will be transferred or discharged.

(c) The agency must deliver the required notice by hand or by mail.

(d) If the agency delivers the written notice by mail:
   (1) The notice must be mailed at least eight working days before the date of discharge or transfer; and
   (2) The agency must speak with the client by telephone or in person to ensure the client's knowledge of the transfer or discharge at least five days before the date of discharge or transfer.

(e) An agency may transfer or discharge a client without prior notice required by subsection (b) of this section:
   (1) Upon the client's request;
   (2) If the client's medical needs require transfer, such as a medical emergency;
   (3) In the event of a disaster when the client's health and safety is at risk in accordance with provisions of §97.256 of this chapter (relating to Emergency Preparedness Planning and Implementation);
   (4) for the protection of staff or a client after the agency has made a documented reasonable effort to notify the client, the client's family and physician, and appropriate state or local authorities of the agency's concerns for staff or client safety, and in accordance with agency policy;
   (5) According to physician orders; or
   (6) If the client fails to pay for services, except as prohibited by federal law.

(f) An agency must keep the following in the client's file:
   (1) A copy of the written notification provided to the client or the client's parent, family, spouse, significant other or legal representative;
   (2) Documentation of the personal contact with the client if the required notice was delivered by mail; and
   (3) Documentation that the client's attending physician or practitioner was notified of the date of discharge.

Utah:

R432-700-15 Termination of Services

1) The agency may discharge a patient under any of the following circumstances:
   (a) **A licensed practitioner signs a discharge statement for termination of services;**
   (b) Treatment objectives are met;

(c) The patient's status changes, which make treatment objectives unattainable and new treatment objectives are not an alternative;
(d) The family situation changes and affects the delivery of services;
(e) The patient or family is uncooperative in efforts to attain treatment objectives;
(f) The patient moves from the geographic area served by the agency;
(g) The physician fails to renew orders as required by the rules for skilled nursing or therapy services or, the patient changes physician's and the agency cannot obtain orders for continuation of services from the new physician;
(h) The patient's payment sources are exhausted and the agency is fiscally unable to provide free or part-cost care;
(i) The agency discontinues a particular service or terminates all services;
(j) The agency can no longer provide quality care in the place for residence;
(k) The patient or family requests agency services to be discontinued;
(l) The patient dies;
(m) The patient or family is unable or unwilling to provide an environment that ensures safety for the both the patient and provider of service; or
(n) The patient's payor excludes the agency from participating as a covered provider or refuses to authorize services the agency determines are medically necessary.

(2) The person who is assigned to supervise and coordinate care for a particular patient must complete a discharge summary when services to the patient are terminated.

Virginia:

Discharge/Orders/Summary: In agencies licensed by the state of Virginia, the patient is assured at least 5 days written notice prior to discharge or referral in service except when a medical emergency exists, when the patient's physician orders admission to an inpatient facility, or when discharge is determined by the chief administrative officer to be necessary to protect the health and welfare of the staff member providing services. Patients will receive an oral and written explanation of the reason for discharge or referral.

12VAC5-381-10. Definitions.

"Discharge or termination summary" means a final written summary filed in a closed client record of the service delivered, goals achieved and final disposition at the time of client's discharge or termination from service.

12VAC5-381-180. Written policies and procedures.

F. Admission and discharge or termination from service policies and procedures shall include, but are not limited to:
1. Criteria for accepting clients for services offered;
2. The process for obtaining a plan of care or service;
3. Criteria for determining discharge or termination from each service and referral to other agencies or community services; and
4. Process for notifying clients of intent to discharge/terminate or refer, including:
   a. Oral and written notice and explanation of the reason for discharge/termination or referral;
   b. The name, address, telephone number and contact name at the referral organization; and
   c. Documentation in the client record of the referral or notice.

12VAC5-381-280. Client record system.

F. An accurate and complete client record shall be maintained for each client receiving services and shall include, but shall not be limited to:
8. A discharge or termination of service summary.

In addition, client records for skilled and pharmaceutical services shall include:

11. Copies of all summary reports sent to the primary care physician.

12VAC5-381-230. Client rights.
C. Written procedures to implement the policies shall ensure that each client is:
10. Given at least five days written notice when the organization determines to terminate services.

Washington:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation
WAC 246-335-110
Patient/client records.
(1) The licensee must:
(f) Upon request and according to agency policy and procedure, provide patient or client information or a summary of care when the patient or client is transferred or discharged to another agency or facility.

West Virginia:
Discharge/Orders/Summary: Follows Medicare Conditions of Participation

Wisconsin:
HFS 133.09 Acceptance and discharge of patients.
(3) Discharge of patients:
a. Notice of discharge.
1. A home health agency may not discharge a patient for any reason until the agency has discussed the discharge with the patient's legal representative and the patient's attending physician or advance practice nurse prescriber, and has provided written notice to the patient or the patient's legal representative in the timelines specified in this paragraph.
2. The home health agency shall provide the written notice, except when a patient is discharged due to hospital admission that occurs near the end of a 60-day episode of treatment, required under subd. 1 to the patient or the patient's legal representative at least 10 working days in advance of discharge if the reason for discharge is any of the following:
    a. Payment has not been made for the patient's care, following a reasonable opportunity to pay any unpaid billings.
    b. The home health agency is unable to provide the care required by the patient due to a change in the patient's condition that is not an emergency.
3. The home health agency shall provide the written notice under subd. 1. to the patient or the patient's legal representative at the time of discharge if the reason for discharge is any of the following:
    a. The safety of staff is compromised, as documented by the home health agency.
    b. The attending physician orders the discharge for emergency medical reasons.
    c. The patient no longer needs home health care as determined by the attending physician.
4. The home health agency shall insert a copy of the written discharge notice in the patient's medical record.
5. The home health agency shall include in every written discharge notice to a patient's legal representative of all the following:
    a. The reason for discharge
    b. A notice of the patient's right to file a complaint with the department and the department's toll-free home health hotline telephone number and the address and telephone number and the address and telephone number of the department's division of quality assurance.

***Note**: A complaint may be filed by writing the Bureau of Health Services, Division of Quality Assurance, P.O. box 2969, Madison, Wisconsin 53701-2969 or by calling the Wisconsin Home Health Hotline toll free at 1-800-642-6552.*

(b) *Discharge summary*. The home health agency shall complete a written discharge summary within 30 calendar days following discharge of a patient. The discharge summary shall include a description of the care provided and the reason for discharge. The home health agency shall place a copy of the discharge summary in the former patient's medical record. Upon request, the home health agency shall provide a copy of the discharge summary to the former patient, the patient's legal representative, the attending physician, or advanced practice nurse prescriber.

Wyoming:
Discharge /Orders/Summary: Follows Medicare Conditions of Participation

EXHIBIT 12

SHP
STRATEGIC HEALTHCARE PROGRAMS

510 Castillo Street
Santa Barbara, CA 93101-3406
805.963.9446 Fax: 805.963.2102
www.SHPdata.com

May 3, 2017

Lisa Newell
Asst. VP of Quality
Amedisys, Inc. – Corporate Office
3845 American Way Suite A
Baton Rouge, LA 70816

Re: OASIS Data Analytics and CAHPS Vendor

Dear Ms. Newell,

Per your request, this letter confirms that Strategic Healthcare Programs, LLC, ("SHP") is under contract with Amedisys, Inc. as a provider of their Home Health OASIS data analytics and benchmarking. SHP is the designated survey vendor of Amedysis, Inc. and is a CMS approved Home Health and Hospice CAHPS vendor.

Best,

Trish Stone

Trish Stone
Assistant General Counsel

cc: file

SHP Real-Time Star Ratings Preview - Quality of Patient Care

Amedisys, Inc.: (37491) Amedisys - Westminster (5005)

OM/PM: 01/16-04/17, Hosp: 01/16-04/17

Report Date: 5/1/2017

		Process Measures			Outcome Measures					
1	**Initial Decile Rating** High/Low Better (+/-)	Timely Initiation of Care +	Drug Education All Meds +	Flu Vaccine Received +	Improvement in Ambulation +	Improvement in Bed Trf +	Improvement in Bathing +	Improvement in Pain +	Improvement in Dyspnea +	60-Day Hospitalizations -
2	0.5	0.0-81.2	0.0-89.1	0.0-41.8	0.0-50.6	0.0-43.3	0.0-50.6	0.0-47.8	0.0-40.2	21.3-100.0
3	1.0	81.3-87.5	89.2-94.3	41.9-57.0	50.7-58.3	43.4-52.0	50.7-60.3	47.9-58.7	40.3-54.1	19.4-21.2
4	1.5	87.6-90.7	94.4-96.4	57.1-65.6	58.4-63.2	52.1-58.0	60.4-65.8	58.8-64.5	54.2-62.0	18.2-19.3
5	2.0	90.8-92.9	96.5-97.6	65.7-71.3	63.3-66.7	58.1-62.4	65.9-69.5	64.6-68.8	62.1-67.2	17.2-18.1
6	2.5	93.0-94.7	97.7-98.4	71.4-75.3	66.8-69.4	62.5-65.7	69.6-72.5	68.9-72.6	67.3-71.2	16.4-17.1
7	3.0	94.8-95.9	98.5-99.0	75.4-78.8	69.5-71.9	65.8-68.7	72.6-75.3	72.7-76.4	71.3-74.7	15.5-16.3
8	3.5	96.0-97.0	99.1-99.4	78.9-82.2	72.0-74.4	68.8-71.6	75.4-78.3	76.5-80.6	74.8-78.0	14.5-15.4
9	4.0	97.1-97.9	99.5-99.8	82.3-85.6	74.5-77.6	71.7-75.1	78.4-81.9	80.7-85.3	78.1-81.7	13.1-14.4
10	4.5	98.0-99.0	99.9-99.9	85.7-90.5	77.7-83.1	75.2-80.2	82.0-87.1	85.4-92.8	81.8-86.6	11.3-13.0
11	5.0	99.1-100.0	100.0-100.0	90.6-100.0	83.2-100.0	80.3-100.0	87.2-100.0	92.9-100.0	86.7-100.0	0.0-11.2
12	Your HHA Score	*97.1*	*99.7*	*89.4*	*78.1*	*75.1*	*79.9*	*87.1*	*90.2*	*14.7*
13	Your Initial Decile Rating	*4.0*	*4.0*	*4.5*	*4.5*	*4.0*	*4.0*	*4.5*	*5.0*	*3.5*
14	Your Number of Cases (N)	787	782	545	600	595	605	395	320	638
15	National (All HHA) Median	94.7	98.5	75.4	69.5	65.8	72.5	72.7	71.3	16.3
16	Your Statistical Test Probability Value (p-value)	0.001	0.001	0.000	0.000	0.000	0.000	0.000	0.000	0.154
17	Your Statistical Test Results (Is the p-value ≤ 0.050?)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
18	Your HHA Adjusted Rating	*4.0*	*4.0*	*4.5*	*4.5*	*4.0*	*4.0*	*4.5*	*5.0*	*3.0*↓

19	Your Average Adjusted Rating	*4.2*
20	Your Average Adjusted Rating Rounded	*4.0*

Final Step: Convert Your Average Adjusted Rating Rounded (Line 20) to the 1.0 to 5.0 star scale as shown below.

21 Your Overall Star Rating (1.0 to 5.0)

Average Adjusted Rating Rounded	Overall HHC Star Rating	% of CCNs with Rating (04/2017)
4.5 and 5.0	(5.0) ★★★★★	4.14%
4.0	(4.5) ★★★★½	10.07%
3.5	(4.0) ★★★★	15.99%
3.0	(3.5) ★★★½	20.01%
2.5	(3.0) ★★★	19.81%
2.0	(2.5) ★★½	15.90%
1.5	(2.0) ★★	10.08%
1.0	(1.5) ★½	3.68%
0.5	(1.0) ★	0.32%

Hyphens indicate data not available. Italicized scores are CMS closest match.

CMS cut points used (Pub: Outcomes/Process Measures-07/2017, Hospitalizations-07/2017). ☆ Data parameters match star rating. ☆ Data parameters do not match star rating.

SHP SOC/ROC Clinician Overview

Amedisys, Inc.: (37491) Amedisys - Westminster (5005)

Stand: 01/16-04/17, 30/60 Day: 01/16-04/17, HHCAHPS: 01/16-04/17

Report Date: 5/1/2017

Aggregate Scores	Caseload		Overall* HHC Score	SHP Alert Management**			Medicare Traditional			Hospitalizations			Quality Measure Composite Scores			
	SOCs	DCs		⚠ Closed	⚠ Closed	i Closed	Case Weight	Visits (all disc)	Ther Visit Δ	30-Day Rehosp	60-Day ACH	All ACH	Process Measures	Outcomes	PAEs	HHCAHPS
High/Low Better (+/-)	n/a	n/a		+	+	+	n/a	n/a	-	-	-	-	+	+	-	+
SHP National Avg			89%	69%	59%	50%	1.05	16.24	3.24	12%	15%	24%	96%	75%	0.52%	87%
SHP State (MD)			90%	79%	65%	55%	1.09	15.90	3.39	12%	15%	21%	96%	79%	0.47%	86%
Your Organization	**779**	**633**	**89%**	**85%**	**78%**	**54%**	**1.15**	**18.25**	**4.00**	**17%**	**15%**	**20%**	**95%**	**77%**	**0.79%**	**84%**

SOC/ROC Clinician

(Disclosure Not Authorized)	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	69%
(Not Assigned)	311	219	90%	84%	79%	56%	1.09	15.18	3.61	20%	18%	23%	95%	81%	0.55%	89%
AISHA ABDUL-SAMAD	0	0	-	-	40%	50%	-	-	-	-	-	-	-	-	-	-
BOWLING,JOAN	16	9	85%	95%	89%	49%	1.25	22.13	4.63	0%	15%	27%	87%	59%	0.00%	95%
BRETT APPELBAUM	1	1	-	-	100%	-	1.73	32.00	4.00	-	0%	0%	100%	60%	0.00%	-
CANDICE MADDEN-ROBERTS	2	2	-	-	0%	-	1.47	26.00	4.50	-	0%	0%	100%	100%	0.00%	-
CINDY KINGSBURY	0	1	-	-	83%	0%	-	-	-	-	-	100%	100%	-	0.00%	-
CONNOR,RHONDA	14	9	92%	89%	64%	43%	1.08	21.70	4.10	0%	18%	38%	93%	86%	0.88%	93%
CULLEN,DEBORAH	14	13	89%	100%	87%	100%	1.09	18.85	2.00	0%	9%	7%	96%	73%	2.16%	-
CYNTHIA HAYNIE	1	1	-	-	33%	44%	0.95	17.50	4.00	-	0%	0%	100%	33%	9.09%	-
DAVIS,THERESA	1	0	-	100%	100%	100%	2.21	38.00	23.00	-	0%	-	-	-	-	-
DE VRIES, KRISTIN	4	3	-	100%	89%	69%	0.95	11.80	3.00	100%	25%	25%	92%	100%	0.00%	-
DUA,ELIZABETH	0	0	-	-	0%	-	-	-	-	-	-	-	-	-	-	-
ELIZABETH DUA	3	3	-	0%	100%	14%	0.94	9.00	1.67	-	0%	0%	100%	38%	0.00%	-
ERIC SCHNEIDER	13	18	96%	67%	73%	46%	1.26	13.43	3.71	33%	8%	5%	98%	93%	0.00%	-
FLANAGAN, PATRICIA	8	7	88%	67%	89%	71%	0.77	11.00	1.62	-	0%	0%	97%	57%	0.00%	94%
FRANCIS LINDSAY	0	0	-	-	100%	-	-	-	-	-	-	-	-	-	-	-
GILLEGO,MARY ANN	26	17	92%	95%	74%	40%	1.19	12.00	3.33	0%	6%	11%	97%	80%	0.53%	100%
HITCHCOCK,FRANCES	6	5	-	100%	50%	100%	1.03	18.40	4.00	0%	0%	0%	100%	79%	0.00%	-
IME ADDEY	61	58	89%	60%	86%	53%	1.18	21.45	3.91	11%	11%	18%	94%	74%	1.04%	94%
JAMES,CHANTESE	0	0	-	-	33%	0%	-	-	-	-	-	-	-	-	-	-
JENNIFER SCOTT	3	3	-	-	100%	100%	1.82	51.00	1.50	0%	0%	0%	91%	100%	0.00%	-
JORI TORREVILLAS	0	1	-	-	-	-	1.92	26.00	25.00	-	-	0%	100%	20%	0.00%	-
JULIE SHAMBERGER	12	11	90%	60%	94%	71%	1.09	20.93	3.57	25%	10%	14%	91%	86%	0.00%	92%
KATHERINE DUKE	0	0	-	-	-	-	-	-	-	-	-	-	-	-	-	-
KINGSBURY, CINDY	1	0	-	-	28%	5%	2.16	39.00	8.00	-	100%	100%	73%	-	0.00%	-
KRISTI CORTEZ	42	43	92%	78%	89%	73%	1.22	22.90	4.63	33%	19%	25%	98%	81%	0.00%	-
LINDA EGE	14	13	88%	100%	100%	100%	1.06	19.81	4.31	0%	8%	14%	99%	81%	0.71%	48%
LUANN YEALDHALL	42	38	90%	85%	71%	67%	1.09	19.50	3.83	0%	15%	25%	98%	66%	1.94%	100%

SHP SOC/ROC Clinician Overview

Amedisys, Inc.: (37491) Amedisys - Westminster (5005)

Stand: 01/16-04/17, 30/60 Day: 01/16-04/17, HHCAHPS: 01/16-04/17

Report Date: 5/1/2017

Aggregate Scores	Caseload		Overall* HHC Score	SHP Alert Management**			Medicare Traditional			Hospitalizations			Quality Measure Composite Scores			
	SOCs	DCs		⚠ Closed	△ Closed	i Closed	Case Weight	Visits (all disc)	Ther Visit Δ	30-Day Rehosp	60-Day ACH	All ACH	Process Measures	Outcomes	PAEs	HHCAHPS
High/Low Better (+/-)	n/a	n/a		+	+	+	n/a	n/a	-	-	-	-	+	+	-	+
MADDEN-ROBERTS,CANDICE	2	2	-	100%	100%	100%	0.85	1.00	2.00	-	0%	50%	100%	60%	6.67%	-
MARY ABRECHT	11	9	94%	100%	83%	100%	1.12	22.33	6.00	0%	0%	0%	96%	88%	0.00%	-
MARY ANN GILLEGO	19	19	83%	83%	81%	42%	1.24	16.00	5.08	50%	17%	15%	92%	66%	0.50%	-
MICHELE QUIDORT	0	0	-	0%	47%	16%	1.00	9.00	3.00	-	-	-	-	-	-	-
NICOLE KATES	2	4	-	-	100%	100%	1.27	28.67	1.33	-	0%	0%	95%	75%	0.00%	-
O'NEILL,COURTNEY	21	13	90%	91%	83%	78%	1.14	22.85	4.85	0%	25%	31%	94%	80%	0.00%	90%
PARKS,SUSAN	28	16	90%	100%	97%	100%	1.22	19.50	3.58	0%	13%	24%	92%	84%	0.53%	92%
QUIDORT, MICHELE	0	0	-	-	0%	0%	-	-	-	-	-	-	-	-	-	-
QUIDORT,MICHELE	0	0	-	0%	50%	14%	0.93	9.00	2.00	-	-	-	-	-	-	-
SCHLEICHER, STEPHANIE	8	6	98%	100%	81%	94%	0.88	21.89	1.56	-	13%	14%	99%	96%	1.43%	100%
SEAN LIM	35	32	89%	76%	88%	54%	1.28	14.63	5.02	29%	13%	18%	96%	74%	0.78%	93%
SHAMBERGER,JULIE	2	2	-	100%	90%	50%	1.35	18.50	14.50	-	0%	0%	90%	67%	0.00%	-
STEPHANIE SCHLEICHER	29	25	91%	71%	66%	41%	1.08	19.41	3.91	33%	32%	36%	98%	73%	3.99%	92%
STROMBERG, CHRISTINE	0	0	-	100%	54%	16%	-	-	-	-	-	-	-	-	-	-
SUSAN PARKS	27	30	84%	100%	94%	100%	1.39	25.00	5.00	0%	0%	6%	96%	57%	0.62%	-
WENDI SCHUCHMAN	0	0	-	-	40%	11%	-	-	-	-	-	-	-	-	-	-

* Overall HHC (Home Health Compare) Score composite includes 60-Day ACH, HHC Process Measures, HHC Outcomes & HHCAHPS Quality Measures, "-" indicates insufficient data for valid score.

** Scores show % of Critical (!), Potential (-), and Informational (i) SHP Alerts that have been closed (Resolved, Resolve Pending, Dismissed).

Report User Guide

Your Percentile Ranking

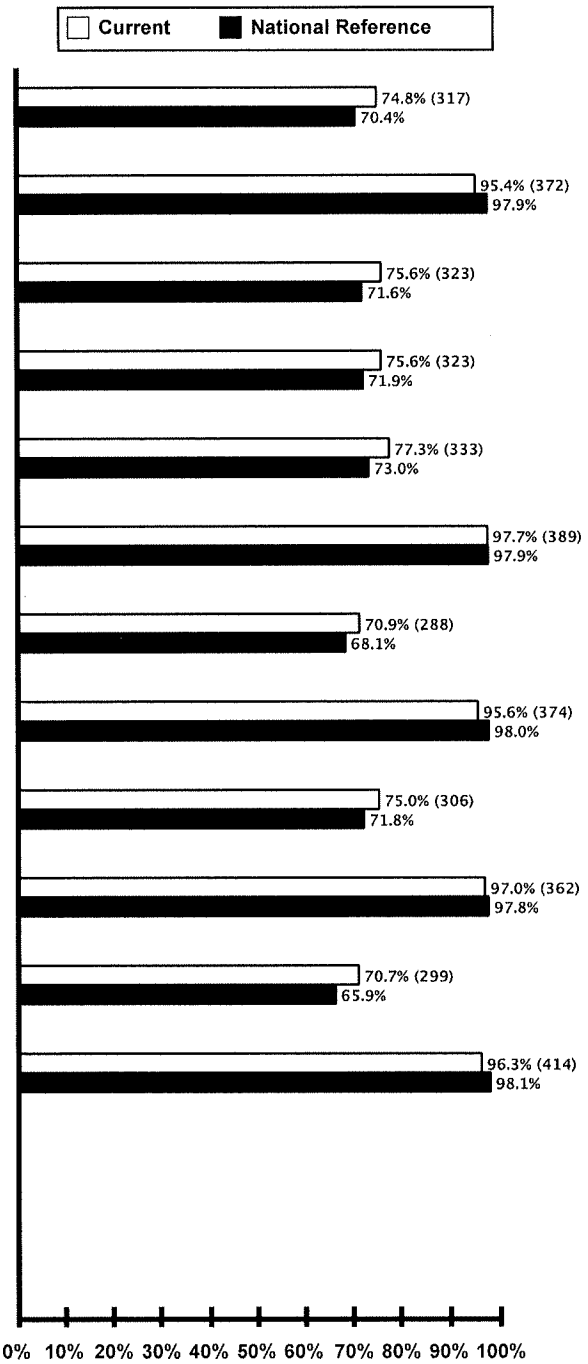
<10%	10-20%	20%-40%	40-60%	60-80%	80-90%	>90%

Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: All
Medicaid Number: 28311

Requested Current Period: 01/2016 - 12/2016
Actual Current Period: 01/2016 - 12/2016
Number of Cases in Current Sample: 434
Number of Cases in Reference Sample: 495956
Date Report Printed: 03/31/2017

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Grooming	424	
	4349733	0.05 **
Stabilization in Grooming	390	
	4554928	0.00 **
Improvement in Upper Body Dressing	427	
	4496525	0.06 *
Improvement in Lower Body Dressing	427	
	4603398	0.08 *
Improvement in Bathing	431	
	4802807	0.04 **
Stabilization in Bathing	398	
	4614146	0.78
Improvement in Toilet Transferring	406	
	4058106	0.22
Stabilization in Toilet Transferring	391	
	4583480	0.00 **
Improvement in Toileting Hygiene	408	
	4212207	0.15
Stabilization in Toileting Hygiene	373	
	4465737	0.31
Improvement in Bed Transferring	423	
	4591821	0.04 **
Stabilization in Bed Transferring	430	
	4862980	0.01 **



* The probability is 10% or less that this difference is due to chance, and 90% or more that the difference is

** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is

\# This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of Care, the statistical significance level will not be displayed on the report.

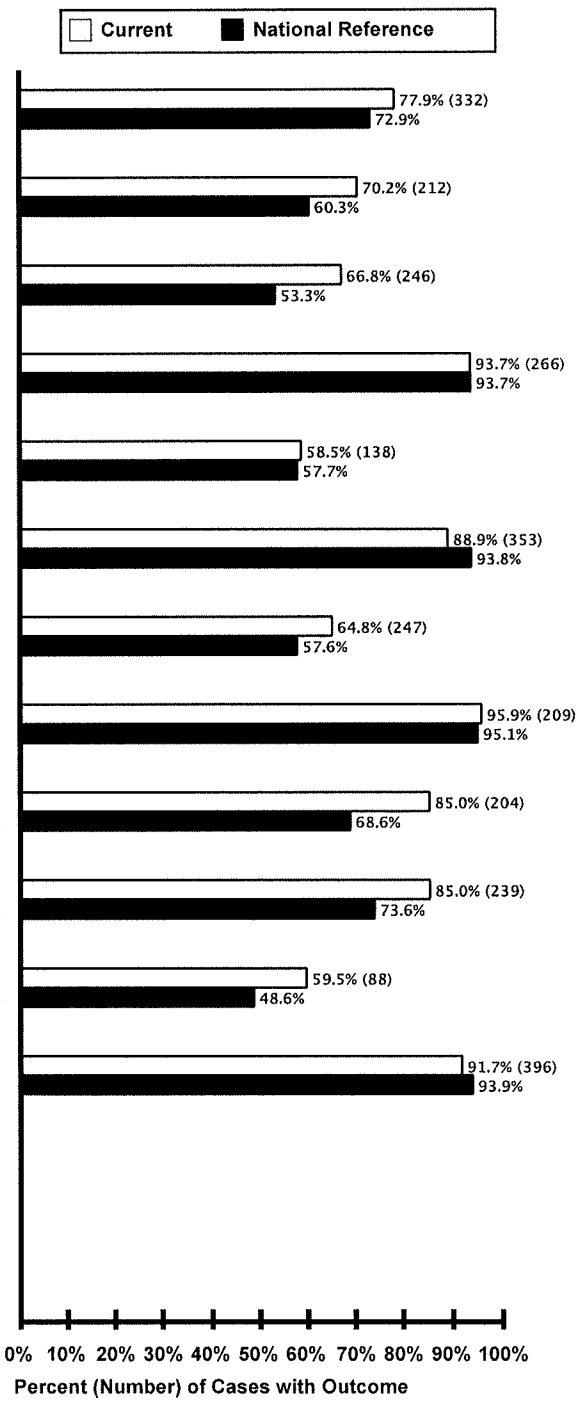
This report has not been approved to meet privacy requirements and can only be used by the home health agency and state agency for defined

Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: All
Medicaid Number: 28311

Requested Current Period: 01/2016 - 12/2016
Actual Current Period: 01/2016 - 12/2016
Number of Cases in Current Sample: 434
Number of Cases in Reference Sample: 495956
Date Report Printed: 03/31/2017

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Ambulation/Locomotion	426 / 4740723	0.02 **
Improvement in Eating	302 / 3100781	0.00 **
Improvement in Light Meal Preparation	368 / 4302812	0.00 **
Stabilization in Light Meal Preparation	284 / 2857387	0.93
Improvement in Phone Use	236 / 1635230	0.82
Stabilization in Phone Use	397 / 4588617	0.00 **
Improvement in Management of Oral Medications	381 / 3971806	0.00 **
Stabilization in Management of Oral Medications	218 / 3012731	0.62
Improvement in Dyspnea	240 / 3596249	0.00 **
Improvement in Pain Interfering with Activity #	281 / 4104731	0.00 **
Improvement in Speech and Language	148 / 2025615	0.01 **
Stabilization in Speech and Language	432 / 4898682	0.06 *



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** The probability is 5% or less that this difference is due to chance, and 95% or more that the difference is

This outcome has been risk adjusted. However, the predictive model for this outcome is less robust than the other predictive models.

Note: When a measure value is calculated using less than 10 Episodes of Care, the statistical significance level will not be displayed on the report.

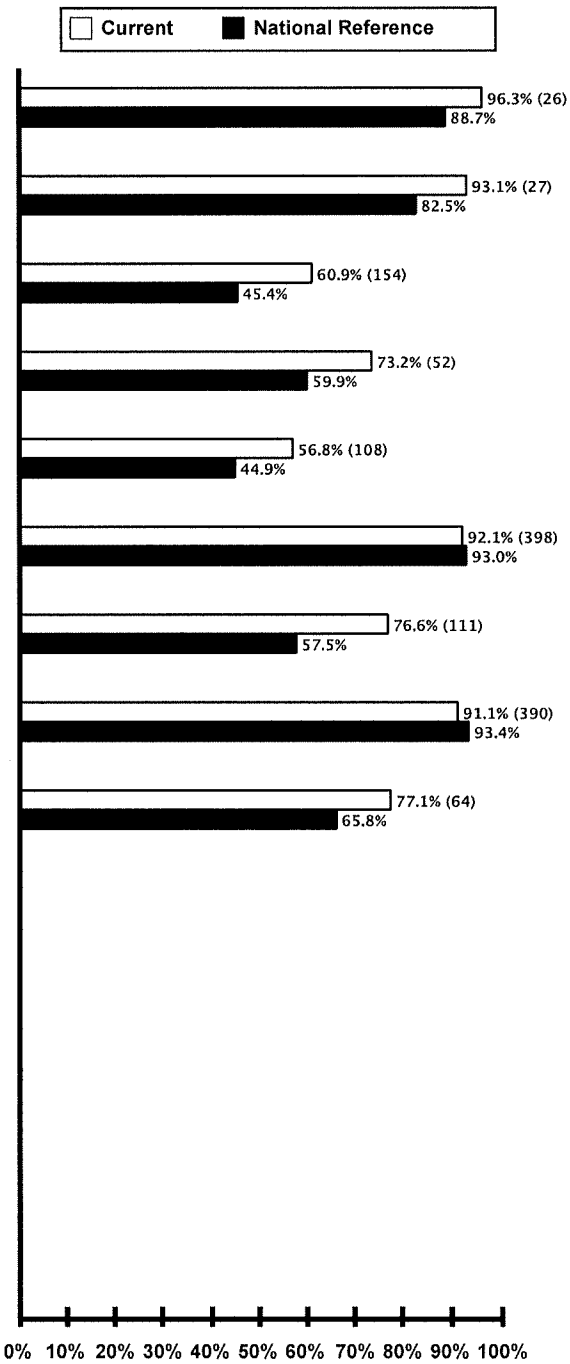
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Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: All
Medicaid Number: 28311

Requested Current Period: 01/2016 - 12/2016
Actual Current Period: 01/2016 - 12/2016
Number of Cases in Current Sample: 434
Number of Cases in Reference Sample: 495956
Date Report Printed: 03/31/2017

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Status of Surgical Wounds #	27	
	670815	0.22
Improvement in Urinary Tract Infection #	29	
	443613	0.12
Improvement in Urinary Incontinence #	253	
	2669612	0.00 **
Improvement in Bowel Incontinence	71	
	679070	0.02 **
Improvement in Confusion Frequency	190	
	2649346	0.00 **
Stabilization in Cognitive Functioning	432	
	4907044	0.47
Improvement in Anxiety Level #	145	
	2413791	0.00 **
Stabilization in Anxiety Level	428	
	4813795	0.07 *
Improvement in Behavior Problem Frequency #	83	
	1020023	0.03 **



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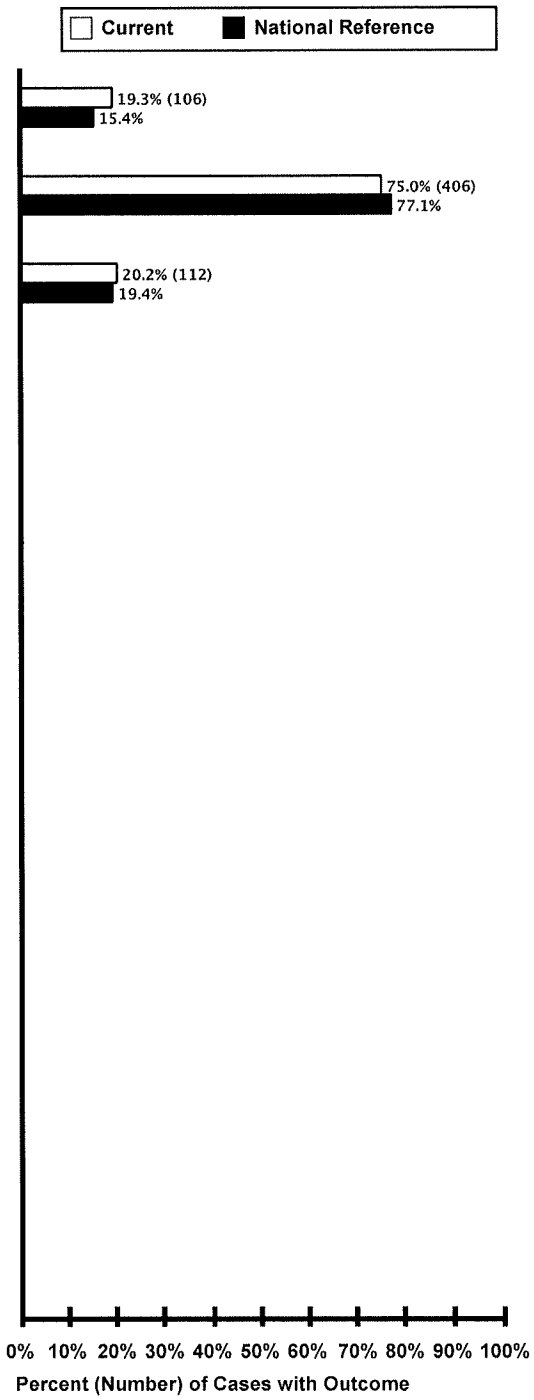
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Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: All
Medicaid Number: 28311

Requested Current Period: 01/2016 - 12/2016
Actual Current Period: 01/2016 - 12/2016
Number of Cases in Current Sample: 555
Number of Cases in Reference Sample: 681836
Date Report Printed: 03/31/2017

Utilization Outcomes:	Elig. Cases	Signif.
Emergency Department w/ Hospitalization	550	
	6668875	0.01 **
Discharged to Community	541	
	6688006	0.25
Acute Care Hospitalization	554	
	6763854	0.60



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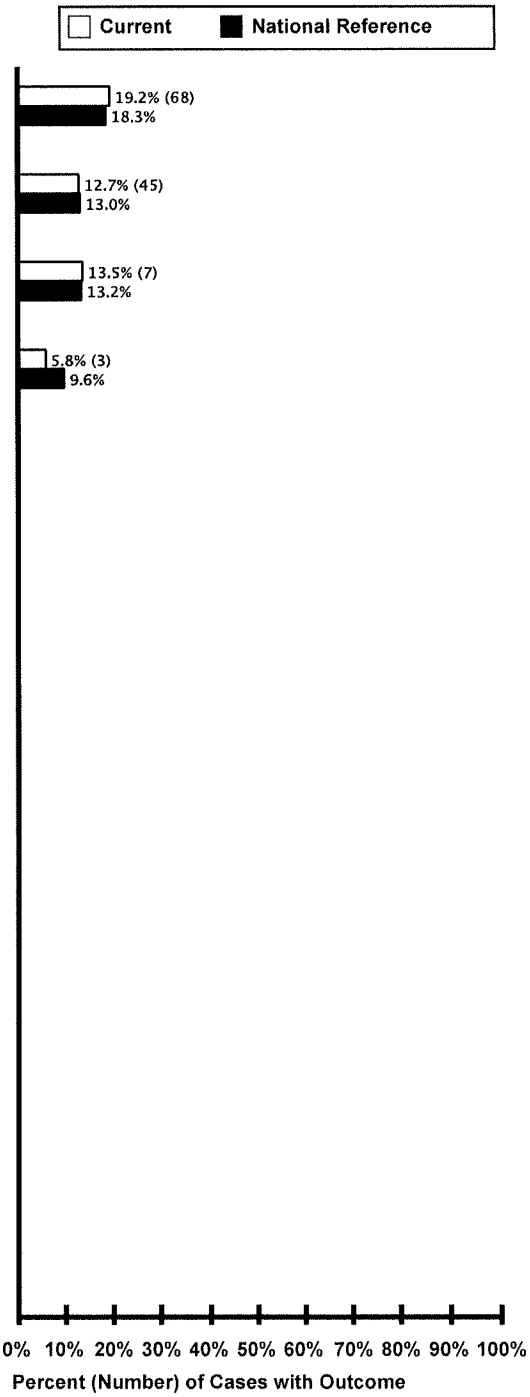
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Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: All
Medicaid Number: 28311

Requested Current Period 10/2015 - 09/2016
Actual Current Period (Claims): 10/2015 - 09/2016
Number of Cases in Current Sample (Claims): 355
Number of Cases in Reference Sample 276841
Date Report Printed: 03/31/2017

Claims Based Outcomes:	Elig. Cases	Signif.
Acute Care Hospitalization During the First 60 Days of Home Health	355 2768411	0.68
Emergency Department w/o Hospitalization During the First 60 Days of Home Health	355 2768411	0.88
Rehospitalization During the First 30 Days of Home Health	52 880146	0.92
Emergency Department Use Without Hospital Readmission During First 30 Days of Home Health	52 880146	0.36



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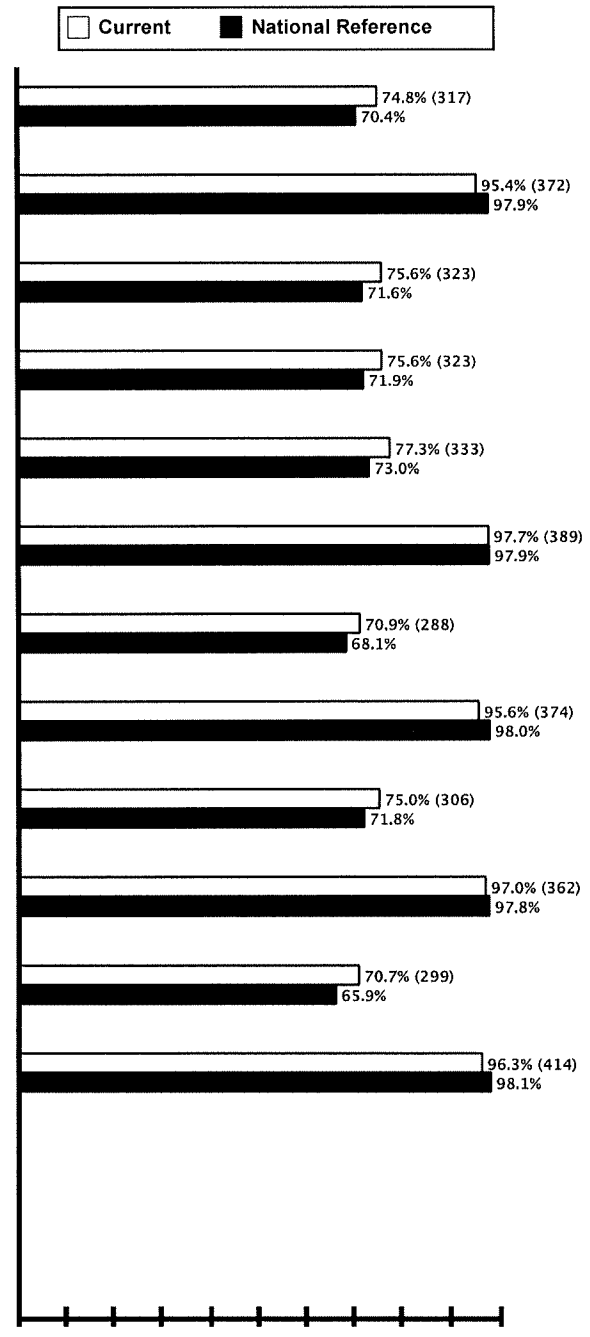
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Risk Adjusted Outcome Report

Agency Name: AMEDISYS HOME HEALTH
Agency ID: MD217048
Location: WESTMINSTER, MD
CCN: 217048 Branch: Parent
Medicaid Number: 28311

Requested Current Period: 01/2016 - 12/2016
Actual Current Period: 01/2016 - 12/2016
Number of Cases in Current Sample: 434
Number of Cases in Reference Sample: 495956
Date Report Printed: 03/31/2017

End Result Outcomes:	Elig. Cases	Signif.
Improvement in Grooming	424	
	4349733	0.05 **
Stabilization in Grooming	390	
	4554928	0.00 **
Improvement in Upper Body Dressing	427	
	4496525	0.06 *
Improvement in Lower Body Dressing	427	
	4603398	0.08 *
Improvement in Bathing	431	
	4802807	0.04 **
Stabilization in Bathing	398	
	4614146	0.78
Improvement in Toilet Transferring	406	
	4058106	0.22
Stabilization in Toilet Transferring	391	
	4583480	0.00 **
Improvement in Toileting Hygiene	408	
	4212207	0.15
Stabilization in Toileting Hygiene	373	
	4465737	0.31
Improvement in Bed Transferring	423	
	4591821	0.04 **
Stabilization in Bed Transferring	430	
	4862980	0.01 **



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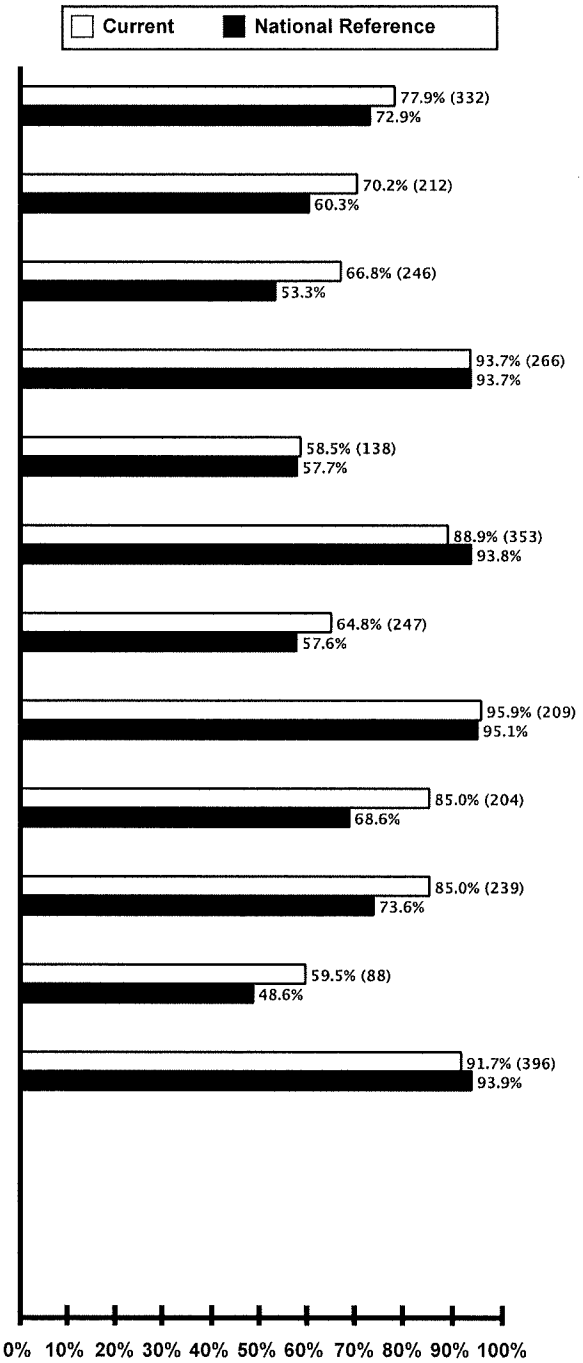
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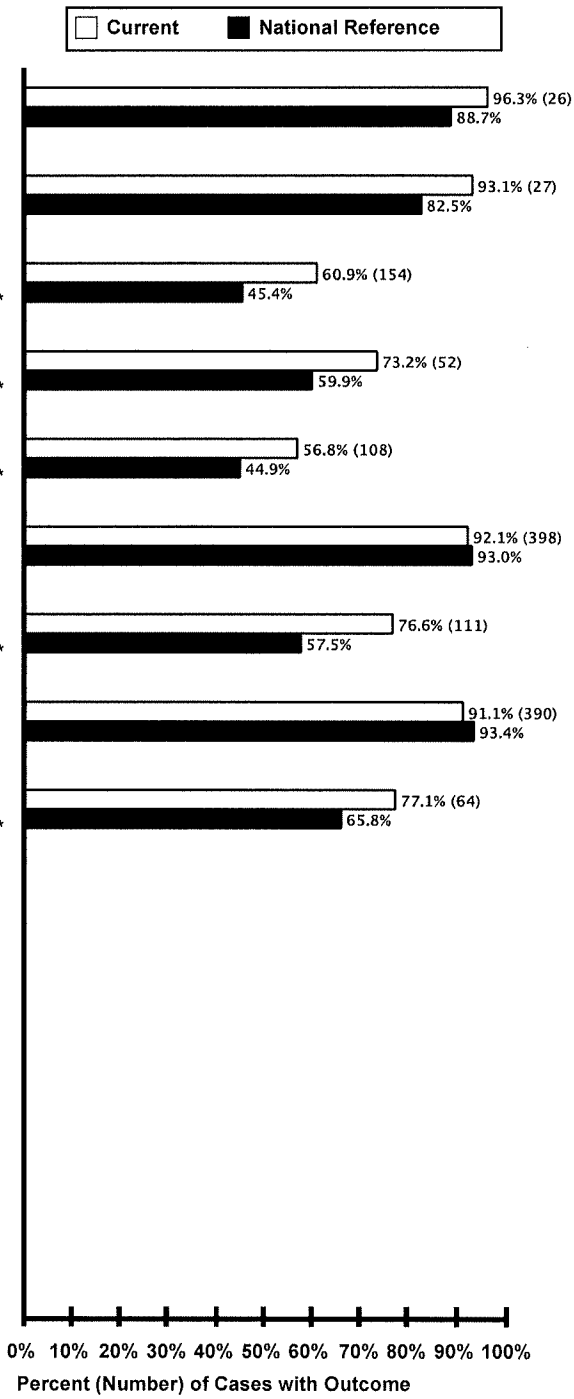
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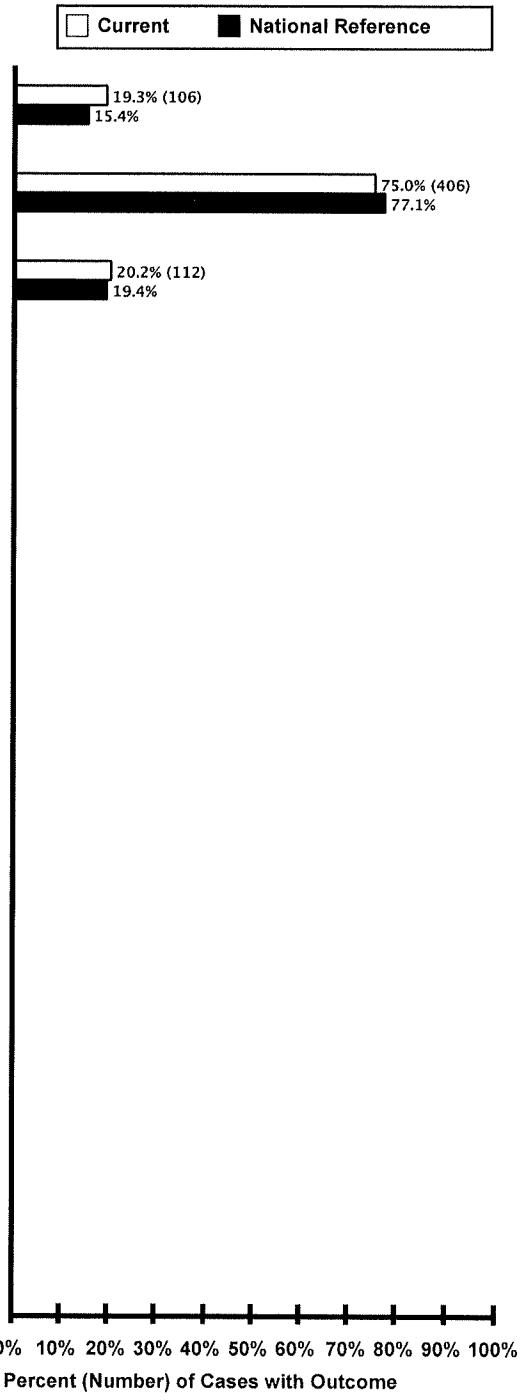
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EXHIBIT 13

Vendor	Sample Year	Sample Month	CCN #	Filename
National Research Corporation	2015	Dec	217048	HH_Amedisys Home Health - Westminster_217048_2015_12.xml
National Research Corporation	2015	Nov	217048	HH_Amedisys Home Health - Westminster_217048_2015_11.xml
National Research Corporation	2015	Oct	217048	HH_Amedisys Home Health - Westminster_217048_2015_10.xml
National Research Corporation	2015	Sep	217048	HH_Amedisys Home Health - Westminster_217048_2015_09.xml
National Research Corporation	2015	Aug	217048	HH_Amedisys Home Health - Westminster_217048_2015_08.xml
National Research Corporation	2015	Jul	217048	HH_Amedisys Home Health - Westminster_217048_2015_07.xml
National Research Corporation	2015	Jun	217048	HH_Amedisys Home Health - Westminster_217048_2015_06.xml
National Research Corporation	2015	Jun	217048	HH_Amedisys Home Health - Westminster_217048_2015_06.xml
National Research Corporation	2015	May	217048	HH_Amedisys Home Health - Westminster_217048_2015_05.xml
National Research Corporation	2015	Apr	217048	HH_Amedisys Home Health - Westminster_217048_2015_04.xml
National Research Corporation	2015	Mar	217048	HH_Amedisys Home Health - Westminster_217048_2015_03.xml
National Research Corporation	2015	Feb	217048	HH_Amedisys Home Health - Westminster_217048_2015_02.xml
National Research Corporation	2015	Jan	217048	HH_Amedisys Home Health - Westminster_217048_2015_01.xml
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OCS HomeCare	2011	Apr	217048	HH_Amedisys Home Health - Westminster_217048_2011_04.xml
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Strategic Healthcare Programs	2016	Sep	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q3_Sep_217048.xml
Strategic Healthcare Programs	2016	Aug	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q3_Aug_217048.xml
Strategic Healthcare Programs	2016	Jul	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q3_Jul_217048.xml
Strategic Healthcare Programs	2016	Jun	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q2_Jun_217048.xml
Strategic Healthcare Programs	2016	May	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q2_May_217048.xml

Strategic Healthcare Programs	2016	Apr	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q2_Apr_217048.xml
Strategic Healthcare Programs	2016	Mar	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q1_Mar_217048.xml
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Strategic Healthcare Programs	2016	Jan	217048	SHP_HHCAHPS_SURVEY_RESULTS_2016_Q1_Jan_217048.xml

Submission Date	# of Patients Sampled	# of Complete Responses	# of Incomplete Responses	Validation Status
3/7/2016	25	9	0	Passed
2/15/2016	29	11	0	Passed
2/12/2016	25	9	0	Passed
1/18/2016	41	12	0	Passed
1/18/2016	26	8	0	Passed
1/18/2016	29	9	0	Passed
10/13/2015	24	4	0	Passed
9/17/2015	24	3	0	Passed
8/11/2015	23	6	0	Passed
7/23/2015	20	10	0	Passed
6/18/2015	25	5	0	Passed
5/21/2015	31	3	0	Passed
4/29/2015	20	2	0	Passed
4/6/2015	30	9	0	Passed
2/26/2015	33	8	0	Passed
2/3/2015	28	9	0	Passed
1/2/2015	29	7	0	Passed
11/24/2014	27	8	0	Passed
11/7/2014	38	11	0	Passed
11/7/2014	38	0	0	Passed
10/1/2014	39	23	0	Passed

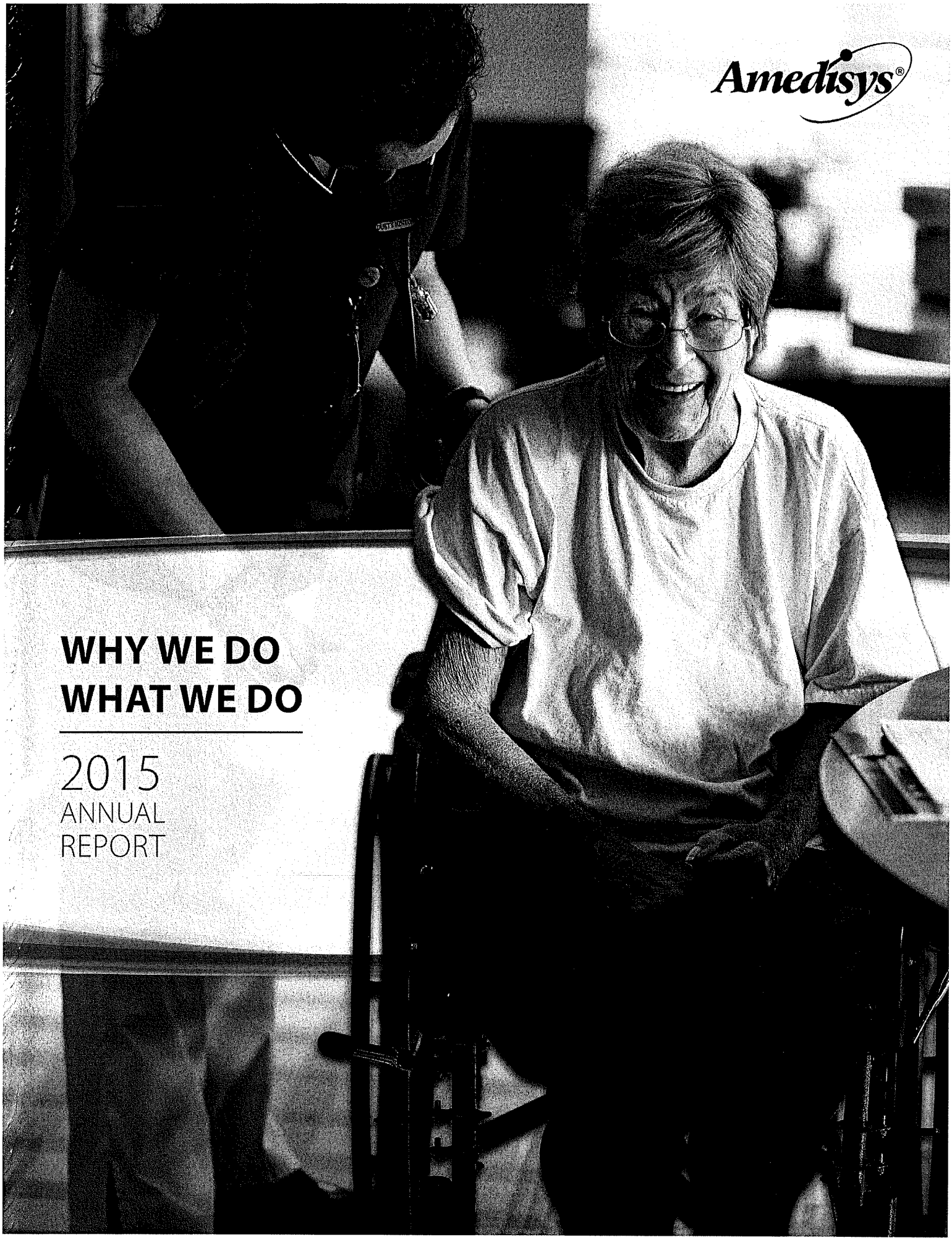
8/18/2014	41	13	0	Passed
7/22/2014	30	12	0	Passed
6/19/2014	41	10	0	Passed
5/13/2014	48	10	0	Passed
4/18/2014	49	18	0	Passed
3/17/2014	43	10	0	Passed
3/6/2014	63	24	0	Passed
1/15/2014	45	9	0	Passed
12/17/2013	43	10	0	Passed
11/19/2013	40	19	0	Passed
10/15/2013	31	4	0	Passed
9/13/2013	42	13	0	Passed
8/19/2013	41	9	0	Passed
7/18/2013	58	16	0	Passed
7/3/2013	49	14	0	Passed
5/22/2013	53	11	0	Passed
4/22/2013	58	16	0	Passed
3/20/2013	41	16	0	Passed
3/14/2013	72	21	0	Passed
3/14/2013	8	4	0	Passed
1/15/2013	8	4	0	Passed
12/18/2012	58	18	0	Passed

11/15/2012	60	20	0	Passed
10/18/2012	41	13	0	Passed
9/19/2012	46	23	0	Passed
8/7/2012	53	24	0	Passed
7/6/2012	49	23	0	Passed
6/6/2012	65	27	0	Passed
5/7/2012	50	18	0	Passed
5/2/2012	49	20	0	Passed
4/18/2012	44	17	0	Passed
3/14/2012	44	17	0	Passed
4/17/2012	67	24	0	Passed
2/14/2012	67	24	0	Passed
4/17/2012	49	15	0	Passed
1/26/2012	49	15	0	Passed
1/13/2012	61	19	0	Passed
1/13/2012	61	0	0	Passed
1/13/2012	61	0	0	Passed
1/19/2012	47	12	0	Passed
1/15/2012	47	12	0	Passed
1/14/2012	53	24	0	Passed
9/29/2011	51	24	0	Passed
8/12/2011	48	19	0	Passed

7/25/2011	51	23	0	Passed
7/18/2011	33	13	0	Passed
7/18/2011	33	0	0	Passed
7/7/2011	33	13	0	Passed
7/18/2011	35	16	0	Passed
7/7/2011	35	16	0	Passed
7/18/2011	53	18	0	Passed
7/6/2011	53	18	0	Passed
3/23/2011	51	18	0	Passed
3/4/2011	40	18	0	Passed
2/9/2011	42	16	0	Passed
1/13/2011	45	22	0	Passed
1/14/2011	46	17	0	Passed
1/6/2011	85	37	0	Passed
4/4/2017	42	13	0	Passed
4/4/2017	46	9	0	Passed
4/4/2017	57	21	0	Passed
1/18/2017	64	15	0	Passed
1/18/2017	29	8	0	Passed
1/18/2017	34	11	0	Passed
10/19/2016	30	8	0	Passed
10/19/2016	30	5	0	Passed

10/19/2016	36	12	0	Passed
7/19/2016	40	11	0	Passed
7/19/2016	21	6	0	Passed
7/19/2016	38	11	0	Passed

EXHIBIT 14



Amedisys®

WHY WE DO WHAT WE DO

2015
ANNUAL
REPORT

Dear Shareholders,

The turnaround of Amedisys that we kicked off in 2014 picked up fresh momentum in 2015, as we defined and began to implement our strategy to continue our transformation into a world-class market leader in post-acute healthcare.

I am very pleased with our financial performance in 2015. Amedisys realized increases in revenue by 6%, in adjusted EBITDA by 51% and in adjusted earnings per share by 103%. As a result, we finished the year with a strong, unlevered balance sheet and significant financial flexibility allowing us to pursue accretive acquisition opportunities.

In broad strokes, we saw an increase in our Medicare Quality of Patient Care and Patient Satisfaction STAR ratings, grew organically and executed on our first acquisitions in years, and moved toward best in class technology to streamline administrative work for our clinicians so they can focus on what they do best – patient care. Throughout the year, our more than 16,000 employees made no fewer than eight million visits. As a bonus, NASDAQ invited us to ring the opening bell this past December.

We also made significant progress in all four of our key strategies:

Achieve Clinical Distinction
When it comes to achieving outstanding patient outcomes – the very heart of our overall strategy – nothing speaks louder in the markets we serve than our clinical results. And the benchmark numbers for the all-important STAR ratings from Medicare are in.

Our average score for quality of patient care across all home health care centers in our January 2016 update was 3.49, our best performance to date, compared to an industry average of 3.25 – and 30% of our centers attained a rating of 4 STARS or better. Equally positive, our patient survey rating of 4.35 STARS in our January 2016 update was higher than the industry average of 4.03. As CMS and other healthcare payers continue to transition to value and outcomes-based reimbursement, we will continue to invest in quality.

But we have no intention of stopping there. By the end of 2017 our goal is for all of our home health care centers to achieve a quality STAR rating of 4 or higher.

Become An Employer of Choice
To be the best company we can be, we took steps in 2015 to create an environment that will inspire our employees to bring the best of themselves to the job each day, to better serve our patients, our colleagues, and our referring physicians and hospitals. In other words, we need to recruit, develop and retain outstanding, talented people. People are our most important asset, representing a large majority of our costs. We are executing on several fronts to improve our return on human capital.

To start, we conducted a survey among our employees to measure their level of engagement – how emotionally committed they are to Amedisys and its mission. Our overall engagement score, reflecting responses about employee pride, advocacy, loyalty and satisfaction, was 72% – slightly higher than the Kenexa World Norm average of 70% – with pride about working for Amedisys, the factor that ranked the highest.

This baseline data lent insight into how we are doing but also showed what we need to keep doing and how we can perform even better. Employee retention will improve as we understand more about key drivers of employee satisfaction. Our industry generally experiences high turnover and the direct and indirect costs of turnover are high. During the year, we lowered turnover by 4% with a goal of another 4% reduction by the end of 2016.

Operational Excellence and Efficiency
In May, we announced the decision to move away from our proprietary software and transition to HomeCare HomeBase (HCHB), a leading home health and hospice IT platform that enables our clinicians to better focus on care delivery. Our experience with implementation thus far has been outstanding,with positive feedback

from our clinical staff and minimal disruption to operations. This move has also enabled us to take a closer look at inefficient processes that have become ingrained in our operations. As we look into the rest of 2016 and 2017, we have a detailed plan to deliver approximately $46 million of cost savings, mostly from reductions in IT-related G&A expense and other efficiencies enabled by HCHB.

As I mentioned, we've received positive feedback from the 209 locations that have implemented HCHB, as well as others now in the process of doing so. As of April, all hospice care centers have implemented the software. To fulfill its maximum potential and achieve all the benefits available, we're accelerating our roll-out timeline for home health as well. By November 1, 2016, seven months ahead of our original plan, all of our care centers will be live on HCHB.

Driving Growth

We delivered on organic growth in both of our business units during the year. Home health Medicare admissions grew 3% and hospice admissions grew by 16%. In home health, we will continue to emphasize organic growth in traditional Medicare fee-for-service patients. In hospice, we look to build on a strong 2015 and are confident in the trends we are seeing in the business.

We completed our first significant acquisition in several years in December, acquiring Infinity HomeCare in Florida. Infinity is a market leader in Florida and complements our geographic footprint. In March 2016, we also acquired Associated Home Care, the leading personal care agency in Massachusetts, a move in line with our long-term strategy to broaden our scope of clinical services that can be delivered at home.

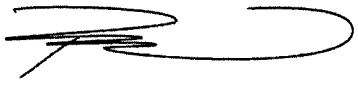
With our three lines of business – home health, hospice and now, personal care – we are extending the traditional continuum of care to give patients unprecedented opportunities to stay at home. This versatility will allow us to better coordinate our services and transition patients as needed to just the right level of care.

Orchestrating Our Strategies

Simply put, we want to do more in the home. If care is provided in the home, we want to understand it, participate in it and eventually coordinate it. This means further expansion of our capabilities and services to treat both higher and lower acuity patients in our traditional post-acute space, expansion into the pre-acute space and going even as far as providing some acute services inside the home to patients who have traditionally been treated in the emergency room or hospital. We are at the innovation forefront of this new world of home health and plan to develop organically and inorganically a capability set that allows Amedisys to do the most, for the most, all inside of the patient's home.

We have a solid strategy in place and the right leadership team to help us realize it, but none of this would be possible without the dedication of our more than 16,000 employees who either see patients every day or support those who do. I am amazed at the compassion and dedication I see from this team every day – and want to take this opportunity to thank them for doing what they do each and every day.

We are privileged to take care of those who need our help the most – and will continue to focus on bringing the best care possible to them. It's a virtuous circle – the better we perform for our patients and employees, the better we perform as a company. And the better we operate as a company, the better we can all ultimately serve our patients.



Paul Kusserow
President and Chief Executive Officer

FINANCIAL HIGHLIGHTS - AMEDISYS, INC. 2015

(Adjusted - amounts in millions, except per share data)[1]

YEAR ENDED DECEMBER 31,	**2015**	2014
Home Health revenue	**1,004.1**	956.9
Hospice revenue	**275.4**	247.6
Total net service revenue	**$1,279.5**	$1,204.5
Gross Margin %	***43.3%***	*42.6%*
EBITDA	**$112.0**	$74.3
	8.8%	6.2%
EPS[2]	**$1.48**	$0.73
Free cash flow[3]	**$80.4**	$(89.5)
Total revenue growth	**6%**	(4%)

Same store growth:		
Home Health Medicare admissions	**3%**	0%
Home Health non-Medicare admissions	**18%**	17%
Hospice admissions	**16%**	(3%)
Hospice average daily census	**12%**	(4%)

Outstanding Debt and Liquidity as of December 31, 2015:	
Credit Facility - Total	**300.0**
Term Loan	**100.0**
Outstanding Revolver	**-**
Letters of Credit	**21.0**
Available Revolver	**179.0**
Cash Balance	**27.5**
Available Liquidity[4]	**206.5**

[1] The financial results for 2015 and 2014 are adjusted for certain items and should be considered a non-GAAP financial measure. A reconciliation of these non-GAAP financial measures is included in the 8-K earnings release filed on March 8, 2016.

[2] EPS from continuing operations of $(0.09) in 2015 and $0.40 in 2014 on a GAAP basis.

[3] Free cash flow defined as cash flow from operations less capital expenditures and required debt repayments. Free cash flow in 2014 includes impact of Department of Justice settlement.

[4] Liquidity defined as the sum of cash balance and available revolving line of credit.

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

FORM 10-K

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended: December 31, 2015

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission File Number: 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.)

5959 S. Sherwood Forest Blvd., Baton Rouge, LA 70816
(Address of principal executive offices, including zip code)
(225) 292-2031 or (800) 467-2662
(Registrant's telephone number, including area code)

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

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

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☒ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ☐ No ☒

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

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 Act). Yes ☐ No ☒

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 30, 2015 (the last business day of the registrant's most recently completed second fiscal quarter) was $679,670,884. For purposes of this determination shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of March 4, 2016, the registrant had 33,329,102 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for its 2016 Annual Meeting of Stockholders (the "2016 Proxy Statement") to be filed pursuant to the Securities Exchange Act of 1934 with the Securities and Exchange Commission within 120 days of December 31, 2015 are incorporated herein by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "plans," "anticipates," "intends," "projects," "estimates," "may," "might," "would," "should" and similar 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 Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Critical Accounting Estimates" within "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Unless otherwise provided, "Amedisys," "we," "us," "our," and the "Company" refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2015, 2014 and 2013, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2015 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the "Investors" page under the "SEC Filings" link.

PART I

ITEM 1. BUSINESS

Overview

Amedisys, Inc. is a leading healthcare at home company, providing outstanding home health, hospice and personal care. We deliver the care that is best for our patients, whether that is home-based recovery and rehabilitation after an operation or injury, care that empowers patients to manage a chronic disease, or hospice care at the end of life.

We are among the largest, best established and most advanced providers of home health and hospice care in the United States, with 408 care centers in 34 states. Our 16,100 employees deliver the highest quality of care to the doorsteps of patients in need, making more than 7.5 million patient visits to 360,000 patients annually. Over 2,200 hospitals and 61,900 physicians nationwide have chosen us as a partner in post-acute care.

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

The company's continuous quality improvement efforts show in outcomes and publicly reported quality measures. We're standardizing our clinical care, streamlining how we operate and partnering as a post-acute care provider to an increasing number of hospitals and health systems across the country. Our mission is nothing less than putting the best clinicians in the home, with the tools needed to provide the best possible care and outcomes. Ultimately, we are in the business of delivering superior value to employees, referral sources, payors – and most of all – patients and their families.

We are privileged to take care of our patients wherever they call home – a private house, an apartment, a rehabilitation facility or an assisted living community. Our clinicians go behind the scenes to enter otherwise private spaces, caring for patients who feel safe and cared for and for others who are struggling with poverty and dysfunction. We see it all – we get the whole picture of our patients – which enables us to develop and administer the right care plan for each one in conjunctions with primary care physicians and other providers.

Our services are primarily paid for by Medicare due to the age demographics of our patient base (average age 81). Medicare represented approximately 80% to 84% of our net service revenue over the last three years. We remain focused on maintaining a profitable and strategically important managed care contract portfolio.

Our Home Health Segment:

Amedisys Home Health provides experienced, compassionate healthcare to help our patients recover from surgery or illness, live with chronic diseases, and prevent avoidable hospital readmissions. Our care team includes skilled nurses who are trained and certified to administer medications, care for wounds, monitor vital signs and provide a wide range of other nursing services; therapists specialized in physical, speech and occupational therapy; and aides who assist our patients with completing important personal tasks.

We take an empowering approach to helping our patients and their families understand their condition, how to manage it and how to live life to the fullest with a chronic disease or other health condition. Our professional and compassionate clinicians are trained to understand the whole patient – not just their medical diagnosis.

This commitment to clinical distinction is evident in our clinical performance measures such as Star Ratings. Amedisys has an average Quality Star Rating of 3.5 and an average Patient Survey Overall Star Rating of 4.4. Our goal is to have all of our care centers achieve a 4.0 Quality Star Rating, and we are implementing targeted action plans to continue to improve the quality of care we deliver for our patients across the country.

Our Hospice Segment:

Hospice is a special form of care that is designed to provide comfort and support for those who are dealing with a terminal illness. It is a compassionate form of care that promotes dignity and affirms quality of life for the patient, family members and other loved ones.

Individuals with a terminal illness such as heart disease, pulmonary disease, Alzheimer's, HIV/AIDS or cancer may be eligible for hospice care, if they have a life expectancy of six months or less.

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

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

By working to accept every patient with a life expectancy of six months or less who wants our compassionate care, we fulfill our hospice mission and strengthen our standing in the community.

Our Personal Care Segment:

On March 1, 2016, Amedisys acquired its first private-duty – an important step in executing our strategy of improving the continuity of care our patients receive as their clinical needs change.

We believe that private duty services are highly synergistic with our core skilled home health and hospice businesses, and that by acquiring these capabilities in one of our most successful regions we will realize these benefits quickly.

Responding to Changing Regulatory and Reimbursement Environment:

Effective October 2012, Medicare began to impose a financial penalty on hospitals that have excessive rates of patient readmissions within 30 days after hospital discharge. We believe this regulation provides an opportunity for providers of post-acute care who can demonstrate the ability to maintain or reduce patient acute care hospital readmission rates. We are working to take advantage of this opportunity further improving the quality of care we provide and implementing disease management programs designed to be responsive to the needs of patients served by the hospitals we call upon.

The passage of the Patient Protection and Affordable Care Act ("PPACA") has resulted in several programs being introduced by the Centers for Medicare and Medicaid Services ("CMS") that offer the opportunity to participate in initiatives that align home health providers with hospitals, physicians, managed care payors and other referral sources to coordinate care and/or pilot alternative reimbursement structures. One such program is the CMS Bundled Payments for Care Improvement Initiative ("BPCI"). We participated in a "Model 3 – 90-Day Post-Acute" BPCI bundle across two regions during 2014. This is an at-risk model in which CMS sets a bundle target price based on historical costs. On October 29, 2014, we notified CMS of our plan to withdraw from the two Model 3 bundles.

In addition to the BPCI program, PPACA introduced Accountable Care Organization ("ACO") programs. An ACO is a group of doctors, hospitals and other health care providers who come together voluntarily to give

coordinated high-quality care to Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. While these programs are presently not material to our business or our financial results, we are currently participating in several ACOs and monitoring their results.

AMS3/Homecare Homebase Implementation:

During 2015, we made the strategic decision to discontinue AMS3, our third generation, proprietary operating system, and transition to Homecare Homebase ("HCHB"), a leading home health and hospice platform. As of December 31, 2015, we have 84 care centers on HCHB (44 home health care centers and 40 hospice care centers). We will continue the rollout during 2016, with an anticipated completion date of November 1, 2016.

Acquisitions:

On July 24, 2015, we acquired one hospice care center in Tennessee for a total purchase price of $5.8 million.

On October 2, 2015, we acquired the regulatory assets of home health care center in Georgia for a total purchase price of $0.3 million.

On December 31, 2015, we acquired Infinity HomeCare ("Infinity") for a total purchase price of $63 million. Infinity owned and operated 15 home health care centers servicing the state of Florida.

Financial Information:

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

Our Employees

As of March 4, 2016, we employed approximately 16,100 employees, consisting of approximately 11,200 home health care employees, 2,600 hospice care employees, 1,500 personal care employees and 800 corporate and divisional support employees.

Payment for Our Services

Home Health Medicare

The Medicare home health benefit is available both for patients who need care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing but intermittent care. As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. Medicare rates are based on the severity of the patient's condition, his or her service needs and other factors relating to the cost of providing services and supplies, bundled into 60-day episodes of care. An episode starts with the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier. If a patient is still in treatment on the 60th day, a recertification assessment is undertaken to determine whether the patient needs additional care. If the patient's physician determines that further care is necessary, another episode begins on the 61st day (regardless of whether a billable visit is rendered on that day) and ends 60 days later. The first day of a consecutive episode, therefore, is not necessarily the new episode's first billable visit.

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

Period	Base episode payment
January 1, 2013 through December 31, 2013	2,138
January 1, 2014 through December 31, 2014	2,869
January 1, 2015 through December 31, 2015	2,961
January 1, 2016 through December 31, 2016	2,965

Payments can be adjusted for: (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 during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before an episode was complete; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) a payment adjustment 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. Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. In addition, we make adjustments to Medicare revenue if we find that we are unable to obtain appropriate billing documentation, authorizations or face to face documentation.

Home Health Non-Medicare

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

Hospice Medicare

The Medicare hospice benefit is also available to Medicare-eligible patients with terminal illnesses, certified by a physician, where life expectancy is six months or less. Medicare rates are based on standard prospective rates for delivering care over a base 90-day or 60-day period (90-day episodes of care for the first two episodes and 60-day episodes of care for any subsequent episodes). Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Rates are set based on specific levels of care, are adjusted by a wage index to reflect health care labor costs across the country and are established annually through federal legislation. We make adjustments to Medicare revenue when we find we are unable to obtain appropriate billing documentation, authorizations or face to face documentation and other reasons unrelated to credit risk. The levels of care are routine care, general inpatient care, continuous home care and respite care. 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.

We bill Medicare for hospice services on a monthly basis and our payments are subject to two fixed annual caps, which are assessed on a provider number basis. Generally, each hospice care center has its own provider number. However, where we have created branch care centers to help our parent care centers serve a geographic location, the parent and branch may have the same provider number. The annual caps per patient, known as hospice caps, are calculated and published by the Medicare fiscal intermediary on an annual basis and cover the twelve month period from November 1 through October 31. The caps can be subject to annual and retroactive adjustments, which can cause providers to be required to reimburse the Medicare program if such caps are exceeded.

The two caps are detailed below:

- ***Inpatient Cap.*** When we provide hospice care on an inpatient basis, the payments that we are entitled to receive at the higher inpatient reimbursement rate are subject to a cap. This cap limits the number of days that are paid at the inpatient care rate (both respite and general) under a provider number to 20% of the total number of days of hospice care (both inpatient and in-home) that is furnished to all Medicare patients served by the provider. The daily Medicare payment rate for any inpatient days of service that exceed the cap is at the routine home care rate, and the provider is required to reimburse Medicare for any amounts it receives in excess of the cap; and

- ***Overall Payment Cap.*** This cap is calculated by the Medicare fiscal intermediary at the end of each hospice cap period to determine the maximum allowable payments per provider number. We estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation.

Our ability to stay within these limitations depends on a number of factors, each determined on a provider number basis, including the average length of stay and mix in level of care.

Hospice Non-Medicare

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

Controls over Our Business System Infrastructure

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

- ***Coding*** – Specified diagnosis codes are assigned to each of our patients based on their particular health condition and ailment (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. In order to reduce associated risk of coding failures, we provide coding training and annual update training to clinical assessment managers; provide coding training during orientation for new employees; provide monthly specialized coding education; obtain outside expert coding instruction; utilize coding software in our POC system; and have automated coding edits based on pre-defined compliance metrics in our POC system.
- ***Clinical Operations*** – Regulatory requirements allow patients to be admitted to home health care if they are considered homebound and require certain clinical services. These clinical services include: educating the patient about their disease; assessment and observation of disease status; delivery of clinical skills such as wound care; administration of injections or intravenous fluids; and management and evaluation of a patient's plan of care. In order to help monitor and promote compliance with regulatory requirements, we complete audits of patient charts; administer survey guideline education; hold recurrent homecare regulatory education; utilize outside expert regulatory services; and have a toll-free hotline to offer additional assistance.
- ***Billing*** – We maintain controls over our billing processes to help promote accurate and complete billing. In order to promote the accuracy and completeness of our billing, we have annual billing compliance testing; use formalized billing attestations; limit access to billing systems; hold weekly operational meetings; use automated daily billing operational indicators; and take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures in accordance with a well-publicized "Zero Tolerance Policy".
- ***Patient Recertification*** – In order to be recertified for an additional episode of care, a patient must continue to meet qualifying criteria and have a continuing medical need. This could be caused by changes in the patient's condition requiring changes to the patient's medical regimen or modified care protocols within the episode of care. The patient's progress towards goals is evaluated prior to recertification. As with the initial episode of care, a recertification requires orders from the patient's physician. Before any employee recommends recertification to a physician, we conduct a care center level, multidisciplinary care team conference. We also monitor centralized automated compliance recertification metrics to identify, monitor, and, where we deem appropriate, audit care centers that have relatively high recertification levels.

- ***Compliance*** – The quality and reputation of our personnel and operations are critical to our success. We develop, implement and maintain ethics, compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice care centers. Our ethics and compliance program includes a Code of Ethical Business Conduct for our employees, officers, directors and affiliates and a process for reporting regulatory or ethical concerns to our Chief Compliance Officer through a confidential hotline, which is augmented by exit interviews of departing employees and monthly interviews with randomly-selected, current employees. We promote a culture of compliance within our company through persistent messages from our senior leadership to our employees stressing the importance of strict compliance with legal requirements and company policies and procedures. We also employ a comprehensive compliance training program that includes mandatory compliance training and testing for all new employees upon hire and annually for all staff thereafter. In addition to our compliance training, we also conduct numerous proactive, compliance audits focusing on key risk areas, which are conducted by clinical auditors who work for our Compliance Department.

Our Regulatory Environment

We are highly regulated by federal, state and local authorities. Regulations and policies frequently change, and we monitor changes through trade and governmental publications and associations. Our home health and hospice subsidiaries are certified by CMS and therefore are eligible to receive payment for services through the Medicare system.

We are also subject to federal, state and local laws and regulations dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, environmental issues and adverse event reporting and recordkeeping. Federal, state and local governments are expanding the number of regulatory requirements on businesses.

We have set forth below a discussion of the regulations that we believe most significantly affect our home health and hospice businesses.

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

Home health and hospice care centers operate under licenses granted by the health authorities of their respective states. Additionally, certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or competitive changes. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting either from population increases or a reduction in competing providers. These states ration the entry of new providers or services and the expansion of existing providers or services in their markets through a CON process, which is periodically evaluated. Currently, state health authorities in 17 states and the District of Columbia require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health care center, and state health authorities in 11 states and the District of Columbia require a CON to operate a hospice care center.

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

In every state where required, our locations possess a license and/or CON or POA issued by the state health authority that determines the local service areas for the home health or hospice care center. In general, the process for opening a home health or hospice care center begins by a provider submitting an application for licensure and certification to the state and federal regulatory bodies, which is followed by a testing period of

transmitting data from the applicant to CMS. Once this process is complete, the care center receives a provider agreement and corresponding number and can begin billing for services that it provides unless a CON or POA is required. For those states that require a CON or POA, the provider must also complete a separate application process before billing can commence and receive required approvals for capital expenditures exceeding amounts above prescribed thresholds.

State CON and POA laws generally provide that, prior to the addition of new capacity, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The process is intended to promote comprehensive health care planning, assist in providing high-quality health care at the lowest possible cost and avoid unnecessary duplication by ensuring that only those health care facilities and operations that are needed will be built and opened.

Medicare Participation

Our care centers must comply with regulations promulgated by the United States Department of Health and Human Services in order to participate in the Medicare program and receive Medicare payments. Among other things, these regulations, known as "conditions of participation," relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with state and local laws and regulations. CMS has adopted alternative sanction enforcement options which allow CMS (i) effective as of July 1, 2013, to impose temporary management, direct plans of correction, or direct training, and (ii) effective as of July 1, 2014, to impose payment suspensions and civil monetary penalties in each case on providers out of compliance with the conditions of participation. CMS issued a proposed rule on October 9, 2014, revising the current home health conditions of participation. We provided public comments on the proposed changes, but we cannot predict the content or effective date of any final rule revising the home health conditions of participation. As of the date of this filing, the proposed rule has not been finalized.

CMS has engaged a number of third party firms, including Recovery Audit Contractors ("RACs"), Program Safeguard Contractors ("PSCs"), Zone Program Integrity Contractors ("ZPICs") and Medicaid Integrity Contributors ("MICs"), to conduct extensive reviews of claims data and state and Federal Government health care program laws and regulations applicable to healthcare providers. These audits evaluate the appropriateness of billings submitted for payment. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

Federal and State Anti-Fraud and Anti-Kickback Laws

As a provider under the Medicare and Medicaid systems, we are subject to various anti-fraud and abuse laws, including the Federal health care programs' anti-kickback statute and, where applicable, its state law counterparts. Subject to certain exceptions, these laws prohibit any offer, payment, solicitation or receipt of any form of remuneration to induce or reward the referral of business payable under a government health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered under a government health care program. Affected government health care programs include any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits/programs), including certain state health care programs that receive federal funds, such as Medicaid. A related law forbids the offer or transfer of anything of value, including certain waivers of co-payment obligations and deductible amounts, to a beneficiary of Medicare or Medicaid that is likely to influence the beneficiary's selection of health care providers, again subject to certain exceptions. Violations of the anti-fraud and abuse laws can result in the imposition of substantial civil and criminal penalties and, potentially, exclusion from furnishing services under any government health care program. In addition, the states in which we operate generally have laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers where they are designed to obtain the referral of patients from a particular provider.

Stark Laws

Congress adopted legislation in 1989, known as the "Stark Law," that generally prohibited a physician from ordering clinical laboratory services for a Medicare beneficiary where the entity providing that service has a financial relationship (including direct or indirect ownership or compensation relationships) with the physician (or a member of his/her immediate family), and further prohibits such entity from billing for or receiving payment for such services, unless a specified exception is available. The Stark Law was amended through additional legislation, known as "Stark II," which became effective January 1, 1993. That legislation extended the Stark Law prohibitions beyond clinical laboratory services to a more extensive list of statutorily defined "designated health services," which includes, among other things, home health services, durable medical equipment and outpatient prescription drugs. Violations of the Stark Law result in payment denials and may also trigger civil monetary penalties and program exclusion. Several of the states in which we conduct business have also enacted statutes similar in scope and purpose to the federal fraud and abuse laws and the Stark Laws. These state laws may mirror the Federal Stark Laws or may be different in scope. The available guidance and enforcement activity associated with such state laws varies considerably.

Federal and State Privacy and Security Laws

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), directed that the Secretary of the U.S. Department of Health and Human Services ("HHS") promulgate regulations prescribing standard requirements for electronic health care transactions and establishing protections for the privacy and security of individually identifiable health information, known as "protected health information." The HIPAA transactions regulations establish form, format and data content requirements for most electronic health care transactions, such as health care claims that are submitted electronically. The HIPAA privacy regulations establish comprehensive requirements relating to the use and disclosure of protected health information. The HIPAA security regulations establish minimum standards for the protection of protected health information that is stored or transmitted electronically. Violations of the privacy and security regulations are punishable by civil and criminal penalties.

The American Recovery and Economic Reinvestment Act of 2009 ("ARRA"), signed into law by President Obama on February 17, 2009, contained significant changes to the privacy and security provisions of HIPAA, including major changes to the enforcement provisions. Among other things, ARRA significantly increased the amount of civil monetary penalties that can be imposed for violations of HIPAA. ARRA also authorized state attorneys general to bring civil enforcement actions under HIPAA. These enhanced penalties and enforcement provisions went into effect immediately upon enactment of ARRA. ARRA also required that HHS promulgate regulations requiring that certain notifications be made to individuals, to HHS and potentially to the media in the event of breaches of the privacy of protected health information. These breach notification regulations went into effect on September 23, 2009, and HHS began to enforce violations on February 22, 2010. Violations of the breach notification provisions of HIPAA can trigger the increased civil monetary penalties described above.

ARRA's numerous other changes to HIPAA have delayed effective dates and require the issuance of implementing regulations by HHS. The Health Information Technology for Economic and Clinical Health ("HITECH") Act was enacted in conjunction with ARRA. On January 25, 2013, HHS issued final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the HITECH Act, which had been previously issued as a proposed rule on July 14, 2010. Among other things, these modifications make business associates of covered entities directly liable for compliance with certain HIPAA requirements, strengthen the limitations on the use and disclosure of protected health information without individual authorizations, and adopt the additional HITECH Act enhancements, including enforcement of noncompliance with HIPAA due to willful neglect. The changes to HIPAA enacted as part of ARRA reflect a Congressional intent that HIPAA's privacy and security provisions be more strictly enforced. It is likely that these changes will stimulate increased enforcement activity and enhance the potential that health care providers will be subject to financial penalties for violations of HIPAA.

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

The False Claims Act

The Federal False Claims Act gives the Federal Government an additional way to police false bills or requests for payment for health care services. Under the False Claims Act, the government may fine any person who knowingly submits, or participates in submitting, claims for payment to the Federal Government which are false or fraudulent, or which contain false or misleading information. Any person who knowingly makes or uses a false record or statement to avoid paying the Federal Government, or knowingly conceals or avoids an obligation to pay money to the Federal Government, may also be subject to fines under the False Claims Act. Under the False Claims Act, the term "person" means an individual, company, or corporation. The Federal Government has widely used the False Claims Act to prosecute Medicare and other governmental program fraud in areas such as violations of the Federal anti-kickback statute or the Stark Laws, coding errors, billing for services not provided, and submitting false cost reports. The False Claims Act has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and that bill for care that is not medically necessary. In addition to government enforcement, the False Claims Act authorizes private citizens to bring qui tam or "whistleblower" lawsuits, greatly extending the practical reach of the False Claims Act. The penalty for violation of the False Claims Act is a minimum of $5,500 for each fraudulent claim plus three times the amount of damages caused to the government as a result of each fraudulent claim.

The Fraud Enforcement and Recovery Act of 2009 ("FERA") amended the False Claims Act with the intent of enhancing the powers of government enforcement authorities and whistleblowers to bring False Claims Act cases. In particular, FERA attempts to clarify that liability may be established not only for false claims submitted directly to the government, but also for claims submitted to government contractors and grantees. FERA also seeks to clarify that liability exists for attempts to avoid repayment of overpayments, including improper retention of federal funds. FERA also included amendments to False Claims Act procedures, expanding the government's ability to use the Civil Investigative Demand process to investigate defendants, and permitting government complaints in intervention to relate back to the filing of the whistleblower's original complaint. FERA is likely to increase both the volume and liability exposure of False Claims Act cases brought against health care providers.

On February 12, 2016, CMS finalized the so-called "60-day rule," which is the obligation of providers to report and return Medicare overpayments within 60 days of identifying the same. A provider who retains overpayments beyond 60 days may be liable under the False Claims Act. "Identification" is identified as when a person "has, or should have through the exercise of reasonable diligence," identified and quantified the amount of an overpayment. Providers must report and return overpayments even if they did not cause the overpayment.

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

Civil Monetary Penalties

The United States Department of Health and Human Services may impose civil monetary penalties upon any person or entity who presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation. In addition, persons who have been excluded from the Medicare or Medicaid program and still retain ownership in a participating entity, or who contract with excluded persons, may be penalized. Penalties also are applicable in certain other cases, including violations of the Federal anti-kickback statute, payments to limit certain patient services and improper execution of statements of medical necessity.

FDA Regulation

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

Patient Protection and Affordable Care Act

In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"). Even as of December 31, 2015, it is difficult to predict the full impact of PPACA due to the law's complexity and phased in effective dates, as well as our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. PPACA calls for a number of changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates decreases in home health reimbursement rates, including a four-year phased rebasing of the home health payment system that began in 2014 and will continue through 2017. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors." PPACA has established a number of new requirements impacting our business operations, and promises to give rise to other changes that could significantly impact our businesses in the future. For example, PPACA also mandates the creation of a home health value-based purchasing program, the development of quality measures, and the testing of alternative payment and delivery models, including ACOs and the Bundled Payments for Care Improvement initiative. See Part I, Item 1A, "Risk Factors: Risks Related to Laws and Government Regulations" for a more complete discussion of PPACA and the risks it presents to our businesses.

Our Competitors

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

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and

financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled "Investors" on our website home page. 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 "Investors" 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 "Investors" subpage of our website. In addition, we make available on the Investors subpage of our website (under the link "SEC Filings"), free of charge, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, ownership reports on Forms 3, 4 and 5 and any amendments to those reports as soon as reasonably practicable after we electronically file or furnish such reports with the SEC. Further, copies of our Certificate of Incorporation and Bylaws, our Code of Ethical Business Conduct, our Corporate Governance Guidelines and the charters for the Audit, Compensation, Nominating and Corporate Governance and Quality of Care Committees of our Board are also available on the Investors subpage of our website (under the link "Corporate Governance"). Reference to our website does not constitute incorporation by reference of the information contained on the website and should not be considered part of this document.

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

ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks faced by Amedisys. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

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

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

Risks Related to Reimbursement

Because a high percentage of our revenue is derived from Medicare, reductions in Medicare rates, rate increases that do not cover cost increases and/or significant changes to the Medicare payment methodology or eligibility requirements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our net service revenue is primarily derived from Medicare, which accounted for 80%, 82% and 84% of our revenue during 2015, 2014 and 2013, respectively. Payments received from Medicare are subject to changes made through federal legislation. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. These changes, as further detailed in Part I, Item 1, "Business: Payment for Our Services," can include changes to base episode payments and adjustments for home health services, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility and documentation requirements or changes designed to restrict utilization. Any such changes, including retroactive adjustments, adopted in the future by CMS could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

We could be affected adversely by the continuing efforts of governmental payors to contain health care costs. We cannot assure you that reimbursement payments under governmental payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Any such changes could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

With respect to our hospice operations, overall payments made by Medicare to each provider number (generally corresponding to a hospice care center) are subject to an inpatient cap amount and an overall payment cap, which

are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we may be required to reimburse the Medicare program for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Adverse developments in the United States could lead to a reduction in Federal Government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the Federal Government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the Federal Government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by the United States Congress to complete the federal budget process and fund government operations may result in a Federal Government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. As an example, the failure of the 2011 Joint Select Committee to meet its Deficit Reduction goal resulted in an automatic reduction in Medicare home and hospice payments of 2% beginning April 1, 2013.

Historically, state budget pressures have resulted in reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services.

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

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

Our non-Medicare revenue and profitability are affected by continuing efforts of third party payors to maintain or reduce costs of health care by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. There can be no assurance that third party payors will make timely payments for our services, and there is no assurance that we will continue to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare sources of revenue and any changes in payment levels from current or future third party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Laws and Government Regulations

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

On April 23, 2014, with no admissions of liability on our part, we entered into a settlement agreement with the U.S. Department of Justice relating to certain of our clinical and business operations. Concurrently with our entry into this agreement, we entered into a Corporate Integrity Agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA, which has a term of five years, formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing

compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization ("IRO") to perform certain auditing and reviews and prepare certain reports regarding our compliance with federal health care programs, our billing submissions to federal health care programs and our compliance and risk mitigation programs; and provide certain reports and management certifications to the OIG. Additionally, the CIA specifically requires that we report substantial overpayments that we discover we have received from the federal health care programs, as well as probable violations of federal health care laws. Upon breach of the CIA, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. Although we believe that we are currently in compliance with the CIA, any violations of the agreement could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Pending civil litigation could have a material adverse effect on the Company.

We and certain of our current and former directors, senior executives and other employees are defendants in a federal securities class action. We are also a defendant in several wage and hour law putative collective and class action lawsuits. See Part II, Item 8, Note 10 – Commitments and Contingencies for a more detailed description of these proceedings. These actions remain in preliminary stages and it is not yet possible to assess their probable outcome or our potential liability, if any. We cannot provide any assurances that the legal and other costs associated with the defense of these actions, the amount of time required to be spent by management on these matters and the ultimate outcome of these actions will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our insurance may not cover all of the costs associated with defending the pending federal securities class action, and any potential liability costs associated with this matter, and we maintain no insurance that covers any portion of the pending wage and hour putative collective and class action lawsuits.

With respect to the pending securities class action, we may be obligated to indemnify (and advance legal expenses to) both current and former officers, employees and directors in connection with this matter. We maintain directors' and officers' liability insurance that we believe should cover a portion of the legal costs and potential liability costs associated with this matter. However, such insurance coverage does not extend to all of these expenditures, and the insurance limits may be insufficient even with respect to expenditures that would otherwise be covered. Furthermore, our insurance carriers may seek to deny coverage in this matter, in which case we may have to fund the indemnification amounts owed to such directors and officers ourselves. We do not maintain any insurance that will cover any part of the wage and hour putative collective and class action lawsuits in which we are defendants. If our insurance coverage is denied or is not adequate, it may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

- licensure and certification;
- adequacy and quality of health care services;
- qualifications of health care and support personnel;

- quality and safety of medical equipment;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources;
- operating policies and procedures;
- policies and procedures regarding employee relations;
- addition of facilities and services;
- billing for services;
- requirements for utilization of services;
- documentation required for billing and patient care; and
- reporting and maintaining records regarding adverse events.

These laws and regulations, and their interpretations, are subject to change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows by:

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

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

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

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

material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Moreover, an adverse review, audit or investigation could result in:

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

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

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

Each of our care centers must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a care center, we may receive a notice of deficiency from the applicable state surveyor. If that care center then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program or subjected to alternative sanctions. CMS outlined its alternative sanction enforcement options for home health care centers through a regulation published in 2012; under the regulation, CMS may impose temporary management, direct a plan of correction, direct training or impose payment suspensions and civil monetary penalties, in each case, upon providers who fail to comply with the conditions of participation. Termination of one or more of our care centers from the Medicare program for failure to satisfy the program's conditions of participation, or the imposition of alternative sanctions, could disrupt operations, require significant attention by management, or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations and cash flows. CMS issued a proposed rule on October 9, 2014, revising the Medicare conditions of participation for home health care centers across the industry, with an unknown effective date. We provided public comments on the proposed changes, but do not know at this time what effect the finalized revisions will have on our operations, and there can be no assurances that the revisions will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

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

PPACA makes a number of changes to Medicare payment rates and also calls for a rebasing of the home health payment system that began in 2014 and will continue through 2017. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors."

For example, as a result of the PPACA, CMS added two regulations that became effective April 1, 2011: (1) a face-to-face encounter requirement for home health and hospice services and (2) changes to the home health therapy assessment schedule, which requires additional patient evaluations and certifications. These and other regulations implementing the provisions of the PPACA may similarly increase our costs, decrease our revenues, expose us to expanded liability or require us to revise the ways in which we conduct our business.

PPACA also calls for a number of other changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates creation of a home health value-based purchasing program, the development of quality measures, and decreases in home health reimbursement rates, including rebasing, as further described in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors." In addition, PPACA requires the Secretary of Health and Human Services to test different models for delivery of care, some of which will involve home health services. It also requires the Secretary to establish a national pilot program for integrated care for patients with certain conditions, bundling payment for acute hospital care, physician services, outpatient hospital services (including emergency department services) and post-acute care services, which would include home health. PPACA created the Center for Medicare and Medicaid Innovation ("CMMI"), which has launched the Bundled Payments for Care Improvement initiative designed to encourage doctors, hospitals and other health care providers, including home health providers, to work together to better coordinate care for patients both when they are in the hospital and after they are discharged. In October 2011 CMS published final Medicare Shared Savings Program regulations, which use accountable care organizations ("ACOs") to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. PPACA further directs the Secretary to conduct a study to evaluate cost and quality of care among efficient home health care centers and specifically focusing on access to care and treating Medicare beneficiaries with varying severity levels of illness, and provide a report to Congress no later than March 1, 2014, which report was issued in 2014 after the March 1 deadline. At this time, it is not possible to predict with any certainty how these initiatives will be implemented and what impact they may have on our business.

In addition, various health care reform proposals similar to the federal reforms described above have also emerged at the state level, including in several states which we operate. Moreover, in January 2011, the Medicare Payment Advisory Commission voted to recommend to Congress that it make additional changes to the home health payment system, noting that such recommendations may include further payment reductions and/or a beneficiary copayment obligation. We cannot predict with certainty what health care initiatives, if any, will be implemented at the state level, or what the ultimate effect of federal health care reform or any future legislation or regulation may have on us or on our business and consolidated financial condition, results of operations and cash flows.

Finally, in addition to impacting our Medicare businesses, PPACA may also significantly affect our non-Medicare businesses. PPACA makes many changes to the underwriting and marketing practices of private

payors. The resulting economic pressures could prompt these payors to seek to lower their rates of reimbursement for the services we provide. At this time, it is not possible to estimate what impact PPACA may have on our non-Medicare businesses.

Risks Related to our Growth Strategies

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

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

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

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

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

Changes in federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, PPACA authorized CMS to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. The moratoria on new enrollments may be applied to categories of providers or to specific geographic regions. For example, in 2014, CMS adopted a temporary moratorium on new provider locations in certain regions of Texas, Michigan, Florida and Illinois. If a moratorium is imposed on the enrollment of new home health or hospice providers in a geographic area we desire to service, it could have a material impact on our ability to open new care centers. Additionally, in 2010, CMS implemented and amended a regulation known as the "36 Month Rule" that is applicable to home health care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health care centers – those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition – from assuming the Medicare billing privileges of the acquired care center. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy.

Risks Related to our Operations

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

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

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

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

Further, the introduction of new and enhanced service offerings by others, in combination with industry consolidation and the development of strategic relationships by our competitors, could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

Managed care organizations and other third party payors continue to consolidate, which enhances their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if these organizations terminate us as a provider and/or engage our competitors as a preferred or exclusive provider. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

If we are unable to react competitively to new developments, our operating results may suffer. Further, if states remove existing CONs or POAs, we would face increased competition in these states. For example, in 2013, the Governor of South Carolina vetoed funding for that state's CON program, effectively shutting down the program. Following a judicial challenge, the South Carolina Supreme Court ruled in April 2014 that the South Carolina Department of Health and Environmental Control was statutorily obligated to administer the CON program, regardless of the Governor's veto. Following this ruling, legislation has been introduced in the South Carolina House of Representatives for the purpose of limiting the application of that state's CON program. We do not know at this time what the outcome of this matter will be in South Carolina, and whether this will have any impact upon our operations. Similarly, there can be no assurances that other states will not seek to eliminate or limit their existing CON or POA programs in a similar manner, leading to increased competition in these states, Further, we cannot assure you that we will be able to compete successfully against current or future competitors, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

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

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

Our business depends on effective, secure and operational information systems which include software that was developed in-house and systems provided by external contractors and other service providers. We have developed and use a proprietary Windows™-based clinical software system with our POC system to collect assessment data, schedule and log patient visits, communicate with patients' physicians regarding their plan of care and monitor treatments and outcomes in accordance with established medical standards. Our clinical software system integrates several of the key processes critical to our business: billing and collections functionality; accounting; human resources; payroll; and employee benefits programs provided by third parties. During 2015, we made the strategic decision to discontinue our proprietary operating system and transition to a leading home health and hospice platform. While we anticipate the completion of the rollout of this new platform to all of our care centers during 2016, we continue to operate on both systems as of the date of this filing. Problems with, or the failure of, our technology and systems or any system upgrades or programming changes associated with such technology and systems, including any problems we may experience with the implementation of the new clinical software system, could have a material adverse effect on data capture, medical documentation, billing, collections, assessment of internal controls and management and reporting capabilities. Any such problems or failures and the costs incurred in correcting any such problems or failures, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, to the extent our external information technology contractors or other service providers become insolvent or fail to support the software or systems we have licensed from them, our operations could be materially adversely affected.

Our care centers also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, human resources, payroll and other information. If we experience a reduction in the

performance, reliability, or availability of our information systems, our operations and ability to produce timely and accurate reports could be materially adversely affected.

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

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems, and the introduction of computer viruses to our systems. Our security measures may be inadequate to prevent security breaches and our business operations could be materially adversely affected by federal and state fines and penalties, cancellation of contracts and loss of patients if security breaches are not prevented.

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

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

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

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

Our revenue is determined by a number of factors, including our mix of patients and the rates of payment among payors. Changes in the case mix of our patients, payment methodologies or the payor mix among Medicare, Medicaid and private payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

A significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate, or slower growth rates could result in the need to perform an impairment analysis under Accounting Standard Codification ("ASC") Topic 350 "Intangibles – Goodwill and Other" in future periods in addition to our annual impairment test. If we were to conclude that a write down of goodwill is necessary, then we would record the appropriate charge, which could result in material charges that are adverse to our consolidated financial condition and results of operations. See Part II, Item 8, Note 5 – Goodwill and Other Intangible Assets, Net to our consolidated financial statements for additional information.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $261.7 million as of December 31, 2015 and if we make additional acquisitions, it is likely that we will record additional intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment and other identifiable intangible assets of $86.7 million as of December 31, 2015, which we review both on a periodic basis for indefinite lived intangible assets as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our consolidated financial condition and results of operations.

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

We compete for qualified personnel with other healthcare providers. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with attractive benefit packages than we originally anticipated which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our care center employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

The services we offer involve an inherent risk of professional liability and related substantial damage awards. As of March 4, 2016, we had approximately 16,100 employees (11,200 home health, 2,600 hospice, 1,500 personal care and 800 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their acts or omissions. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits, or multiple claims requiring us to pay deductibles could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with Medicare requirements and the other laws to which we are subject. Adverse publicity surrounding any aspect of our business, including the death or disability of any of our patients due to our failure to provide proper care, or due to any failure on our part to comply with Medicare requirements or other laws to which we are subject, could negatively affect our Company's overall reputation and the willingness of referral sources to refer patients to us.

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

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

Our operations could be impacted by natural disasters.

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

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

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

In addition, timing delays in billings and collections may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, Medicare or other provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

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

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

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

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

As of December 31, 2015, we had total outstanding indebtedness of approximately $100.0 million, comprised mainly of indebtedness incurred in connection with our April 23, 2014 settlement agreement with the U.S. Department of Justice relating to certain of our clinical and business operations. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and impair our ability to fulfill other obligations in several ways, including:

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

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

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

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

- incur additional debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;
- create liens;
- enter into transactions with affiliates;
- make acquisitions;
- enter into joint ventures;
- merge or consolidate;
- invest in foreign subsidiaries;
- amend acquisition documents;
- enter into certain swap agreements;
- make certain restricted payments;
- transfer, sell or leaseback assets; and
- make fundamental changes in our corporate existence and principal business.

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

Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile.

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

- our operating and financial performance;
- variances in our quarterly financial results compared to research analyst expectations;
- the depth and liquidity of the market for our common stock;
- future sales of common stock by the Company or large stockholders or the perception that such sales could occur;
- investor, analyst and media perception of our business and our prospects;

- developments relating to litigation or governmental investigations;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters;
- departure of key personnel;
- changes in the Medicare, Medicaid and private insurance payment rates for home health and hospice;
- announcements by us or our competitors of significant contracts, acquisitions, strategic partnerships, joint ventures or capital commitments; or
- general economic and stock market conditions.

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

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. "Short sale" is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2015, investors held a short position of approximately 1.2 million shares of our common stock which represented 3.7% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

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

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

	As of December 31, 2015
Common stock outstanding	33,607,282
Preferred stock outstanding	—
Common stock available under 2008 Omnibus Incentive Compensation Plan	1,274,934
Stock options outstanding	838,494
Stock options exercisable	62,500
Non-vested stock outstanding	500,888
Non-vested stock units outstanding	498,929

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

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

Our certificate of incorporation currently authorizes us to issue up to 60,000,000 shares of common stock and 5,000,000 shares of undesignated preferred stock. Our Board of Directors may cause us to issue additional stock to discourage an attempt to obtain control of our company. For example, shares of stock could be sold to

purchasers who might support our Board of Directors in a control contest or to dilute the voting or other rights of a person seeking to obtain control. In addition, our Board of Directors could cause us to issue preferred stock entitling holders to vote separately on any proposed transaction, convert preferred stock into common stock, demand redemption at a specified price in connection with a change in control, or exercise other rights designed to impede a takeover.

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our executive office is located in Nashville, Tennessee in a leased property consisting of approximately 15,825 square feet; our corporate headquarters is located in Baton Rouge, Louisiana in a leased property consisting of approximately 110,000 square feet. We believe we have adequate space to accommodate our corporate staff located in these locations for the foreseeable future.

In addition to our executive office and corporate headquarters, we also lease facilities for our home health and hospice care centers. Generally, these leases have an initial term of five years with a three year early termination option, but range from one to seven years. Most of these leases also contain an option to extend the lease period. The following table shows the location of our 329 Medicare-certified home health care centers and 79 hospice care centers at December 31, 2015:

State	Home Health	Hospice	State	Home Health	Hospice
Alabama	30	7	New Jersey	2	1
Arkansas	5	—	New York	4	—
Arizona	3	—	New Hampshire	2	2
California	4	—	North Carolina	8	6
Connecticut	4	1	Ohio	—	1
Delaware	2	—	Oklahoma	6	—
Florida	28	—	Oregon	4	1
Georgia	62	6	Pennsylvania	7	6
Illinois	3	—	Rhode Island	1	2
Indiana	5	1	South Carolina	19	7
Kansas	1	1	Tennessee	43	11
Kentucky	17	—	Texas	—	1
Louisiana	11	4	Virginia	14	1
Massachusetts	5	8	West Virginia	11	6
Maine	2	4	Wisconsin	1	—
Maryland	8	2	Washington, D.C.	1	—
Mississippi	10	—	Total	329	79
Missouri	6	—			

ITEM 3. LEGAL PROCEEDINGS

See Part II, Item 8, Note 10 – Commitments and Contingencies for information concerning our legal proceedings.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information and Holders

Our common stock trades on the NASDAQ under the trading symbol "AMED." The following table presents the range of high and low sales prices for our common stock for the periods indicated as reported on NASDAQ:

	Price Range of Common Stock	
	High	Low
Year Ended December 31, 2015:		
First Quarter	$31.27	$25.83
Second Quarter	43.61	24.81
Third Quarter	48.34	36.11
Fourth Quarter	45.00	34.72
Year Ended December 31, 2014:		
First Quarter	$17.61	$13.85
Second Quarter	18.20	12.86
Third Quarter	22.58	15.31
Fourth Quarter	30.48	19.03

As of March 4, 2016, there were approximately 521 holders of record of our common stock.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors as our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends.

Purchases of Equity Securities

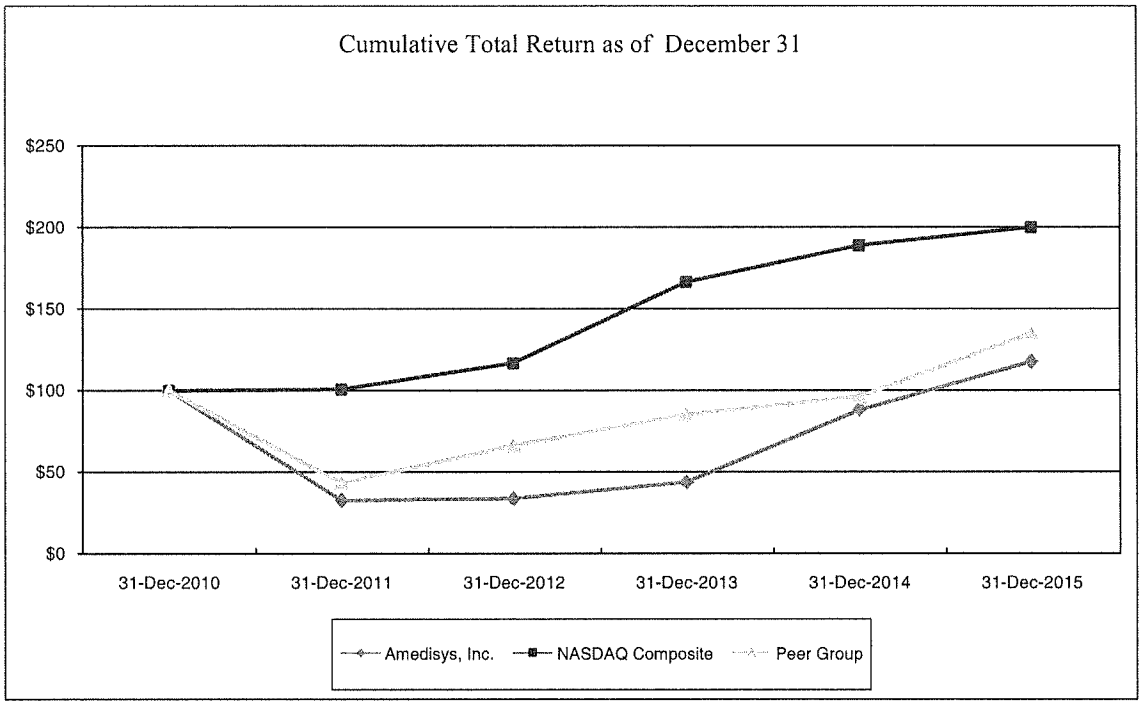
The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2015:

Period	(a) Total Number of Share (or Units) Purchased	(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs
October 1, 2015 to October 31, 2015	—	$ —	—	$ —
November 1, 2015 to November 30, 2015	2,474	39.58	—	—
December 1, 2015 to December 31, 2015	6,360	40.61	116,859	70,418,957
	8,834(1)	$40.32	116,859	$70,418,957

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

Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2015, with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group) on December 31, 2010 and the reinvestment of dividends. The peer group we selected is comprised of: LHC Group, Inc. ("LHCG") and Almost Family, Inc. ("AFAM"). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been paid on our common stock.



	12/31/2010	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015
Amedisys, Inc.	$100.00	$ 32.57	$ 33.75	$ 43.67	$ 87.61	$117.37
NASDAQ Composite	$100.00	$100.53	$116.92	$166.19	$188.78	$199.95
Peer Group	$100.00	$ 42.92	$ 65.93	$ 84.73	$ 95.67	$134.79

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

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for the five-year period ended December 31, 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).

	2015	2014	2013	2012	2011
	(Amounts in thousands)				
Balance Sheet Data:					
Total assets	$685,085	$669,742	$726,406	$730,595	$858,285
Total debt, including current portion	$100,000	$116,372	$ 46,904	$102,711	$145,439
Total Amedisys, Inc. stockholders' equity	$409,568	$397,167	$372,201	$452,340	$518,868
Cash dividends declared per common share	$ —	$ —	$ —	$ —	$ —

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

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2015, 2014 and 2013. This discussion should be read in conjunction with our audited financial statements included in Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1, "Business" of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues, operating results and expectations. See "Special Caution Concerning Forward-Looking Statements" for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A, "Risk Factors."

Overview

We are a provider of high-quality, low-cost home health services to the chronic, co-morbid, aging American population, with approximately 80%, 82% and 84% of our revenue derived from Medicare for 2015, 2014 and 2013, respectively.

Our operations involve servicing patients through our two reportable business segments: home health and hospice. 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. As of December 31, 2015, we owned and operated 329 Medicare-certified home health care centers and 79 Medicare-certified hospice care centers in 34 states within the United States and the District of Columbia, including 15 home health care centers acquired from Infinity HomeCare on December 31, 2015, which are not included in our operating results.

2015 Developments

- Discontinued AMS3, our third generation, proprietary operating system and transitioned to Homecare Homebase ("HCHB"), a leading platform for home health and hospice companies.
- Entered into new Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million and terminated each of our Prior Credit Agreement and Second Lien Credit Agreement.
- Operationalized the transition to the 10th revision of the International Classification of Diseases ("ICD-10")
- Closed the acquisition of Infinity HomeCare on December 31, 2015 (Infinity HomeCare is not included in our operating results).

2016 Outlook

- Continue the rollout of HCHB with anticipated completion date in the second half of 2016.
- Renew focus on potential acquisitions.
- 1.4% reduction in Medicare reimbursement payments for home health industry.
- 1.1% increase in Medicare reimbursement payments for hospice industry.
- Transition to new hospice payment methodology

Financial Performance

The year ended December 31, 2015 continued our significant operational improvement that began during 2014. Our improvement began with the closure and/or consolidation of care centers that had a material, negative impact on our operating results. The reduction in the number of operating care centers enabled us to restructure our

regional and corporate support functions. Additionally, we have seen improvement in the remaining care centers in both of our operating segments with a return to home health same store Medicare admissions growth and a significant increase in hospice admissions and average daily census.

Our home health care centers have experienced same store Medicare revenue and admissions growth. The home health segment has seen a significant increase in non-Medicare revenue, an increase in revenue per episode while maintaining a relatively flat cost per visit and reductions in operating expenses which have helped deliver a $29 million improvement in our operating results over the year ended December 31, 2014 (see "Results of Operations").

Our hospice segment has shown consistent growth in admissions and average daily census combined with strong cost controls, all of which have helped deliver a $13 million improvement in our operating results over the year ended December 31, 2014 (see "Results of Operations").

Owned and Operated Care Centers

	Home Health	Hospice
At December 31, 2012	435	97
Acquisitions/Startups	2	1
Closed/Consolidated	(70)	(6)
At December 31, 2013	367	92
Closed/Consolidated/Sold	(51)	(12)
At December 31, 2014	316	80
Acquisitions (1)	15	1
Closed/Consolidated/Sold	(2)	(2)
At December 31, 2015	329	79

(1) The 15 home health care centers acquired from Infinity HomeCare on December 31, 2015 are not included in our operating results.

When we refer to "same store business," we mean home health and hospice care centers that we have operated for at least the last twelve months; when we refer to "acquisitions," we mean home health and hospice care centers that we acquired within the last twelve months; and when we refer to "start-ups," we mean home health or hospice care centers opened by us in the last twelve months. Once a care center has been in operation for a twelve month period, the results for that particular care center are included as part of our same store business from that date forward. Non-Medicare revenue, admissions, recertifications or completed episodes, includes home health revenue, admissions, recertifications or completed episodes of care for those payors that pay on an episodic or per visit basis, which includes Medicare Advantage programs and private payors.

Economic and Industry Factors

Home health and hospice services are a highly fragmented, highly competitive industry. The degree of competiveness varies depending upon whether our care centers operate in states that require a certificate of need (CON) or permit of approval (POA). In such states, expansion by existing providers or entry into the market by new providers is permitted only where determination is made by state health authorities that a given amount of unmet need exists. Currently, 67% and 40% of our home health and hospice care centers, respectively operate in CON/POA states.

As the Federal government continues to debate a reduction in expenditures and a reform of the Medicare system, our industry continues to face reimbursement pressures. Specifically, the industry has been impacted by a 2% sequestration payment reduction beginning April 1, 2013. In addition to the sequestration cut, the Centers for

Medicare and Medicaid Services ("CMS") instituted a rebasing cut of approximately $81 (2.7%) per year for 2014 – 2017; however, we do expect some offset from a market basket updated in each of these years. The following payment adjustments are effective for the years indicated based on CMS's final rules relative to Medicare reimbursement:

	Home Health(1)			Hospice		
	2016	2015	2014	2016(2)	2015	2014
Market Basket Update	2.3 %	2.6 %	2.3 %	2.4 %	2.9 %	2.5 %
Rebasing	(2.4)	(2.8)	(2.7)	—	—	—
ICD-9 Coding Change	—	—	(0.6)	—	—	—
50/50 Blend of Wage Index	—	—	—	0.2	—	—
Nominal Case Mix Adjustment	(0.9)	—	—	—	—	—
PPACA Adjustment	—	—	—	(0.3)	(0.3)	(0.3)
Budget Neutrality Adjustment Factor	—	0.4	—	(0.7)	(0.7)	(0.7)
Productivity Adjustment	(0.4)	(0.5)	—	(0.5)	(0.5)	(0.5)
	(1.4)%	(0.3)%	(1.0)%	1.1 %	1.4 %	1.0 %

(1) Our impact could differ depending on differences in the wage index and coding changes.
(2) Effective for services provided from October 1, 2015 to September 30, 2016.

As part of the 2016 final rule issued in October 2015, CMS finalized their proposal to implement a Home Health Value-Based Purchasing model in nine states that seeks to test whether incentives for better care can improve outcomes in the delivery of home health services. Financial impacts from this change, either positive or negative, would begin January 1, 2018, applied to that calendar year based on 2015 performance data. Currently, care centers operating in the states included in the proposed model account for approximately 26% of our home health Medicare revenue.

Governmental Inquiries and Investigations and Other Litigation

September 2010 Civil Investigative Demand Issued by the U.S. Department of Justice

On September 27, 2010, we received a Civil Investigative Demand ("CID") issued by the U.S. Department of Justice pursuant to the federal False Claims Act. The CID required the delivery of a wide range of documents and information relating to the Company's clinical and business operations, including reimbursement and billing claims submitted to Medicare for home health services, and related compliance activities. The CID generally covered the period from January 1, 2003. On April 26, 2011, we received a second CID related to the CID issued in September 2010, which generally covered the same time period as the previous CID and required the production of additional documents. Such CIDs are often associated with previously filed qui tam actions, or lawsuits filed under seal under the False Claims Act ("FCA"), 31 U.S.C. § 3729 et seq. Qui tam actions are brought by private plaintiffs suing on behalf of the federal government for alleged FCA violations. Subsequently, the Company and certain current and former employees received additional CIDs for additional documents and/ or testimony.

In May 2012, we made a disclosure to CMS under the agency's Stark Law Self-Referral Disclosure Protocol relating to certain services agreements between a subsidiary of ours and a large physician group (the "Stark Law Self-Referral Matter"). During some period of time since December 2007, the arrangements appear not to have complied in certain respects with an applicable exemption to the Stark Law referral prohibition. Medicare revenue earned as a result of referrals from the physician group from May 2008 to May 2012, the relevant four year "lookback" period under the Stark Law Self-Referral Disclosure Protocol, was approximately $4 million. On January 11, 2013, one of our subsidiaries received a CID from the United States Attorney's Office for the Northern District of Georgia seeking certain information relating to that subsidiary's relationship with this physician group

On April 23, 2014, with no admission of liability on our part, we entered into a settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral Matter. Pursuant to the settlement agreement, on May 2, 2014, we paid the United States an initial payment in the amount of $116.5 million representing the first installment of $115 million plus interest thereon due under the settlement agreement, and on October 23, 2014, we paid the United States an additional payment in the amount of $35.8 million, representing the second and final installment of $35 million plus interest thereon due under the settlement agreement.

The settlement agreement also resolves allegations made against us by various qui tam relators, who are required to dismiss their claims with prejudice. We accrued and paid various relators' attorneys' fees and expenses in the aggregate sum of approximately $3.9 million during 2014.

In connection with the settlement agreement, on April 23, 2014, we entered into a corporate integrity agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization to perform certain 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 CIA has a term of five years. We expect the CIA to impact operating expenses by approximately $1 to $2 million annually.

May 2015 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.

November 2015 Civil Investigative Demand Issued by the U.S. Department of Justice

On November 3, 2015, 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 Morgantown, West Virginia area.

See Item 8, Note 10 – Commitments and Contingencies to our consolidated financial statements for additional information regarding our April 2014 CIA, the May 2015 Subpoena issued by the U.S. Department of Justice, the November 2015 CID issued by the U.S. Department of Justice and for a discussion of and updates regarding class action litigation we are involved in. No assurances can be given as to the timing or outcome of these items.

Results of Operations

Consolidated

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

	For the Years Ended December 31,		
	2015	2014	2013
Net service revenue	$1,280.5	$1,204.5	$1,249.3
Gross margin, excluding depreciation and amortization	554.6	513.4	531.3
% of revenue	*43.3%*	*42.6%*	*42.5%*
Other operating expenses	486.5	486.3	526.8
% of revenue	*38.0%*	*40.4%*	*42.2%*
U.S. Department of Justice settlement	—	—	150.0
Asset impairment charge	77.3	3.1	9.5
Operating (loss) income	(9.2)	24.0	(155.0)
Total other income (expense), net	8.9	(3.1)	1.5
Income tax (expense) benefit	(2.0)	(7.7)	58.8
Effective income tax rate	*650.6%*	*36.6%*	*(38.3%)*
(Loss) income from continuing operations	(2.3)	13.3	(94.7)
Net loss from discontinued operations	—	(0.2)	(3.1)
Net (income) loss attributable to noncontrolling interests	(0.7)	(0.3)	1.6
Net (loss) income attributable to Amedisys, Inc.	$ (3.0)	$ 12.8	$ (96.2)

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

Our 2015 results were impacted by a $75 million non-cash charge to write off the software costs incurred related to the development of AMS3 Home Health and Hospice and a $2 million non-cash charge to reduce the carrying value of our corporate headquarters.

During the first quarter of 2014, we committed to a plan to consolidate 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and close 23 home health care centers and six hospice care centers. As a result of this exit activity, we reduced our regional leadership structure and corporate support functions. Separate from the restructuring costs, we also recorded severance costs associated with the departure of our former Chief Executive Officer, a charge for relator fees associated with our U.S. Department of Justice settlement during the first quarter of 2014 and a non-cash other intangibles impairment charge during the fourth quarter of 2014. The following details the costs associated with these activities (amounts in millions):

	For the Year Ended December 31, 2014			
	Home Health	Hospice	Corporate	Total
Severance(a)	$ 2.0	$ 0.1	$—	$ 2.1
Restructuring severance	2.1	0.6	3.0	5.7
Lease terminations	1.9	0.2	—	2.1
Other intangibles impairment	1.6	1.5	—	3.1
Exit and restructuring activities cost	7.6	2.4	3.0	13.0
U.S. Department of Justice Settlement/Relator Fees	—	—	3.9	3.9
Total	$ 7.6	$ 2.4	$ 6.9	$16.9

(a) Includes $0.8 million and $0.1 million for severance included in cost of service for home health and hospice, respectively.

Our operating results have been impacted by the sale, closure and consolidation of numerous care centers as mentioned above. Accordingly, our results for the year ended December 31, 2015 are not fully comparable to the year ended December 31, 2014.

Our operating income, excluding the $77 million asset impairment charges in 2015 and the $17 million in costs incurred in 2014 noted above, increased $27 million as our home health operating income increased $29 million, our hospice operating income increased $13 million and our corporate operating expense increased $15 million. The primary drivers of our improvement in performance were the closure/consolidation of care centers that had a negative operating contribution, an increase in our revenue per episode, an increase in non-Medicare revenue, growth in hospice census and a reduction in operating expenses. The increase in corporate operating expenses is primarily due to the $6 million Wage and Hour Litigation settlement accrual and HCHB maintenance and hosting and implementation costs of $8 million. The increase in HCHB maintenance and hosting is offset by a $4 million decrease in depreciation and amortization as we move from our proprietary software to HCHB.

Total other income (expense), net decreased $1 million from prior year after considering the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2015	2014
Legal settlements	$ 7.4	$ 1.1
Equity in earnings from equity method investment	6.7	—
Life insurance proceeds	1.0	—
Debt refinance costs	(3.2)	(0.5)
Gain (loss) on disposal of property and equipment or sale of care centers	0.2	0.7
	$12.1	$ 1.3

The difference in income tax expense in 2015 and 2014 is driven primarily by the decrease in income before income taxes. Additionally, the effective tax rate for the year ended December 31, 2015 does not provide a meaningful comparison to other periods. The effective tax rate for the year is influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to (loss) income before income taxes. A significant asset impairment was recorded during the three-month period ended March 31, 2015, resulting in a scenario where the company's (loss) income before income taxes for 2015 was near zero. Consequently, for 2015, the relationship between the "effective tax rate drivers" and (loss) income before income taxes is distorted.

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

Our operating results have been impacted by the sale, closure and consolidation of 54 care centers mentioned above as well as the closure of an additional 9 care centers since December 31, 2013. Additionally, 76 care centers were exited during 2013. Accordingly, our results for the year ended December 31, 2014 are not fully comparable to the year ended December 31, 2013.

Our 2013 results were impacted by an accrual of $150 million and recognition of a deferred tax benefit of $56 million for the settlement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral Matter. In addition, we recorded asset impairment charges of $9 million related to other intangibles during 2013.

Our operating income, excluding the $17 million in costs incurred in 2014 noted above and the U.S. Department of Justice settlement and the asset impairment charge in 2013, increased $36 million as our home health operating income increased $27 million, our hospice operating income increased $5 million and corporate

expenses decreased $4 million. Additionally, the first quarter of 2013 was not impacted by sequestration as it was not in effect until April 1, 2013. The estimated impact of sequestration was $21 million for 2014 compared to $18 million in 2013.

Income tax expense for 2014 and 2013 includes a favorable adjustment of $2 million related to various tax credits for state employment and training and state and federal research development.

Home Health Division

The following table summarizes our home health segment results from continuing operations:

	For the Years Ended December 31,		
	2015	2014	2013
Financial Information *(in millions)*:			
Medicare	$ 761.4	$ 751.5	$ 803.8
Non-Medicare	243.7	205.4	183.9
Net service revenue	1,005.1	956.9	987.7
Cost of service	584.2	559.4	578.9
Gross margin	420.9	397.5	408.8
Other operating expenses	280.6	294.4	333.8
Operating income	$ 140.3	$ 103.1	$ 75.0
Key Statistical Data:			
Medicare:			
Same Store Volume (1):			
Revenue	3%	1%	(10%)
Admissions	3%	0%	0%
Recertifications	(1%)	1%	(18%)
Total (2):			
Admissions	178,226	177,243	190,507
Recertifications	99,762	102,263	107,908
Completed episodes	269,227	272,864	292,984
Visits	4,797,734	4,794,609	5,177,976
Average revenue per episode (3)	$ 2,825	$ 2,768	$ 2,758
Visits per completed episode (4)	17.5	17.3	17.5
Non-Medicare:			
Same Store Volume (1):			
Revenue	21%	19%	(20%)
Admissions	18%	17%	(13%)
Recertifications	14%	13%	(24%)
Total (2):			
Admissions	96,934	83,940	76,669
Recertifications	35,870	32,074	30,304
Visits	1,954,543	1,651,745	1,531,781
Total (2):			
Cost per Visit	$ 86.52	$ 86.77	$ 86.27
Visits	6,752,277	6,446,354	6,709,757

(1) Same store Medicare and Non-Medicare revenue, admissions or recertifications growth 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) Based on continuing operations for all periods presented.

(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.

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

Overall, our operating income excluding the $8 million in exit activity costs in 2014, increased $29 million on a $22 million increase in gross margin and a $7 million decline in other operating expenses. 2014 results included revenue of $16 million and operating losses of $5 million for those care centers that were closed, consolidated or sold.

Net Service Revenue

Our Medicare revenue increase of approximately $10 million consisted of a $16 million increase due to higher revenue per episode offset by $6 million due to lower volumes. The decrease in volumes is primarily due to the sale, closure and consolidation of 51 care centers since December 31, 2013, as we experienced a 3% increase in same store admissions in 2015. Net service revenue includes a reduction of $1 million for the estimated impact of the 2016 rate change. The impact for 2016 is estimated to be approximately $14 million.

Our non-Medicare revenue increased $38 million as we have focused on contracted payors with significant concentrations in our markets and those that add incremental margin to our operations.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our results are not fully comparable to prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,		
	2015	2014	2013
Revenue *(in millions)*:			
Operating care centers	$1,005.1	$941.2	$895.6
Closed/Consolidated/Sold care centers	—	15.7	92.1
Net service revenue	1,005.1	956.9	987.7

Cost of Service, Excluding Depreciation and Amortization

Our cost of service, excluding the $1 million in exit activity costs in 2014, increased $26 million primarily as a result of a 5% increase in visits. Our cost per visit remained relatively flat.

Other Operating Expenses

Other operating expenses, excluding the $7 million in exit activity costs in 2014, decreased $7 million due to decreases in other care center related expenses as a result of our closure and consolidation strategy and the reduction in divisional leadership; the majority of the reductions were in salaries and benefits and rent expense, offset by $5 million increase in legal expense related to the self-disclosure matter. In addition, our provision for doubtful accounts decreased $3 million and our depreciation and amortization expense decreased $4 million compared to 2014.

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

Overall, our operating income, excluding the $8 million in exit activity costs in 2014 and the $8 million asset impairment charge in 2013, increased $27 million on an $11 million decline in gross margin offset by a $38 million decline in other operating expenses.

Net Service Revenue

Our Medicare revenue decline of approximately $52 million consisted of $53 million due to lower volumes and $2 million due to sequestration offset by a $3 million increase related to revenue per episode. The decrease in volumes is primarily due to the sale, closure and consolidation of 51 care centers since December 31, 2013, as we experienced an increase in same store revenue and recertifications.

Our non-Medicare revenue increased $21 million which is primarily due to increases in volumes and an increase in our revenue per visit. We are experiencing significant growth in our non-Medicare business as we have focused on contract payors with significant concentrations in our markets.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service, excluding the $1 million in exit activity costs in 2014, decreased $20 million primarily as a result of our decrease in Medicare volumes which was offset by an 8% increase in non-Medicare visits as our cost per visit remained relatively flat.

Other Operating Expenses

Other operating expenses, excluding the $7 million in exit activity costs in 2014 and the $8 million asset impairment charge in 2013, decreased $38 million due to a $43 million decrease in other care center related expenses as a result of our closure and consolidation strategy and the reduction in divisional leadership; the majority of the reductions were in salaries and benefits, rent expense and travel costs offset by a $5 million increase in our provision for doubtful accounts due to the increase in non-Medicare revenue.

Hospice Division

The following table summarizes our hospice segment results from continuing operations:

	For the Years Ended December 31,		
	2015	2014	2013
Financial Information *(in millions)*:			
Medicare	$ 258.5	$ 232.6	$ 246.4
Non-Medicare	16.9	15.0	15.2
Net service revenue	275.4	247.6	261.6
Cost of service	141.7	131.7	139.1
Gross margin	133.7	115.9	122.5
Other operating expenses	66.0	63.4	73.5
Operating income	$ 67.7	$ 52.5	$ 49.0
Key Statistical Data:			
Same Store Volume (1):			
Medicare revenue	13%	(2%)	(9%)
Non-Medicare revenue	18%	6%	(3%)
Hospice admits	16%	(3%)	(3%)
Average daily census	12%	(4%)	(8%)
Total (2):			
Hospice admits	19,205	17,081	18,335
Average daily census	5,105	4,632	4,987
Revenue per day	$147.78	$146.51	$143.77
Cost of service per day	$ 76.06	$ 77.93	$ 76.45
Discharge average length of stay	92	100	100

(1) Same store Medicare and Non-Medicare revenue, Hospice admits or average daily census volume is the percent increase (decrease) in our Medicare and Non-Medicare revenue, Hospice admits or average daily census for the period as a percent of the Medicare and Non-Medicare revenue, Hospice admits or average daily census of the prior period.
(2) Based on continuing operations for all periods presented.

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

Overall, our operating income, excluding the $2 million in exit activity costs in 2014, increased $13 million on an $18 million increase in gross margin offset by a $5 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $28 million, primarily as the result of an increase in our average daily census as a result of a 16% increase in hospice admissions. We benefitted from a 1.4% hospice rate increase effective October 1, 2014. The base rate for hospice services provided from October 1, 2015 to September 30, 2016 will increase 1.1% as a result of the final rule issued by CMS in August 2015.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our results are not fully comparable to prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,		
	2015	2014	2013
Revenue *(in millions)*:			
Operating care centers	$275.4	$243.4	$243.7
Closed/Consolidated/Sold care centers	—	4.2	17.9
Net service revenue	275.4	247.6	261.6

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $10 million as the result of a 10% increase in average daily census offset by a decrease in cost of service per day. We experienced significant improvement in pharmacy and DME cost per day during 2015.

Other Operating Expenses

Other operating expenses, excluding the $2 million in exit activity costs in 2014, increased $5 million due to increases in other care center related expenses, primarily salaries and benefits expense and travel costs.

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

Overall, our operating income, excluding the $2 million in exit activity costs in 2014 and the $1 million impairment charge in 2013, increased $5 million on a $14 million decline in revenue, an $8 million decline in cost of service and an $11 million decline in other operating expenses.

Net Service Revenue

Our hospice revenue decreased $14 million, primarily as the result of a decrease in our average daily census. The decrease in average daily census is primarily due to the sale, closure and consolidation of 12 care centers since

December 31, 2013. The decrease in revenue was offset by a $2 million decrease in our hospice cap expense as our decline in average daily census and a decrease in admissions has resulted in a decrease in our overall cap expense. We benefitted from a 1.0% hospice rate increase effective October 1, 2013, and beginning October 1, 2014, the fiscal year 2015 hospice base rate increased approximately 1.4%.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service decreased $8 million, or 5%, as the result of a 7% decrease in average daily census offset by an increase in cost of service per day. Our cost of service per day has been negatively impacted by an increase in pharmacy costs as a result of new CMS guidance which became effective on May 1, 2014.

Other Operating Expenses

Other operating expenses, excluding the $2 million in exit activity costs in 2014 and the $1 million impairment charge in 2013, decreased $11 million due to a $7 million decrease in other care center related expenses due to our care center closure and consolidation strategy and a $4 million decrease in our provision for doubtful accounts.

Corporate

The following table summarizes our corporate results from continuing operations:

	For the Years Ended December 31,		
	2015	2014	2013
Financial Information *(in millions):*			
Other operating expenses	$126.5	$114.4	$104.5
Depreciation and amortization	13.4	17.2	24.5
Total before impairment and U.S. Department of Justice settlement (1)	$139.9	$131.6	$129.0

(1) Total of $217.2 million on a GAAP basis for the year ended December 31, 2015 (including $77.3 million asset impairment charge). Total of $279.0 million on a GAAP basis for the year ended December 31, 2013 (including $150.0 U.S. Department of Justice settlement).

Corporate expenses consist of cost relating to our 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.

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

Excluding the $77 million asset impairment charge in 2015 and the $7 million in exit and restructuring activities costs and relator fees associated with our U.S. Department of Justice settlement agreement during 2014, corporate other operating expenses increased $15 million which is inclusive of the $6 million Wage and Hour Litigation settlement accrual, $4 million in HCHB maintenance and hosting costs, $4 million related to HCHB implementation and $2 million in severance costs.

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

Excluding the 2014 exit and restructuring activities costs and relator fees associated with our U.S. Department of Justice settlement agreement and the U.S. Department of Justice settlement in 2013, corporate expenses

decreased $4 million primarily due to a decrease in depreciation and amortization. Our corporate salaries and wages experienced an increase due to the addition of resources for the roll-out of AMS3, our enhanced point of care system.

Liquidity and Capital Resources

Cash Flows

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

	For the Years Ended December 31,		
	2015	2014	2013
Cash provided by (used in) operating activities	$107.8	$(65.5)	$102.3
Cash used in investing activities	(67.4)	(14.3)	(46.5)
Cash (used in) provided by financing activities	(20.9)	70.5	(53.0)
Net increase (decrease) in cash and cash equivalents	19.5	(9.3)	2.8
Cash and cash equivalents at beginning of period	8.0	17.3	14.5
Cash and cash equivalents at end of period	$ 27.5	$ 8.0	$ 17.3

Cash provided by operating activities increased $173.3 million during 2015 compared to 2014 primarily due to an increase in our operating performance as compared to 2014 and the payment of $150.0 million in 2014 under our settlement agreement with the U.S. Department of Justice. For additional information regarding our operating performance, see "Results of Operations". The recognition of the asset impairment charge of $77.3 million, which resulted in the net loss for 2015 is a non-cash item and therefore has no impact on our cash flow from operations. Cash used in operating activities increased $167.8 million during 2014 compared to 2013 primarily due to the payment of the U.S. Department of Justice Settlement. Adjusting for the $152.3 million settlement and interest payment, we generated $86.8 million in cash from operating activities during 2014.

Cash used in investing activities increased $53.1 million during 2015 compared to 2014 primarily due to our acquisition activity ($69.1 million) and an increase in capital expenditures ($9.4 million), offset by proceeds from the sale of property and equipment ($20.0 million) and investments ($5.0 million). Cash used in investing activities decreased $32.2 million during 2014 compared to 2013 primarily due to a decrease in capital expenditures of $29.7 million, primarily related to AMS3 development, and a $3.7 million decrease in the purchase of investments.

Cash used in financing activities increased $91.4 million during 2015 compared to 2014 primarily due to an increase in our principal payments of long-term obligations, net of borrowings. We decreased our outstanding long-term obligations, net of borrowings by $16.4 million from December 31, 2014. Cash provided by financing activities increased $123.5 million during 2014 compared to 2013 primarily due to an increase in our borrowings on our revolving line of credit and our Second Lien Loan. We increased our outstanding long-term obligations, net of repayments by $71.1 million from December 31, 2013, primarily to fund the U.S. Department of Justice settlement payment.

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 2015, we spent $9.3 million in routine capital expenditures compared to $7.0 million and $6.5 million during 2014 and 2013, respectively. Routine capital expenditures primarily include equipment and computer

software and hardware. In addition, we spent $12.1 million in non-routine capital expenditures related to software licenses and interfaces compared to $5.0 million and $35.2 million during 2014 and 2013, respectively, related to enhancements to our point of care software. Our routine and non-routine capital expenditures for 2016 are expected to be approximately $9.1 million and $13.3 million, respectively.

On April 23, 2014, we entered into a settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral Matter. Pursuant to the settlement agreement, on May 2, 2014, we paid the United States an initial payment in the amount of $116.5 million, representing the first installment of $115 million plus interest thereon due under the settlement agreement, and on October 23, 2014, we paid the United States an additional payment in the amount of $35.8 million, representing the second and final installment of $35 million plus interest thereon due under the settlement agreement.

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million. The net proceeds of the term loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement dated as of October 22, 2012, as amended with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014, with a principal balance of $70 million.

As of December 31, 2015, we had $27.5 million in cash and cash equivalents and $179.0 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 patient accounts receivable, net increased $25.7 million from December 31, 2014 to December 31, 2015. Our cash collection as a percentage of revenue was 100% and 103% for December 31, 2015 and 2014, respectively. Our days revenue outstanding, net at December 31, 2015 was 31.9 days which is an increase of 2.5 days from December 31, 2014. Our days revenue outstanding, net at December 31, 2015 does not include Infinity HomeCare.

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 and varies by state for Medicaid-reimbursable services and 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 Years Ended December 31,	
	2015	2014
Provision for estimated revenue adjustments (1)	$ 6.1	$ 5.1
Provision for doubtful accounts (2)	14.1	16.4
Total	$20.2	$21.5
As a percent of revenue	1.6%	1.8%

(1) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

(2) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

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 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

	0-90	91-180	181-365	Over 365	Total
At December 31, 2014:					
Medicare patient accounts receivable, net (1)	$62.1	$6.3	$—	$—	$ 68.4
Other patient accounts receivable:					
Medicaid	9.1	1.4	0.7	0.4	11.6
Private	23.4	5.4	2.5	2.3	33.6
Total	$32.5	$6.8	$ 3.2	$ 2.7	$ 45.2
Allowance for doubtful accounts (2)					(14.3)
Non-Medicare patient accounts receivable, net					$ 30.9
Total patient accounts receivable, net					$ 99.3
Days revenue outstanding, net (3)					29.4

(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 Years Ended December 31,	
	2015	2014
Balance at beginning of period	$ 3.1	$ 3.9
Provision for estimated revenue adjustments (a)	6.1	5.1
Write offs	(5.2)	(5.9)
Balance at end of period	$ 4.0	$ 3.1

(a) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

Our estimated revenue adjustments were 4.8% and 4.3% of our outstanding Medicare patient accounts receivable at December 31, 2015 and December 31, 2014, 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 Years Ended December 31,	
	2015	2014
Balance at beginning of period	$ 14.3	$ 14.2
Provision for doubtful accounts (a)	14.1	16.4
Write offs	(11.9)	(16.3)
Balance at end of period	$ 16.5	$ 14.3

(a) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

Our allowance for doubtful accounts was 26.9% and 31.6% of our outstanding Medicaid and private patient accounts receivable at December 31, 2015 and 2014, 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 December 31, 2015 and 2014 by our average daily net patient revenue for the three-month periods ended December 31, 2015 and 2014, respectively.

Indebtedness

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million.

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the "Term Loan"); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the "Revolving Credit Facility"). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our Prior Credit Agreement, dated as of October 22, 2012, as amended (the "Prior Credit Agreement") with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the "Second Lien Credit Agreement"), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan will amortize beginning on March 31, 2016 in 18 quarterly installments (eight quarterly installments of $1.25 million followed by eight quarterly installments of $2.5 million, followed by two quarterly installments of $3.1 million, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and its subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime

rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2015, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.7% for the period August 28, 2015 to December 31, 2015.

As of December 31, 2015, our availability under our $200.0 million Revolving Credit Facility was $179.0 million as we had $21.0 million outstanding in letters of credit.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2015, our consolidated leverage ratio was 0.9 and our consolidated fixed charge coverage ratio was 3.7 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guaranties from wholly-owned subsidiaries that in the aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with the entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs

during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet.

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.

Under the terms of the program, we may 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 may enter into Rule 10b5-1 plans to effect some or all of the repurchases. The timing and the amount of the repurchases, if any, will be 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 2015, pursuant to this program, we repurchased 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million. The repurchased shares are classified as treasury shares.

Contractual Obligations and Medicare Liabilities

Our future contractual obligations and Medicare liabilities at December 31, 2015 were as follows (amounts in millions):

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	4-5 Years	After 5 Years
Long-term obligations	$100.0	$ 5.0	$15.0	$80.0	$—
Interest on long-term obligations (1)	9.6	2.4	4.3	2.9	—
Operating leases	67.9	23.5	27.2	11.7	5.5
Capital commitments	3.1	3.1	—	—	—
Purchase obligations	30.5	9.3	17.2	4.0	—
Uncertain tax positions	4.7	0.6	4.1	—	—
	$215.8	$43.9	$67.8	$98.6	$ 5.5

(1) Interest on debt with variable rates was calculated using the current rate of that particular debt instrument at December 31, 2015.

Critical Accounting Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements, which have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP"). The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses and related disclosures of contingent assets and liabilities. On an ongoing basis, we evaluate our estimates, including those related to revenue recognition, collectability of accounts receivable, reserves related to insurance and litigation, goodwill, intangible assets, income taxes and contingencies. We base these estimates on our historical experience and various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results experienced may vary materially and adversely from our estimates. To the extent there are material differences between our estimates and the actual results, our future results of operations may be affected.

We believe the following critical accounting policies represent our most significant judgments and estimates used in the preparation of our consolidated financial statements.

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. We make adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, and 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. In addition, management evaluates the potential for revenue adjustments and, when appropriate, provides allowances based upon the best available information.

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.

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 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. We make adjustments to Medicare revenue for our discovered inability to obtain appropriate billing documentation or 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 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 December 31, 2015, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $1.4 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016. As of December 31, 2014, we had recorded $2.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2015.

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 visit 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.

Patient Accounts Receivable – Allowance for Doubtful Accounts

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. 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 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.

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. 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.

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 in the period in which a claim is incurred, including with respect to both reported claims and claims

incurred but not reported, up to specified deductible limits. 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.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

Each of our operating segments described in the notes to our financial statements is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice care centers and have also deemed them to be a single reporting unit.

During 2015, we did not record any goodwill impairment charges and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2015. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names, non-compete agreements and reacquired franchise rights. We amortize non-compete agreements, acquired names that we do not intend to use in the future and reacquired franchise rights on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for reacquired franchise rights and acquired names.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2015 and 2014 our net deferred tax assets were $125.2 million and $122.4 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

ITEM 7A. 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 consolidated statements of operations and our consolidated statements of cash flows will be exposed to changes in interest rates. As of December 31, 2015, the total amount of outstanding debt subject to interest rate fluctuations was $100.0 million. A 1.0% interest rate change would cause interest expense to change by approximately $1.0 million annually.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited the accompanying consolidated balance sheets of Amedisys, Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2015. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Amedisys, Inc. and subsidiaries as of December 31, 2015 and 2014, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2015, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Amedisys Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated March 9, 2016, expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 9, 2016

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

	As of December 31,	
	2015	2014
ASSETS		
Current assets:		
Cash and cash equivalents	$ 27,502	$ 8,032
Patient accounts receivable, net of allowance for doubtful accounts of $16,526, and $14,317	125,010	99,325
Prepaid expenses	8,110	8,493
Other current assets	14,641	19,708
Total current assets	175,263	135,558
Property and equipment, net of accumulated depreciation of $141,793 and $146,438	42,695	137,455
Goodwill	261,663	205,587
Intangible assets, net of accumulated amortization of $25,386 and $25,374	44,047	33,193
Deferred income taxes	125,245	124,788
Other assets, net	36,172	33,161
Total assets	$685,085	$669,742
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 25,682	$ 16,056
Payroll and employee benefits	72,546	75,553
Accrued expenses	71,965	56,329
Current portion of long-term obligations	5,000	12,000
Current portion of deferred income taxes	—	2,385
Total current liabilities	175,193	162,323
Long-term obligations, less current portion	95,000	104,372
Other long-term obligations	4,456	5,285
Total liabilities	274,649	271,980
Commitments and Contingencies – Note 10		
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; 34,786,966, and 34,569,526 shares issued; and 33,607,282 and 33,594,572 shares outstanding	35	35
Additional paid-in capital	504,290	481,762
Treasury stock at cost 1,179,684, and 974,954 shares of common stock	(26,966)	(19,860)
Accumulated other comprehensive income	15	15
Retained earnings	(67,806)	(64,785)
Total Amedisys, Inc. stockholders' equity	409,568	397,167
Noncontrolling interests	868	595
Total equity	410,436	397,762
Total liabilities and equity	$685,085	$669,742

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

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)
Basic earnings per common share:			
(Loss) income from continuing operations attributable to Amedisys, Inc. common stockholders	$ (0.09)	$ 0.40	$ (2.98)
Discontinued operations, net of tax	—	(0.01)	(0.10)
(Loss) income attributable to Amedisys, Inc. common stockholders	$ (0.09)	$ 0.39	$ (3.08)
Weighted average shares outstanding	33,018	32,301	31,247
Diluted earnings per common share:			
(Loss) income from continuing operations attributable to Amedisys, Inc. common stockholders	$ (0.09)	$ 0.40	$ (2.98)
Discontinued operations, net of tax	—	(0.01)	(0.10)
(Loss) income attributable to Amedisys, Inc. common stockholders	$ (0.09)	$ 0.39	$ (3.08)
Weighted average shares outstanding	33,018	32,823	31,247
Amounts attributable to Amedisys, Inc. common stockholders:			
(Loss) income from continuing operations	$ (3,021)	$ 12,992	$ (93,105)
Discontinued operations, net of tax	—	(216)	(3,073)
Net (loss) income	$ (3,021)	$ 12,776	$ (96,178)

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE (LOSS) INCOME
(Amounts in thousands)

	For the Years Ended December 31,		
	2015	2014	2013
Net (loss) income	$(2,312)	$13,089	$(97,775)
Other comprehensive income (loss)	—	—	—
Comprehensive (loss) income	(2,312)	13,089	(97,775)
Comprehensive (income) loss attributable to non-controlling interests	(709)	(313)	1,597
Comprehensive (loss) income attributable to Amedisys, Inc.	$(3,021)	$12,776	$(96,178)

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands, except common stock shares)

	Total	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock	Accumulated Other Comprehensive Loss (Income)	Retained Earnings	Noncontrolling Interests
Balance, December 31, 2012	$454,233	31,876,508	32	450,792	(17,116)	15	18,617	1,893
Issuance of stock – employee stock purchase plan	3,181	303,989	—	3,181	—	—	—	—
Issuance of stock – 401(k) plan	8,581	702,391	1	8,580	—	—	—	—
Exercise of stock options	261	37,558	—	261	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	493,524	—	—	—	—	—	—
Non-cash compensation	6,519	—	—	6,519	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(2,152)	—	—	(2,152)	—	—	—	—
Surrendered shares	(1,060)	—	—	—	(1,060)	—	—	—
Acquired noncontrolling interests	145	—	—	—	—	—	—	145
Noncontrolling interest distribution	(163)	—	—	—	—	—	—	(163)
Assets contributed to equity investment	709	—	—	709	—	—	—	—
Net loss	(97,775)	—	—	—	—	—	(96,178)	(1,597)
Balance, December 31, 2013	372,479	33,413,970	33	467,890	(18,176)	15	(77,561)	278
Issuance of stock – employee stock purchase plan	2,433	176,796	—	2,433	—	—	—	—
Issuance of stock – 401(k) plan	7,062	430,919	1	7,061	—	—	—	—
Exercise of stock options	564	28,229	—	564	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	519,612	1	(1)	—	—	—	—
Non-cash compensation	5,597	—	—	5,597	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(579)	—	—	(579)	—	—	—	—
Surrendered shares	(1,684)	—	—	—	(1,684)	—	—	—
Sale of noncontrolling interest	(1,549)	—	—	(493)	—	—	—	(1,056)
Decrease in noncontrolling interest	350	—	—	(710)	—	—	—	1,060
Net income	13,089	—	—	—	—	—	12,776	313
Balance, December 31, 2014	397,762	34,569,526	35	481,762	(19,860)	15	(64,785)	595
Issuance of stock – employee stock purchase plan	2,204	79,323	—	2,204	—	—	—	—
Issuance of stock – 401(k) plan	6,032	184,412	—	6,032	—	—	—	—
Exercise of stock options	399	15,380	—	399	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	(61,675)	—	—	—	—	—	—
Non-cash compensation	11,824	—	—	11,824	—	—	—	—
Tax benefit from stock options exercised and restricted stock vesting	2,073	—	—	2,073	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(4)	—	—	(4)	—	—	—	—
Surrendered shares	(2,525)	—	—	—	(2,525)	—	—	—
Shares repurchased	(4,581)	—	—	—	(4,581)	—	—	—
Noncontrolling interest distribution	(436)	—	—	—	—	—	—	(436)
Net loss	(2,312)	—	—	—	—	—	(3,021)	709
Balance, December 31, 2015	$410,436	34,786,966	$ 35	$504,290	$(26,966)	$ 15	$(67,806)	$ 868

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

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

	For the Years Ended December 31,		
	2015	2014	2013
Cash Flows from Operating Activities:			
Net (loss) income	$ (2,312)	$ 13,089	$ (97,775)
Adjustments to reconcile net (loss) income to net cash provided by (used in) operating activities:			
Depreciation and amortization	20,036	28,347	37,383
Provision for doubtful accounts	14,053	16,369	16,461
Non-cash compensation	11,824	5,597	6,519
401(k) employer match	6,089	6,216	7,998
Loss on disposal of property and equipment	775	4,592	2,742
Gain on sale of care centers	(184)	(2,967)	(1,752)
Deferred income taxes	(677)	22,561	(57,095)
Write off of deferred debt issuance costs/debt discount	2,512	488	121
Equity in earnings from equity method investments	(9,823)	(2,991)	(1,520)
Amortization of deferred debt issuance costs/debt discount	959	797	699
Return on equity investment	5,610	2,025	1,650
Asset impairment charge	77,268	3,107	9,492
Changes in operating assets and liabilities, net of impact of acquisitions:			
Patient accounts receivable	(36,493)	(5,290)	41,578
Other current assets	6,455	(6,269)	(501)
Other assets	(3,523)	1,694	(1,596)
Accounts payable	7,639	(3,168)	(9,876)
U.S. Department of Justice settlement	—	(150,000)	150,000
Accrued expenses	8,406	3,495	(6,104)
Other long-term obligations	(829)	(3,226)	3,839
Net cash provided by (used in) operating activities	107,785	(65,534)	102,263
Cash Flows from Investing Activities:			
Proceeds from sale of deferred compensation plan assets	1,229	11	128
Proceeds from the sale of property and equipment	20,000	3	1,809
Purchases of deferred compensation plan assets	(19)	(132)	(111)
Purchases of property and equipment	(21,429)	(12,008)	(41,736)
Purchase of investments	(3,485)	(6,407)	(10,067)
Proceeds from sale of investment	5,000	—	—
Acquisitions of businesses, net of cash acquired	(69,130)	—	(1,627)
Proceeds from disposition of care centers	413	4,233	5,146
Net cash used in investing activities	(67,421)	(14,300)	(46,458)
Cash Flows from Financing Activities:			
Proceeds from issuance of stock upon exercise of stock options and warrants	399	564	261
Proceeds from issuance of stock to employee stock purchase plan	2,204	2,433	3,181
Tax benefit from stock options exercised and restricted stock vesting	2,073	—	57
Non-controlling interest distribution	(436)	—	(163)
Proceeds from revolving line of credit	63,400	241,800	25,500
Repayments of revolving line of credit	(78,400)	(226,800)	(25,500)
Proceeds from issuance of long-term obligations	100,000	68,250	—
Debt issuance costs	(2,553)	(1,780)	(576)
Principal payments of long-term obligations	(103,000)	(13,904)	(55,807)
Purchase of company stock	(4,581)	—	—
Net cash (used in) provided by financing activities	(20,894)	70,563	(53,047)
Net increase (decrease) in cash and cash equivalents	19,470	(9,271)	2,758
Cash and cash equivalents at beginning of period	8,032	17,303	14,545
Cash and cash equivalents at end of period	$ 27,502	$ 8,032	$ 17,303
Supplemental Disclosures of Cash Flow Information:			
Cash paid for interest	$ 6,175	$ 7,602	$ 3,990
Cash paid for income taxes, net of refunds received	$ (12,185)	$ (1,766)	$ 3,385
Supplemental Disclosures of Non-Cash Financing and Investing Activities:			
(Sale) acquisition of non-controlling interests	$ —	$ (1,549)	$ 145

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

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2015

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 80%, 82% and 84% of our revenue derived from Medicare for 2015, 2014 and 2013, respectively. As of December 31, 2015, we owned and operated 329 Medicare-certified home health care centers and 79 Medicare-certified hospice care centers in 34 states within the United States and the District of Columbia.

Use of Estimates

Our accounting and reporting policies conform with U.S. Generally Accepted Accounting Principles ("U.S. GAAP"). In preparing the consolidated financial statements, we are required to make estimates and assumptions that impact the amounts reported in the 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. Our exit activity during the last three years may affect the comparability of our operating results. In accordance with applicable accounting guidance, the results of operations for the care centers closed, sold or classified as held for sale during 2013 are presented in discontinued operations in our consolidated financial statements. See Note 4 – Discontinued Operations and Assets Held for Sale for additional information regarding our discontinued operations.

Principles of Consolidation

These 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 consolidated financial statements, and business combinations accounted for as purchases have been included in our 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%. During 2013, we recorded a $1.3 million goodwill impairment charge related to an investment that was consolidated. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our consolidated financial statements.

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 $25.7 million as of December 31, 2015 and $18.8 million as of December 31, 2014. During 2015, our investment in the Heritage Healthcare Innovation Fund, LP ("Heritage"), one of our equity method investees with a carrying value of $19.9 million as of December 31, 2015, became a significant subsidiary. Summarized financial information of Heritage as of and for the twelve-month period ended September 30, 2015, is as follows: current assets of $3.5 million, total assets of $170.4 million, current and total liabilities of less than $0.1 million, total investment income of $72.5 million, total expenses of $3.5 million and net increase in partners' capital from operations of $69.0 million. We record our share of the investment on a one quarter lag.

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. The aggregate carrying amount of our cost method investment which was sold during 2015 was $5.0 million as of December 31, 2014.

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 December 31, 2015 and 2014, the difference between the cash received from Medicare for a request for anticipated payment ("RAP") on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our consolidated balance sheets for such periods.

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 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%, 98%, and 99% of our total net Medicare hospice service revenue for 2015, 2014 and 2013, respectively. 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 December 31, 2015, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $1.4 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016. As of December 31, 2014, we had recorded $2.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2015.

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.

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit and all highly liquid debt instruments with maturities of three months or less when purchased.

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 December 31, 2015, there is one single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables (approximately 10.5%). 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 64% and 69% of our net patient accounts receivable at December 31, 2015 and December 31, 2014, 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 2015, 2014 and 2013, we recorded $6.1 million, $5.1 million and $9.0 million, respectively, in estimated revenue adjustments to Medicare revenue.

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 resubmitted.

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 and Hospice

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.

We consider our reporting units to represent asset groups for purposes of testing long-lived assets for impairment. We assess the impairment of a long-lived asset group whenever events or changes in circumstances indicate that the asset's carrying value may not be recoverable. Factors we consider important that could trigger an impairment review include but are not limited to the following:

- A significant change in the extent or manner in which the long-lived asset group is being used.
- A significant change in the business climate that could affect the value of the long-lived asset group.
- A significant change in the market value of the assets included in the asset group.

If we determine that the carrying value of long-lived assets may not be recoverable, we compare the carrying value of the asset group to the undiscounted cash flows expected to be generated by the asset group. If the carrying value exceeds the undiscounted cash flows, an impairment charge is indicated. An impairment charge is recognized to the extent that the carrying value of the asset group exceeds its fair value.

We generally provide for depreciation over the following estimated useful service lives.

	Years
Building	39
Leasehold improvements	Lesser of life or lease or expected useful life
Equipment and furniture	3 to 7
Vehicles	5
Computer software	3 to 7

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 million 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; no further depreciation expense for the asset was recorded. 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 asset was sold during the three-month period ended December 31, 2015 and the Company now leases relevant office space.

The following table summarizes the balances related to our property and equipment for 2015 and 2014 (amounts in millions):

	As of December 31,	
	2015	2014
Land	$ —	$ 3.2
Building and leasehold improvements	2.3	25.3
Equipment and furniture	89.6	97.2
Computer software	92.6	158.2
	184.5	283.9
Less: accumulated depreciation	(141.8)	(146.4)
	$ 42.7	$ 137.5

Depreciation expense for 2015, 2014 and 2013 was $20.0 million, $28.0 million and $35.2 million, respectively.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and

liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

Each of our operating segments described in Note 15 – Segment Information is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice care centers and have also deemed them to be a single reporting unit.

During 2015, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units was considered at risk of impairment as of October 31, 2015. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names, non-compete agreements and reacquired franchise rights. We amortize non-compete agreements, acquired names that we do not intend to use in the future and reacquired franchise rights on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for reacquired franchise rights and acquired names.

Debt Issuance Costs

We amortize deferred debt issuance costs related to our long-term obligations over its term through interest expense, unless the debt is extinguished, in which case unamortized balances are immediately expensed. We amortized $0.8 million, $0.7 million and $0.7 million in deferred debt issuance costs in 2015, 2014 and 2013, respectively. As of December 31, 2015 and 2014, we had unamortized debt issuance costs of $3.4 million and $2.8 million, respectively, recorded as other assets in our accompanying consolidated balance sheets. During the third quarter of 2015, we expensed $1.0 million of unamortized debt issuance costs when we entered into our new Credit Agreement. In connection with the new Credit Agreement we recorded an additional $2.4 million in

deferred debt issuance costs as other assets in our consolidated balance sheet. The unamortized debt issuance costs of $3.4 million at December 31, 2015, will be amortized over a weighted-average amortization period of 4.6 years.

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. For our other financial instruments, including our cash and cash equivalents, patient accounts receivable, accounts payable, payroll and employee benefits and accrued expenses, we estimate the carrying amounts' approximate fair value. As of December 31, 2015, the carrying amount 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.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2015 and 2014 our net deferred tax assets were $125.2 million and $122.4 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

Share-Based Compensation

We record all share-based compensation as expense in the financial statements measured at the fair value of the award. We recognize compensation cost on a straight-line basis over the requisite service period for each separately vesting portion of the award. We reflect the excess tax benefits related to stock option exercises as financing cash flows. Share-based compensation expense for 2015, 2014 and 2013 was $11.8 million, $5.6 million and $6.5 million, respectively, and the total income tax benefit recognized for these expenses was $4.7 million, $2.0 million and $2.5 million, respectively.

Weighted-Average Shares Outstanding

Net (loss) income 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 earnings attributable to Amedisys, Inc. common stockholders (amounts in thousands):

	For the Years Ended December 31,		
	2015	2014	2013
Weighted average number of shares outstanding – basic	33,018	32,301	31,247
Effect of dilutive securities:			
Stock options	—	1	—
Non-vested stock and stock units	—	521	—
Weighted average number of shares outstanding – diluted	33,018	32,823	31,247
Anti-dilutive securities	922	106	688

Advertising Costs

We expense advertising costs as incurred. Advertising expense for 2015, 2014 and 2013 was $6.9 million, $4.7 million and $3.9 million, respectively.

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. As of December 31, 2015, we have $3.4 million of unamortized debt issuance costs that would be reclassified from a long-term asset to a reduction in the carrying amount of our debt.

In November 2015, the FASB issued ASU 2015-17, *Balance Sheet Classification of Deferred Taxes (Topic 740)*, which simplifies the presentation of deferred income taxes. This ASU requires that deferred tax assets and

liabilities be classified as noncurrent in the balance sheet. The current requirement that deferred tax assets and liabilities be offset and presented as a single amount was not affected by the amendments in ASU 2015-17. The ASU is effective for annual and interim periods beginning on or after December 15, 2016. Early adoption is permitted. We have chosen to early adopt this ASU on a prospective basis. Adoption of this ASU resulted in a reclassification of our net current deferred tax liability to the net noncurrent deferred tax asset in our consolidated balance sheet as of December 31, 2015. Prior periods were not retrospectively adjusted.

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.

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 for each transaction. 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.

On July 24, 2015, we acquired one hospice care center in Tennessee for a total purchase price of $5.8 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($5.5 million) and other intangibles ($0.3 million).

On October 2, 2015, we acquired the regulatory assets of home health care center in Georgia for a total purchase price of $0.3 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($0.3 million).

On December 31, 2015, we acquired Infinity HomeCare ("Infinity") for a total purchase price of $63 million, net of cash acquired (subject to certain adjustments), of which $3.2 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. Infinity owned and operated 15 home health care centers servicing the state of Florida. In connection with the acquisition, we recorded goodwill ($50.2 million), other intangibles ($10.9 million) and other assets and liabilities, net ($1.9 million). Approximately $47.6 million of the $50.2 recorded as goodwill is expected to be deductible for income tax purposes over approximately 15 years.

The following table contains unaudited pro forma condensed consolidated statement of operations information assuming that the Infinity transaction closed on January 1, 2014, for the years ended December 31, 2015 and 2014 (amounts in millions, except per share data):

	2015	2014
Net service revenue	$1,327.3	$1,247.6
Operating (loss) income	(7.9)	21.0
Net income	0.2	10.9
Basic earnings per share	$ 0.01	$ 0.34
Diluted earnings per share	$ 0.01	$ 0.33

The pro forma information presented above includes adjustments for (i) interest expense, (ii) amortization of identifiable intangible assets and (iii) income tax provision using the Company's statutory tax rate. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operations that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information.

4. DISCONTINUED OPERATIONS AND ASSETS HELD FOR SALE

As part of our ongoing management of our portfolio of care centers, we review each care center's current financial performance, market penetration, forecasted market growth and the impact of proposed CMS payment revisions. If the review indicates a care center should be closed, we first determine whether we can consolidate the care center with a care center servicing the same market. If a consolidation is not viable, we evaluate whether we have the opportunity to sell the care center or must close the care center. As a result of our review, we consolidated 41 home health care centers and five hospice care centers with care centers servicing the same markets, sold 19 home health care centers and one hospice care center and closed 10 home health care centers during 2013. We had previously classified 28 of these care centers as held for sale during 2013 and three care centers remained classified as held for sale at December 31, 2013. During 2014, we sold assets associated with two of these care centers and consolidated one of these care centers with a care center servicing the same market. There were no care centers classified as held for sale as of December 31, 2014.

As we exited certain geographical areas and in accordance with applicable accounting guidance, the care centers which were closed, sold or classified as held for sale in 2013 (32 home health care centers and one hospice care center) are presented as discontinued operations in our consolidated financial statements. The care centers consolidated with care centers servicing the same markets are presented in continuing operations as we expect continuing cash flows from these markets. For additional information on the care centers consolidated with care centers servicing the same markets and the care centers sold, see Note 13 – Exit Activities and Restructuring Activities.

Net revenues and operating results for the periods presented for those care centers classified as discontinued operations are as follows (dollars in millions):

	For the Years Ended December 31,		
	2015	2014	2013
Net revenues	$—	$(0.3)	$31.2
(Loss) before income taxes	—	(0.3)	(5.3)
Income tax benefit	—	0.1	2.2
Discontinued operations, net of tax	$—	$(0.2)	$(3.1)

5. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

During 2015, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2015. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

During the fiscal year 2014, we recognized a non-cash other intangible impairment charge of $0.9 million during step one of our 2014 annual goodwill impairment test. In addition, we recorded non-cash impairment charges of $2.2 million related to those care centers that were closed or consolidated during 2014 as discussed in Note 13 – Exit and Restructuring Activities.

During the fiscal year 2013, we recognized the following: a non-cash goodwill impairment charge of $1.3 million and a non-cash other intangibles impairment charge of $8.2 million. The non-cash goodwill impairment charge related to an investment that was consolidated as discussed in Note 1- Nature of Operations, Consolidation and Presentation of Financial Statements. Included in the non-cash other intangibles impairment charge discussed above is $4.6 million recognized during step one of our 2013 annual goodwill impairment test and $3.6 million related to intangibles associated with those care centers that were closed or consolidated during 2013 as discussed in Note 13 – Exit and Restructuring Activities.

The following table summarizes the activity related to our goodwill for the 2015, 2014 and 2013 (amounts in millions):

	Goodwill		
	Home Health	Hospice	Total
Balances at December 31, 2012	$18.2	$191.4	$209.6
Additions	0.1	0.9	1.0
Write-off (1)	(0.4)	—	(0.4)
Impairment	(1.3)	—	(1.3)
Balances at December 31, 2013	16.6	192.3	208.9
Write-off (1)	(0.1)	(3.2)	(3.3)
Balances at December 31, 2014	16.5	189.1	205.6
Additions	50.6	5.5	56.1
Balances at December 31, 2015	$67.1	$194.6	$261.7

(1) Write-off of goodwill related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.

The following table summarizes the activity related to our other intangible assets, net for 2015, 2014 and 2013 (amounts in millions):

	Other Intangible Assets, Net			
	Certificates of Need and Licenses	Acquired Names of Business	Non-Compete Agreements & Reacquired Franchise Rights	Total
Balances at December 31, 2012	$33.7	$11.5	$ 1.8	$47.0
Additions	0.6	—	—	0.6
Write-off (1)	(1.1)	—	—	(1.1)
Impairment	(7.8)	(0.4)	—	(8.2)
Amortization	—	—	(1.6)	(1.6)
Balances at December 31, 2013	25.4	11.1	0.2	36.7
Write-off (1)	(0.2)	—	—	(0.2)
Impairment	(2.1)	(1.0)	—	(3.1)
Amortization	—	—	(0.2)	(0.2)
Balances at December 31, 2014	23.1	10.1	—	33.2
Additions	1.1	4.1	5.9	11.1
Write-off (1)	(0.3)	—	—	(0.3)
Amortization	—	—	—	—
Balances at December 31, 2015	$23.9	$14.2	$ 5.9	$44.0

(1) Write-off of intangible assets related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.
(2) The weighted average amortization period of our non-compete agreements is 3.0 years.

See Note 3 – Acquisitions for further details on additions to goodwill and other intangible assets, net.

The estimated aggregate amortization expense for each of the five succeeding years is as follows (amounts in millions):

2016	$ 2.0
2017	2.0
2018	1.9
2019	—
2020	—
	$ 5.9

6. DETAILS OF CERTAIN BALANCE SHEET ACCOUNTS

Additional information regarding certain balance sheet accounts is presented below (amounts in millions):

	As of December 31,	
	2015	2014
Other current assets:		
Payroll tax escrow	$ 6.2	$ 1.0
Medicare withholds	—	0.1
Income tax receivable	0.5	15.0
Due from joint ventures	1.8	1.4
Other	6.1	2.2
	$14.6	$19.7
Other assets:		
Workers' compensation deposits	$ 0.3	$ 0.3
Health insurance deposits	1.2	1.2
Other miscellaneous deposits	1.5	0.7
Deferred financing fees	3.4	2.8
Investments	25.7	23.8
Other	4.1	4.4
	$36.2	$33.2
Accrued expenses:		
Health insurance	$11.7	$11.2
Workers' compensation	23.9	19.8
Legal and other settlements	10.5	5.2
Lease liability	0.6	0.8
Charity care	0.7	0.7
Estimated Medicare cap liability	1.4	2.8
Hospice cost of revenue	6.8	5.7
OIG self-disclosure accrual	4.7	—
Patient liability	5.1	4.3
Other	6.6	5.8
	$72.0	$56.3
Other long-term obligations:		
Reserve for uncertain tax positions	$ 0.7	$ 0.5
Deferred compensation plan liability	2.8	3.3
Other	0.9	1.5
	$ 4.4	$ 5.3

7. LONG-TERM OBLIGATIONS

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

	As of December 31,	
	2015	2014
$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 (2.42% at December 31, 2015); due August 28, 2020	$100.0	$ —
$60.0 million Term Loan; $3.0 million principal payments plus accrued interest payable quarterly; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage; due October 26, 2017	—	33.0
$120.0 million Revolving Credit Facility; interest only quarterly payments; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage; due October 26, 2017	—	15.0
$70.0 million Second Lien Loan; interest only quarterly payments; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage; due July 28, 2020	—	70.0
Discount on Second Lien Loan	—	(1.6)
	100.0	116.4
Current portion of long-term obligations	(5.0)	(12.0)
Total	$ 95.0	$104.4

Maturities of debt as of December 31, 2015 are as follows (amounts in millions):

	Long-term obligations
2016	$ 5.0
2017	5.0
2018	10.0
2019	10.0
2020	70.0
	$100.0

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million (the "Credit Facilities").

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the "Term Loan"); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the "Revolving Credit Facility"). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement, dated as of October 22, 2012, as amended (the "Prior Credit Agreement") with

a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the "Second Lien Credit Agreement"), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan will amortize beginning on March 31, 2016 in 18 quarterly installments (eight quarterly installments of $1.25 million followed by eight quarterly installments of $2.5 million, followed by two quarterly installments of $3.1 million, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and our subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2015, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.7% for the period August 28, 2015 to December 31, 2015.

As of December 31, 2015, our availability under our $200.0 million Revolving Credit Facility was $179.0 million as we had $21.0 million outstanding in letters of credit.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2015, our consolidated leverage ratio was 0.9 and our consolidated fixed charge coverage ratio was 3.7 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guarantees from wholly-owned subsidiaries that in the

aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with our entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet.

8. INCOME TAXES

Income taxes attributable to continuing operations consist of the following (amounts in millions):

	For the Years Ended December 31,		
	2015	2014	2013
Current income tax expense/(benefit):			
Federal	$ 2.2	$(13.9)	$ (2.0)
State and local	0.5	(1.1)	0.3
	2.7	(15.0)	(1.7)
Deferred income tax expense/(benefit):			
Federal	(0.5)	21.0	(43.2)
State and local	(0.1)	1.6	(13.9)
Foreign	(0.1)	0.1	—
	(0.7)	22.7	(57.1)
Income tax expense/(benefit) from continuing operations	$ 2.0	$ 7.7	$(58.8)

Total income tax expense for the years ended December 31, 2015, 2014 and 2013 was allocated as follows (amounts in millions):

	For the Years Ended December 31,		
	2015	2014	2013
Income from continuing operations	$ 2.0	$ 7.7	$(58.8)
Income from discontinued operations	—	(0.1)	(2.2)
Interest expense	0.2	(0.1)	0.1
Goodwill	(0.1)	—	—
Stockholders' equity	(2.1)	0.6	2.2
	$—	$ 8.1	$(58.7)

A reconciliation of significant differences between the reported amount of income tax expense and the expected amount of income tax expense that would result from applying the U.S. federal statutory income tax rate of 35 percent to income before taxes from continuing operations is as follows:

	For the Years Ended December 31,		
	2015 (1)	2014	2013
Income tax expense/(benefit) at U.S. federal statutory rate	35.0 %	35.0 %	(35.0)%
State and local income taxes, net of federal income tax benefit	(7.1)	5.8	(4.4)
Valuation allowance	79.1	1.5	—
Tax credits	136.0	(8.4)	(1.2)
Uncertain tax positions	(230.3)	0.6	2.3
Other items, net (2)	(663.3)	2.1	—
Income tax expense/(benefit)	(650.6)%	36.6 %	(38.3)%

(1) The information provided for the year ended December 31, 2015 does not provide a meaningful reconciliation of the effective tax rate or comparable to other periods. The effective tax rate for the year is influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to income or loss before taxes. A significant asset impairment was recorded in the first quarter, resulting in a scenario where the company's loss before tax for the year was near zero. Consequently, for 2015, the relationship between the "effective tax rate drivers" and loss before taxes is distorted.

(2) Includes various items such as, non-deductible expenses, non-taxable income, return-to-accrual adjustments, and foreign tax rate differential.

As of December 31, 2015 and 2014, the Company had income taxes receivable of $0.5 million and $15.0 million, respectively, included in other current assets. The $15.0 million receivable at December 31, 2014, primarily includes a U.S. federal tax receivable of $14.3 million from the carry back of U.S. federal net operating losses to December 31, 2012 and 2011. During 2015, the Company received the $14.3 million U.S. federal refund from the carry back claims.

Deferred tax assets (liabilities) consist of the following components (amounts in millions):

	As of December 31,	
	2015	2014
Deferred tax assets:		
Allowance for doubtful accounts	$ 6.4	$ 5.6
Accrued expenses	—	1.2
Accrued bonus	4.0	—
Workers' compensation	9.8	8.1
Amortization of intangible assets	72.2	89.2
Share-based compensation	5.0	3.3
Net operating loss carryforwards (1)	48.5	59.3
Tax credit carryforwards (2)	4.7	2.6
Other	5.1	1.8
Gross deferred tax assets	155.7	171.1
Less: valuation allowance	(0.3)	(0.6)
Net deferred tax assets	155.4	170.5
Deferred tax (liabilities):		
Property and equipment	(9.5)	(31.3)
Deferred revenue	(18.5)	(16.8)
Other liabilities	(2.2)	—
Gross deferred tax (liabilities)	(30.2)	(48.1)
Net deferred tax assets (liabilities)	$125.2	$122.4

(1) The net operating loss ("NOL") carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the NOL carry forwards, as of December 31, 2015 and 2014, are presented net of unrecognized tax benefits of $3.1 million.

(2) The tax credit carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the tax credit carry forwards, as of December 31, 2015 and 2014, are presented net of unrecognized tax benefits of $0.7 million and $0.3 million, respectively.

Classification in the consolidated balance sheet (amounts in millions):

	As of December 31,	
	2015(1)	2014
Current deferred tax liabilities	—	(2.4)
Noncurrent deferred tax assets	125.2	124.8
Net deferred tax assets (liabilities)	$125.2	$122.4

(1) In November 2015, the FASB issued ASU 2015-17, *Balance Sheet Classification of Deferred Taxes (Topic 740)*, which required that deferred tax liabilities and assets be classified as noncurrent. Since early adoption is permitted, the Company has decided to apply ASU 2015-17 to the current period, resulting in a classification of all December 31, 2015 deferred tax assets and liabilities as noncurrent. The Company has not, however, retrospectively adjusted the prior period balances.

As of December 31, 2015, we have U.S. NOL carry forwards of $116.3 million that are available to reduce future taxable income and begins to expire in 2034. In addition, we have research and development tax credits, employment tax credits, and alternative minimum tax credits of $1.9 million, $0.4 million and $1.0 million, respectively, available to reduce future U.S. federal income taxes. The research and development tax credits and employment tax credits begin to expire in 2032, and the alternative minimum tax credits are available indefinitely.

As of December 31, 2015, we have state NOL carry forwards of $254.3 million that are available to reduce future taxable income. In addition, we have $3.1 million of various state tax credits available to reduce future taxable income. The state NOL and tax credit carry forwards begin to expire at various times.

The valuation allowance for deferred tax assets as of December 31, 2015 and 2014 was $0.3 million and $0.6 million, respectively. The net change in the total valuation allowance for the year ended December 31, 2015 and December 31, 2014 was a decrease of $0.3 million and an increase of $0.3 million, respectively. The valuation allowance during 2015 and 2014 was primarily related to certain state NOL and state tax credit carry forwards.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income in those jurisdictions during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities (including the impact of available carry back and carry forward periods), projected future taxable income, and tax-planning strategies in making this assessment. In order to fully realize the deferred tax assets, the Company will need to generate future taxable income before the expiration of the carry forwards governed by the tax code. Based on the current level of pretax earnings (excluding the significant asset impairment recorded during the three-month period ended March 31, 2015) and estimates of future taxable income, the Company will generate the minimum amount of future taxable income to support the realization of the deferred tax assets. As a result, management believes that it is more likely than not that we will realize the benefits of these deferred tax assets, net of the existing valuation allowances at December 31, 2015. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carry forward period are reduced.

Uncertain Tax Positions

We account for uncertain tax positions in accordance with the authoritative guidance for uncertain tax positions. A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows (amounts in millions):

	For the Years Ended December 31,	
	2015	2014
Balance at beginning of period	$ 4.0	$ 3.9
Additions for tax positions related to current year	—	0.3
Additions for tax positions related to prior year	1.0	—
Reductions for tax positions related to prior years	—	—
Lapse of statute of limitations	(0.3)	(0.2)
Settlements	—	—
Balance at end of period	$ 4.7	$ 4.0

As of December 31, 2015, there are $0.2 million, $0.7 million and $3.8 million of unrecognized tax benefits recorded in accrued expenses, other long-term obligations and deferred income taxes, respectively, within the consolidated balance sheet.

Included in the balance of unrecognized tax benefits at December 31, 2015 is $4.7 million of tax benefits that, if recognized in future periods, would impact our effective tax rate.

During the years ended December 31, 2015 and 2014, we recognized interest and penalties of $0.2 million and $0.1 million, respectively, as components of penalties or interest expense in connection with our reserve for uncertain tax positions. Interest and penalties, related to uncertain tax positions, included in the consolidated balance sheet at December 31, 2015 and 2014 were less than $0.2 million for each year.

We are subject to income taxes in the U.S. and in many of the 50 individual states, with significant operations in Louisiana, Alabama, Georgia, and Tennessee. We are open to examination in the U.S. and in various individual states for tax years ended December 31, 2012 through December 31, 2015. We are also open to examination in various states for the years ended 2001 – 2015 resulting from net operating losses generated and available for carry forward from those years.

We believe that it is reasonably possible that decreases of up to $0.6 million in unrecognized tax benefits, each of which are individually insignificant, may be recognized by the end of December 31, 2016 as a result of an anticipated settlement and lapse of the statute of limitations.

9. CAPITAL STOCK AND SHARE-BASED COMPENSATION

We are authorized by our Certificate of Incorporation to issue 60,000,000 shares of common stock, $0.001 par value and 5,000,000 shares of preferred stock, $0.001 par value. As of December 31, 2015, there were 34,786,966 and 33,607,282 shares of common stock issued and outstanding, respectively, and no shares of preferred stock issued or outstanding. Our Board of Directors is authorized to fix the dividend rights and terms, conversion and voting rights, redemption rights and other privileges and restrictions applicable to our preferred stock.

Share-Based Awards

Our 2008 Omnibus Incentive Compensation Plan (the "Plan") authorizes the grant of various types of equity-based awards, such as stock awards, restricted stock units, stock appreciation rights and stock options to eligible participants, which include all of our employees and all employees of our 50% or more owned subsidiaries, our non-employee directors and certain consultants. The vesting terms of the awards may be tied to continued employment (or, for our non-employee directors, continued service on the Board of Directors) and/or achievement of certain pre-determined performance goals. We refer to stock awards subject to service-based vesting conditions as "non-vested stock" and restricted stock units subject to service-based and performance-based or market-based vesting conditions as "non-vested stock units." The Plan is administered by the Compensation Committee of our Board of Directors, which determines, within the provisions of the Plan, those eligible employees to whom, and the times at which, awards shall be granted. The Compensation Committee, in its discretion, may delegate its authority and duties under the Plan to specified officers; however, only the Compensation Committee may approve the terms of awards to our executive officers.

Equity-based awards may be granted for a number of shares not to exceed, in the aggregate, approximately 5.5 million shares of common stock, and we had approximately 1.3 million shares available at December 31, 2015. The price per share for stock options shall be of no less than the greater of (a) 100% of the fair value of a

share of common stock on the date the option is granted or (b) the aggregate par value of the shares of our common stock on the date the option is granted. If a stock option is granted to any owner of 10% or more of our total combined voting power of us and our subsidiaries, the price is to be at least 110% of the fair value of a share of our common stock on the date the award is granted. Each equity-based award vests ratably over a 12 month-to-six year period, with the exception of those issued under contractual arrangements that specify otherwise, that may be exercised during a period as determined by our Compensation Committee or as otherwise approved by our Compensation Committee. The contractual terms of stock options exercised shall not exceed ten years from the date such option is granted.

Employee Stock Purchase Plan ("ESPP")

We have a plan whereby our eligible employees may purchase our common stock at 85% of the market price at the time of purchase. On June 7, 2012, our stockholders ratified an amendment adopted by our Board of Directors to increase the total number of shares of our common stock authorized for the issuance under our ESPP from 2,500,000 shares to 4,500,000 shares, and as of December 31, 2015, there were 1,522,288 shares available for future issuance. The following is a detail of the purchases that were made or pending Board of Director approval under the plan:

Employee Stock Purchase Plan Period	Shares Issued	Price
2013 and Prior	2,755,337	$13.67
January 1, 2014 to March 31, 2014	52,718	12.66
April 1, 2014 to June 30, 2014	38,679	14.23
July 1, 2014 to September 30, 2014	32,573	17.14
October 1, 2014 to December 31, 2014	20,221	24.95
January 1, 2015 to March 31, 2015	24,368	22.76
April 1, 2015 to June 30, 2015	15,750	33.77
July 1, 2015 to September 30, 2015	18,984	32.27
October 1, 2015 to December 31, 2015	19,082	33.42
	2,977,712	

ESPP expense included in general and administrative expense in our accompanying consolidated statements of operations was $0.4 million, $0.4 million and $0.5 million for 2015, 2014 and 2013, respectively.

Stock Options

We use the Black-Scholes option pricing model to estimate the fair value of our stock options. There were no stock options granted during 2013; there were 590,647 and 250,000 options granted during 2015 and 2014, respectively. Stock option compensation expense included in general and administrative expense in our accompanying consolidated statements of operations was $3.8 million and $0.1 million for 2015 and 2014, respectively.

The fair value of the 2015 awards were estimated using the following assumptions:

Risk Free Rate	1.46% – 1.93%
Expected Volatility	53.87% – 58.05%
Expected Term	5.50 – 6.76 years
Weighted Average Fair Value	$13.45 – $23.21

We used the simplified method to estimate the expected term for the stock options granted during 2015.

The following table presents our stock option activity for 2015:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Contractual Life (Years)
Outstanding options at January 1, 2015	277,536	$26.40	8.99
Granted	590,647	31.73	
Exercised	(15,380)	25.93	
Canceled, forfeited or expired	(14,309)	25.16	
Outstanding options at December 31, 2015	838,494	$30.18	9.31
Exercisable options at December 31, 2015	62,500	$26.65	8.96

The aggregate intrinsic value of our outstanding options and exercisable options at December 31, 2015 was $8.1 million and $0.8 million, respectively. Total intrinsic value of options exercised was $0.2 million, $0.1 million and $0.2 million for 2015, 2014 and 2013, respectively.

The following table presents our non-vested stock option award activity for 2015:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock options at January 1, 2015	250,000	$26.65
Granted	590,647	31.73
Vested	(62,500)	26.65
Forfeited	(2,153)	43.63
Non-vested stock options at December 31, 2015	775,994	$30.47

At December 31, 2015, there was $9.8 million of unrecognized compensation cost related to stock options that we expect to be recognized over a weighted-average period of 2.6 years.

Non-Vested Stock

We issue shares of non-vested stock with vesting terms ranging from one to six years. The compensation expense is determined based on the market price of our common stock at the date of grant applied to the total number of shares that are anticipated to fully vest. Non-vested stock compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $5.0 million, $4.6 million and $5.2 million for 2015, 2014 and 2013, respectively.

The following table presents our non-vested stock award activity for 2015:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock at January 1, 2015	917,959	$15.17
Granted	93,256	28.48
Vested	(355,396)	14.69
Canceled, forfeited or expired	(154,931)	14.34
Non-vested stock at December 31, 2015	500,888	$18.24

The weighted average grant date fair value of non-vested stock granted was $28.48, $16.38 and $10.91 in 2015, 2014, and 2013, respectively.

At December 31, 2015, there was $4.1 million of unrecognized compensation cost related to non-vested stock award payments that we expect to be recognized over a weighted average period of 1.4 years.

Non-Vested Stock Units – Service-Based

We issue non-vested stock unit awards that are service-based, performance-based or a combination of both with vesting terms ranging from one to six years. Based on the terms and conditions of these awards, we determine if the awards should be recorded as either equity or liability instruments. The compensation expense is determined based on the market price of our common stock at the date of grant, applied to the total number of units that are anticipated to vest, unless the award specifies differently. We account for such awards similar to our non-vested stock awards; however, no shares of stock are issued to the recipient until the stock unit awards have vested and after the pre-determined delivery date has occurred. Service-based non-vested stock unit compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $1.0 million for 2015.

The following table presents our service-based non-vested stock units activity for 2015:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2015	—	$ —
Granted	186,314	37.98
Vested	—	—
Canceled, forfeited or expired	(2,982)	43.63
Non-vested stock units at December 31, 2015	183,332	$37.89

The weighted average grant date fair value of service-based non-vested stock units granted was $37.98 in 2015.

At December 31, 2015, there was $5.9 million of unrecognized compensation cost related to our service-based non-vested stock units that we expect to be recognized over a weighted average period of 2.7 years.

Non-Vested Stock Units – Service-Based and Performance-Based Awards

During 2015, we awarded performance-based awards to certain employees. The target level established by the award, which is based on the Company's 2015 adjusted earnings before interest, taxes and depreciation ("EBITDA"), provided for the recipients to receive 154,732 non-vested stock units if the target was achieved. The target number of shares to be potentially awarded has been reduced by forfeitures as indicated in the table below. Performance-based non-vested stock units compensation expense included in general and administrative expenses in our consolidated statements of operations was $1.3 million for 2015.

The following table presents our performance-based non-vested stock units activity for 2015:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2015	—	$ —
Granted	154,732	39.54
Vested	—	—
Canceled, forfeited or expired	(3,669)	43.63
Non-vested stock units at December 31, 2015	151,063	$39.44

The weighted average grant date fair value of performance-based non-vested stock units granted was $39.54 in 2015.

At December 31, 2015, there were $4.6 million in unrecognized compensation costs related to our performance-based non-vested stock units that we expect to be recognized over a weighted average period of 2.2 years.

Non-Vested Stock Units – Service-Based and Market-Based Awards

During 2013, we awarded market-based awards to certain employees. The target level established by the award, which is based on our average December 2015 stock price, provided for the recipients to receive 417,330 non-vested stock units if the target is achieved. If the target objective is surpassed to the point of achieving the projected maximum payout, the recipients would receive 667,728 non-vested stock units. The target number of shares to be potentially awarded has been reduced by forfeitures as indicated in the table below.

For market-based awards, the effect of the market condition is reflected in the fair value of the awards at the date of grant using a Monte-Carlo simulation model. A Monte-Carlo simulation model estimates the fair value of the market-based award based upon the expected term, risk-free interest rate and expected volatility. Compensation expense for market-based awards is recognized over the vesting period regardless of whether the market conditions are expected to be achieved. Market-based non-vested stock units compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $0.3 million, $0.5 million and $0.8 million for 2015, 2014 and 2013, respectively. The fair value of the 2013 award was estimated using the following assumptions:

Forward Interest Rate	0.327 % – 1.460%
Expected Volatility	54.38%
Requisite Service Period	3 years
Fair Value	$ 10.51

The following table presents our market-based non-vested stock units activity for 2015:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2015	225,745	$10.51
Granted	—	—
Vested	—	—
Canceled, forfeited or expired	(61,211)	10.51
Non-vested stock units at December 31, 2015	164,534	$10.51

The weighted average grant date fair value of market-based non-vested stock units granted was $10.51 in 2013.

At December 31, 2015, there were $0.2 million in unrecognized compensation costs related to our market-based non-vested stock units that we expect to be recognized over a weighted average period of 0.3 years.

10. 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. 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. No assurances can be given about the timing or outcome of this matter.

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 Federal Fair Labor Standards Act ("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 will be submitted to the Court for preliminary approval and plaintiffs will request certification of Pennsylvania and Kentucky classes for the sole purpose of this proposed settlement. If the Court grants preliminary approval, notice will be 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 will hold 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 have reduced our accrual to $5.3 million as of December 31, 2015.

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, thereby denying her overtime. The plaintiff alleges violations of federal and state law and seeks damages under the 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 referenced above. On December 23, 2015 the parties agreed to explore the possibility of a mediated settlement of the Illinois case, and a mediation is scheduled to occur on April 18, 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 us 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 or reasonably estimate the potential liability, if any, 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. No assurance can be given as to the timing or outcome of this investigation.

Civil Investigative Demand 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. No assurance can be given as to the timing or outcome of this investigation.

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

Shareholder Derivative Action

On August 24, 2015, Michael Bonhette, an alleged shareholder of the Company filed a derivative lawsuit in the United States District Court for the Middle District of Louisiana, purporting to assert claims on behalf of the Company against certain of our officers and directors. We were named as a nominal defendant in this action. The derivative complaint alleged that certain of our officers and directors breached their fiduciary duties to the Company by agreeing to allegedly unlawful provisions in the Company's Credit Agreement dated as of October 22, 2012, as amended (the "Prior Credit Agreement"), and the Company's Second Lien Credit Agreement dated as of July 28, 2014 (the "Second Lien Credit Agreement"). Each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated on August 28, 2015.

On October 14, 2015, the United Stated District Court for the Middle District of Louisiana issued an order granting a motion for dismissal voluntarily filed by the plaintiffs in this matter. Effective as of such date, the derivative lawsuit was dismissed without prejudice and at the cost of the plaintiffs.

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 have identified several such reportable events and have notified the OIG as required. The final resolution of these matters is still pending. As of December 31, 2015, we have an accrual in the amount of $4.7 million to cover all repayments of extrapolated overpayments, damages and penalties that we believe could be assessed.

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

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 CMS conduct extensive review of claims data to identify potential improper payments under the Medicare program.

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 dispute these findings, and our Dayton subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are 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 have now been decided in favor of our Dayton subsidiary in full, 10 claims have been decided in favor of our Dayton subsidiary in part, and 28 claims have been decided against or not appealed by our Dayton subsidiary. The ALJ has ordered the MAC to recalculate the extrapolation amount based on the ALJ's decision. The Medicare Appeals Council can decide on its own motion to review the ALJ's decisions. As of December 31, 2015, we have recorded no liability with respect to the pending appeals as we do not believe that an estimate of a reasonably possible loss or range of loss can be made at this time.

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 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. In the event we pay any amount of 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 December 31, 2015, we have recorded no liability for this claim as we do not believe that an estimate of a reasonably possible loss or range of loss can be made at this time.

Operating Leases

We have leased office space at various locations under non-cancelable agreements that expire between 2016 and 2026, and require various minimum annual rentals. Our typical operating leases are for lease terms of one to seven years and may include, in addition to base rental amounts, certain landlord pass-through costs for our pro-rata share of the lessor's real estate taxes, utilities and common area maintenance costs. Some of our operating leases contain escalation clauses, in which annual minimum base rentals increase over the term of the lease.

Total minimum rental commitments as of December 31, 2015 are as follows (amounts in millions):

2016	$23.5
2017	16.0
2018	11.2
2019	7.4
2020	4.3
Future years	5.5
Total	$67.9

Rent expense for non-cancelable operating leases was $23.7 million, $26.5 million and $29.8 million for 2015, 2014 and 2013.

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.

The following table presents details of our insurance programs, including amounts accrued for the periods indicated (amounts in millions) in accrued expenses in our accompanying balance sheets. The amounts accrued below represent our total estimated liability for individual claims that are less than our noted insurance coverage amounts, which can include outstanding claims and claims incurred but not reported.

	As of December 31,	
Type of Insurance	2015	2014
Health insurance	$11.7	$11.2
Workers' compensation	23.9	20.8
Professional liability	4.1	3.9
	39.7	35.9
Less: long-term portion	(0.9)	(1.0)
	$38.8	$34.9

The retention limit per claim for our health insurance, worker's compensation and professional liability is $0.9 million, $0.5 million and $0.3 million, respectively.

Employment Contracts

We have commitments related to employment contracts with a number of our senior executives. These contracts generally commit us to pay severance benefits under certain circumstances.

Other

We are subject to various other types of claims and disputes arising in the ordinary course of our business. While the resolution of such issues is not presently determinable, we believe that the ultimate resolution of such matters will not have a significant effect on our consolidated financial condition, results of operations and cash flows.

11. EMPLOYEE BENEFIT PLANS

401(K) Benefit Plan

We maintain a plan qualified under Section 401(k) of the Internal Revenue Code for all employees who have reached 21 years of age, effective the first month after hire date. Under the plan, eligible employees may elect to defer a portion of their compensation, subject to Internal Revenue Service limits.

During 2015, 2014 and 2013, our match of contributions to be made to each eligible employee contribution is $0.375 for every $1.00 of contribution made up to the first 6% of their salary. The match is discretionary and thus is subject to change at the discretion of management. These contributions are made in the form of our common stock, valued based upon the fair value of the stock as of the end of each calendar quarter end. We expensed approximately $6.1 million, $6.2 million and $7.8 million for 2015, 2014 and 2013, respectively.

Deferred Compensation Plan

We had a Deferred Compensation Plan for additional tax-deferred savings to a select group of management or highly compensated employees. Amounts credited under the Deferred Compensation Plan were funded into a rabbi trust, which is managed by a trustee. The trustee has the discretion to manage the assets of the Deferred Compensation Plan as deemed fit, thus the assets are not necessarily reflective of the same investment choices made by the participants.

Effective January 1, 2015, all prospective salary deferrals ceased. Participants will be allowed to make transactions with any remaining account balances as they wish per plan guidelines.

12. 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. Purchases may be made 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 may enter into Rule 10b5-1 plans to effect some or all of the repurchases. The stock repurchase program is scheduled to expire on September 6, 2016.

The timing and the amount of the repurchases, if any, will be 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 2015, pursuant to this program, we repurchased 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million. The repurchased shares are classified as treasury shares.

13. EXIT AND RESTRUCTURING ACTIVITIES

As of December 31, 2013, we reported three home health care centers as held for sale. During 2014, we sold assets associated with two of these care centers for cash consideration of approximately $0.8 million and recognized a gain of approximately $0.8 million which is included in discontinued operations. The remaining care center classified as held for sale was consolidated with a care center servicing the same market during 2014.

During 2014, the Company sold its interest in five home health and four hospice care centers in Wyoming and Idaho for approximately $5.0 million and recognized a gain of $2.1 million. We also exited our hospice inpatient unit in New Hampshire and recognized a loss of $0.5 million.

In addition to the exit activity related to the care centers mentioned above, we consolidated 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and closed 22 home health care centers and four hospice care centers during 2014. In connection with these care centers, we recorded non-cash charges of $2.2 million in other intangibles impairment expense related to the write-off of intangible assets, $2.1 million in other general and administrative expenses related to lease termination costs and $2.1 million in salaries and benefits related to severance costs. These care centers were not concentrated in certain selected geographical areas and did not meet the criteria to be classified as discontinued operations in accordance with applicable accounting guidance.

During 2013, we sold assets associated with two home health care centers in Alaska and Washington, as well as a hospice care center in Washington for cash consideration of approximately $1.6 million and recognized a gain of approximately $1.0 million which is included in discontinued operations. We also sold our membership interest in one of our unconsolidated joint ventures for cash consideration of approximately $0.5 million and recognized a loss of approximately $0.7 million, which is included in other income (expense).

We also reported 28 care centers as held for sale and sold assets associated with 17 of these home health care centers for cash consideration of approximately $1.4 million and recognized a gain of approximately $0.7 million which is included in discontinued operations. We closed eight of our home health care centers previously classified as held for sale and recorded charges of $0.1 million for the write-off of intangible assets and $0.5 million related to lease termination costs which are included in discontinued operations. Three of these home health care centers remained classified as held for sale as of December 31, 2013.

In addition to the sale and available for sale care centers mentioned above, we consolidated 41 operating home health care centers and five operating hospice care centers with care centers servicing the same markets and closed two home health care centers as of December 31, 2013. In connection with these care centers, we recorded charges of $3.6 million in goodwill and other intangibles impairment expense related to the write-off of intangible assets, $1.5 million in other general and administrative expenses related to lease termination costs and $1.8 million in salaries and benefits related to severance costs during 2013.

The care centers that were closed or sold in 2013 are presented in discontinued operations in our consolidated financial statements. See Note 4 – Discontinued Operations and Assets Held For Sale for additional information.

Restructuring Activity

During 2014, we restructured our regional leadership and corporate support functions. As such, we recorded charges of $3.4 million in salaries and benefits related to severance costs. In addition, during 2014, William F. Borne stepped down from his positions as Chief Executive Officer, Chairman and a member of our Board of Directors and we recorded charges of $2.3 million in salaries and benefits related to severance costs.

Our reserve activity for our 2014 and 2013 exit and restructuring activity is as follows (amounts in millions):

	2014 Exit Activity		2013 Exit Activity	
	Lease Termination	Severance	Lease Termination	Severance
Balances at December 31, 2012	$—	$—	$—	$—
Charge in 2013	—	—	2.0	1.8
Cash expenditures in 2013	—	—	(0.5)	(0.5)
Balances at December 31, 2013	—	—	1.5	1.3
Charge in 2014	2.1	7.8	—	—
Cash expenditures in 2014	(1.6)	(5.5)	(1.2)	(1.3)
Balances at December 31, 2014	0.5	2.3	0.3	—
Charge in 2015	—	—	—	—
Cash expenditures in 2015	(0.4)	(1.9)	(0.2)	—
Balances at December 31, 2015	$ 0.1	$ 0.4	$ 0.1	$—

14. VALUATION AND QUALIFYING ACCOUNTS

The following table summarizes the activity and ending balances in our allowance for doubtful accounts and estimated revenue adjustments (amounts in millions):

Allowance for Doubtful Accounts

Year End	Balance at Beginning of Year	Provision for Doubtful Accounts(1)	Write-Offs	Balance at End of Year
2015	$14.3	$14.1	$(11.9)	$16.5
2014	14.2	16.4	(16.3)	14.3
2013	21.0	16.4	(23.2)	14.2

(1) Includes $0.1 million and $0.6 million from discontinued operations for the years ended December 31, 2014 and 2013, respectively.

Estimated Revenue Adjustments

Year End	Balance at Beginning of Year	Provision for Estimated Revenue Adjustments(1)	Write-Offs	Balance at End of Year
2015	$3.1	$6.1	$ (5.2)	$4.0
2014	3.9	5.1	(5.9)	3.1
2013	6.4	9.4	(11.9)	3.9

(1) Includes $0.1 million and $0.4 million from discontinued operations for the years ended December 31, 2014 and 2013, respectively.

15. SEGMENT INFORMATION

Our operations involve servicing patients through our two reportable business segments: home health and hospice. 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 the essential activities of daily living. Our hospice segment provides palliative care and comfort to terminally ill patients and their families. 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).

	For the Year Ended December 31, 2015			
	Home Health	Hospice	Other	Total
Net service revenue	$1,005.1	$275.4	$ —	$1,280.5
Cost of service, excluding depreciation and amortization	584.2	141.7	—	725.9
General and administrative expenses	263.2	62.7	126.5	452.4
Provision for doubtful accounts	12.2	1.9	—	14.1
Depreciation and amortization	5.2	1.4	13.4	20.0
Goodwill and other intangibles impairment charge	—	—	77.3	77.3
Operating expenses	864.8	207.7	217.2	1,289.7
Operating income (loss)	$ 140.3	$ 67.7	$(217.2)	$ (9.2)

	For the Year Ended December 31, 2014			
	Home Health	Hospice	Other	Total
Net service revenue	$956.9	$247.6	$ —	$1,204.5
Cost of service, excluding depreciation and amortization	559.4	131.7	—	691.1
General and administrative expenses	269.0	58.3	114.4	441.7
Provision for doubtful accounts	14.8	1.5	—	16.3
Depreciation and amortization	9.0	2.1	17.2	28.3
Goodwill and other intangibles impairment charge	1.6	1.5	—	3.1
Operating expenses	853.8	195.1	131.6	1,180.5
Operating income (loss)	$103.1	$ 52.5	$(131.6)	$ 24.0

	For the Year Ended December 31, 2013			
	Home Health	Hospice	Other	Total
Net service revenue	$987.7	$261.6	$ —	$1,249.3
Cost of service, excluding depreciation and amortization	578.9	139.1	—	718.0
General and administrative expenses	304.8	64.7	104.5	474.0
Provision for doubtful accounts	10.2	5.7	—	15.9
Depreciation and amortization	10.3	2.1	24.5	36.9
U.S. Department of Justice settlement	—	—	150.0	150.0
Goodwill and other intangibles impairment charge	8.5	1.0	—	9.5
Operating expenses	912.7	212.6	279.0	1,404.3
Operating income (loss)	$ 75.0	$ 49.0	$(279.0)	$ (155.0)

16. UNAUDITED SUMMARIZED QUARTERLY FINANCIAL INFORMATION

	Revenue	Net Income (Loss) Attributable to Amedisys, Inc.	Net Income (Loss) Attributable to Amedisys, Inc. Common Stockholders(1)	
			Basic	Diluted
2015:				
1st Quarter (2)(3)	$ 301.6	$(35.0)	$(1.07)	$(1.07)
2nd Quarter (3)	314.1	10.6	0.32	0.32
3rd Quarter (2)(3)(5)	326.4	8.4	0.25	0.25
4th Quarter (3)(4)(5)	338.4	12.9	0.39	0.38
	$1,280.5	$ (3.0)	$(0.09)	$(0.09)
2014:				
1st Quarter (6)(7)	$ 298.7	$(12.4)	$(0.39)	$(0.39)
2nd Quarter (8)(9)	305.0	7.6	0.24	0.23
3rd Quarter (9)(10)	300.3	8.4	0.26	0.26
4th Quarter (6)	300.5	9.1	0.28	0.28
	$1,204.5	$ 12.8	$ 0.39	$ 0.39

(1) Because of the method used in calculating per share data, the quarterly per share data may not necessarily total to the per share data as computed for the entire year.

(2) During the first quarter of 2015, we recorded a non-cash asset impairment charge to write-off the software costs incurred related to the development of AMS3 Home Health and Hospice in the amount of $45.5 million, net of income taxes. During the third quarter of 2015, we recorded a non-cash asset impairment charge related to our corporate headquarters in the amount of $1.2 million, net of income taxes.

(3) During each of the four quarters of 2015, we incurred certain costs associated with various legal matters. Net of income taxes, these costs amounted to $1.3 million, $4.8 million, $0.2 million and $(1.1) million for the three-month periods ended March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015, respectively.

(4) During the fourth quarter of 2015, we recorded an accrual related to an OIG Self-Disclosure matter. Net of income taxes, this charge amounted to $3.4 million.

(5) During the third and fourth quarters of 2015, we incurred certain costs associated with the implementation of Homecare Homebase. Net of income taxes, these costs amounted to $1.2 million and $1.4 million for the three-month periods ended September 30, 2015 and December 31, 2015, respectively.

(6) During the first and fourth quarters of 2014, we recognized non-cash other intangibles impairment charges of $1.4 million and $0.6 million, net of income taxes.

(7) During the first quarter of 2014, we recorded charges for the accrual of various relators' attorneys' fees and expenses in connection with the settlement agreement to resolve the U.S. Department of Justice investigation and the Stark Law Self-Referral matter and exit and restructuring activity costs. Net of income taxes, these charges amounted to $2.4 million and $6.1 million, respectively.

(8) During the second quarter of 2014, we recorded an accrual related to an OIG Self-Disclosure matter. Net of income taxes, this charge amounted to $0.9 million. Additionally, our results included a software write-off in the amount of $0.9 million, net of income taxes.

(9) Our results for the second quarter of 2014, included a gain related to the sale of care centers in the amount of $1.3 million, net of income taxes. Our results for the three months ended September 30, 2014, included a loss related to the disposal of our in-patient facility in the amount of $0.3 million, net of income taxes.

(10) During the third quarter of 2014, we recorded a charge related to the write-off of deferred financing fees in the amount of $0.3 million, net of income taxes.

17. SUBSEQUENT EVENT

On March 1, 2016, we acquired Associated Home Care, a private-duty home healthcare company with nine care centers for a purchase price of $28 million.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. 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 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 Annual Report on Form 10-K, as of December 31, 2015, 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 December 31, 2015, the end of the period covered by this Annual Report on Form 10-K.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Exchange Act. Under the supervision and with the participation of our management, including our principal executive officer and our principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control – Integrated Framework*, our management concluded our internal control over financial reporting was effective as of December 31, 2015.

Our internal control system is designed to provide reasonable assurance to our management and Board of Directors regarding the preparation and fair presentation of published financial statements. All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

In conducting this evaluation, management did not include an assessment of internal control over financial reporting at Infinity HomeCare. As previously disclosed, on December 31, 2015, the Company completed the acquisition of Infinity HomeCare and consolidated the financial results of Infinity effective as of such date. Infinity accounted for approximately 1% of total assets and no revenue as of and for the year ended December 31, 2015. As a result of its evaluation, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2015 based on those criteria.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Controls

During 2015, we began the implementation of Homecare Homebase ("HCHB") with a total of 84 care centers operating on HCHB as of December 31, 2015. 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 other changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that have occurred during the quarter ended December 31, 2015 that have materially affected, or are reasonably likely to materially affect, 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 December 2015, the end of the period covered by this Annual Report.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited Amedisys, Inc.'s internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control – Integrated Framework (2013),* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Amedisys, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Annual Report on Internal Control over Financial Reporting* under Item 9A. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Amedisys, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2015, based on criteria established in *Internal Control – Integrated Framework (2013),* issued by COSO.

Amedisys, Inc. acquired Infinity HomeCare on December 31, 2015, and management excluded from its assessment of the effectiveness of Amedisys, Inc.'s internal control over financial reporting as of December 31, 2015, Infinity HomeCare's internal control over financial reporting associated with approximately 1% of total assets and no revenues included in the consolidated financial statements of Amedisys, Inc as of and for the year ended December 31, 2015. Our audit of internal control over financial reporting of Amedisys, Inc. also excluded an evaluation of the internal control over financial reporting of Infinity HomeCare.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Amedisys, Inc. and subsidiaries as of December 31, 2015 and 2014, and the related consolidated statements of operations, comprehensive (loss) income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2015, and our report dated March 9, 2016, expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 9, 2016

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2016 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2015.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees, including our principal executive officer, principal financial officer and principal accounting officer. This code of ethics, which is entitled Code of Ethical Business Conduct, is posted at our internet website, http://www.amedisys.com. Any amendments to, or waivers of the code of ethics will be disclosed on our website promptly following the date of such amendment or waiver.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2016 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2015.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is incorporated by reference to the 2016 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2015.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this item is incorporated by reference to the 2016 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2015.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is incorporated by reference to the 2016 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2015.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. Financial Statements

All financial statements are set forth under Part II, Item 8 of this report.

2. Financial Statement Schedules

There are no financial statement schedules included in this report as they are either not applicable or included in the financial statements.

3. Exhibits

The Exhibits are listed in the Exhibit Index required by Item 601 of Regulation S-K immediate following the signature pages of this report, which is incorporated by reference.

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.

By: /s/ PAUL B. KUSSEROW
Paul B. Kusserow,
President, Chief Executive Officer and
Member of the Board

Date: March 9, 2016

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the date indicated:

Signature	Title	Date
/s/ PAUL B. KUSSEROW **Paul B. Kusserow**	President, Chief Executive Officer and Member of the Board (Principal Executive Officer)	March 9, 2016
/s/ RONALD A. LABORDE **Ronald A. LaBorde**	Vice Chairman, Chief Financial Officer and Member of the Board (Principal Financial Officer)	March 9, 2016
/s/ SCOTT G. GINN **Scott G. Ginn**	Senior Vice President of Finance and Accounting and Controller (Principal Accounting Officer)	March 9, 2016
/s/ LINDA J. HALL **Linda J. Hall**	Director	March 9, 2016
/s/ JAKE L. NETTERVILLE **Jake L. Netterville**	Director	March 9, 2016
/s/ BRUCE D. PERKINS **Bruce D. Perkins**	Director	March 9, 2016
/s/ DONALD A. WASHBURN **Donald A. Washburn**	Non-Executive Chairman of the Board	March 9, 2016
/s/ NATHANIEL M. ZILKHA **Nathaniel M. Zilkha**	Director	March 9, 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-K. 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. The registrant agrees to furnish to the Commission supplementally upon request a copy of any schedules or exhibits omitted pursuant to Item 601(b)(2) of Regulation S-K of any material plan of acquisition, disposition or reorganization set forth below.

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 February 24, 2014	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	3.2
4.1	Common Stock Specimen	The Company's Registration Statement on Form S-3 filed August 20, 2007	333-145582	4.8
10.1	Form of Director Indemnification Agreement dated February 12, 2009	The Company's Annual Report on Form 10-K for the year ended December 31, 2008	0-24260	10.1
10.2*	Amended and Restated Amedisys, Inc. Employee Stock Purchase Plan dated June 7, 2012	The Company's Current Report on Form 8-K filed June 8, 2012	0-24260	10.1
10.3*	Composite Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan (inclusive of Plan amendments dated June 7, 2012 and October 25, 2012, April 23, 2015 and June 4, 2015 and the full text of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan)	Appendix A to the Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.3
10.4*	Form of Nonvested Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.3
10.5*	Form of Restricted Stock Unit Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.4
10.6*	Form of Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.6

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.7*	Form of Performance Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.7
10.8	Form of Restricted Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.8
10.9*	Form of Restricted Performance Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.9
10.10*	Composite Amedisys, Inc. 1998 Stock Option Plan (inclusive of amendments dated June 10, 2004, June 8, 2006 and June 22, 2006 and the full text of the Amedisys, Inc. 1998 Stock Option Plan)	The Company's Registration Statement on Form S-8 filed June 22, 2007	333-143967	4.2
10.11*	Composite Director's Stock Option Plan (inclusive of Plan amendments dated June 10, 2004, and the full text of the Directors Stock Option Plan)	The Company's Annual Report on Form 10-K for the year ended December 31, 2005	0-24260	10.4
10.12*	Employment Agreement dated December 11, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Paul B. Kusserow	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.12
10.13.1*	Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed November 2, 2011	0-24260	10.1
10.13.2*	Amendment No. 1 dated December 29, 2011 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed December 30, 2011	0-24260	10.2
10.13.3*	Amendment No. 2 dated December 19, 2012 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.10.3
10.13.4*	Amendment No. 3 dated May 1, 2014 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.4

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.14*	Agreement by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Dale E. Redman dated as of March 24, 2014	The Company's Current Report on Form 8-K dated March 19, 2014	0-24260	99.1
10.15.1*	Amended and Restated Employment Agreement dated January 3, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Jeffrey D. Jeter	The Company's Current Report on Form 8-K filed January 7, 2011	0-24260	10.2
10.15.2*	Amendment No. 1 dated December 19, 2012 to Amended and Restated Employment Agreement dated January 3, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Jeffrey D. Jeter	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.11.12
10.15.3*	Amendment No. 2 dated May 1, 2014 to Amended and Restated Employment Agreement dated January 3, 2011 by and among Amedisys, Inc., Amedisys Holding L.L.C. and Jeffrey D. Jeter	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.6
10.16.1*	Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and David R. Bucey	The Company's Current Report on Form 8-K filed July 27, 2010	0-24260	10.2
10.16.2*	Amendment No. 1 dated January 3, 2011 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and David R. Bucey	The Company's Current Report on Form 8-K filed January 7, 2011	0-24260	10.7
10.16.3*	Amendment No. 2 dated December 19, 2012 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and David R. Bucey	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.13.3
10.16.4*	Amendment No. 3 dated May 1, 2014 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and David R. Bucey	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.7
10.17.1*	Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Michael O. Fleming, M.D.	The Company's Current Report on Form 8-K filed July 27, 2010	0-24260	10.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.17.2*	Amendment No. 1 dated January 3, 2011 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Michael O. Fleming, M.D.	The Company's Current Report on Form 8-K filed January 7, 2011	0-24260	10.6
10.17.3*	Amendment No. 2 dated December 19, 2012 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Michael O. Fleming, M.D.	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.12.3
10.17.4*	Amendment No. 3 dated May 1, 2014 to Amended and Restated Employment Agreement dated July 23, 2010 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Michael O. Fleming, M.D.	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.5
10.18	Amedisys Holding, L.L.C. Severance Plan for Key Executives dated as of April 30, 2015 (inclusive of all amendments thereto adopted on or before December 17, 2015)	The Company's Current Report on Form 8-K dated December 22, 2015	0-24260	10.1
10.19.1	Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Current Report on Form 8-K filed on October 30, 2012	0-24260	10.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.19.2	First Amendment and Limited Waiver dated as of September 4, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.1
10.19.3	Second Amendment dated as of November 11, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.19.4	Third Amendment dated as of April 17, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014	0-24260	10.3
10.19.5	Fourth Amendment dated as of July 28, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.1.2
10.20	Security and Pledge Agreement dated as of November 11, 2013, among Amedisys, Inc., Amedisys Holding, L.L.C., the Guarantors party thereto and JPMorgan Chase Bank, N.A., not in its individual capacity but solely as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.2
10.21	Second Lien Credit Agreement dated as of July 28, 2014 by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the banks and other financial institutions or entities from time to time parties thereto as lenders, and Cortland Capital Market Services LLC, as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.8

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.22	Second Lien Security and Pledge Agreement dated as of July 28, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C, the guarantors party thereto and Cortland Capital Market Services LLC, not in its individual capacity, but solely as collateral agent for the secured parties	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.9
10.23	Intercreditor Agreement dated as of July 28, 2014 by and among JPMorgan Chase Bank, N.A., as Administrative Agent for the first priority secured parties, Cortland Capital Market Services LLC, as Administrative Agent for the second priority secured parties, and the direct and indirect subsidiaries of Amedisys, Inc. and Amedisys Holding, L.L.C. from time to time party thereto	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.10
10.24.1	Credit Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain subsidiaries of Amedisys, Inc. party thereto as guarantors, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, JPMorgan Chase Bank, N.A., as Syndication Agent, Citizens Bank, N.A., Compass Bank, Fifth Third Bank, and Regions Bank, as Co-Documentation Agents, the lenders party thereto, Merrill Lynch, Pierce Fenner & Smith Incorporated, Citizens Bank N.A., Fifth Third Bank and J.P. Morgan Securities LLC, as Joint Lead Arrangers, and Merrill Lynch, Pierce, Fenner & Smith Incorporated and J.P. Morgan Securities LLC, as Joint Bookrunners	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.1
10.24.2	Security Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "grantors" on the signature pages thereto and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.24.3	Pledge Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "pledgers" on the signature pages thereto, and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.3
10.25	Settlement Agreement effective April 23, 2014 by and among (a) the United States of America, acting through the United States Department of Justice and on Behalf of the Office of Inspector General of the Department of Health and Human Services, (b) Amedisys, Inc. and Amedisys Holding, L.L.C. and (c) the various Relators named therein	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.1
10.26	Corporate Integrity Agreement effective April 22, 2014 between the Office of Inspector General of the Department of Health and Human Services and Amedisys, Inc. and Amedisys Holding, L.L.C.	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.2
† 10.27	Agreement and Plan of Merger dated October 31, 2015 by and among Amedisys Health Care West, L.L.C., IHC Acquisitions, L.L.C., Infinity Home Care, L.L.C., Axiom HealthEquity Holdings Management, LLC, Infinity Healthcare Holdings, LLC, and Amedisys, Inc.			
† 10.28	Agreement of Purchase and Sale dated as of November 25, 2015, between Amedisys, Inc., through its wholly-owned subsidiary, Amedisys Property, L.L.C., as seller and Franciscan Missionaries of Our Lady of the Lake Heath System, Inc., as purchaser.			
† 21.1	Subsidiaries of the Registrant			
† 23.1	Consent of KPMG LLP			
† 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			

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
† 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			

Exhibit 31.1

CERTIFICATION

I, Paul B. Kusserow, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2015, 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: March 9, 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 Annual Report on Form 10-K for the year ended December 31, 2015, 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: March 9, 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 Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015 (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: March 9, 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 Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2015 (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: March 9, 2016

/S/ Ronald A. LaBorde

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

COMPANY LEADERSHIP

BOARD OF DIRECTORS

Donald A. Washburn
Non-Executive Chairman of the Board
Private Investments

Linda J. Hall
Entrepreneur-in-Residence
Carlson School of Business at the University of Minnesota

Julie Klapstein*
Former CEO
Availity

Paul B. Kusserow
President and Chief Executive Officer
Amedisys, Inc.

Ronald A. LaBorde
Vice Chairman and Chief Financial Officer
Amedisys, Inc.

Richard Lechleiter*
President
Catholic Education Foundation
Retired Executive Vice President and Chief Financial Officer, Kindred Healthcare, Inc.

Jake L. Netterville
Chairman, Emeritus, of the Board of Directors
Postlethwaite & Netterville, A Professional Accounting Corporation

Bruce D. Perkins
Former President of Healthcare Services
Humana

Jeffrey A. Rideout, M.D., M.A., FACP*
President and CEO
the Integrated Healthcare Association

Nathaniel M. Zilkha
Head of Credit and Global
Co-Head of Special Situations
KKR

EXECUTIVE OFFICERS

Paul B. Kusserow
President and Chief Executive Officer

Ronald A. LaBorde
Vice Chairman and Chief Financial Officer

Jeffrey D. Jeter
Chief Compliance Officer

Jane E. Carmody, DNP, MBA, RN, CENP
Chief Clinical Operations Officer

Martin B. Howard
Chief Information Officer

David L. Kemmerly
General Counsel and Senior Vice President of Government Affairs

Daniel P. McCoy
Chief Operating Officer

Larry R. Pernosky
Chief Human Resources Officer

Stephen E. Seim
Chief Strategy Officer

* *Board member as of April 20, 2016*

Performance Graph

A performance graph comparing the cumulative total stockholder return on our common stock for the five-year period ended December 31, 2015, with the cumulative total return on the NASDAQ composite Index and peer-group Index over the same period is Included in the Form 10-K.

Independent Accountants

KPMG LLP
Baton Rouge, Louisiana

Annual Meeting

The annual meeting of stockholders will take place on June 2, 2016, at 12:00 p.m. (CDT) at the company's corporate headquarters, 3854 American Way, Suite A, Baton Rouge, Louisiana.

Stock Listing

The company's common stock is listed on the NASDAQ Global Select Market under the symbol "AMED."

Transfer Agent and Registrar

American Stock Transfer & Trust Company, LLA
6201 15th Avenue
Brooklyn, New York 11219
800.937.5449

Form 10-K Exhibits

A copy of all exhibits to the company's Annual Report on Forms 10-K as filed with the Securities and Exchange Commission is available free of charge on our website at www.amedisys.com or by contacting:

Amedisys, Inc.
3854 American Way, Suite A,
Baton Rouge, LA 70816
Investor@amedisys.com

Amedisys on the Internet

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 "Investors" 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 "Investors" subpage of our website. In addition, we make available on the "Investors" 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, Nominating and Corporate Governance, Quality of Care and Compliance and Ethics Committees of our Board are also available on the "Investors" subpage of our website (under the link "Corporate Governance").

Forward-Looking Statements

When included in this document, 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 the requirements stipulated in our corporate integrity agreement, and changes in law or developments with respect to any litigation relating 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 Part I, Item 1A—"Risk Factors" and Part II, Item 7—"Critical Accounting Policies" within "Management's Discussion and Analysis of Financial Condition and Results of Operations" set forth in our Annual Report on Form 10-K for the year ended December 31, 2015.



www.amedisys.com

EXHIBIT 15



2016
Annual Report

Amedisys®

Dear Fellow Shareholders,

It was a little more than two years ago that we sat down and really listened. From our patients, to our employees, to our referral sources, to our markets – we looked at the essence of what we do and what drives our business, talked with our employees about what "best" looked like and asked our patients what they wanted. We built our strategy around the themes that emerged from these conversations. Our four-pronged strategy appears straightforward, because it comes from the people we serve and those that serve them. Consistently delivering on it requires discipline, thoughtfulness and relentless focus. We want to be the gold standard in our selected disciplines. We believe we know what we should be, and we are working hard to get there. Like a family road trip with the inevitable question, "Are we there yet?" - we aren't. But we are well on our way, and our results show we're making good progress.

Our stakeholders have lots of reasons to be happy with our performance in 2016. We reported revenue of $1.44 billion, a 12% increase over 2015, adjusted EBITDA of $110 million and adjusted EPS of $1.55 per diluted share. We grew organically in all of our business units, with particular strength in the hospice and personal care segments.

We achieved a key milestone in December as we completed the conversion from our internally developed technology platform to HomeCare HomeBase (HCHB). We accomplished this with unprecedented speed, converting nearly 400 care centers in just over a year. While this caused some operational disruption during 2016, we are pleased to see this disruption winding down in the first quarter of 2017. Our front line clinicians are happy with the way HCHB supports greater efficiency for them in the home, and we believe this will support continued improvement in the quality of care our patients receive, as well as better clinician productivity.

Also during the year, we closed on three acquisitions, continuing our efforts to use capital to build our business. Our free cash flow is strong and improving, giving us enough financial flexibility to invest in promising expansion opportunities we identify in the future.

More specifically, we progressed on all four of our key strategies.

ACHIEVE CLINICAL DISTINCTION

Our primary mission is to provide our patients with outstanding clinical care. No metric better demonstrates this commitment than our latest ratings in home health from the all-important Medicare Star Rating program.

We improved our average Star rating each quarter in 2016, with the January 2017 release ranking our Quality of Patient Care score of 3.91 Stars and Patient Satisfaction score of 3.80 Stars. We are striving for further improvement in 2017, with our April average score for Quality of Patient Care across all of our home health care centers of 4.03 Stars, a 15% increase over last year. That's our best performance to date. Three-quarters of our centers (75%) attained a rating of 4 Stars or better, compared to a little over one-quarter last year (32%). With CMS and other payors intending to shift to reimbursement models based on the quality of care delivered, we expect to be well positioned to capitalize on this trend.

Our agenda for clinical care remains ambitious. We're aiming for all of our home health care centers to achieve a quality Star rating of 4 or higher by the end of 2017.

Our hospice quality is equally impressive. Our quality of patient care ranks above the national CMS average on all seven quality measures tracked. In patient experience, we rank above the national CMS average on all eight quality measures tracked. In last year's CMS hospice final rule, CMS signaled their intention to create a rating system similar to home health's Star ratings that will be publicly available. We expect to be at or near the top of the industry once those ratings are finalized.

BECOME AN EMPLOYER OF CHOICE

Because our people are our most important asset, and are responsible for the quality of the care our patients receive, we took further steps toward improving our "return on people." We are building a Culture of Engagement, whereby our employees are inspired every day to bring their best self to work. This enables them to better serve our patients, colleagues and referring physicians and hospitals — helping us to better recruit, retain and develop outstanding, talented people.

In an industry that generally experiences high turnover rates, typically in the mid-30 percent range, our overall voluntary turnover declined to 22% in 2016, with turnover among our full time employees, who are responsible for 85% of our patient visits, falling to 18%.

To drive continued improvement as an organization, we continue to listen to our people. Our second annual People Engagement Survey response rate was 24% higher than last year. The responses told us both what we are doing well, and where we can improve. Based on this feedback, each of our leaders has developed specific plans to address the opportunities identified in their areas. As we improve our understanding of the drivers of employee satisfaction through these engagement efforts, we expect our retention rates to continue to improve, increasing our return on our human capital.

OPERATIONAL EXCELLENCE AND EFFICIENCY

During 2016, Amedisys reached a major milestone in bringing better information technology to our employees: HCHB software went live in all our home health and hospice care centers, seven months ahead of our original target. In transitioning from our proprietary software to this leading IT platform, we're now optimizing efficiency and equipping our clinicians to better focus on care delivery. Additionally, in 2015 we committed to realize $46 million in annualized run rate efficiencies by the end of 2017, and the successful completion of this platform migration is a key milestone in delivering these savings.

Already we have improved the productivity of our existing staff, and now have the ability to deploy our resources more effectively. We will continue to maximize efficiencies in putting the right people in the right places at the right time to deliver the right high-quality care, and innovate aggressively along these lines.

In 2016, we also designed and developed a propriety productivity and staffing tool that compiles, evaluates and correlates data to drive staffing optimization. This tool permits operators to more deeply manage clinician productivity to better understand the operational levers available to manage our clinician capacity.

DRIVING GROWTH

Amedisys grew in all lines of business during 2016 despite challenges with the rapid rollout of HCHB. Amedisys acquired Associated Home Care, a leading personal care agency in Massachusetts – a move consistent with our long-term strategy to broaden our scope of services that can be delivered at home. The Company also acquired Professional Profiles, a personal care agency based in Danvers, Massachusetts, and in early 2017, Home Staff, LLC, a personal care provider, headquartered in Worcester, Massachusetts. We are now the largest personal care provider in Massachusetts, caring for more than 15,000 patients annually. We also acquired Visiting Nurse Association of Long Island, a nonprofit organization based in Garden City, New York.

In hospice, we've produced strong, consistent organic growth, with average daily census increasing by 16% and reaching 5,900 by the end of 2016. We see this as a validation of the outstanding care provided by our hospice team, the growing acceptance of the value of hospice care, and patient's desire to remain in their homes.

In home health, same store episodic admissions grew by 4%, we completed over seven million patient visits and grew our census to over 55,000 patients. We continue to believe the combination of improved business development processes, recent leadership additions, and improved capacity driven by our new platform and tools will allow us to see solid year over year organic growth in the second half of 2017.

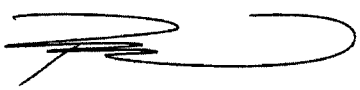
A PROMISING OUTLOOK

The arrival of the new President has sparked the most questions from investors over the last few months. At this early stage, we are working closely with our peers in home health and hospice to communicate our point of view to the Trump Administration. We would like to see a regulatory environment more conducive to patient care in the home. We believe we have the opportunity as an industry to show the value that healthcare in the home provides, including lower costs, better outcomes and higher patient satisfaction.

We remain focused on acquisition growth opportunities. Our current acquisition pipeline collectively represents well over $100 million in adjusted EBITDA. The good news is that we have both strong free cash flow and a strong balance sheet. We have the ability to act on strategic opportunities that we identify across each of our business segments. With our operating team and scalable infrastructure in place, and with consumer preferences, aging demographics and the cost advantages of home-based care working in our favor, we are well-positioned to be an industry consolidator with an aging-in-place solution in a highly fragmented market.

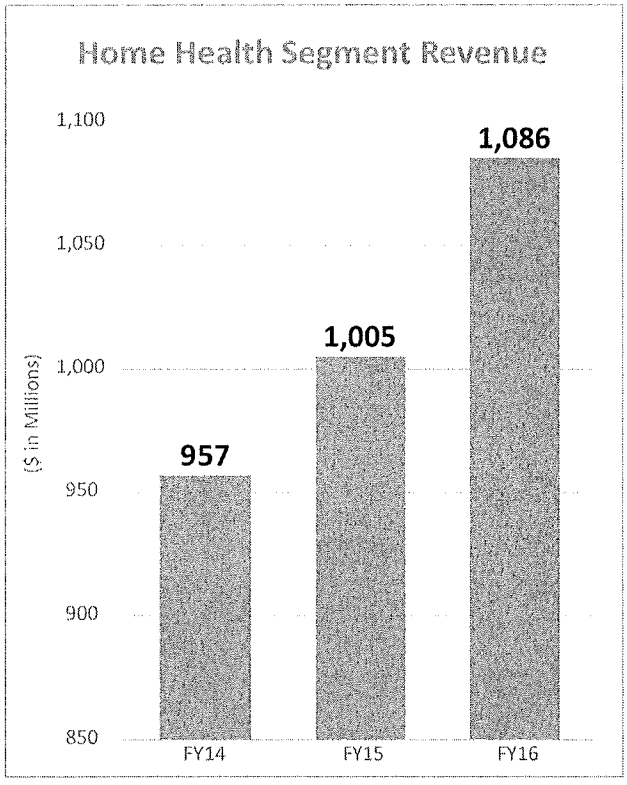
Regardless of the potential policy and regulatory changes driven by the federal government, providing the highest quality of care is fundamental for us. What matters most is to do right by our patients and their families. That commitment distinguishes us more than anything else from our competition, and serves as a major driver of future growth. Our goal remains nothing less than to be the partner of choice wherever our patients call home.

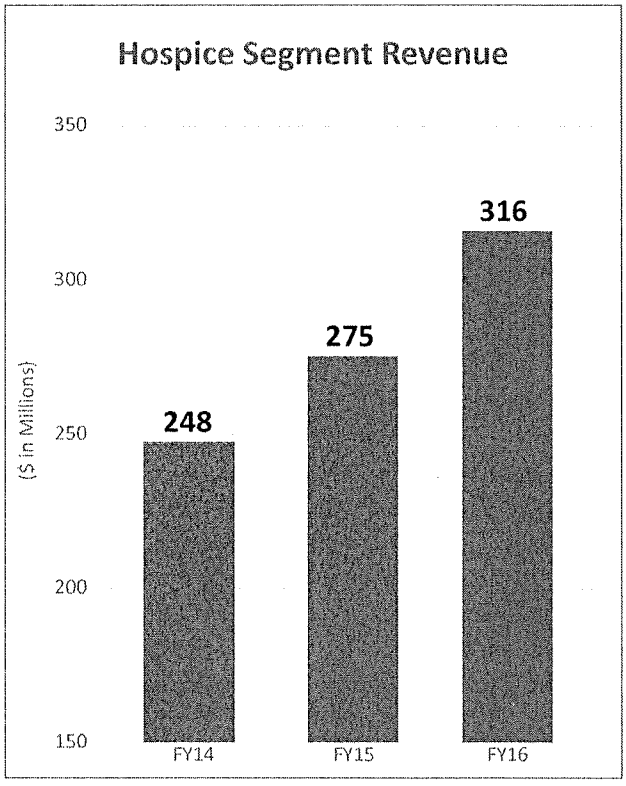
To our shareholders, thank you for your commitment to Amedisys. Despite the large-scale change that the organization initiated and implemented in 2016, we delivered solid results and built a strong foundation for the future. Of course, none of this would have been possible without the commitment of our more than 16,000 employees - your efforts keep exceeding our expectations. We expect to build upon our progress in 2017 and look forward to our continued success.

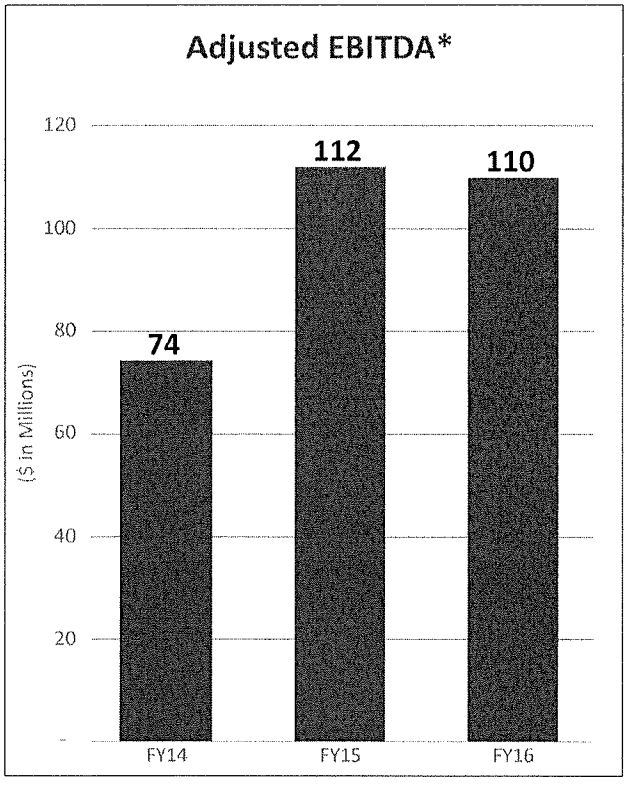


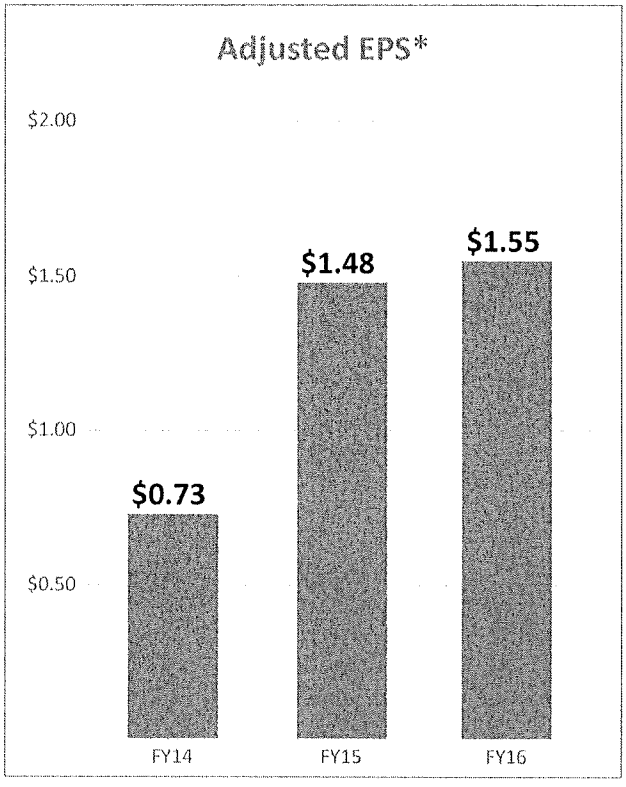
Paul Kusserow
President and Chief Executive Officer

2016 FINANCIALS









*The financial results for the years ended December 31, 2014, December 31, 2015 and December 31, 2016 are adjusted for certain items and should be considered non-GAAP financial measures. A reconciliation of these non-GAAP financial measures is included in the corresponding Form 8-K detailing annual results filed on February 28, 2017 and March 8, 2016.

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

FORM 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended: December 31, 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)

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

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

Securities registered pursuant to Section 12(g) of the Act: None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☑ No ☐

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. Yes ☐ No ☑

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate 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 if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☐

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

Large accelerated filer ☑ Accelerated filer ☐ Non-accelerated filer ☐ (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 Act). Yes ☐ No ☑

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 30, 2016 (the last business day of the registrant's most recently completed second fiscal quarter) was $1.0 billion. For purposes of this determination shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 24, 2017, the registrant had 33,607,420 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for its 2017 Annual Meeting of Stockholders (the "2017 Proxy Statement") to be filed pursuant to the Securities Exchange Act of 1934 with the Securities and Exchange Commission within 120 days of December 31, 2016 are incorporated herein by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "plans," "anticipates," "intends," "projects," "estimates," "may," "might," "would," "should" and similar 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 healthcare industry, our ability to integrate our personal care segment into our business efficiently, 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, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate, manage and keep our information systems secure, our ability to comply with 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 Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Critical Accounting Estimates" within "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Unless otherwise provided, "Amedisys," "we," "us," "our," and the "Company" refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2016, 2015 and 2014, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2016 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the "Investors" page under the "SEC Filings" link.

PART I

ITEM 1. BUSINESS

Overview

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

We are among the largest, best established and most advanced providers of home health and hospice care in the United States, with 420 care centers in 34 states. Our 16,000 employees deliver the highest quality of care to the doorsteps of patients in need, making more than 7.5 million patient visits to 385,000 patients annually. Over 2,200 hospitals and 61,900 physicians nationwide have chosen us as a partner in post-acute care.

Our services are primarily paid for by Medicare due to the age demographics of our patient base (average age 81). Medicare represented approximately 78% to 82% of our net service revenue over the last three years. We remain focused on maintaining a profitable and strategically important managed care contract portfolio.

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

Our strategy is to become the best choice for care wherever our patients call home by excelling in clinical distinction, operational excellence and efficiency and growth. Our mission is to provide compassionate home health, hospice and personal care services that apply the most advanced clinical practices toward allowing our patients to maintain a sense of independence, quality of life and dignity. We believe that focusing on providing excellent care and becoming an employer of choice across the United States will differentiate us from our competitors.

Our Home Health Segment:

Amedisys Home Health provides experienced, compassionate healthcare to help our patients recover from surgery or illness, live with chronic diseases, and prevent avoidable hospital readmissions with 327 care centers located in 32 states. Our care team includes skilled nurses who are trained and certified to administer medications, care for wounds, monitor vital signs and provide a wide range of other nursing services; therapists specialized in physical, speech and occupational therapy; and aides who assist our patients with completing important personal tasks.

We take an empowering approach to helping our patients and their families understand their condition, how to manage it and how to live life to the fullest with a chronic disease or other health condition. Our professional and compassionate clinicians are trained to understand the whole patient – not just their medical diagnosis.

This commitment to clinical distinction is evident in our clinical performance measures such as Star Ratings. In the Center for Medicare and Medicaid Services ("CMS") preview reports for the April 2017 release, the Quality of Patient Care star average across all Amedisys providers is 4.03. This number is subject to change for the final release, and CMS has indicated proposed changes that may impact star scores starting with the July 2017 release. Our goal is to have all of our care centers achieve a 4.0 Quality Star Rating, and we are implementing targeted action plans to continue to improve the quality of care we deliver for our patients across the country. Our Patient Satisfaction average as of the last known release was 3.76, outperforming the industry average of 3.67.

Our Hospice Segment:

Hospice is a special form of care that is designed to provide comfort and support for those who are dealing with a terminal illness. It is a compassionate form of care that promotes dignity and affirms quality of life for the patient, family members and other loved ones. We operate 79 hospice care centers in 21 states.

Individuals with a terminal illness such as heart disease, pulmonary disease, Alzheimer's, HIV/AIDS or cancer may be eligible for hospice care, if they have a life expectancy of six months or less.

At Amedisys Hospice, our focus is on building and retaining an exceptional team, delivering the highest quality care and service to our patients and their families, and establishing Amedisys as the preferred and preeminent hospice provider in each community we serve. In order to realize these goals, we invest in tailored training, development, and recognition programs for our employees, with specific focus in 2016 on the implementation of a new electronic medical record, employee skills training and leadership development. This has led to our team's consistent achievement at or above the national average in family satisfaction results and quality scores, as well as the trust of the healthcare community driving a 17% increase in new patient admissions and a 16% increase in census.

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

By working to accept every patient with a life expectancy of six months or less who wants our compassionate care, we fulfill our hospice mission and strengthen our standing in the community.

Our Personal Care Segment:

On March 1, 2016, Amedisys acquired its first personal care company – an important step in executing our strategy of improving the continuity of care our patients receive as their clinical needs change. Our new segment was further expanded when we purchased the assets of Professional Profiles, Inc. on September 1, 2016. We now operate 14 personal-care care centers in Massachusetts.

Personal care provides assistance with the essential activities of daily living. We believe that personal care services are highly synergistic with our core skilled home health and hospice businesses, and that by acquiring these capabilities in one of our most successful regions we will realize these benefits quickly.

Responding to Changing Regulatory and Reimbursement Environment:

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

Homecare Homebase Implementation:

During 2015, we made the strategic decision to discontinue AMS3, our third generation, proprietary operating system, and transition to Homecare Homebase ("HCHB"), a leading home health and hospice platform. We completed our rollout of HCHB during 2016 with all our care centers fully transitioned to our new platform as of November 1, 2016.

Acquisitions:

On March 1, 2016, we acquired Associated Home Care for a total purchase price of $27.7 million. Associated Home Care owned and operated nine personal-care care centers servicing the state of Massachusetts.

On September 1, 2016, we acquired the assets of four personal-care care centers in Massachusetts for a total purchase price of $4.4 million.

On October 20, 2016, we acquired the assets of a home health care center in New York for a total purchase price of $4.6 million.

Financial Information:

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

Our Employees

As of February 24, 2017, we employed approximately 16,000 employees, consisting of approximately 10,800 home health care employees, 2,800 hospice care employees, 1,800 personal care employees and 600 corporate and divisional support employees.

Payment for Our Services

Home Health Medicare

The Medicare home health benefit is available both for patients who need care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing but intermittent care. As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. Medicare rates are based on the severity of the patient's condition, his or her service needs and other factors relating to the cost of providing services and supplies, bundled into 60-day episodes of care. An episode starts with the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier. If a patient is still in treatment on the 60th day, a recertification assessment is undertaken to determine whether the patient needs additional care. If the patient's physician determines that further care is necessary, another episode begins on the 61st day (regardless of whether a billable visit is rendered on that day) and ends 60 days later. The first day of a consecutive episode, therefore, is not necessarily the new episode's first billable visit.

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

Period	Base episode payment
January 1, 2014 through December 31, 2014	$2,869
January 1, 2015 through December 31, 2015	$2,961
January 1, 2016 through December 31, 2016	$2,965
January 1, 2017 through December 31, 2017	$2,990

Payments can be adjusted for: (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 during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before an episode was complete; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) a payment adjustment 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. Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. In addition, we make adjustments to Medicare revenue if we find that we are unable to obtain appropriate billing documentation, authorizations or face to face documentation.

Home Health Non-Medicare

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

Hospice Medicare

The Medicare hospice benefit is also available to Medicare-eligible patients with terminal illnesses, certified by a physician, where life expectancy is six months or less. Medicare rates are based on standard prospective rates for delivering care over a base 90-day or 60-day period (90-day episodes of care for the first two episodes and 60-day episodes of care for any subsequent episodes). Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Rates are set based on specific levels of care, are adjusted by a wage index to reflect health care labor costs across the country and are established annually through federal legislation. We make adjustments to Medicare revenue when we find we are unable to obtain appropriate billing documentation, authorizations or face to face documentation and other reasons unrelated to credit risk. The levels of care are routine care, general inpatient care, continuous home care and respite care. 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, on January 1, 2016, Medicare also began reimbursing for a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse ("RN") or medical social worker ("MSW") for patients in a routine level of care.

We bill Medicare for hospice services on a monthly basis and our payments are subject to two fixed annual caps, which are assessed on a provider number basis. Generally, each hospice care center has its own provider number. However, where we have created branch care centers to help our parent care centers serve a geographic location, the parent and branch may have the same provider number. The annual caps per patient, known as hospice caps, are calculated and published by the Medicare fiscal intermediary on an annual basis and cover the twelve month period from November 1 through October 31. The caps can be subject to annual and retroactive adjustments, which can cause providers to be required to reimburse the Medicare program if such caps are exceeded.

The two caps are detailed below:

- ***Inpatient Cap.*** When we provide hospice care on an inpatient basis, the payments that we are entitled to receive at the higher inpatient reimbursement rate are subject to a cap. This cap limits the number of days that are paid at the inpatient care rate (both respite and general) under a provider number to 20% of the total number of days of hospice care (both inpatient and in-home) that is furnished to all Medicare patients served by the provider. The daily Medicare payment rate for any inpatient days of service that exceed the cap is at the routine home care rate, and the provider is required to reimburse Medicare for any amounts it receives in excess of the cap; and
- ***Overall Payment Cap.*** This cap is calculated by the Medicare fiscal intermediary at the end of each hospice cap period to determine the maximum allowable payments per provider number. We estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation.

Our ability to stay within these limitations depends on a number of factors, each determined on a provider number basis, including the average length of stay and mix in level of care.

Hospice Non-Medicare

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

Personal Care Non-Medicare

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

Controls over Our Business System Infrastructure

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

- ***Coding*** – Specified diagnosis codes are assigned to each of our patients based on their particular health condition and ailment (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. In order to reduce associated risk of coding failures, we provide coding training and annual update training to clinical assessment managers; provide coding training during orientation for new employees; provide monthly specialized coding education; obtain outside expert coding instruction; have certified coders code all patient outcome and assessment information sets ("OASIS") and have automated coding edits based on pre-defined compliance metrics in our point of care ("POC") system.
- ***Clinical Operations*** – Regulatory requirements allow patients to be admitted to home health care if they are considered homebound and require skilled nursing, physical therapy or speech therapy services. These clinical services include: educating the patient about their disease; assessment and observation of disease status; delivery of clinical skills such as wound care; administration of injections or intravenous fluids; management and evaluation of a patient's plan of care; physical therapy services to assist patients with functional limitations and speech therapy services for speech or swallowing disorders. In order to help monitor and promote compliance with regulatory requirements, we provide education on Medicare Guidelines and Conditions of participation; hold recurrent homecare regulatory education; utilize outside expert regulatory services; and have a toll-free hotline to offer additional assistance.
- ***Billing*** – We maintain controls over our billing processes to help promote accurate and complete billing. In order to promote the accuracy and completeness of our billing, we have annual billing compliance testing; use formalized billing attestations; limit access to billing systems; hold weekly operational meetings; use automated daily billing operational indicators; and take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures in accordance with a well-publicized "Zero Tolerance Policy".
- ***Patient Recertification*** – In order to be recertified for an additional episode of care, a patient must continue to meet qualifying criteria and have a continuing medical need. This could be caused by changes in the patient's condition requiring changes to the patient's medical regimen or modified care protocols within the episode of care. The patient's progress towards goals is evaluated prior to recertification. As with the initial episode of care, a recertification requires orders from the patient's physician. Before any employee recommends recertification to a physician, we conduct a care center level, multidisciplinary care team conference.

- ***Compliance*** – The quality and reputation of our personnel and operations are critical to our success. We develop, implement and maintain ethics, compliance and quality improvement programs as a component of the centralized corporate services provided to our home health and hospice care centers. Our ethics and compliance program includes a Code of Ethical Business Conduct for our employees, officers, directors and affiliates and a process for reporting regulatory or ethical concerns to our Chief Compliance Officer through a confidential hotline, which is augmented by exit interviews of departing employees and monthly interviews with randomly-selected, current employees. We promote a culture of compliance within our company through persistent messages from our senior leadership to our employees stressing the importance of strict compliance with legal requirements and company policies and procedures. We also employ a comprehensive compliance training program that includes mandatory compliance training and testing for all new employees upon hire and annually for all staff thereafter. In addition to our compliance training, we also conduct numerous proactive, compliance audits focusing on key risk areas, which are conducted by clinical auditors who work for our Compliance Department.

Our Regulatory Environment

We are highly regulated by federal, state and local authorities. Regulations and policies frequently change, and we monitor changes through trade and governmental publications and associations. Our home health and hospice subsidiaries are certified by CMS and therefore are eligible to receive payment for services through the Medicare system.

We are also subject to federal, state and local laws and regulations dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, environmental issues and adverse event reporting and recordkeeping. Federal, state and local governments are expanding the number of regulatory requirements on businesses.

We have set forth below a discussion of the regulations that we believe most significantly affect our home health and hospice businesses.

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

Home health and hospice care centers operate under licenses granted by the health authorities of their respective states. Additionally, certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or demonstrative usage of additional providers. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting either from population increases or a reduction in competing providers. These states ration the entry of new providers or services and the expansion of existing providers or services in their markets through a CON process, which is periodically evaluated and updated as required by applicable state law. Currently, state health authorities in 17 states and the District of Columbia require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health care center, and state health authorities in 12 states and the District of Columbia require a CON to operate a hospice care center.

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

In every state where required, our care centers possess a license and/or CON or POA issued by the state health authority that determines the local service areas for the home health or hospice care center. In general, the process for opening a home health or hospice care center begins by a provider submitting an application for licensure and certification to the state and federal regulatory bodies, which is followed by a testing period of

transmitting data from the applicant to CMS. Once this process is complete, the care center receives a provider agreement and corresponding number and can begin billing for services that it provides unless a CON or POA is required. For those states that require a CON or POA, the provider must also complete a separate application process before billing can commence and receive required approvals for capital expenditures exceeding amounts above prescribed thresholds.

State CON and POA laws generally provide that, prior to the addition of new capacity, the construction of new facilities or the introduction of new services, a designated state health planning agency must determine that a need exists for those beds, facilities or services. The process is intended to promote comprehensive health care planning, assist in providing high-quality health care at the lowest possible cost and avoid unnecessary duplication by ensuring that only those health care facilities and operations that are needed will be built and opened.

Medicare Participation

Our care centers must comply with regulations promulgated by the United States Department of Health and Human Services and CMS in order to participate in the Medicare program and receive Medicare payments. Among other things, these regulations, known as "conditions of participation ("COPs")," relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with state and local laws and regulations. CMS has adopted alternative sanction enforcement options which allow CMS (i) effective as of July 1, 2013, to impose temporary management, direct plans of correction, or direct training, and (ii) effective as of July 1, 2014, to impose payment suspensions and civil monetary penalties in each case on providers out of compliance with the conditions of participation. CMS issued a proposed rule on October 9, 2014, revising the current home health conditions of participation. We provided public comments on the proposed changes. On January 12, 2017, CMS finalized the new COPs and published them in the Federal Register. The new COPs are currently scheduled to go into effect on July 13, 2017, though that could be further delayed.

CMS has engaged a number of third party firms, including Recovery Audit Contractors ("RACs"), Program Safeguard Contractors ("PSCs"), Zone Program Integrity Contractors ("ZPICs") and Medicaid Integrity Contributors ("MICs"), to conduct extensive reviews of claims data and state and Federal Government health care program laws and regulations applicable to healthcare providers. These audits evaluate the appropriateness of billings submitted for payment. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

Federal and State Anti-Fraud and Anti-Kickback Laws

As a provider under the Medicare and Medicaid systems, we are subject to various anti-fraud and abuse laws, including the Federal health care programs' anti-kickback statute and, where applicable, its state law counterparts. Subject to certain exceptions, these laws prohibit any offer, payment, solicitation or receipt of any form of remuneration to induce or reward the referral of business payable under a government health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered under a government health care program. Affected government health care programs include any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits/programs), including certain state health care programs that receive federal funds, such as Medicaid. A related law forbids the offer or transfer of anything of value, including certain waivers of co-payment obligations and deductible amounts, to a beneficiary of Medicare or Medicaid that is likely to influence the beneficiary's selection of health care providers, again subject to certain exceptions. Violations of the anti-fraud and abuse laws can result in the imposition of substantial civil and criminal penalties and, potentially, exclusion from furnishing services under any government health care program. In addition, the states in which we operate generally have laws that prohibit certain direct or indirect payments or fee-splitting arrangements between health care providers where they are designed to obtain the referral of patients from a particular provider.

Stark Laws

Congress adopted legislation in 1989, known as the "Stark Law," that generally prohibited a physician from ordering clinical laboratory services for a Medicare beneficiary where the entity providing that service has a financial relationship (including direct or indirect ownership or compensation relationships) with the physician (or a member of his/her immediate family), and further prohibits such entity from billing for or receiving payment for such services, unless a specified exception is available. The Stark Law was amended through additional legislation, known as "Stark II," which became effective January 1, 1993. That legislation extended the Stark Law prohibitions beyond clinical laboratory services to a more extensive list of statutorily defined "designated health services," which includes, among other things, home health services, durable medical equipment and outpatient prescription drugs. Violations of the Stark Law result in payment denials and may also trigger civil monetary penalties and program exclusion. Several of the states in which we conduct business have also enacted statutes similar in scope and purpose to the federal fraud and abuse laws and the Stark Laws. These state laws may mirror the Federal Stark Laws or may be different in scope. The available guidance and enforcement activity associated with such state laws varies considerably.

Federal and State Privacy and Security Laws

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), directed that the Secretary of the U.S. Department of Health and Human Services ("HHS") promulgate regulations prescribing standard requirements for electronic health care transactions and establishing protections for the privacy and security of individually identifiable health information, known as "protected health information." The HIPAA transactions regulations establish form, format and data content requirements for most electronic health care transactions, such as health care claims that are submitted electronically. The HIPAA privacy regulations establish comprehensive requirements relating to the use and disclosure of protected health information. The HIPAA security regulations establish minimum standards for the protection of protected health information that is stored or transmitted electronically. Violations of the privacy and security regulations are punishable by civil and criminal penalties.

The American Recovery and Economic Reinvestment Act of 2009 ("ARRA"), signed into law by President Obama on February 17, 2009, contained significant changes to the privacy and security provisions of HIPAA, including major changes to the enforcement provisions. Among other things, ARRA significantly increased the amount of civil monetary penalties that can be imposed for violations of HIPAA. ARRA also authorized state attorneys general to bring civil enforcement actions under HIPAA. These enhanced penalties and enforcement provisions went into effect immediately upon enactment of ARRA. ARRA also required that HHS promulgate regulations requiring that certain notifications be made to individuals, to HHS and potentially to the media in the event of breaches of the privacy of protected health information. These breach notification regulations went into effect on September 23, 2009, and HHS began to enforce violations on February 22, 2010. Violations of the breach notification provisions of HIPAA can trigger the increased civil monetary penalties described above.

ARRA's numerous other changes to HIPAA have delayed effective dates and require the issuance of implementing regulations by HHS. The Health Information Technology for Economic and Clinical Health ("HITECH") Act was enacted in conjunction with ARRA. On January 25, 2013, HHS issued final modifications to the HIPAA Privacy, Security, and Enforcement Rules mandated by the HITECH Act, which had been previously issued as a proposed rule on July 14, 2010. Among other things, these modifications make business associates of covered entities directly liable for compliance with certain HIPAA requirements, strengthen the limitations on the use and disclosure of protected health information without individual authorizations, and adopt the additional HITECH Act enhancements, including enforcement of noncompliance with HIPAA due to willful neglect. The changes to HIPAA enacted as part of ARRA reflect a Congressional intent that HIPAA's privacy and security provisions be more strictly enforced. It is likely that these changes will stimulate increased enforcement activity and enhance the potential that health care providers will be subject to financial penalties for violations of HIPAA.

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

The False Claims Act

The Federal False Claims Act gives the Federal Government an additional way to police false bills or requests for payment for health care services. Under the False Claims Act, the government may fine any person who knowingly submits, or participates in submitting, claims for payment to the Federal Government which are false or fraudulent, or which contain false or misleading information. Any person who knowingly makes or uses a false record or statement to avoid paying the Federal Government, or knowingly conceals or avoids an obligation to pay money to the Federal Government, may also be subject to fines under the False Claims Act. Under the False Claims Act, the term "person" means an individual, company, or corporation. The Federal Government has widely used the False Claims Act to prosecute Medicare and other governmental program fraud in areas such as violations of the Federal anti-kickback statute or the Stark Laws, coding errors, billing for services not provided, and submitting false cost reports. The False Claims Act has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and that bill for care that is not medically necessary. In addition to government enforcement, the False Claims Act authorizes private citizens to bring qui tam or "whistleblower" lawsuits, greatly extending the practical reach of the False Claims Act. The penalty for violation of the False Claims Act is a minimum of $5,500 for each fraudulent claim plus three times the amount of damages caused to the government as a result of each fraudulent claim.

The Fraud Enforcement and Recovery Act of 2009 ("FERA") amended the False Claims Act with the intent of enhancing the powers of government enforcement authorities and whistleblowers to bring False Claims Act cases. In particular, FERA attempts to clarify that liability may be established not only for false claims submitted directly to the government, but also for claims submitted to government contractors and grantees. FERA also seeks to clarify that liability exists for attempts to avoid repayment of overpayments, including improper retention of federal funds. FERA also included amendments to False Claims Act procedures, expanding the government's ability to use the Civil Investigative Demand process to investigate defendants, and permitting government complaints in intervention to relate back to the filing of the whistleblower's original complaint. FERA is likely to increase both the volume and liability exposure of False Claims Act cases brought against health care providers.

On February 12, 2016, CMS finalized the so-called "60-day rule," which is the obligation of providers to report and return Medicare overpayments within 60 days of identifying the same. A provider who retains overpayments beyond 60 days may be liable under the False Claims Act. "Identification" is identified as when a person "has, or should have through the exercise of reasonable diligence," identified and quantified the amount of an overpayment. The final rule also established a six year lookback period, meaning overpayments must be reported and returned if a person identifies the overpayment within six years of the date the overpayment was received. Providers must report and return overpayments even if they did not cause the overpayment.

In June 2016, the Department of Justice issued a rule that more than doubles civil monetary penalties under the False Claims Act. These increases took effect on August 1, 2016 and apply to False Claims Act violations after November 2, 2015.

In addition to the False Claims Act, the Federal Government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the Federal Government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act. As part of the Deficit

Reduction Act of 2005 (the "DRA"), Congress provided states an incentive to adopt state false claims acts consistent with the Federal False Claims Act. Additionally, the DRA required providers who receive $5 million or more annually from Medicaid to include information on Federal and state false claims acts, whistleblower protections and the providers' own policies on detecting and preventing fraud in their written employee policies.

Civil Monetary Penalties

The United States Department of Health and Human Services may impose civil monetary penalties upon any person or entity who presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies, depending on the offense, from $2,000 to $50,000 per violation. In addition, persons who have been excluded from the Medicare or Medicaid program and still retain ownership in a participating entity, or who contract with excluded persons, may be penalized. Penalties also are applicable in certain other cases, including violations of the Federal anti-kickback statute, Stark Law or False Claims Act, and payments to limit certain patient services and improper execution of statements of medical necessity.

FDA Regulation

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

Patient Protection and Affordable Care Act

In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"). Since the 2016 election, it has been widely discussed that the PPACA will be "repealed and replaced." The effect of any major modification or repeal of the PPACA on our business, operations, or financial condition cannot be predicted at this time.

Even as of December 31, 2016, it is difficult to predict the full impact of PPACA due to the law's complexity and phased in effective dates, as well as our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. PPACA calls for a number of changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates decreases in home health reimbursement rates, including a four-year phased rebasing of the home health payment system that began in 2014 and will continue through 2017. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors." PPACA has established a number of new requirements impacting our business operations, and promises to give rise to other changes that could significantly impact our businesses in the future. For example, PPACA also mandates the creation of a home health value-based purchasing program, the development of quality measures, and the testing of alternative payment and delivery models, including ACOs and the Bundled Payments for Care Improvement initiative. See Part I, Item 1A, "Risk Factors: Risks Related to Laws and Government Regulations" for a more complete discussion of PPACA and the risks it presents to our businesses.

The Improving Medicare Post-Acute Care Transformation Act

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

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

The Comprehensive Care for Joint Replacement Bundled Payment Program

In November 2015, CMS announced the final Comprehensive Care for Joint Replacement bundled payment program ("CJR Program"). The CJR Program implements a mandatory payment model in which acute care hospitals in 67 metropolitan statistical areas will receive a bundled payment for all inpatient care provided in connection with a lower extremity joint replacement or reattachment procedure, as well as for all related care provided within a 90-day episode of care following discharge from such hospital. The bundled payment will be in lieu of separate payments provided to post-acute healthcare providers for services provided within such 90-day episode of care. The CJR Program will test this payment model over five performance periods between April 1, 2016 and December 31, 2020 to see if Medicare expenditures can be reduced while at the same time improving care coordination and preserving or enhancing the quality of care provided to Medicare beneficiaries.

Pre-Claim Review Demonstration for Home Health Services

On June 8, 2016, CMS announced the implementation of a three year Medicare pre-claim review demonstration for home health services provided to beneficiaries in the states of Illinois, Florida, Texas, Michigan and Massachusetts. The demonstration began in Illinois in August 2016 and will expand to Florida for home health services that begin on or after April 1, 2017. CMS is expected to announce staggered start dates for the other states in the coming months. The pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. The pre-claim review demonstration may result in an increase in administrative costs or reimbursement delays related to home health services in such states, which could have an adverse effect on our results of operations and cash flow.

Home Health Groupings Model

In the Calendar Year 2017 Home Health Proposed Rule, released in July 2016, CMS provided information regarding potential changes to the Home Health Prospective Payment System ("HHPPS"), known as the Home Health Groupings Model ("HHGM"). Among a number of major differences from the current payment system, the HHGM would distinguish between referrals from institutions and those from the community, with

community referrals receiving lower payments. In addition, a 60-day episode would consist of two 30-day periods, each paid separately, with the initial 30-day period paid higher than any other period. CMS did not solicit comments at that time but noted that a more detailed Technical Report would be released with additional research and analysis conducted on the HHGM. The HHGM Technical Report was issued in December 2016. We are closely monitoring this potential change to the HHPPS and have joined industry stakeholders in directly engaging CMS on this concept and its impact on home health agencies. CMS has not indicated if HHGM will be included in the Calendar Year 2018 Home Health Proposed Rule which will be released in mid-summer 2017. At this time we are unable to determine the impact this potential change in reimbursement methodology might have on Amedisys.

Our Competitors

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

Available Information

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

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

ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks faced by Amedisys. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

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

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

Risks Related to Reimbursement

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

Our net service revenue is primarily derived from Medicare, which accounted for 78%, 80% and 82% of our revenue during 2016, 2015 and 2014, respectively. Payments received from Medicare are subject to changes made through federal legislation. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. These changes, as further detailed in Part I, Item 1, "Business: Payment for Our Services," can include changes to base episode payments and adjustments for home health services, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility and documentation requirements or changes designed to restrict utilization. Any such changes, including retroactive adjustments, adopted in the future by the Center for Medicare and Medicaid Services ("CMS") could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

On September 1, 2016, CMS published annual changes in Medicaid hospice payment rates. As finalized, CMS estimates hospices will see a 2.1% ($350 million) increase in Medicare payments for fiscal year 2017, which reflects a market basket update of 2.7%, reduced by 0.6% as required by PPACA. 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. In addition, the rule finalizes changes to the hospice quality reporting program, including new quality measures. The final rule also describes a potential future enhanced data collection instrument as well as plans to publicly display quality measures and other hospice data beginning in the middle of 2017. As of December 31, 2016, we estimate our impact of the 2017 final rule to be an increase of approximately 2%.

In October 2016, CMS issued a final rule to update and revise Medicare home health reimbursement rates for calendar year 2017. The final rule implements the final year of the four-year phase-in of the rebasing adjustments

to the home health prospective payment system 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. As of December 31, 2016, we estimate our impact of the 2017 final rule to be a decrease of approximately 2%.

On February 2, 2016 CMS published a final rule adding new requirements for Medicaid home health services. Among other things, the final rule requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician practitioner must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than 6 months prior to the start of services. Although the final rule's stated effective date is July 1, 2016, CMS created an exception for state legislation by giving state agencies that require state legislation to until July 1, 2017 or July 1, 2018 to publish requirements imposed by the rule.

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

We could be affected adversely by the continuing efforts of governmental payors to contain health care costs. We cannot assure you that reimbursement payments under governmental payor programs, including Medicare supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Any such changes could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

Quality reporting requirements may negatively impact Medicare reimbursement.

Hospice quality reporting was mandated by PPACA, which directs the Secretary to establish quality reporting requirements for hospice programs. For fiscal year 2014, and each subsequent year, failure to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. This quality reporting program is currently "pay-for-reporting," meaning it is the act of submitting data that determines compliance with program requirements.

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

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

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

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

Adverse developments in the United States could lead to a reduction in Federal Government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the Federal Government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the Federal Government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by the United States Congress to complete the federal budget process and fund government operations may result in a Federal Government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. As an example, the failure of the 2011 Joint Select Committee to meet its Deficit Reduction goal resulted in an automatic reduction in Medicare home and hospice payments of 2% beginning April 1, 2013.

Historically, state budget pressures have resulted in reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services.

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

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

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

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

Risks Related to Laws and Government Regulations

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

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

Pending civil litigation could have a material adverse effect on the Company.

We and certain of our current and former directors, senior executives and other employees are defendants in a federal securities class action. We are also a defendant in several class action lawsuits. See Part II, Item 8, Note 10 – Commitments and Contingencies for a more detailed description of these proceedings. These actions remain in preliminary stages and it is not yet possible to assess their probable outcome or our potential liability, if any. We cannot provide any assurances that the legal and other costs associated with the defense of these actions, the amount of time required to be spent by management on these matters and the ultimate outcome of these actions will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our insurance may not cover all of the costs associated with defending the pending federal securities class action, and any potential liability costs associated with this matter, and we maintain no insurance that covers any portion of the pending class action lawsuits.

With respect to the pending securities class action, we may be obligated to indemnify (and advance legal expenses to) both current and former officers, employees and directors in connection with this matter. We maintain directors' and officers' liability insurance that we believe should cover a portion of the legal costs and potential liability costs associated with this matter. However, such insurance coverage does not extend to all of these expenditures, and the insurance limits may be insufficient even with respect to expenditures that would otherwise be covered. Furthermore, our insurance carriers may seek to deny coverage in this matter, in which case we may have to fund the indemnification amounts owed to such directors and officers ourselves. We do not

maintain any insurance that will cover any part of the class action lawsuits in which we are defendants. If our insurance coverage is denied or is not adequate, it may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

These laws and regulations, and their interpretations, are subject to change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows by:

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

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

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

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. We also are subject to audits under various government programs, including the RAC, ZPIC, PSC and MIC programs as well as in accordance with the requirements of our CIA, in which third party firms engaged by CMS or by the Company conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare program. Private pay sources also reserve the right to conduct audits. If billing errors are identified in the sample of reviewed claims, the billing error can be extrapolated to all claims filed which could result in a larger overpayment than originally identified in the sample of reviewed claims. Our costs to respond to and defend reviews, audits and investigations may be significant and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Moreover, an adverse review, audit or investigation could result in:

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

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

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

Each of our care centers must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a care center, we may receive a notice of deficiency from the applicable state surveyor. If that care center then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program or subjected to alternative sanctions. CMS outlined its alternative sanction enforcement options for home health care centers through a regulation published in 2012; under the regulation, CMS may impose temporary management, direct a plan of correction, direct training or impose payment suspensions and civil monetary penalties, in each case, upon providers who fail to comply with the conditions of participation. Termination of one or more of our care centers from the Medicare program for failure to satisfy the program's conditions of participation, or the imposition of alternative sanctions, could disrupt operations, require significant attention by management, or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations and cash flows. CMS issued a proposed rule on October 9, 2014, revising the Medicare conditions of participation for home health care centers across the industry, with an unknown effective date. We provided public comments on the proposed changes, but do not know at this time what effect the finalized revisions will have on our operations, and there can be no assurances that the revisions will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

We are required to comply with federal and state laws, generally referred to as "anti-kickback laws," that prohibit certain direct and indirect payments or other financial arrangements between health care providers that are

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

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

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

PPACA makes a number of changes to Medicare payment rates and also calls for a rebasing of the home health payment system that began in 2014 and will continue through 2017. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors."

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

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

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

In addition to impacting our Medicare businesses, PPACA may also significantly affect our non-Medicare businesses. PPACA makes many changes to the underwriting and marketing practices of private payors. The resulting economic pressures could prompt these payors to seek to lower their rates of reimbursement for the services we provide. At this time, it is not possible to estimate what impact PPACA may have on our non-Medicare businesses.

Finally, efforts to repeal or substantially modify provisions of the PPACA continue in Congress. The ultimate outcomes of legislative efforts to repeal, substantially amend, eliminate or reduce funding for the PPACA is unknown. While these attempts have not been successful to date, the results of the Presidential and Congressional elections in 2016 could have a significant impact on future efforts to amend or repeal PPACA. In addition to the prospect for legislative repeal or revision, the President and members of his administration hostile to the PPACA could seek to impose substantial changes upon the PPACA through administrative action, including revised regulation and other Executive Branch action. The effect of any major modification or repeal of the PPACA on our business, operations, or financial condition cannot be predicted, but could be materially adverse.

Risks Related to our Growth Strategies

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

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

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

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

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

Changes in federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, PPACA authorized CMS to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. The moratoria on new enrollments may be applied to categories of providers or to specific geographic regions. In 2012, the OIG released a report that concluded Medicare had overpaid home health agencies due to inappropriate and questionable billing practices. Citing this report, in 2014, CMS adopted a temporary moratorium on new home health agencies and home health agency subunits in certain regions of Texas, Michigan, Florida and Illinois. On July 29, 2016, CMS announced it was extending such moratorium for an additional six months, and that the moratorium would be expanded statewide in each targeted state. If a moratorium is imposed on the enrollment of new home health or hospice providers in a geographic area we desire to service, it could have a material impact on our ability to open new care centers. Additionally, in 2010,

CMS implemented and amended a regulation known as the "36 Month Rule" that is applicable to home health care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health care centers – those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition – from assuming the Medicare billing privileges of the acquired care center. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy.

We could face a variety of risks by expanding into our personal care line of business.

We established a personal care segment of our business with the acquisition of Associated Home Care, which closed on March 1, 2016. Risks of our entry into the new personal care segment include, without limitation: (i) potential diversion of management's time and other resources from our existing home health and hospice businesses; (ii) unanticipated liabilities or contingencies; (iii) the need for additional capital and other resources to expand into this new line of business; and (iv) inefficient integration of operational and management systems and controls. Entry into a new line of business may also subject us to new laws and regulations with which we are not familiar, and may lead to increased litigation and regulatory risk. If we are unable to successfully implement our growth strategies, our revenue and profitability may not grow as we expect, our competitiveness may be materially and adversely affected, and our reputation and business may be harmed.

Risks Related to our Operations

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

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

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

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

Further, the introduction of new and enhanced service offerings by others, in combination with industry consolidation and the development of strategic relationships by our competitors, could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

Managed care organizations and other third party payors continue to consolidate, which enhances their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if these organizations terminate us as

a provider and/or engage our competitors as a preferred or exclusive provider. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

If we are unable to react competitively to new developments, our operating results may suffer. Further, if states remove existing CONs or POAs, we would face increased competition in these states. For example, in 2013, the Governor of South Carolina vetoed funding for that state's CON program, effectively shutting down the program. Following a judicial challenge, the South Carolina Supreme Court ruled in April 2014 that the South Carolina Department of Health and Environmental Control was statutorily obligated to administer the CON program, regardless of the Governor's veto. Following this ruling, legislation has been introduced in the South Carolina House of Representatives for the purpose of limiting the application of that state's CON program. We do not know at this time what the outcome of this matter will be in South Carolina, and whether this will have any impact upon our operations. Similarly, there can be no assurances that other states will not seek to eliminate or limit their existing CON or POA programs in a similar manner, leading to increased competition in these states. Further, we cannot assure you that we will be able to compete successfully against current or future competitors, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

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

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

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

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

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

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

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems, and the introduction of computer viruses or other malicious software programs to our systems. Our security measures may be inadequate to prevent security breaches and our business operations could be materially adversely affected by federal and state fines and penalties, legal claims or proceedings, cancellation of contracts and loss of patients if security breaches are not prevented.

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

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

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

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

Our revenue is determined by a number of factors, including our mix of patients and the rates of payment among payors. Changes in the case mix of our patients, payment methodologies or the payor mix among Medicare, Medicaid and private payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

A significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate, or slower growth rates could result in the need to perform an impairment analysis under Accounting Standard Codification ("ASC") Topic 350 "Intangibles – Goodwill and Other" in future periods in addition to our annual impairment test. If we were to conclude that a write down of goodwill is necessary, then we would record the appropriate charge, which could result in material charges that are adverse to our consolidated financial condition and results of operations. See Part II, Item 8, Note 5 – Goodwill and Other Intangible Assets, Net to our consolidated financial statements for additional information.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $289.0 million as of December 31, 2016 and if we make additional acquisitions, it is likely that we will record additional intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment and other identifiable intangible assets of $83.8 million as of December 31, 2016, which we review both on a periodic basis for indefinite lived intangible assets as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our consolidated financial condition and results of operations.

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

We compete for qualified personnel with other healthcare providers. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there

are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with attractive benefit packages than we originally anticipated which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our care center employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

The services we offer involve an inherent risk of professional liability and related substantial damage awards. As of February 24, 2017, we had approximately 16,000 employees (10,800 home health, 2,800 hospice, 1,800 personal care and 600 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their acts or omissions. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits, or multiple claims requiring us to pay deductibles, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with Medicare requirements and the other laws to which we are subject. Adverse publicity surrounding any aspect of our business, including the death or disability of any of our patients due to our failure to provide proper care, or due to any failure on our part to comply with Medicare requirements or other laws to which we are subject, could negatively affect our Company's overall reputation and the willingness of referral sources to refer patients to us.

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

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

Our operations could be impacted by natural disasters.

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

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

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

In addition, timing delays in billings and collections may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, Medicare or other provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

CMS is implementing a three-year pre-claim review demonstration for home health services in the states of Illinois, Florida, Michigan, Massachusetts, and Texas, which will be phased in during 2016 and 2017, depending on the state. CMS is testing whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud occurring among home health agencies providing services to Medicare beneficiaries. Additionally, CMS is testing whether the demonstration helps reduce expenditures while maintaining or improving quality of care. The pre-claim review demonstration for home health services does not create new clinical documentation requirements. CMS has indicated that home health agencies will submit the same information they currently submit for payment, but will do so earlier in the process. CMS has further indicated that this demonstration should not delay care to Medicare beneficiaries and does not alter the Medicare home health benefit. However, this process could result in increased administrative costs or delays in reimbursement for home health services in states subject to the demonstration.

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

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

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

are unable to raise the necessary funds on acceptable terms, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

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

As of December 31, 2016, we had total outstanding indebtedness of approximately $95.7 million, comprised mainly of indebtedness incurred in connection with our April 23, 2014 settlement agreement with the U.S. Department of Justice relating to certain of our clinical and business operations. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and impair our ability to fulfill other obligations in several ways, including:

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

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

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

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

- incur additional debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;
- create liens;
- enter into transactions with affiliates;
- make acquisitions;
- enter into joint ventures;
- merge or consolidate;
- invest in foreign subsidiaries;
- amend acquisition documents;
- enter into certain swap agreements;
- make certain restricted payments;
- transfer, sell or leaseback assets; and
- make fundamental changes in our corporate existence and principal business.

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

Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile.

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

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

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

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. "Short sale" is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2016, investors held a short position of approximately 3.2 million shares of our common stock which represented 9.5% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

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

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

	As of December 31, 2016
Common stock outstanding	33,597,215
Preferred stock outstanding	—
Common stock available under 2008 Omnibus Incentive Compensation Plan	1,204,572
Stock options outstanding	1,008,157
Stock options exercisable	281,458
Non-vested stock outstanding	209,378
Non-vested stock units outstanding	474,286

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

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

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

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our executive office is located in Nashville, Tennessee in a leased property consisting of 15,825 square feet; our corporate headquarters is located in Baton Rouge, Louisiana in a leased property consisting of 75,243 square feet. We believe we have adequate space to accommodate our corporate staff located in these locations for the foreseeable future.

In addition to our executive office and corporate headquarters, we also lease facilities for our home health, hospice and personal-care care centers. Generally, these leases have an initial term of five years with a three year early termination option, but range from one to seven years. Most of these leases also contain an option to extend the lease period. The following table shows the location of our 327 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers at December 31, 2016:

State	Home Health	Hospice	Personal Care	State	Home Health	Hospice	Personal Care
Alabama	30	7	—	New Jersey	2	1	—
Arkansas	5	—	—	New York	5	—	—
Arizona	3	—	—	New Hampshire	2	2	—
California	4	—	—	North Carolina	8	6	—
Connecticut	4	1	—	Ohio	—	1	—
Delaware	2	—	—	Oklahoma	6	—	—
Florida	28	—	—	Oregon	3	1	—
Georgia	62	6	—	Pennsylvania	7	6	—
Illinois	2	—	—	Rhode Island	1	2	—
Indiana	5	1	—	South Carolina	19	7	—
Kansas	1	1	—	Tennessee	43	11	—
Kentucky	17	—	—	Texas	—	1	—
Louisiana	10	4	—	Virginia	14	1	—
Massachusetts	5	8	14	West Virginia	11	6	—
Maine	2	4	—	Wisconsin	1	—	—
Maryland	8	2	—	Washington, D.C.	1	—	—
Mississippi	10	—	—	Total	327	79	14
Missouri	6	—	—				

ITEM 3. LEGAL PROCEEDINGS

See Part II, Item 8, Note 10 – Commitments and Contingencies for information concerning our legal proceedings.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market under the trading symbol "AMED". The following table presents the range of high and low sales prices for our common stock for the periods indicated as reported on NASDAQ:

	Price Range of Common Stock	
	High	Low
Year Ended December 31, 2016:		
First Quarter	$48.48	$31.16
Second Quarter	54.42	46.12
Third Quarter	55.16	45.48
Fourth Quarter	48.13	34.58
Year Ended December 31, 2015:		
First Quarter	$31.27	$25.83
Second Quarter	43.61	24.81
Third Quarter	48.34	36.11
Fourth Quarter	45.00	34.72

As of February 24, 2017, there were approximately 513 holders of record of our common stock.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors as our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends; provided, however, that we may pay (i) dividends payable solely in our equity securities and (ii) dividends if (1) no default or event of default under the Credit Agreement shall have occurred and be continuing at the time of such dividend or would result therefrom, (2) we demonstrate that, upon giving pro forma effect to such dividend, our consolidated leverage ratio (as defined in the Credit Agreement) is less than 2.00 to 1.0 and (3) we demonstrate a minimum liquidity of $50 million upon giving effect to such dividend.

Purchases of Equity Securities

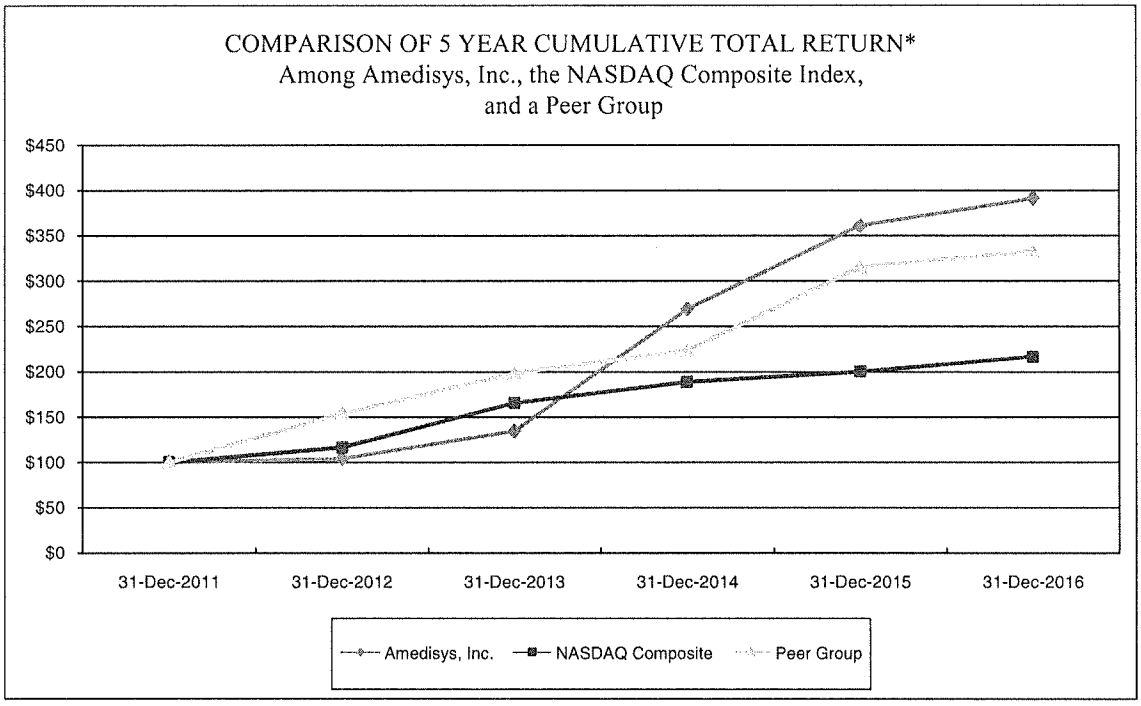
The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2016:

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
October 1, 2016 to October 31, 2016	676	$43.86	—	$ —
November 1, 2016 to November 30, 2016	—	—	—	—
December 1, 2016 to December 31, 2016	11,472	42.85	—	—
	12,148(1)	$42.91	—	$ —

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

Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2016, with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group) on December 31, 2011 and the reinvestment of dividends. The peer group we selected is comprised of: LHC Group, Inc. ("LHCG") and Almost Family, Inc. ("AFAM"). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been paid on our common stock.



	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
Amedisys, Inc.	$100.00	$103.64	$134.10	$269.02	$360.40	$390.74
NASDAQ Composite	$100.00	$116.41	$165.47	$188.69	$200.32	$216.54
Peer Group	$100.00	$153.62	$198.06	$223.44	$314.73	$331.94

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

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for the five-year period ended December 31, 2016, based on our continuing operations. The financial data for the years ended December 31, 2016, 2015 and 2014 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.

	2016 (1)	2015 (2)	2014 (3)	2013 (4)	2012 (5)
	(Amounts in thousands, except per share data)				
Income Statement Data:					
Net service revenue	$1,437,454	$1,280,541	$1,204,554	$1,249,344	$1,440,836
Operating income (loss) from continuing operations	$ 57,340	$ (9,166)	$ 24,047	$ (154,971)	$ (108,855)
Net income (loss) from continuing operations attributable to Amedisys, Inc.	$ 37,261	$ (3,021)	$ 12,992	$ (93,105)	$ (80,262)
Net income (loss) from continuing operations attributable to Amedisys, Inc. per basic share	$ 1.12	$ (0.09)	$ 0.40	$ (2.98)	$ (2.68)
Net income (loss) from continuing operations attributable to Amedisys, Inc. per diluted share	$ 1.10	$ (0.09)	$ 0.40	$ (2.98)	$ (2.68)

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

(2) 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).

(3) 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).

(4) 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).

(5) 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).

	2016	2015	2014	2013	2012
	(Amounts in thousands)				
Balance Sheet Data:					
Total assets (1)	$734,029	$681,715	$666,956	$724,237	$728,132
Total debt, including current portion (1)	$ 93,029	$ 96,630	$113,586	$ 44,735	$100,248
Total Amedisys, Inc. stockholders' equity	$460,203	$409,568	$397,167	$372,201	$452,340
Cash dividends declared per common share	$ —	$ —	$ —	$ —	$ —

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

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

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2016, 2015 and 2014. This discussion should be read in conjunction with our audited financial statements included in Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1, "Business" of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues, operating results and expectations. See "Special Caution Concerning Forward-Looking Statements" for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A, "Risk Factors."

Overview

We are a provider of high-quality in-home healthcare and related services to the chronic, co-morbid, aging American population, with approximately 78%, 80% and 82% of our revenue derived from Medicare for 2016, 2015 and 2014, respectively.

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgery. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. Our personal care segment provides patients assistance with the essential activities of daily living. As of December 31, 2016, we owned and operated 327 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.

2016 Developments

- Completed the rollout of Homecare Homebase ("HCHB"), a leading platform for home health and hospice companies, to all of our care centers.
- Integrated Infinity HomeCare which we acquired on December 31, 2015.
- Closed the acquisition of Associated Home Care on March 1, 2016, which resulted in the establishment of our personal care segment which was further expanded with the purchase of the assets of Professional Profiles, Inc. on September 1, 2016.

2017 Strategy

- Continue to focus on growth through acquisitions in all three segments and increased volumes in existing care centers.
- Continue to focus on commitment to clinical distinction with a goal of all care centers achieving a 4.0 Quality Star Rating.
- Gain operating efficiencies from investments in infrastructure, including HCHB.
- Focus on recruitment and retention of world class employees while fostering a culture of engagement to become the employer of choice in the industry.

Financial Performance

The year ended December 31, 2016 continued our focus on operational improvements that began during 2014 despite the disruption related to the conversion from our proprietary operating system to HCHB.

Our home health care centers experienced same store revenue and admissions growth in 2016. The home health segment saw an increase in non-Medicare revenue and Medicare revenue per episode offset by increases in cost per visit and other operating expenses which resulted in a $2 million reduction in our operating income over the year ended December 31, 2015 (see "Results of Operations").

Our hospice segment achieved significant growth in admissions and average daily census combined with strong cost controls in 2016, all of which helped deliver an $8 million improvement in our operating income over the year ended December 31, 2015 (see "Results of Operations").

Care Centers Summary

	Home Health	Hospice	Personal Care
At December 31, 2013	367	92	—
Closed/Consolidated/Sold	(51)	(12)	—
At December 31, 2014	316	80	—
Acquisitions	15	1	—
Closed/Consolidated/Sold	(2)	(2)	—
At December 31, 2015	329	79	—
Acquisitions/Start-Ups	1	—	14
Closed/Consolidated	(3)	—	—
At December 31, 2016	327	79	14

When we refer to "same store business," we mean home health, hospice and personal-care care centers that we have operated for at least the last twelve months; when we refer to "acquisitions," we mean home health, hospice and personal-care care centers that we acquired within the last twelve months; and when we refer to "start-ups," we mean home health, hospice and personal-care care centers opened by us in the last twelve months. Once a care center has been in operation for a twelve month period, the results for that particular care center are included as part of our same store business from that date forward. Non-Medicare revenue, admissions, recertifications or completed episodes includes home health revenue, admissions, recertifications or completed episodes of care for those payors that pay on an episodic or per visit basis, which includes Medicare Advantage programs and private payors.

Economic and Industry Factors

Home health, hospice and personal care services are a highly fragmented and highly competitive industry. The degree of competiveness varies based upon whether our care centers operate in states that require a certificate of need (CON) or permit of approval (POA). In such states, expansion by existing providers or entry into the market by new providers is permitted only where determination is made by state health authorities that a given amount of unmet healthcare need exists. Currently, 68% and 40% of our home health and hospice care centers, respectively operate in CON/POA states.

As the Federal government continues to debate a reduction in expenditures and a reform of the Medicare system, our industry continues to face reimbursement pressures. The Centers for Medicare and Medicaid Services ("CMS") instituted a rebasing cut of approximately $81 per episode (2.7%) per year for 2014 – 2017; however,

we do expect some offset from a market basket update in each of these years. The following payment adjustments are effective for the years indicated based on CMS's final rules relative to Medicare reimbursement:

	Home Health			Hospice		
	2017 (1)	2016	2015	2017 (2)	2016	2015
Market Basket Update	2.8 %	2.3 %	2.6 %	2.7 %	2.4 %	2.9 %
Rebasing	(2.3)	(2.4)	(2.8)	—	—	—
50/50 Blend of Wage Index	—	—	—	—	0.2	—
Nominal Case Mix Adjustment	(0.9)	(0.9)	—	—	—	—
PPACA Adjustment	—	—	—	(0.3)	(0.3)	(0.3)
Budget Neutrality Adjustment Factor	—	—	0.4	—	(0.7)	(0.7)
Productivity Adjustment	(0.3)	(0.4)	(0.5)	(0.3)	(0.5)	(0.5)
	(0.7)%	(1.4)%	(0.3)%	2.1 %	1.1 %	1.4 %

(1) Effective for episodes scheduled to be completed on or after January 1, 2017.
(2) Effective for services provided from October 1, 2016 to September 30, 2017.

Our company-specific impact of the final rules could differ depending on differences in the wage index and the impact of coding and outlier changes.

As part of the 2016 final rule issued in October 2015, CMS finalized their proposal to implement a Home Health Value-Based Purchasing model in nine states that seeks to test whether incentives for better care can improve outcomes in the delivery of home health services. Financial impacts from this change, either positive or negative, would begin January 1, 2018, applied to that calendar year based on 2015 performance data. Care centers operating in the states included in the proposed model account for approximately 31% of our 2016 home health Medicare revenue.

Governmental Inquiries and Investigations and Other Litigation

September 2010 Civil Investigative Demand Issued by the U.S. Department of Justice

On April 23, 2014, with no admission of liability on our part, we entered into a settlement agreement to resolve the U.S. Department of Justice investigation which began with a Civil Investigative Demand ("CID") issued by the U.S. Department of Justice on September 27, 2010 and the Stark Law Self-Referral Matter disclosed to CMS in May 2012. Pursuant to the settlement agreement, on May 2, 2014, we paid the United States an initial payment in the amount of $116.5 million representing the first installment of $115 million plus interest thereon due under the settlement agreement, and on October 23, 2014, we paid the United States an additional payment in the amount of $35.8 million, representing the second and final installment of $35 million plus interest thereon due under the settlement agreement.

The settlement agreement also resolved allegations made against us by various qui tam relators, who were required to dismiss their claims with prejudice. We accrued and paid various relators' attorneys' fees and expenses in the aggregate sum of approximately $3.9 million during 2014.

In connection with the settlement agreement, on April 23, 2014, we entered into a corporate integrity agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization to perform certain 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 CIA has a term of five years. We expect the CIA to impact operating expenses by approximately $1 to $2 million annually.

May 2015 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.

November 2015 Civil Investigative Demand Issued by the U.S. Department of Justice

On November 3, 2015, 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 Morgantown, West Virginia area.

June 2016 Civil Investigative Demand Issued by the U.S. Department of Justice

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.

See Item 8, Note 10 – Commitments and Contingencies to our consolidated financial statements for additional information regarding our April 2014 CIA, the May 2015 Subpoena issued by the U.S. Department of Justice, the November 2015 CID issued by the U.S. Department of Justice, the June 2016 CID issued by the U.S. Department of Justice and for a discussion of and updates regarding class action litigation we are involved in. No assurances can be given as to the timing or outcome of these items.

Results of Operations

Consolidated

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

	For the Years Ended December 31,		
	2016	2015	2014
Net service revenue	$1,437.4	$1,280.5	$1,204.5
Gross margin, excluding depreciation and amortization	604.4	554.6	513.4
% of revenue	42.0%	43.3%	42.6%
Other operating expenses	542.7	486.5	486.3
% of revenue	37.7%	38.0%	40.4%
Asset impairment charge	4.4	77.3	3.1
Operating income (loss)	57.3	(9.2)	24.0
Total other income (expense), net	4.2	8.9	(3.1)
Income tax expense	(23.9)	(2.0)	(7.7)
Effective income tax rate	38.9%	650.6%	36.6%
Income (loss) from continuing operations	37.6	(2.3)	13.3
Net loss from discontinued operations	—	—	(0.2)
Net income attributable to noncontrolling interests	(0.4)	(0.7)	(0.3)
Net income (loss) attributable to Amedisys, Inc.	$ 37.3	$ (3.0)	$ 12.8

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Our 2016 operating results include the results of Infinity HomeCare ("Infinity"), Associated Home Care and Professional Profiles beginning on the date of their acquisition. These three acquisitions accounted for $85 million of our $157 million increase in revenue and $35 million of our $56 million increase in other operating expenses. Our operating results were also impacted by an increase of approximately $21 million in costs associated with our move to HCHB. Approximately $8 million relates to implementation services provided by a third party while $4 million is the result of a non-cash charge to write off assets (primarily laptops) not compatible with our new platform. The remaining $9 million is related to disruption in care center operations as well as additional corporate resources to support multiple systems. In addition to the $21 million related to HCHB, we experienced an increase of $5 million in bad debt and contractual reserves due to increased write-offs and accounts receivable aging due to the HCHB disruption. While we anticipated these costs to continue as we completed the roll-out, our care centers generally return to normal operating results approximately 60 to 90 days after implementation; we completed the HCHB roll-out during the three-month period ended December 31, 2016. Additionally, our results were impacted by approximately $12 million as a result of the 2016 CMS rate cut.

Total other income (expense), net decreased $1 million in 2016 from 2015 after considering the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2016	2015
Legal settlements	$ 2.3	$ 7.4
Equity in earnings from equity method investment	3.5	6.7
Interest expense related to tax audit reserve	(0.6)	—
Life insurance proceeds	—	1.0
Debt refinance costs	—	(3.2)
Interest expense related to long-term obligations	(4.5)	(7.6)
Gain (loss) on disposal of property and equipment or sale of care centers	—	0.2
	$ 0.7	$ 4.5

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

Our 2015 results were impacted by a $75 million non-cash charge to write off the software costs incurred related to the development of AMS3 Home Health and Hospice and a $2 million non-cash charge to reduce the carrying value of our corporate headquarters.

During the first quarter of 2014, we committed to a plan to consolidate 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and close 23 home health care centers and six hospice care centers. As a result of this exit activity, we reduced our regional leadership structure and corporate support functions. Separate from the restructuring costs, we also recorded severance costs associated with the departure of our former Chief Executive Officer and a charge for relator fees associated with our U.S. Department of Justice settlement during the first quarter of 2014. Additionally, we recorded a non-cash other intangibles impairment charge during the fourth quarter of 2014. The following details the costs associated with these activities (amounts in millions):

	For the Year Ended December 31, 2014			
	Home Health	Hospice	Corporate	Total
Severance (a)	$ 2.0	$ 0.1	$—	$ 2.1
Restructuring severance	2.1	0.6	3.0	5.7
Lease terminations	1.9	0.2	—	2.1
Other intangibles impairment	1.6	1.5	—	3.1
Exit and restructuring activities cost	7.6	2.4	3.0	13.0
U.S. Department of Justice Settlement/Relator Fees	—	—	3.9	3.9
Total	$ 7.6	$ 2.4	$ 6.9	$16.9

(a) Includes $0.8 million and $0.1 million for severance included in cost of service for home health and hospice, respectively.

Our operating results were impacted by the sale, closure and consolidation of numerous care centers as mentioned above. Accordingly, our results for the year ended December 31, 2015 were not fully comparable to the year ended December 31, 2014.

Our operating income, excluding the $77 million asset impairment charges in 2015 and the $17 million in costs incurred in 2014 noted above, increased $27 million as our home health operating income increased $29 million, our hospice operating income increased $13 million and our corporate operating expense increased $15 million.

The primary drivers of our improvement in performance were the closure/consolidation of care centers that had a negative operating contribution, an increase in our revenue per episode, an increase in non-Medicare revenue, growth in hospice census and a reduction in operating expenses. The increase in corporate operating expenses was primarily due to the $6 million Wage and Hour Litigation settlement accrual and HCHB maintenance and hosting and implementation costs of $8 million. The increase in HCHB maintenance and hosting was offset by a $4 million decrease in depreciation and amortization as we moved from our proprietary software to HCHB.

Total other income (expense), net decreased $1 million in 2015 from 2014 after considering the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2015	2014
Legal settlements	$ 7.4	$ 1.1
Equity in earnings from equity method investment	6.7	—
Life insurance proceeds	1.0	—
Debt refinance costs	(3.2)	(0.5)
Gain (loss) on disposal of property and equipment or sale of care centers	0.2	0.7
	$12.1	$ 1.3

The difference in income tax expense in 2015 and 2014 was driven primarily by the decrease in income before income taxes. Additionally, the effective tax rate for the year ended December 31, 2015 does not provide a meaningful comparison to other periods. The effective tax rate for the year was influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to (loss) income before income taxes. A significant asset impairment was recorded during the three-month period ended March 31, 2015, resulting in a scenario where the company's (loss) income before income taxes for 2015 was near zero. Consequently, for 2015, the relationship between the "effective tax rate drivers" and (loss) income before income taxes was distorted.

Home Health Division

The following table summarizes our home health segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions)*:			
Medicare	$ 822.4	$ 761.4	$ 751.5
Non-Medicare	263.1	243.7	205.4
Net service revenue	1,085.5	1,005.1	956.9
Cost of service	643.7	584.2	559.4
Gross margin	441.8	420.9	397.5
Other operating expenses	303.2	280.6	294.4
Operating income	$ 138.6	$ 140.3	$ 103.1
Key Statistical Data:			
Medicare:			
Same Store (1):			
Revenue	2%	3%	1%
Admissions	3%	3%	0%
Recertifications	0%	(1%)	1%
Total (2):			
Admissions	194,662	178,226	177,243
Recertifications	103,193	99,762	102,263
Completed episodes	289,862	269,227	272,864
Visits	5,124,002	4,797,734	4,794,609
Average revenue per completed episode (3)	$ 2,839	$ 2,825	$ 2,768
Visits per completed episode (4)	17.5	17.5	17.3
Non-Medicare:			
Same Store (1):			
Revenue	8%	21%	19%
Admissions	2%	18%	17%
Recertifications	8%	14%	13%
Total (2):			
Admissions	98,448	96,934	83,940
Recertifications	38,618	35,870	32,074
Visits	2,050,975	1,954,543	1,651,745
Total (2):			
Visiting Clinician Cost per Visit	$ 81.18	$ 78.23	$ 78.47
Clinical Manager Cost per Visit	$ 8.53	$ 8.29	$ 8.30
Total Cost per Visit	$ 89.71	$ 86.52	$ 86.77
Visits	7,174,977	6,752,277	6,446,354

(1) Same store information represents 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; based on continuing operations for all periods presented.

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

(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.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Overall, our operating income decreased $2 million on a $21 million increase in gross margin offset by a $23 million increase in other operating expenses. These results are inclusive of Infinity which accounted for $49 million of our total revenue increase and $18 million of other operating expenses. Our results have been negatively impacted by approximately $12 million related to the CMS rate cut which became effective January 1, 2016 and approximately $6 million as the result of disruptions associated with the roll-out of HCHB.

Net Service Revenue

Our Medicare revenue increased $61 million which is inclusive of $48 million from acquired care centers. The increase in same store revenue is due to higher admission volumes. Our revenue per episode was relatively flat despite the impact of the CMS rate cut in 2016; the increase was due to an increase in patient acuity.

Our non-Medicare revenue increased approximately $19 million, with revenues from episodic payors increasing 16% while our revenue from per visit payors grew 5%. 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 $59 million primarily as a result of a 6% increase in visits and a 4% increase in cost per visit. The increase in cost per visit is primarily due to higher health insurance expense, planned wage increases and additional costs related to our HCHB roll-out. We believe that the impact of the HCHB roll-out is temporary and will normalize now that the roll-out is complete.

Other Operating Expenses

Other operating expenses increased $23 million due to increases in other care center related expenses, primarily salaries and benefits, travel and training expense and HCHB maintenance and hosting fees. Other operating expense related to care centers acquired from Infinity were approximately $18 million. We have completed the consolidation of our legacy Florida operations with Infinity and the conversion of Infinity to our back office platform.

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

Overall, our operating income excluding the $8 million in exit activity costs in 2014, increased $29 million on a $22 million increase in gross margin and a $7 million decline in other operating expenses. 2014 results included revenue of $16 million and operating losses of $5 million for those care centers that were closed, consolidated or sold.

Net Service Revenue

Our Medicare revenue increase of approximately $10 million consisted of a $16 million increase due to higher revenue per episode offset by $6 million due to lower volumes. The decrease in volumes is primarily due to the sale, closure and consolidation of 51 care centers since December 31, 2013, as we experienced a 3% increase in same store admissions in 2015. Net service revenue included a reduction of $1 million for the estimated impact of the 2016 rate change.

Our non-Medicare revenue increased $38 million as we have focused on contracted payors with significant concentrations in our markets and those that add incremental margin to our operations.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our 2015 results were not fully comparable to the prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,	
	2015	2014
Revenue *(in millions)*:		
Operating care centers	$1,005.1	$941.2
Closed/Consolidated/Sold care centers	—	15.7
Net service revenue	1,005.1	956.9

Cost of Service, Excluding Depreciation and Amortization

Our cost of service, excluding the $1 million in exit activity costs in 2014, increased $26 million primarily as a result of a 5% increase in visits. Our cost per visit remained relatively flat.

Other Operating Expenses

Other operating expenses, excluding the $7 million in exit activity costs in 2014, decreased $7 million due to decreases in other care center related expenses as a result of our closure and consolidation strategy and the reduction in divisional leadership; the majority of the reductions were in salaries and benefits and rent expense, offset by a $5 million increase in legal expense related to the self-disclosure matter. In addition, our provision for doubtful accounts decreased $3 million and our depreciation and amortization expense decreased $4 million compared to 2014.

Hospice Division

The following table summarizes our hospice segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information ***(in millions):***			
Medicare	$ 297.7	$ 258.5	$ 232.6
Non-Medicare	18.3	16.9	15.0
Net service revenue	316.0	275.4	247.6
Cost of service	163.1	141.7	131.7
Gross margin	152.9	133.7	115.9
Other operating expenses	77.0	66.0	63.4
Operating income	$ 75.9	$ 67.7	$ 52.5
Key Statistical Data:			
Same Store (1):			
Medicare revenue	15%	13%	(2%)
Non-Medicare revenue	9%	18%	6%
Hospice admissions	17%	16%	(3%)
Average daily census	16%	12%	(4%)
Total (2):			
Hospice admissions	22,526	19,205	17,081
Average daily census	5,912	5,105	4,632
Revenue per day, net	$146.05	$147.78	$146.51
Cost of service per day	$ 75.36	$ 76.06	$ 77.93
Average discharge length of stay	96	92	100

(1) Same store information presented 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; based on continuing operations for all periods presented.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Overall, our operating income increased $8 million on a $19 million increase in gross margin offset by an $11 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased approximately $41 million due to an increase in our average daily census as a result of a 17% increase in hospice admissions. We benefited from a 1.1% hospice rate increase effective October 1, 2015. Beginning January 1, 2016, CMS 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 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.

Our revenue per day was impacted by an increase in contractual reserves and write-offs which occurred during the HCHB roll-out. We expect to return to normal levels during 2017.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $21 million as the result of a 16% increase in average daily census.

Other Operating Expenses

Other operating expenses increased $11 million due to increases in other care center related expenses, primarily salaries and benefits and HCHB maintenance and hosting fees. 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 approximately $4 million, which is reflective of an increase in our accounts receivable aging. We do expect to return to normal days revenue outstanding, net now that we are on one operating platform.

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

Overall, our operating income, excluding the $2 million in exit activity costs in 2014, increased $13 million on an $18 million increase in gross margin offset by a $5 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $28 million, primarily as the result of an increase in our average daily census as a result of a 16% increase in hospice admissions. We benefitted from a 1.4% hospice rate increase effective October 1, 2014.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our 2015 results were not fully comparable to the prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,	
	2015	2014
Revenue *(in millions)*:		
Operating care centers	$275.4	$243.4
Closed/Consolidated/Sold care centers	—	4.2
Net service revenue	275.4	247.6

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $10 million as the result of a 10% increase in average daily census offset by a decrease in cost of service per day. We experienced significant improvement in pharmacy and DME cost per day during 2015.

Other Operating Expenses

Other operating expenses, excluding the $2 million in exit activity costs in 2014, increased $5 million due to increases in other care center related expenses, primarily salaries and benefits expense and travel costs.

Personal Care Division

The following table summarizes our personal care segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions)*:			
Medicare	$ —	$—	—
Non-Medicare	35.9	—	—
Net service revenue	35.9	—	—
Cost of service	26.3	—	—
Gross margin	9.6	—	—
Other operating expenses	8.1	—	—
Operating income	$ 1.5	$—	$—
Key Statistical Data:			
Billable hours	1,539,093	—	—
Clients served	51,520	—	—

Year Ended December 31, 2016

On March 1, 2016, we acquired Associated Home Care, a personal care home health care company with 9 care centers. On September 1, 2016, we acquired the assets of Professional Profiles, Inc. which owned and operated 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 division for 2016 was approximately $2 million on net service revenue of $36 million and cost of service of $26 million; other operating expenses were approximately $8 million.

Corporate

The following table summarizes our corporate results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions)*:			
Other operating expenses	$141.9	$126.5	$114.4
Depreciation and amortization	12.4	13.4	17.2
Total operating expenses before asset impairment charge	$154.3	$139.9	$131.6
Asset impairment charge	4.4	77.3	—
Total operating expenses	$158.7	$217.2	$131.6

Corporate expenses consist of costs relating to our 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.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Corporate other operating expenses have increased approximately $14 million which is inclusive of approximately $12 million in corporate support expenses related to acquisitions, a $3 million increase in non-cash compensation and a $4 million increase related to HCHB implementation costs offset by decreases of approximately $5 million in various other costs (including a $2 million decrease in legal settlement expenses).

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

Excluding the $77 million asset impairment charge in 2015 and the $7 million in exit and restructuring activities costs and relator fees associated with our U.S. Department of Justice settlement agreement during 2014, corporate other operating expenses increased $15 million which is inclusive of the $6 million Wage and Hour Litigation settlement accrual, $4 million in HCHB maintenance and hosting costs, $4 million related to HCHB implementation and $2 million in severance costs.

Liquidity and Capital Resources

Cash Flows

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

	For the Years Ended December 31,		
	2016	2015	2014
Cash provided by (used in) operating activities	$ 62.2	$107.8	$(65.5)
Cash used in investing activities	(52.0)	(67.4)	(14.3)
Cash (used in) provided by financing activities	(7.5)	(20.9)	70.5
Net increase (decrease) in cash and cash equivalents	2.7	19.5	(9.3)
Cash and cash equivalents at beginning of period	27.5	8.0	17.3
Cash and cash equivalents at end of period	$ 30.2	$ 27.5	$ 8.0

Cash provided by operating activities decreased $45.6 million during 2016 compared to 2015 primarily due to a decrease in our cash collections relative to growth in accounts receivable as our days revenue outstanding, net increased eight days (approximately $41 million) from December 31, 2015. For additional information regarding our operating performance, see "Results of Operations". Cash provided by operating activities increased $173.3 million during 2015 compared to 2014 primarily due to an increase in our operating performance as compared to 2014 and the payment of the $150.0 million in 2014 under our settlement agreement with the U.S. Department of Justice. The recognition of the asset impairment charge of $77.3 million, which resulted in the net loss for 2015 was a non-cash item and therefore had no impact on our cash flow from operations.

Cash used in investing activities decreased $15.4 million during 2016 compared to 2015 primarily due to decreases in cash paid for acquisitions ($33.6 million), capital expenditures ($5.7 million) and investments ($2.4 million), offset by decreases in proceeds from the sale of property and equipment related to the sale of our former corporate headquarters and in proceeds from the sale of investments. Cash used in investing activities increased $53.1 million during 2015 compared to 2014 primarily due to our acquisition activity ($69.1 million) and an increase in capital expenditures ($9.4 million), offset by proceeds from the sale of property and equipment ($20.0 million) and investments ($5.0 million).

Cash used in financing activities decreased $13.4 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. Cash used in financing activities increased $91.4 million during 2015 compared to 2014 primarily due to an increase in our borrowings under our long-term obligations partially offset by principal payments.

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 2016, we spent $6.8 million in routine capital expenditures compared to $9.3 million and $7.0 million during 2015 and 2014, respectively. Routine capital expenditures primarily include equipment and computer software and hardware. In addition, we spent $8.9 million in non-routine capital expenditures related to leasehold improvements and IT infrastructure upgrades compared to $12.1 million and $5.0 million during 2015 and 2014, respectively, related to enhancements to our point of care software. Our capital expenditures for 2017 are expected to be approximately $10.0 million – $12.0 million.

During 2014, we paid the U.S. government $152.3 million representing the $150 million settlement plus interest thereon due under the settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral Matter.

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million. The net proceeds of the term loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement dated as of October 22, 2012, as amended with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014, with a principal balance of $70 million.

As of December 31, 2016, we had $30.2 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 patient accounts receivable, net increased $41.0 million from December 31, 2015 to December 31, 2016. Our cash collection as a percentage of revenue was 99% and 100% for December 31, 2016 and 2015, respectively. Our days revenue outstanding, net at December 31, 2016 was 40.2 days which is an increase of 8.3 days from December 31, 2015. 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 now that we have completed our HCHB implementation and are completely off our legacy system. Our days revenue outstanding, net at December 31, 2015 does not include Infinity HomeCare, which was acquired on December 31, 2015.

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 and varies by state for Medicaid-reimbursable services and 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 Years Ended December 31,	
	2016	2015
Provision for estimated revenue adjustments	$ 7.9	$ 6.1
Provision for doubtful accounts	19.5	14.1
Total	$27.4	$20.2
As a percent of revenue	1.9%	1.6%

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 December 31, 2016:					
Medicare patient accounts receivable, net (1)	$82.7	$17.1	$ 1.4	$—	$101.2
Other patient accounts receivable:					
Medicaid	13.6	3.6	3.6	0.2	21.0
Private	39.8	10.4	7.6	3.8	61.6
Total	$53.4	$14.0	$11.2	$ 4.0	$ 82.6
Allowance for doubtful accounts (2)					(17.7)
Non-Medicare patient accounts receivable, net					$ 64.9
Total patient accounts receivable, net					$166.1
Days revenue outstanding, net (3)					40.2

	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 Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 4.0	$ 3.1
Provision for estimated revenue adjustments	7.9	6.1
Write offs	(7.8)	(5.2)
Balance at end of period	$ 4.1	$ 4.0

Our estimated revenue adjustments were 3.9% and 4.8% of our outstanding Medicare patient accounts receivable at December 31, 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 Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 16.5	$ 14.3
Provision for doubtful accounts	19.5	14.1
Write offs	(18.3)	(11.9)
Balance at end of period	$ 17.7	$ 16.5

Our allowance for doubtful accounts was 21.5% and 26.9% of our outstanding Medicaid and private patient accounts receivable at December 31, 2016 and 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 December 31, 2016 and 2015 by our average daily net patient revenue for the three-month periods ended December 31, 2016 and 2015, respectively.

Indebtedness

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million.

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the "Term Loan"); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the "Revolving Credit Facility"). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our Prior Credit Agreement, dated as of October 22, 2012, as amended (the "Prior Credit Agreement") with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the "Second Lien Credit Agreement"), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan began amortizing on March 31, 2016 and will continue amortizing over 14 quarterly installments (four remaining quarterly installments of

$1.25 million followed by eight quarterly installments of $2.5 million beginning March 31, 2018, followed by two quarterly installments of $3.1 million beginning March 31, 2020, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and its subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2016, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.5% for 2016 and 2.7% for the period August 28, 2015 to December 31, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 3.5% for 2016.

As of December 31, 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.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2016, our consolidated leverage ratio was 1.0 and our consolidated fixed charge coverage ratio was 3.8 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guaranties from wholly-owned subsidiaries that in the aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as

of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with the entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet during 2015 which was reclassified to long-term obligations, less current portion during 2016 in accordance with Accounting Standards Update 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs.*

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.

Under the terms of the program, we may 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 may enter into Rule 10b5-1 plans to effect some or all of the repurchases. The timing and the amount of the repurchases, if any, was 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.

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 during 2016 and 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million during 2015. The repurchased shares are classified as treasury shares. The stock repurchase program expired on September 6, 2016.

Contractual Obligations and Medicare Liabilities

Our future contractual obligations and Medicare liabilities at December 31, 2016 were as follows (amounts in millions):

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	4-5 Years	After 5 Years
Long-term obligations	$ 95.7	$ 5.2	$20.5	$70.0	$—
Interest on long-term obligations (1)	8.3	2.6	4.5	1.2	—
Operating leases	72.0	23.5	30.5	13.4	4.6
Capital commitments	1.2	1.2	—	—	—
Purchase obligations	47.3	14.0	24.8	8.5	—
Uncertain tax positions	4.1	0.3	3.8	—	—
	$228.6	$46.8	$84.1	$93.1	$ 4.6

(1) Interest on debt with variable rates was calculated using the current rate of that particular debt instrument at December 31, 2016.

Critical Accounting Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements, which have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP"). The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses and related disclosures of contingent assets and liabilities. On an ongoing basis, we evaluate our estimates, including those related to revenue recognition, collectability of accounts receivable, reserves related to insurance and litigation, goodwill, intangible assets, income taxes and contingencies. We base these estimates on our historical experience and various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results experienced may vary materially and adversely from our estimates. To the extent there are material differences between our estimates and the actual results, our future results of operations may be affected.

We believe the following critical accounting policies represent our most significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenue Recognition

We earn net service revenue through our home health, hospice and personal-care 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. We make adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, and 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. In addition, management evaluates the potential for revenue adjustments and, when appropriate, provides allowances based upon the best available information.

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 the number of days elapsed during an episode of care.

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 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. We make adjustments to Medicare revenue for our discovered inability to obtain appropriate billing documentation or 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 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 December 31, 2016, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $0.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016. As of December 31, 2015, we had recorded $1.4 million 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 visit 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 – Allowance for Doubtful Accounts

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. 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 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.

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. 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.

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 in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported, up to specified deductible limits. These costs have generally been estimated based upon independent third-party actuarial calculations which consider historical claims data. Such estimates, and the resulting reserves, are reviewed and updated by us on a quarterly basis.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the

excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

Each of our operating segments described in the notes to our financial statements is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice and personal-care care centers and have also deemed them to be a single reporting unit.

During 2016, we did not record any goodwill impairment charges and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names and non-compete agreements. We amortize non-compete agreements and acquired names that we do not intend to use in the future on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for acquired names.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2016 and 2015 our net deferred tax assets were $107.9 million and $125.2 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax

jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

ITEM 7A. 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) or the Prime Rate and therefore, our consolidated statements of operations and our consolidated statements of cash flows are exposed to changes in interest rates. As of December 31, 2016, the total amount of outstanding debt subject to interest rate fluctuations was $95.0 million. A 1.0% interest rate change would cause interest expense to change by approximately $0.9 million annually.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited the accompanying consolidated balance sheets of Amedisys, Inc. and subsidiaries (the Company) as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Amedisys, Inc. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 1, 2017, expressed an unqualified opinion on the effectiveness of Amedisys, Inc.'s internal control over financial reporting.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 1, 2017

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

	As of December 31,	
	2016	2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 30,197	$ 27,502
Patient accounts receivable, net of allowance for doubtful accounts of $17,716, and $16,526	166,056	125,010
Prepaid expenses	7,397	8,110
Other current assets	11,260	14,641
Total current assets	214,910	175,263
Property and equipment, net of accumulated depreciation of $138,650 and $141,793	36,999	42,695
Goodwill	288,957	261,663
Intangible assets, net of accumulated amortization of $27,864 and $25,386	46,755	44,047
Deferred income taxes	107,940	125,245
Other assets, net	38,468	32,802
Total assets	$734,029	$681,715
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 30,358	$ 25,682
Payroll and employee benefits	82,480	72,546
Accrued expenses	63,290	71,965
Current portion of long-term obligations	5,220	5,000
Total current liabilities	181,348	175,193
Long-term obligations, less current portion	87,809	91,630
Other long-term obligations	3,730	4,456
Total liabilities	272,887	271,279
Commitments and Contingencies – Note 10		
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; 35,253,577, and 34,786,966 shares issued; and 33,597,215 and 33,607,282 shares outstanding	35	35
Additional paid-in capital	537,472	504,290
Treasury stock at cost 1,656,362, and 1,179,684 shares of common stock	(46,774)	(26,966)
Accumulated other comprehensive income	15	15
Retained earnings	(30,545)	(67,806)
Total Amedisys, Inc. stockholders' equity	460,203	409,568
Noncontrolling interests	939	868
Total equity	461,142	410,436
Total liabilities and equity	$734,029	$681,715

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

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

	For the Years Ended December 31,		
	2016	2015	2014
Net service revenue	$1,437,454	$1,280,541	$1,204,554
Cost of service, excluding depreciation and amortization	833,055	725,915	691,061
General and administrative expenses:			
Salaries and benefits	306,981	279,425	292,497
Non-cash compensation	16,401	11,824	5,597
Other	180,048	161,186	143,644
Provision for doubtful accounts	19,519	14,053	16,294
Depreciation and amortization	19,678	20,036	28,307
Asset impairment charge	4,432	77,268	3,107
Operating expenses	1,380,114	1,289,707	1,180,507
Operating income (loss)	57,340	(9,166)	24,047
Other income (expense):			
Interest income	75	71	94
Interest expense	(5,164)	(10,783)	(8,217)
Equity in earnings from equity method investments	5,588	9,823	2,991
Miscellaneous, net	3,727	9,747	2,061
Total other income (expense), net	4,226	8,858	(3,071)
Income (loss) before income taxes	61,566	(308)	20,976
Income tax expense	(23,935)	(2,004)	(7,671)
Income (loss) from continuing operations	37,631	(2,312)	13,305
Discontinued operations, net of tax	—	—	(216)
Net income (loss)	37,631	(2,312)	13,089
Net income attributable to noncontrolling interests	(370)	(709)	(313)
Net income (loss) attributable to Amedisys, Inc.	$ 37,261	$ (3,021)	$ 12,776
Basic earnings per common share:			
Income (loss) from continuing operations attributable to Amedisys, Inc. common stockholders	$ 1.12	$ (0.09)	$ 0.40
Discontinued operations, net of tax	—	—	(0.01)
Income (loss) attributable to Amedisys, Inc. common stockholders	$ 1.12	$ (0.09)	$ 0.39
Weighted average shares outstanding	33,198	33,018	32,301
Diluted earnings per common share:			
Income (loss) from continuing operations attributable to Amedisys, Inc. common stockholders	$ 1.10	$ (0.09)	$ 0.40
Discontinued operations, net of tax	—	—	(0.01)
Income (loss) attributable to Amedisys, Inc. common stockholders	$ 1.10	$ (0.09)	$ 0.39
Weighted average shares outstanding	33,741	33,018	32,823
Amounts attributable to Amedisys, Inc. common stockholders:			
Income (loss) from continuing operations	$ 37,261	$ (3,021)	$ 12,992
Discontinued operations, net of tax	—	—	(216)
Net income (loss)	$ 37,261	$ (3,021)	$ 12,776

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(Amounts in thousands)

	For the Years Ended December 31,		
	2016	2015	2014
Net income (loss)	$37,631	$(2,312)	$13,089
Other comprehensive income (loss)	—	—	—
Comprehensive income (loss)	37,631	(2,312)	13,089
Comprehensive income attributable to non-controlling interests	(370)	(709)	(313)
Comprehensive income (loss) attributable to Amedisys, Inc.	$37,261	$(3,021)	$12,776

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands, except common stock shares)

	Total	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock	Accumulated Other Comprehensive Loss (Income)	Retained Earnings	Noncontrolling Interests
Balance, December 31, 2013	$372,479	33,413,970	33	467,890	(18,176)	15	(77,561)	278
Issuance of stock – employee stock purchase plan	2,433	176,796	—	2,433	—	—	—	—
Issuance of stock – 401(k) plan	7,062	430,919	1	7,061	—	—	—	—
Exercise of stock options	564	28,229	—	564	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	519,612	1	(1)	—	—	—	—
Non-cash compensation	5,597	—	—	5,597	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(579)	—	—	(579)	—	—	—	—
Surrendered shares	(1,684)	—	—	—	(1,684)	—	—	—
Sale of noncontrolling interest	(1,549)	—	—	(493)	—	—	—	(1,056)
Decrease in noncontrolling interest	350	—	—	(710)	—	—	—	1,060
Net income	13,089	—	—	—	—	—	12,776	313
Balance, December 31, 2014	397,762	34,569,526	35	481,762	(19,860)	15	(64,785)	595
Issuance of stock – employee stock purchase plan	2,204	79,323	—	2,204	—	—	—	—
Issuance of stock – 401(k) plan	6,032	184,412	—	6,032	—	—	—	—
Exercise of stock options	399	15,380	—	399	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	(61,675)	—	—	—	—	—	—
Non-cash compensation	11,824	—	—	11,824	—	—	—	—
Tax benefit from stock options exercised and restricted stock vesting	2,073	—	—	2,073	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(4)	—	—	(4)	—	—	—	—
Surrendered shares	(2,525)	—	—	—	(2,525)	—	—	—
Shares repurchased	(4,581)	—	—	—	(4,581)	—	—	—
Noncontrolling interest distribution	(436)	—	—	—	—	—	—	(436)
Net loss	(2,312)	—	—	—	—	—	(3,021)	709
Balance, December 31, 2015	410,436	34,786,966	35	504,290	(26,966)	15	(67,806)	868
Issuance of stock – employee stock purchase plan	2,483	63,688	—	2,483	—	—	—	—
Issuance of stock – 401(k) plan	6,682	145,660	—	6,682	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	257,263	—	—	—	—	—	—
Non-cash compensation	16,401	—	—	16,401	—	—	—	—
Tax benefit from stock options exercised and restricted stock vesting	7,241	—	—	7,241	—	—	—	—
Surrendered shares	(7,493)	—	—	—	(7,493)	—	—	—
Shares repurchased	(12,315)	—	—	—	(12,315)	—	—	—
Noncontrolling interest distribution	(329)	—	—	—	—	—	—	(329)
Assets contributed to equity investment	405	—	—	375	—	—	—	30
Net income	37,631	—	—	—	—	—	37,261	370
Balance, December 31, 2016	$461,142	35,253,577	$ 35	$537,472	$(46,774)	$ 15	$(30,545)	$ 939

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

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

	For the Years Ended December 31,		
	2016	2015	2014
Cash Flows from Operating Activities:			
Net income (loss)	$ 37,631	$ (2,312)	$ 13,089
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Depreciation and amortization	19,678	20,036	28,347
Provision for doubtful accounts	19,519	14,053	16,369
Non-cash compensation	16,401	11,824	5,597
401(k) employer match	6,875	6,089	6,216
Write-off of investment	196	—	—
Loss on disposal of property and equipment	582	775	4,592
Gain on sale of care centers	—	(184)	(2,967)
Deferred income taxes	24,547	(677)	22,561
Write off of deferred debt issuance costs/debt discount	—	2,512	488
Equity in earnings from equity method investments	(5,588)	(9,823)	(2,991)
Amortization of deferred debt issuance costs/debt discount	740	959	797
Return on equity investment	4,323	5,610	2,025
Asset impairment charge	4,432	77,268	3,107
Changes in operating assets and liabilities, net of impact of acquisitions:			
Patient accounts receivable	(55,519)	(36,493)	(5,290)
Other current assets	4,231	6,455	(6,269)
Other assets	(11,415)	(3,523)	1,694
Accounts payable	3,970	7,639	(3,168)
U.S. Department of Justice settlement	—	—	(150,000)
Accrued expenses	(7,618)	8,406	3,495
Other long-term obligations	(726)	(829)	(3,226)
Net cash provided by (used in) operating activities	62,259	107,785	(65,534)
Cash Flows from Investing Activities:			
Proceeds from sale of deferred compensation plan assets	230	1,229	11
Proceeds from the sale of property and equipment	—	20,000	3
Purchases of deferred compensation plan assets	—	(19)	(132)
Purchases of property and equipment	(15,717)	(21,429)	(12,008)
Purchase of investments	(1,040)	(3,485)	(6,407)
Proceeds from sale of investment	—	5,000	—
Acquisitions of businesses, net of cash acquired	(35,522)	(69,130)	—
Proceeds from disposition of care centers	—	413	4,233
Net cash used in investing activities	(52,049)	(67,421)	(14,300)
Cash Flows from Financing Activities:			
Proceeds from issuance of stock upon exercise of stock options and warrants	—	399	564
Proceeds from issuance of stock to employee stock purchase plan	2,483	2,204	2,433
Tax benefit from stock options exercised and restricted stock vesting	7,241	2,073	—
Non-controlling interest distribution	(329)	(436)	—
Proceeds from revolving line of credit	134,500	63,400	241,800
Repayments of revolving line of credit	(134,500)	(78,400)	(226,800)
Proceeds from issuance of long-term obligations	—	100,000	68,250
Principal payments of long-term obligations	(5,000)	(103,000)	(13,904)
Debt issuance costs	—	(2,553)	(1,780)
Purchase of company stock	(12,315)	(4,581)	—
Assets contributed to equity investment	405	—	—
Net cash (used in) provided by financing activities	(7,515)	(20,894)	70,563
Net increase (decrease) in cash and cash equivalents	2,695	19,470	(9,271)
Cash and cash equivalents at beginning of period	27,502	8,032	17,303
Cash and cash equivalents at end of period	$ 30,197	$ 27,502	$ 8,032
Supplemental Disclosures of Cash Flow Information:			
Cash paid for interest	$ 2,897	$ 6,175	$ 7,602
Cash paid for income taxes, net of refunds received	$ 755	$ (12,185)	$ (1,766)
Supplemental Disclosures of Non-Cash Financing and Investing Activities:			
(Sale) acquisition of non-controlling interests	$ —	$ —	$ (1,549)

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

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016

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, hospice and personal care services with approximately 78%, 80% and 82% of our revenue derived from Medicare for 2016, 2015 and 2014, respectively. As of December 31, 2016, we owned and operated 327 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.

Use of Estimates

Our accounting and reporting policies conform with U.S. Generally Accepted Accounting Principles ("U.S. GAAP"). In preparing the consolidated financial statements, we are required to make estimates and assumptions that impact the amounts reported in the 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 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 consolidated financial statements, and business combinations accounted for as purchases have been included in our 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 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 $27.8 million as of December 31, 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.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue Recognition

We earn net service revenue through our home health, hospice and personal-care 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 the number of days elapsed during an episodes of care. As of December 31, 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 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 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%, 99%, and 98% of our total net Medicare hospice service revenue for 2016, 2015 and 2014, respectively. 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.

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 December 31, 2016, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $0.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years

ended October 31, 2013 through October 31, 2016. As of December 31, 2015, we had recorded $1.4 million 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.

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit and all highly liquid debt instruments with maturities of three months or less when purchased.

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 December 31, 2016, there is one single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables (approximately 10.1%). 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 61% and 64% of our net patient accounts receivable at December 31, 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 2016, 2015 and 2014, we recorded $7.9 million, $6.1 million and $5.1 million, respectively, in estimated revenue adjustments to Medicare revenue.

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 resubmitted.

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.

We consider our reporting units to represent asset groups for purposes of testing long-lived assets for impairment. We assess the impairment of a long-lived asset group whenever events or changes in circumstances indicate that the asset's carrying value may not be recoverable. Factors we consider important that could trigger an impairment review include but are not limited to the following:

- A significant change in the extent or manner in which the long-lived asset group is being used.

- A significant change in the business climate that could affect the value of the long-lived asset group.
- A significant change in the market value of the assets included in the asset group.

If we determine that the carrying value of long-lived assets may not be recoverable, we compare the carrying value of the asset group to the undiscounted cash flows expected to be generated by the asset group. If the carrying value exceeds the undiscounted cash flows, an impairment charge is indicated. An impairment charge is recognized to the extent that the carrying value of the asset group exceeds its fair value.

We generally provide for depreciation over the following estimated useful service lives.

	Years
Building	39
Leasehold improvements	Lesser of life or lease or expected useful life
Equipment and furniture	3 to 7
Vehicles	5
Computer software	3 to 5

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 ("AMS3"). 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 million to write-off the software costs incurred related to the development of AMS3.

During 2015, we began the transition of all our care centers from our proprietary operating system to Homecare Homebase ("HCHB"), a leading home health and hospice platform, with all of our care centers operating on HCHB as of December 31, 2016. As part of our conversion process, we determined that a number of assets (primarily laptops) were not compatible with HCHB and had no other alternative or secondary use. As a result, we recorded a non-cash asset impairment charge of $4.4 million to write-off these assets during the three-month period ended December 31, 2016.

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; no further depreciation expense for the asset was recorded. 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 asset was sold during the three-month period ended December 31, 2015 and the Company now leases equivalent office space.

The following table summarizes the balances related to our property and equipment for 2016 and 2015 (amounts in millions):

	As of December 31,	
	2016	2015
Building and leasehold improvements	6.9	2.3
Equipment and furniture	71.9	89.6
Computer software	96.8	92.6
	175.6	184.5
Less: accumulated depreciation	(138.6)	(141.8)
	$ 37.0	$ 42.7

Depreciation expense for 2016, 2015 and 2014 was $17.2 million, $20.0 million and $28.0 million, respectively.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

Each of our operating segments described in Note 15 – Segment Information is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice care centers and personal-care care centers and have also deemed them to be a single reporting unit.

During 2016, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units was considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names and non-compete agreements. We amortize non-compete agreements and acquired names that we do not intend to use in the future on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for acquired names.

Debt Issuance Costs

We amortize deferred debt issuance costs related to our long-term obligations over its term through interest expense, unless the debt is extinguished, in which case unamortized balances are immediately expensed. We amortized $0.7 million, $0.8 million and $0.7 million in deferred debt issuance costs in 2016, 2015 and 2014, respectively. As of December 31, 2016 and 2015, we had unamortized debt issuance costs of $2.7 million and $3.4 million, respectively, recorded as long-term obligations, less current portion in our accompanying consolidated balance sheets. The unamortized debt issuance costs of $2.7 million at December 31, 2016, will be amortized over a weighted-average amortization period of 3.7 years.

Fair Value of Financial Instruments

The following details our financial instruments where the carrying value and the fair value differ (amounts in millions):

		Fair Value at Reporting Date Using		
Financial Instrument	As of December 31, 2016	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term obligations	$95.7	$ —	$97.8	$ —

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. For our other financial instruments, including our cash and cash equivalents, patient accounts receivable, accounts payable, payroll and employee benefits and accrued expenses, we estimate the carrying amounts' approximate fair value.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2016 and 2015 our net deferred tax assets were $107.9 million and $125.2 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

Share-Based Compensation

We record all share-based compensation as expense in the financial statements measured at the fair value of the award. We recognize compensation cost on a straight-line basis over the requisite service period for each separately vesting portion of the award. We reflect the excess tax benefits related to stock option exercises as financing cash flows. Share-based compensation expense for 2016, 2015 and 2014 was $16.4 million, $11.8 million and $5.6 million, respectively, and the total income tax benefit recognized for these expenses was $6.4 million, $4.7 million and $2.0 million, respectively.

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 Years Ended December 31,		
	2016	2015	2014
Weighted average number of shares outstanding – basic	33,198	33,018	32,301
Effect of dilutive securities:			
Stock options	162	—	1
Non-vested stock and stock units	381	—	521
Weighted average number of shares outstanding – diluted	33,741	33,018	32,823
Anti-dilutive securities	221	922	106

Advertising Costs

We expense advertising costs as incurred. Advertising expense for 2016, 2015 and 2014 was $7.8 million, $6.9 million and $4.7 million, respectively.

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 does not expect an impact on its consolidated financial statements upon implementation of ASU 2014-09 and ASU 2015-14 on January 1, 2018, but is still evaluating the effect the standard will have on its related disclosures.

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 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. While the Company expects adoption of this standard to lead to a material increase in the assets and liabilities recorded on our balance sheet, we are still evaluating the overall impact on our consolidated financial statements and related disclosures and the effect of the standard on our 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 element of the new standard that will have the most impact on our consolidated financial statements will be income tax consequences. Excess tax benefits and tax deficiencies on share-based compensation awards will now be included in our tax provision within our consolidated statement of operations as discrete items in the reporting period in which they occur, rather than our current accounting of recording in additional paid-in capital on our consolidated balance sheets.

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, hospice and personal care 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.

2016 Acquisitions

Personal Care Division

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). We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 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) in connection with the acquisition. We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 years.

Home Health Division

On October 20, 2016, we acquired the assets of a former nonprofit organization in New York for a purchase price of $4.6 million. During the three-month period ended December 31, 2016, we recorded goodwill ($4.4 million) and other intangibles – certificate of need ($0.2 million) in connection with the acquisition. We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 years.

The following table contains unaudited pro forma condensed consolidated statement of operations information assuming that our 2016 acquisitions closed on January 1, 2015, for the years ended December 31, 2016 and 2015 (amounts in millions, except per share data):

	2016	2015
Net service revenue	$1,449.7	$1,322.2
Operating income (loss)	53.9	(7.8)
Net income	35.0	0.4
Basic earnings (loss) per share	$ 1.04	$ (0.01)
Diluted earnings (loss) per share	$ 1.03	$ (0.01)

The pro forma information presented above includes adjustments for (i) amortization of identifiable intangible assets and (ii) income tax provision using the Company's statutory tax rate. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operations that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information.

2015 Acquisitions

Hospice Division

On July 24, 2015, we acquired one hospice care center in Tennessee for a total purchase price of $5.8 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($5.5 million) and other intangibles ($0.3 million).

Home Health Division

On October 2, 2015, we acquired the assets of a home health care center in Georgia for a total purchase price of $0.3 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($0.3 million).

On December 31, 2015, we acquired Infinity HomeCare ("Infinity") for a total purchase price of $63 million, net of cash acquired (subject to certain adjustments), of which $3.2 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. Infinity owned and operated 15 home health care centers servicing the state of Florida. In connection with the acquisition, we recorded goodwill ($50.2 million), other intangibles ($10.9 million) and other assets and liabilities, net ($1.9 million). Approximately $47.6 million of the $50.2 recorded as goodwill is expected to be deductible for income tax purposes over approximately 15 years.

4. DISCONTINUED OPERATIONS AND ASSETS HELD FOR SALE

As of December 31, 2013, we had three care centers classified as held for sale. During 2014, we sold assets associated with two of these care centers and consolidated one of these care centers with a care center servicing the same market. There were no care centers classified as held for sale as of December 31, 2014.

As we exited certain geographical areas and in accordance with applicable accounting guidance, the care centers which were classified as held for sale as of December 31, 2013 and subsequently sold in 2014 are presented as discontinued operations in our consolidated financial statements. The care center consolidated with a care center servicing the same markets is presented in continuing operations as we expect continuing cash flows from these markets. For additional information on the care centers consolidated with care centers servicing the same markets and the care centers sold, see Note 13 – Exit Activities and Restructuring Activities.

Operating results for the twelve-month period ended December 31, 2014 for those care centers classified as discontinued operations are as follows: loss before income taxes of $0.3 million, income tax benefit of $0.1 million and net loss from discontinued operations of $0.2 million.

5. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

During 2016, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

During the fiscal year 2015, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units were considered at risk of impairment.

During the fiscal year 2014, we recognized a non-cash other intangible impairment charge of $0.9 million during step one of our 2014 annual goodwill impairment test. In addition, we recorded non-cash impairment charges of $2.2 million related to those care centers that were closed or consolidated during 2014 as discussed in Note 13 – Exit and Restructuring Activities.

The following table summarizes the activity related to our goodwill for 2016, 2015 and 2014 (amounts in millions):

	Goodwill			
	Home Health	Hospice	Personal Care	Total
Balances at December 31, 2013	$16.6	$192.3	$ —	$208.9
Write-off (1)	(0.1)	(3.2)	—	(3.3)
Balances at December 31, 2014	16.5	189.1	—	205.6
Additions	50.6	5.5	—	56.1
Balances at December 31, 2015	67.1	194.6	—	261.7
Additions	4.4	—	22.7	27.1
Adjustments related to acquisitions	0.1	—	—	0.1
Balances at December 31, 2016	$71.6	$194.6	$22.7	$288.9

(1) Write-off of goodwill related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.

During 2016, we adjusted goodwill by $0.1 million as a result of our completion of the purchase price accounting for our 2015 acquisition of Infinity.

The following table summarizes the activity related to our other intangible assets, net for 2016, 2015 and 2014 (amounts in millions):

	Other Intangible Assets, Net			
	Certificates of Need and Licenses	Acquired Names of Business	Non-Compete Agreements (2)	Total
Balances at December 31, 2013	$25.4	$11.1	$ 0.2	$36.7
Write-off (1)	(0.2)	—	—	(0.2)
Impairment	(2.1)	(1.0)	—	(3.1)
Amortization	—	—	(0.2)	(0.2)
Balances at December 31, 2014	23.1	10.1	—	33.2
Additions	1.1	4.1	5.9	11.1
Write-off	(0.3)	—	—	(0.3)
Balances at December 31, 2015	23.9	14.2	5.9	44.0
Additions	0.2	3.5	1.5	5.2
Amortization	—	—	(2.5)	(2.5)
Balances at December 31, 2016	$24.1	$17.7	$ 4.9	$46.7

(1) Write-off of intangible assets related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.
(2) The weighted average amortization period of our non-compete agreements is 1.9 years.

See Note 3 – Acquisitions for further details on additions to goodwill and other intangible assets, net.

The estimated aggregate amortization expense related to intangible assets for each of the five succeeding years is as follows (amounts in millions):

2017	$ 2.7
2018	2.2
2019	—
2020	—
2021	—
	$ 4.9

6. DETAILS OF CERTAIN BALANCE SHEET ACCOUNTS

Additional information regarding certain balance sheet accounts is presented below (amounts in millions):

	As of December 31,	
	2016	2015
Other current assets:		
Payroll tax escrow	$ 6.7	$ 6.2
Income tax receivable	1.3	0.5
Due from joint ventures	1.7	1.8
Other	1.6	6.1
	$11.3	$14.6
Other assets:		
Workers' compensation deposits	$ 0.4	$ 0.3
Health insurance deposits	0.5	1.2
Other miscellaneous deposits	0.9	1.5
Investments	27.8	25.7
Other	8.9	4.1
	$38.5	$32.8
Accrued expenses:		
Health insurance	$10.6	$11.7
Workers' compensation	26.8	23.9
Legal and other settlements	5.7	10.5
Lease liability	0.4	0.6
Charity care	1.4	0.7
Estimated Medicare cap liability	0.8	1.4
Hospice cost of revenue	7.2	6.8
OIG self-disclosure accrual	—	4.7
Patient liability	4.3	5.1
Other	6.1	6.6
	$63.3	$72.0
Other long-term obligations:		
Reserve for uncertain tax positions	$ 0.3	$ 0.7
Deferred compensation plan liability	1.8	2.8
Other	1.6	0.9
	$ 3.7	$ 4.4

7. LONG-TERM OBLIGATIONS

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

	As of December 31,	
	2016	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 (2.77% at December 31, 2016); due August 28, 2020	$95.0	$100.0
$200.0 million Revolving Credit Facility; interest only quarterly 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	(2.7)	(3.4)
	93.0	96.6
Current portion of long-term obligations	(5.2)	(5.0)
Total	$87.8	$ 91.6

Maturities of debt as of December 31, 2016 are as follows (amounts in millions):

	Long-term obligations
2017	$ 5.2
2018	10.5
2019	10.0
2020	70.0
2021	—
	$95.7

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million (the "Credit Facilities").

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the "Term Loan"); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the "Revolving Credit Facility"). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement, dated as of October 22, 2012, as amended (the "Prior Credit Agreement") with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the "Second Lien Credit Agreement"), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan began amortizing on March 31, 2016 and will

continue amortizing over 14 quarterly installments (four remaining quarterly installments of $1.25 million followed by eight quarterly installments of $2.5 million, followed by two quarterly installments of $3.1 million, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and our subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2016, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.5% for 2016 and 2.7% for the period August 28, 2015 to December 31, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 3.5% for 2016.

As of December 31, 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.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2016, our consolidated leverage ratio was 1.0 and our consolidated fixed charge coverage ratio was 3.8 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guarantees from wholly-owned subsidiaries that in the aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all

wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with our entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet during 2015 which was reclassified to long-term obligations, less current portion during 2016 in accordance with ASU 2015-03.

Promissory Notes

Our promissory note outstanding of $0.7 million, issued in conjunction with an acquisition, bears an interest rate of 2.6%.

8. INCOME TAXES

Income taxes attributable to continuing operations consist of the following (amounts in millions):

	For the Years Ended December 31,		
	2016	2015	2014
Current income tax expense/(benefit):			
Federal	$(0.5)	$ 2.2	$(13.9)
State and local	(0.1)	0.5	(1.1)
	(0.6)	2.7	(15.0)
Deferred income tax expense/(benefit):			
Federal	22.1	(0.5)	21.0
State and local	2.4	(0.1)	1.6
Foreign	—	(0.1)	0.1
	24.5	(0.7)	22.7
Income tax expense/(benefit) from continuing operations	$23.9	$ 2.0	$ 7.7

Total income tax expense for the years ended December 31, 2016, 2015 and 2014 was allocated as follows (amounts in millions):

	For the Years Ended December 31,		
	2016	2015	2014
Income from continuing operations	$23.9	$ 2.0	$ 7.7
Income from discontinued operations	—	—	(0.1)
Interest expense	(0.1)	0.2	(0.1)
Goodwill	—	(0.1)	—
Stockholders' equity	(7.2)	(2.1)	0.6
	$16.6	$—	$ 8.1

A reconciliation of significant differences between the reported amount of income tax expense and the expected amount of income tax expense that would result from applying the U.S. federal statutory income tax rate of 35 percent to income before taxes from continuing operations is as follows:

	For the Years Ended December 31,		
	2016	2015 (1)	2014
Income tax expense at U.S. federal statutory rate	35.0 %	35.0 %	35.0 %
State and local income taxes, net of federal income tax benefit	4.8	(7.1)	5.8
Valuation allowance	0.1	79.1	1.5
Tax credits	(0.6)	136.0	(8.4)
Uncertain tax positions	(1.0)	(230.3)	0.6
Other items, net (2)	0.6	(663.3)	2.1
Income tax expense/(benefit)	38.9 %	(650.6)%	36.6 %

(1) The information provided for the year ended December 31, 2015 does not provide a meaningful reconciliation of the effective tax rate or comparable to other periods. The effective tax rate for the year is influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to income or loss before taxes. A significant asset impairment was recorded in the first quarter, resulting in a scenario where the company's loss before tax for the year was near zero. Consequently, for 2015, the relationship between the "effective tax rate drivers" and loss before taxes is distorted.

(2) Includes various items such as, non-deductible expenses, non-taxable income, return-to-accrual adjustments, and foreign tax rate differential.

As of December 31, 2016 and 2015, the Company had income taxes receivable of $1.3 million and $0.5 million, respectively, included in other current assets.

Deferred tax assets (liabilities) consist of the following components (amounts in millions):

	As of December 31,	
	2016	2015
Deferred tax assets:		
Allowance for doubtful accounts	$ 6.9	$ 6.4
Accrued payroll & employee benefits	11.4	5.1
Workers' compensation	10.9	9.8
Amortization of intangible assets	56.3	72.2
Share-based compensation	7.8	5.0
Net operating loss carryforwards (1)	44.2	48.5
Tax credit carryforwards (2)	4.8	4.7
Other	1.1	4.0
Gross deferred tax assets	143.4	155.7
Less: valuation allowance	(0.4)	(0.3)
Net deferred tax assets	143.0	155.4
Deferred tax (liabilities):		
Property and equipment	(7.8)	(9.5)
Deferred revenue	(23.2)	(18.5)
Investment in partnerships	(3.2)	(0.2)
Other liabilities	(0.9)	(2.0)
Gross deferred tax (liabilities)	(35.1)	(30.2)
Net deferred tax assets (liabilities)	$107.9	$125.2

(1) The net operating loss ("NOL") carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the NOL carry forwards, as of December 31, 2016 and 2015, are presented net of unrecognized tax benefits of $3.1 million.

(2) The tax credit carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the tax credit carry forwards are presented net of unrecognized tax benefits of $0.7 million for each of the years ended December 31, 2016 and 2015.

As of December 31, 2016, we have U.S. net operating loss ("NOL") carry forwards of $102.1 million that are available to reduce future taxable income and begin to expire in 2034. In addition, we have research and development tax credits, employment tax credits, and alternative minimum tax credits of $1.9 million, $0.2 million and $1.4 million, respectively, available to reduce future U.S. federal income taxes. The research and development tax credits and employment tax credits begin to expire in 2032, and the alternative minimum tax credits are available indefinitely.

As of December 31, 2016, we have state NOL carry forwards of $268.4 million that are available to reduce future taxable income. In addition, we have $3.1 million of various state tax credits available to reduce future taxable income. The state NOL and tax credit carry forwards begin to expire at various times.

The valuation allowance for deferred tax assets as of December 31, 2016 and 2015 was $0.4 million and $0.3 million, respectively. The net change in the total valuation allowance for the year ended December 31, 2016 and December 31, 2015 was an increase of $0.1 million and a decrease of $0.3 million, respectively. The valuation allowance during 2016 and 2015 was primarily related to certain state NOL and state tax credit carry forwards.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income in those jurisdictions during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities (including the impact of available carry back and carry forward periods), projected future taxable income, and tax-planning strategies in making this assessment. In order to fully realize the deferred tax assets, the Company will need to generate future taxable income before the expiration of the carry forwards governed by the tax code. Based on the current level of pretax earnings, the Company will generate the minimum amount of future taxable income to support the realization of the deferred tax assets. As a result, management believes that it is more likely than not that we will realize the benefits of these deferred tax assets, net of the existing valuation allowances at December 31, 2016. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carry forward period are reduced.

Uncertain Tax Positions

We account for uncertain tax positions in accordance with the authoritative guidance for uncertain tax positions. A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows (amounts in millions):

	For the Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 4.7	$ 4.0
Additions for tax positions related to current year	—	—
Additions for tax positions related to prior year	—	1.0
Reductions for tax positions related to prior years	—	—
Lapse of statute of limitations	(0.6)	(0.3)
Settlements	—	—
Balance at end of period	$ 4.1	$ 4.7

As of December 31, 2016, there are $0.3 million and $3.8 million of unrecognized tax benefits recorded in accrued other long-term obligations and deferred income taxes, respectively, within the consolidated balance sheet.

Included in the balance of unrecognized tax benefits at December 31, 2016 is $4.1 million of tax benefits that, if recognized in future periods, would impact our effective tax rate.

During the years ended December 31, 2016 and 2015, we recognized interest and penalties of $(0.1) million and $0.2 million, respectively, as components of penalties or interest expense in connection with our reserve for uncertain tax positions. Interest and penalties, related to uncertain tax positions, included in the consolidated balance sheet at December 31, 2016 and 2015 were less than $0.1 and $0.2 million, respectively.

We are subject to income taxes in the U.S. and in many of the 50 individual states, with significant operations in Louisiana, Alabama, Georgia, and Tennessee. We are open to examination in the U.S. and in various individual states for tax years ended December 31, 2013 through December 31, 2016. We are also open to examination in various states for the years ended 2001 – 2016 resulting from net operating losses generated and available for carry forward from those years.

We believe that it is reasonably possible that decreases of up to $0.3 million in unrecognized tax benefits, each of which are individually insignificant, may be recognized by the end of December 31, 2017 as a result of an anticipated settlement and lapse of the statute of limitations.

9. CAPITAL STOCK AND SHARE-BASED COMPENSATION

We are authorized by our Certificate of Incorporation to issue 60,000,000 shares of common stock, $0.001 par value and 5,000,000 shares of preferred stock, $0.001 par value. As of December 31, 2016, there were 35,253,577 and 33,597,215 shares of common stock issued and outstanding, respectively, and no shares of preferred stock issued or outstanding. Our Board of Directors is authorized to fix the dividend rights and terms, conversion and voting rights, redemption rights and other privileges and restrictions applicable to our preferred stock.

Share-Based Awards

Our 2008 Omnibus Incentive Compensation Plan (the "Plan") authorizes the grant of various types of equity-based awards, such as stock awards, restricted stock units, stock appreciation rights and stock options to eligible participants, which include all of our employees and all employees of our 50% or more owned subsidiaries, our non-employee directors and certain consultants. The vesting terms of the awards may be tied to continued employment (or, for our non-employee directors, continued service on the Board of Directors) and/or achievement of certain pre-determined performance goals. We refer to stock awards subject to service-based vesting conditions as "non-vested stock" and restricted stock units subject to service-based and performance-based or market-based vesting conditions as "non-vested stock units." The Plan is administered by the Compensation Committee of our Board of Directors, which determines, within the provisions of the Plan, those eligible employees to whom, and the times at which, awards shall be granted. The Compensation Committee, in its discretion, may delegate its authority and duties under the Plan to specified officers; however, only the Compensation Committee may approve the terms of awards to our executive officers.

Equity-based awards may be granted for a number of shares not to exceed, in the aggregate, approximately 5.5 million shares of common stock, and we had approximately 1.2 million shares available at December 31, 2016. The price per share for stock options shall be of no less than the greater of (a) 100% of the fair value of a share of common stock on the date the option is granted or (b) the aggregate par value of the shares of our common stock on the date the option is granted. If a stock option is granted to any owner of 10% or more of our total combined voting power of us and our subsidiaries, the price is to be at least 110% of the fair value of a share of our common stock on the date the award is granted. Each equity-based award vests ratably over a 12 month to six year period, with the exception of those issued under contractual arrangements that specify otherwise, that may be exercised during a period as determined by our Compensation Committee or as otherwise approved by our Compensation Committee. The contractual terms of stock options exercised shall not exceed ten years from the date such option is granted.

Employee Stock Purchase Plan ("ESPP")

We have a plan whereby our eligible employees may purchase our common stock at 85% of the market price at the time of purchase. On June 7, 2012, our stockholders ratified an amendment adopted by our Board of Directors to increase the total number of shares of our common stock authorized for the issuance under our ESPP

from 2,500,000 shares to 4,500,000 shares, and as of December 31, 2016, there were 1,460,800 shares available for future issuance. The following is a detail of the purchases that were made or pending Board of Director approval under the plan:

Employee Stock Purchase Plan Period	Shares Issued	Price
2014 and Prior	2,899,528	$13.78
January 1, 2015 to March 31, 2015	24,368	22.76
April 1, 2015 to June 30, 2015	15,750	33.77
July 1, 2015 to September 30, 2015	18,984	32.27
October 1, 2015 to December 31, 2015	19,082	33.42
January 1, 2016 to March 31, 2016	13,850	41.09
April 1, 2016 to June 30, 2016	14,236	42.91
July 1, 2016 to September 30, 2016	16,520	40.32
October 1, 2016 to December 31, 2016	16,882	36.24
	3,039,200	

ESPP expense included in general and administrative expense in our accompanying consolidated statements of operations was $0.4 million for each of 2016, 2015 and 2014, respectively.

Stock Options

We use the Black-Scholes option pricing model to estimate the fair value of our stock options. There were 268,538, 590,647 and 250,000 options granted during 2016, 2015 and 2014, respectively. Stock option compensation expense included in general and administrative expense in our accompanying consolidated statements of operations was $6.3 million, $3.8 million and $0.1 million for 2016, 2015 and 2014, respectively.

The fair value of the 2016 awards were estimated using the following assumptions:

Risk Free Rate	1.19% – 1.58%
Expected Volatility	53.44% – 54.89%
Expected Term	5.86 – 6.25 years
Weighted Average Fair Value	$25.99

We used the simplified method to estimate the expected term for the stock options granted during 2016.

The following table presents our stock option activity for 2016:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Contractual Life (Years)
Outstanding options at January 1, 2016	838,494	$30.18	9.31
Granted	268,538	37.21	
Exercised	—	—	
Canceled, forfeited or expired	(98,875)	35.45	
Outstanding options at December 31, 2016	1,008,157	$31.54	8.42
Exercisable options at December 31, 2016	281,458	$28.86	8.21

The aggregate intrinsic value of our outstanding options and exercisable options at December 31, 2016 was $11.9 million and $3.9 million, respectively. There were no options exercised during 2016. Total intrinsic value of options exercised was $0.2 million and $0.1 million for 2015 and 2014, respectively.

The following table presents our non-vested stock option award activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock options at January 1, 2016	775,994	$30.47
Granted	268,538	37.21
Vested	(219,872)	29.55
Forfeited	(97,961)	35.38
Non-vested stock options at December 31, 2016	726,699	$32.58

At December 31, 2016, there was $7.2 million of unrecognized compensation cost related to stock options that we expect to be recognized over a weighted-average period of 2.1 years.

Non-Vested Stock

We issue shares of non-vested stock with vesting terms ranging from one to six years. The compensation expense is determined based on the market price of our common stock at the date of grant applied to the total number of shares that are anticipated to fully vest. Non-vested stock compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $2.3 million, $5.0 million and $4.6 million for 2016, 2015 and 2014, respectively.

The following table presents our non-vested stock award activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock at January 1, 2016	500,888	$18.24
Granted	21,202	50.55
Vested	(222,783)	18.00
Canceled, forfeited or expired	(89,929)	17.26
Non-vested stock at December 31, 2016	209,378	$22.20

The weighted average grant date fair value of non-vested stock granted was $50.55, $28.48 and $16.38 in 2016, 2015, and 2014, respectively.

At December 31, 2016, there was $1.4 million of unrecognized compensation cost related to non-vested stock award payments that we expect to be recognized over a weighted average period of 0.9 years.

Non-Vested Stock Units

We issue non-vested stock unit awards that are service-based, performance-based or a combination of both with vesting terms ranging from one to six years. Based on the terms and conditions of these awards, we determine if

the awards should be recorded as either equity or liability instruments. The compensation expense is determined based on the market price of our common stock at the date of grant, applied to the total number of units that are anticipated to vest, unless the award specifies differently. We account for such awards similar to our non-vested stock awards; however, no shares of stock are issued to the recipient until the stock unit awards have vested and after the pre-determined delivery date has occurred.

Non-Vested Stock Units – Service-Based

Service-based non-vested stock unit compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $3.6 million and $1.0 million for 2016 and 2015, respectively.

The following table presents our service-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	183,332	$37.89
Granted	147,896	45.60
Vested	(32,607)	38.81
Canceled, forfeited or expired	(49,192)	39.38
Non-vested stock units at December 31, 2016	249,429	$42.05

The weighted average grant date fair value of service-based non-vested stock units granted was $45.60 and $37.98 in 2016 and 2015, respectively.

At December 31, 2016, there was $6.7 million of unrecognized compensation cost related to our service-based non-vested stock units that we expect to be recognized over a weighted average period of 2.2 years.

Non-Vested Stock Units – Service-Based and Performance-Based Awards

During 2016, we awarded performance-based awards to certain employees. The target level established by the award, which is based on the Company's 2016 adjusted earnings before interest, taxes and depreciation ("EBITDA"), provided for the recipients to receive 182,796 non-vested stock units if the target was achieved. The target number of shares to be potentially awarded has been reduced by forfeitures as indicated in the table below. Performance-based non-vested stock units compensation expense included in general and administrative expenses in our consolidated statements of operations was $3.7 million and $1.3 million for 2016 and 2015, respectively.

The following table presents our performance-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	151,063	$39.44
Granted	182,796	46.29
Vested	(44,729)	34.83
Canceled, forfeited or expired	(64,273)	42.41
Non-vested stock units at December 31, 2016	224,857	$45.08

The weighted average grant date fair value of performance-based non-vested stock units granted was $46.29 and $39.54 in 2016 and 2015, respectively.

At December 31, 2016, there were $6.4 million in unrecognized compensation costs related to our performance-based non-vested stock units that we expect to be recognized over a weighted average period of 2.0 years.

Non-Vested Stock Units – Service-Based and Market-Based Awards

During 2013, we awarded market-based awards to certain employees. The target level established by the award, which was based on our average December 2015 stock price, provided for the recipients to receive 417,330 non-vested stock units if the target is achieved. If the target objective was surpassed to the point of achieving the projected maximum payout, the recipients would receive 667,728 non-vested stock units. The target number of shares to be potentially awarded was reduced by forfeitures as indicated in the table below. As of March 3, 2016, it was determined that the market-based objective established by the award was satisfied at maximum payout and as a result, 248,654 stock units were awarded to the recipients on April 1, 2016.

For market-based awards, the effect of the market condition is reflected in the fair value of the awards at the date of grant using a Monte-Carlo simulation model. A Monte-Carlo simulation model estimates the fair value of the market-based award based upon the expected term, risk-free interest rate and expected volatility. Compensation expense for market-based awards is recognized over the vesting period regardless of whether the market conditions are expected to be achieved. Market-based non-vested stock units compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $0.1 million, $0.3 million and $0.5 million for 2016, 2015 and 2014, respectively. The fair value of the 2013 award was estimated using the following assumptions:

Forward Interest Rate	0.327 % – 1.460%
Expected Volatility	54.38%
Requisite Service Period	3 years
Fair Value	$10.51

The following table presents our market-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	164,534	$10.51
Granted (1)	93,257	10.51
Vested	(248,654)	10.51
Canceled, forfeited or expired	(9,137)	10.51
Non-vested stock units at December 31, 2016	—	$ —

(1) Represents shares awarded upon achievement of maximum payout.

The weighted average grant date fair value of market-based non-vested stock units granted was $10.51 in 2013. All of our outstanding market-based non-vested stock units were fully vested as of April 1, 2016.

10. 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. 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. The case is currently in discovery.

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.

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 Demand 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 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 Federal Fair Labor Standards Act ("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, thereby denying her overtime. The plaintiff alleges violations of federal and state law and seeks damages under the 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 had accrued as of September 30, 2016. On August 4, 2016, the Court approved the final settlement of this case. The final payment of $0.6 million was paid on November 21, 2016.

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. The Company resolved the Frontier litigation for $2.9 million during the three-month period ended December 31, 2016.

Other Investigative Matters – Ongoing

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.

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.

Frontier Litigation

Separate from the Frontier litigation described above under "Legal Proceedings – Settled", the Company engaged an independent auditing firm to perform a clinical audit of the hospice care centers acquired by Frontier. No assurances can be given as to the timing or outcome of the audit on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

Other Investigative Matters – Settled

Corporate Integrity Agreement

During the course of our compliance with the CIA, the Company identified several reportable events and notified the OIG as required. As of December 31, 2015, the Company 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.

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 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 December 31, 2016, we have an indemnity receivable for the amount withheld related to the period prior to August 1, 2009.

In July 2016, the Company received a request for medical records from SafeGuard Services, L.L.C. ("SafeGuard"), a ZPIC, related to services provided by some of the care centers that the Company acquired from Infinity Home Care, L.L.C. The review period covers time periods both before and after our ownership of the care centers, which were acquired on December 31, 2015. Subsequent to the initial ZPIC letter, on September 16, 2016, the Company received a letter from SafeGuard notifying the Company that the Winterhaven, Bradenton, and Tampa care centers were on a prepayment review. On October 28, 2016, the company received a "Notice of Suspension of Medicare Payments" for up to 180 days for these three care centers. On January 10, 2017, the Company received a letter from SafeGuard notifying the Company that the Clearwater care center was on a prepayment review. Subsequently, on February 2, 2017, the Company received a "Notice of Suspension of Medicare Payments" for up to 180 days for the Clearwater care center. Based on the information currently available to the Company, the Company cannot predict the timing or outcome of this audit or reasonably estimate the amount or range of potential losses, which may arise from this matter.

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.

Operating Leases

We have leased office space at various locations under non-cancelable agreements that expire between 2017 and 2026, and require various minimum annual rentals. Our typical operating leases are for lease terms of one to seven

years and may include, in addition to base rental amounts, certain landlord pass-through costs for our pro-rata share of the lessor's real estate taxes, utilities and common area maintenance costs. Some of our operating leases contain escalation clauses, in which annual minimum base rentals increase over the term of the lease.

Total minimum rental commitments as of December 31, 2016 are as follows (amounts in millions):

2017	$23.5
2018	17.5
2019	13.0
2020	9.1
2021	4.3
Future years	4.6
Total	$72.0

Rent expense for non-cancelable operating leases was $27.5 million, $23.7 million and $26.5 million for 2016, 2015 and 2014.

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.

The following table presents details of our insurance programs, including amounts accrued for the periods indicated (amounts in millions) in accrued expenses in our accompanying balance sheets. The amounts accrued below represent our total estimated liability for individual claims that are less than our noted insurance coverage amounts, which can include outstanding claims and claims incurred but not reported.

	As of December 31,	
Type of Insurance	2016	2015
Health insurance	$10.6	$11.7
Workers' compensation	26.8	23.9
Professional liability	4.7	4.1
	42.1	39.7
Less: long-term portion	(0.8)	(0.9)
	$41.3	$38.8

The retention limit per claim for our health insurance, worker's compensation and professional liability is $0.9 million, $0.5 million and $0.3 million, respectively.

Employment Contracts

We have commitments related to employment contracts with a number of our senior executives. These contracts generally commit us to pay severance benefits under certain circumstances.

Other

We are subject to various other types of claims and disputes arising in the ordinary course of our business. While the resolution of such issues is not presently determinable, we believe that the ultimate resolution of such matters will not have a significant effect on our consolidated financial condition, results of operations and cash flows.

11. EMPLOYEE BENEFIT PLANS

401(K) Benefit Plan

We maintain a plan qualified under Section 401(k) of the Internal Revenue Code for all employees who have reached 21 years of age, effective the first month after hire date. Under the plan, eligible employees may elect to defer a portion of their compensation, subject to Internal Revenue Service limits.

During 2016, 2015 and 2014, our match of contributions to be made to each eligible employee contribution was $0.375 for every $1.00 of contribution made up to the first 6% of their salary. Effective January 1, 2017, our match of contributions to be made to each eligible employee contribution is $0.44 for every $1.00 of contribution made up to the first 6% of their salary. The match is discretionary and thus is subject to change at the discretion of management. These contributions are made in the form of our common stock, valued based upon the fair value of the stock as of the end of each calendar quarter end. We expensed approximately $6.9 million, $6.1 million and $6.2 million for 2016, 2015 and 2014, respectively.

Deferred Compensation Plan

We had a Deferred Compensation Plan for additional tax-deferred savings to a select group of management or highly compensated employees. Amounts credited under the Deferred Compensation Plan were funded into a rabbi trust, which is managed by a trustee. The trustee has the discretion to manage the assets of the Deferred Compensation Plan as deemed fit, thus the assets are not necessarily reflective of the same investment choices made by the participants.

Effective January 1, 2015, all prospective salary deferrals ceased. Participants will be allowed to make transactions with any remaining account balances as they wish per plan guidelines.

12. 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.

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, was 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.

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 during 2016 and 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million. The repurchased shares are classified as treasury shares. The stock repurchase program expired on September 6, 2016.

13. EXIT AND RESTRUCTURING ACTIVITIES

As of December 31, 2013, we reported three home health care centers as held for sale. During 2014, we sold assets associated with two of these care centers for cash consideration of approximately $0.8 million and recognized a gain of approximately $0.8 million which is included in discontinued operations. The remaining care center classified as held for sale was consolidated with a care center servicing the same market during 2014.

During 2014, the Company sold its interest in five home health and four hospice care centers in Wyoming and Idaho for approximately $5.0 million and recognized a gain of $2.1 million. We also exited our hospice inpatient unit in New Hampshire and recognized a loss of $0.5 million.

In addition to the exit activity related to the care centers mentioned above, we consolidated 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and closed 22 home health care centers and four hospice care centers during 2014. In connection with these care centers, we recorded non-cash charges of $2.2 million in other intangibles impairment expense related to the write-off of intangible assets, $2.1 million in other general and administrative expenses related to lease termination costs and $2.1 million in salaries and benefits related to severance costs. These care centers were not concentrated in certain selected geographical areas and did not meet the criteria to be classified as discontinued operations in accordance with applicable accounting guidance.

Restructuring Activity

During 2014, we restructured our regional leadership and corporate support functions. As such, we recorded charges of $3.4 million in salaries and benefits related to severance costs. In addition, during 2014, William F. Borne stepped down from his positions as Chief Executive Officer, Chairman and a member of our Board of Directors and we recorded charges of $2.3 million in salaries and benefits related to severance costs.

Our reserve activity for our 2014 exit and restructuring activity is as follows (amounts in millions):

	2014 Exit Activity	
	Lease Termination	Severance
Balances at December 31, 2013	$—	$—
Charge in 2014	2.1	7.8
Cash expenditures in 2014	(1.6)	(5.5)
Balances at December 31, 2014	**0.5**	**2.3**
Charge in 2015	—	—
Cash expenditures in 2015	(0.4)	(1.9)
Balances at December 31, 2015	**0.1**	**0.4**
Charge in 2016	—	—
Cash expenditures in 2016	(0.1)	(0.4)
Balances at December 31, 2016	$—	$—

14. VALUATION AND QUALIFYING ACCOUNTS

The following table summarizes the activity and ending balances in our allowance for doubtful accounts and estimated revenue adjustments (amounts in millions):

Allowance for Doubtful Accounts

Year End	Balance at Beginning of Year	Provision for Doubtful Accounts (1)	Write-Offs	Balance at End of Year
2016	$16.5	$19.5	$(18.3)	$17.7
2015	14.3	14.1	(11.9)	16.5
2014	14.2	16.4	(16.3)	14.3

(1) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

Estimated Revenue Adjustments

Year End	Balance at Beginning of Year	Provision for Estimated Revenue Adjustments (1)	Write-Offs	Balance at End of Year
2016	$4.0	$7.9	$(7.8)	$4.1
2015	3.1	6.1	(5.2)	4.0
2014	3.9	5.1	(5.9)	3.1

(1) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

15. 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 the essential activities of daily living. 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).

	For the Year Ended December 31, 2016				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$1,085.5	$316.0	$35.9	$ —	$1,437.4
Cost of service, excluding depreciation and amortization	643.7	163.1	26.3	—	833.1
General and administrative expenses	283.4	70.2	7.9	141.9	503.4
Provision for doubtful accounts	13.8	5.5	0.2	—	19.5
Depreciation and amortization	6.0	1.3	—	12.4	19.7
Asset impairment charge	—	—	—	4.4	4.4
Operating expenses	946.9	240.1	34.4	158.7	1,380.1
Operating income (loss)	$ 138.6	$ 75.9	$ 1.5	$(158.7)	$ 57.3

	For the Year Ended December 31, 2015				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$1,005.1	$275.4	$ —	$ —	$1,280.5
Cost of service, excluding depreciation and amortization	584.2	141.7	—	—	725.9
General and administrative expenses	263.2	62.7	—	126.5	452.4
Provision for doubtful accounts	12.2	1.9	—	—	14.1
Depreciation and amortization	5.2	1.4	—	13.4	20.0
Asset impairment charge	—	—	—	77.3	77.3
Operating expenses	864.8	207.7	—	217.2	1,289.7
Operating income (loss)	$ 140.3	$ 67.7	$ —	$(217.2)	$ (9.2)

	For the Year Ended December 31, 2014				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$956.9	$247.6	$ —	$ —	$1,204.5
Cost of service, excluding depreciation and amortization	559.4	131.7	—	—	691.1
General and administrative expenses	269.0	58.3	—	114.4	441.7
Provision for doubtful accounts	14.8	1.5	—	—	16.3
Depreciation and amortization	9.0	2.1	—	17.2	28.3
Asset impairment charge	1.6	1.5	—	—	3.1
Operating expenses	853.8	195.1	—	131.6	1,180.5
Operating income (loss)	$103.1	$ 52.5	$ —	$(131.6)	$ 24.0

16. UNAUDITED SUMMARIZED QUARTERLY FINANCIAL INFORMATION

	Revenue	Net Income (Loss) Attributable to Amedisys, Inc.	Net Income (Loss) Attributable to Amedisys, Inc. Common Stockholders (1)	
			Basic	Diluted
2016:				
1st Quarter (2)(3)(4)	$ 348.8	$ 6.2	$ 0.19	$ 0.19
2nd Quarter (2)(3)(4)	360.7	10.7	0.32	0.32
3rd Quarter (2)(3)(4)	361.6	11.4	0.34	0.34
4th Quarter (2)(3)(4)(5)	366.3	8.9	0.27	0.26
	$1,437.4	$ 37.3	$ 1.12	$ 1.10
2015:				
1st Quarter (6)(7)	$ 301.6	$(35.0)	$(1.07)	$(1.07)
2nd Quarter (7)	314.1	10.6	0.32	0.32
3rd Quarter (6)(7)(9)	326.4	8.4	0.25	0.25
4th Quarter (7)(8)(9)	338.4	12.9	0.39	0.38
	$1,280.5	$ 3.0	$(0.09)	$(0.09)

(1) Because of the method used in calculating per share data, the quarterly per share data may not necessarily total to the per share data as computed for the entire year.

(2) During each of the four quarters of 2016, we incurred certain costs associated with the implementation of Homecare Homebase. Net of income taxes, these costs amounted to $1.5 million, $1.6 million, $1.2 million and $0.8 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(3) During each of the four quarters of 2016, we incurred certain costs associated with various legal matters. Net of income taxes, these costs amounted to $0.9 million, $0.3 million, $0.2 million and $1.8 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(4) During each of the four quarters of 2016, we incurred certain costs associated with various acquisition costs. Net of income taxes, these costs amounted to $1.0 million, $0.2 million, $0.3 million and $0.5 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(5) During the fourth quarter of 2016, we recorded a non-cash asset impairment charge to write-off assets as a result of our conversion from our proprietary operating system to Homecare Homebase in the amount of $2.7 million, net of income taxes.

(6) During the first quarter of 2015, we recorded a non-cash asset impairment charge to write-off the software costs incurred related to the development of AMS3 Home Health and Hospice in the amount of $45.5 million, net of income taxes. During the third quarter of 2015, we recorded a non-cash asset impairment charge related to our corporate headquarters in the amount of $1.2 million, net of income taxes.

(7) During each of the four quarters of 2015, we incurred certain costs associated with various legal matters. Net of income taxes, these costs amounted to $1.3 million, $4.8 million, $0.2 million and $(1.1) million for the three-month periods ended March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015, respectively.

(8) During the fourth quarter of 2015, we recorded an accrual related to an OIG Self-Disclosure matter. Net of income taxes, this charge amounted to $3.4 million.
(9) During the third and fourth quarters of 2015, we incurred certain costs associated with the implementation of Homecare Homebase. Net of income taxes, these costs amounted to $1.2 million and $1.4 million for the three-month periods ended September 30, 2015 and December 31, 2015, respectively.

17. 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 2016, we incurred costs of approximately $1.6 million 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 2016 we incurred costs of approximately $1.5 million related to this related party engagement.

18. SUBSEQUENT EVENTS

On February 1, 2017, we acquired Home Staff, LLC, a personal care provider with three care centers for a purchase price of $4.0 million.

Unaudited – On February 28, 2017, we signed a definitive agreement to acquire Tenet Healthcare's home health and hospice operations in Arizona, Illinois, Massachusetts and Texas. We do not believe that the closing of this acquisition will have a material impact on our 2017 results of operations.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. 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 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 Annual Report on Form 10-K, as of December 31, 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 December 31, 2016, the end of the period covered by this Annual Report on Form 10-K.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Exchange Act. Under the supervision and with the participation of our management, including our principal executive officer and our principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control – Integrated Framework*, our management concluded our internal control over financial reporting was effective as of December 31, 2016.

Our internal control system is designed to provide reasonable assurance to our management and Board of Directors regarding the preparation and fair presentation of published financial statements. All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

In conducting this evaluation, management did not include an assessment of internal control over financial reporting of Associated Home Care acquired on March 1, 2016 and Professional Profiles, Inc. acquired on September 1, 2016, which are included in the consolidated financial statements of the Company for the year ended December 31, 2016. Associated Home Care and Professional Profiles accounted for approximately 1% of total assets and 2% of revenue as of and for the year ended December 31, 2016. As a result of its evaluation, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2016 based on those criteria.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Controls

During 2015, we began the implementation of Homecare Homebase ("HCHB") with all care centers operating on HCHB as of December 31, 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 other changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that have occurred during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, 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 December 2016, the end of the period covered by this Annual Report.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013),* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Amedisys, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Annual Report on Internal Control over Financial Reporting* under Item 9A. Our responsibility is to express an opinion on Amedisys, Inc.'s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Amedisys, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013),* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Amedisys, Inc. acquired Associated Home Care on March 1, 2016 and the assets of Professional Profiles, Inc. on September 1, 2016, and management excluded from its assessment of the effectiveness of Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, Associated Home Care and Professional Profiles, Inc.'s internal control over financial reporting associated with approximately 1% of total assets and 2% of revenue included in the consolidated financial statements of Amedisys, Inc. as of and for the year ended December 31, 2016. Our audit of internal control over financial reporting of Amedisys, Inc. also excluded an evaluation of the internal control over financial reporting of Associated Home Care and Professional Profiles, Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Amedisys, Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and our report dated March 1, 2017, expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 1, 2017

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees, including our principal executive officer, principal financial officer and principal accounting officer. This code of ethics, which is entitled Code of Ethical Business Conduct, is posted at our internet website, http://www.amedisys.com. Any amendments to, or waivers of, the code of ethics will be disclosed on our website promptly following the date of such amendment or waiver.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. Financial Statements

All financial statements are set forth under Part II, Item 8 of this report.

2. Financial Statement Schedules

There are no financial statement schedules included in this report as they are either not applicable or included in the financial statements.

3. Exhibits

The Exhibits are listed in the Exhibit Index required by Item 601 of Regulation S-K immediate following the signature pages of this report, which is incorporated by reference.

ITEM 16. FORM 10-K SUMMARY

None.

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.

By: /s/ PAUL B. KUSSEROW

Paul B. Kusserow,
President, Chief Executive Officer and
Member of the Board

Date: March 1, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the date indicated:

Signature	Title	Date
/s/ PAUL B. KUSSEROW **Paul B. Kusserow**	President, Chief Executive Officer and Member of the Board (Principal Executive Officer)	March 1, 2017
/s/ GARY D. WILLIS **Gary D. Willis**	Chief Financial Officer (Principal Financial Officer)	March 1, 2017
/s/ SCOTT G. GINN **Scott G. Ginn**	Chief Accounting Officer (Principal Accounting Officer)	March 1, 2017
/s/ LINDA J. HALL **Linda J. Hall**	Director	March 1, 2017
/s/ JULIE D. KLAPSTEIN **Julie D. Klapstein**	Director	March 1, 2017
/s/ RICHARD A. LECHLEITER **Richard A. Lechleiter**	Director	March 1, 2017
/s/ JAKE L. NETTERVILLE **Jake L. Netterville**	Director	March 1, 2017
/s/ BRUCE D. PERKINS **Bruce D. Perkins**	Director	March 1, 2017
/s/ JEFFREY A. RIDEOUT **Jeffrey A. Rideout**	Director	March 1, 2017
/s/ DONALD A. WASHBURN **Donald A. Washburn**	Non-Executive Chairman of the Board	March 1, 2017
/s/ NATHANIEL M. ZILKHA **Nathaniel M. Zilkha**	Director	March 1, 2017

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-K. 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. The registrant agrees to furnish to the Commission supplementally upon request a copy of any schedules or exhibits omitted pursuant to Item 601(b)(2) of Regulation S-K of any material plan of acquisition, disposition or reorganization set forth below.

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
2.1	Equity Purchase Agreement dated February 5, 2016, by and between the Company, as Purchaser, and Michael Trigilro, as Seller	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016	0-24260	2.1
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
4.1	Common Stock Specimen	The Company's Registration Statement on Form S-3 filed August 20, 2007	333-145582	4.8
10.1	Form of Director Indemnification Agreement dated February 12, 2009	The Company's Annual Report on Form 10-K for the year ended December 31, 2008	0-24260	10.1
10.2*	Amended and Restated Amedisys, Inc. Employee Stock Purchase Plan dated June 7, 2012	The Company's Current Report on Form 8-K filed June 8, 2012	0-24260	10.1
†10.3*	Composite Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan (inclusive of Plan amendments dated June 7, 2012 and October 25, 2012, April 23, 2015 and June 4, 2015, January 20, 2017 and February 22, 2017 and the full text of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan)			
10.4*	Form of Nonvested Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.3

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.5*	Form of Restricted Stock Unit Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.4
10.6*	Form of Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.6
10.7*	Form of Performance Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.7
10.8	Form of Restricted Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.8
10.9*	Form of Restricted Performance Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.9
10.10*	Composite Amedisys, Inc. 1998 Stock Option Plan (inclusive of amendments dated June 10, 2004, June 8, 2006 and June 22, 2006 and the full text of the Amedisys, Inc. 1998 Stock Option Plan)	The Company's Registration Statement on Form S-8 filed June 22, 2007	333-143967	4.2
10.11*	Composite Director's Stock Option Plan (inclusive of Plan amendments dated June 10, 2004, and the full text of the Directors Stock Option Plan)	The Company's Annual Report on Form 10-K for the year ended December 31, 2005	0-24260	10.4
10.12*	Employment Agreement dated December 11, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Paul B. Kusserow	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.12
10.13.1*	Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed November 2, 2011	0-24260	10.1
10.13.2*	Amendment No. 1 dated December 29, 2011 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed December 30, 2011	0-24260	10.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.13.3*	Amendment No. 2 dated December 19, 2012 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.10.3
10.13.4*	Amendment No. 3 dated May 1, 2014 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.4
10.14*	Employment Agreement dated as of May 2, 2016 between Amedisys, Inc. and Jeffrey D. Jeter	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016	0-24260	10.1
†10.15*	Amedisys Holding, L.L.C. Severance Plan for Key Executives dated as of April 30, 2015 (inclusive of all amendments thereto adopted on or before December 13, 2016)			
10.16.1	Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Current Report on Form 8-K filed on October 30, 2012	0-24260	10.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.16.2	First Amendment and Limited Waiver dated as of September 4, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.1
10.16.3	Second Amendment dated as of November 11, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.2
10.16.4	Third Amendment dated as of April 17, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014	0-24260	10.3

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.16.5	Fourth Amendment dated as of July 28, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.1.2
10.17	Security and Pledge Agreement dated as of November 11, 2013, among Amedisys, Inc., Amedisys Holding, L.L.C., the Guarantors party thereto and JPMorgan Chase Bank, N.A., not in its individual capacity but solely as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.2
10.18	Second Lien Credit Agreement dated as of July 28, 2014 by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the banks and other financial institutions or entities from time to time parties thereto as lenders, and Cortland Capital Market Services LLC, as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.8
10.19	Second Lien Security and Pledge Agreement dated as of July 28, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C, the guarantors party thereto and Cortland Capital Market Services LLC, not in its individual capacity, but solely as collateral agent for the secured parties	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.9
10.20	Intercreditor Agreement dated as of July 28, 2014 by and among JPMorgan Chase Bank, N.A., as Administrative Agent for the first priority secured parties, Cortland Capital Market Services LLC, as Administrative Agent for the second priority secured parties, and the direct and indirect subsidiaries of Amedisys, Inc. and Amedisys Holding, L.L.C. from time to time party thereto	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.10

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.21.1	Credit Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain subsidiaries of Amedisys, Inc. party thereto as guarantors, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, JPMorgan Chase Bank, N.A., as Syndication Agent, Citizens Bank, N.A., Compass Bank, Fifth Third Bank, and Regions Bank, as Co-Documentation Agents, the lenders party thereto, Merrill Lynch, Pierce Fenner & Smith Incorporated, Citizens Bank N.A., Fifth Third Bank and J.P. Morgan Securities LLC, as Joint Lead Arrangers, and Merrill Lynch, Pierce, Fenner & Smith Incorporated and J.P. Morgan Securities LLC, as Joint Bookrunners	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.1
10.212	Security Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "grantors" on the signature pages thereto and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.2
10.21.3	Pledge Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "pledgers" on the signature pages thereto, and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.3
10.22	Settlement Agreement effective April 23, 2014 by and among (a) the United States of America, acting through the United States Department of Justice and on Behalf of the Office of Inspector General of the Department of Health and Human Services, (b) Amedisys, Inc. and Amedisys Holding, L.L.C. and (c) the various Relators named therein	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.1
10.23	Corporate Integrity Agreement effective April 22, 2014 between the Office of Inspector General of the Department of Health and Human Services and Amedisys, Inc. and Amedisys Holding, L.L.C.	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.24	Agreement and Plan of Merger dated October 31, 2015 by and among Amedisys Health Care West, L.L.C., IHC Acquisitions, L.L.C., Infinity Home Care, L.L.C., Axiom HealthEquity Holdings Management, LLC, Infinity Healthcare Holdings, LLC, and Amedisys, Inc.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.27
10.25	Agreement of Purchase and Sale dated as of November 25, 2015, between Amedisys, Inc., through its wholly-owned subsidiary, Amedisys Property, L.L.C., as seller and Franciscan Missionaries of Our Lady of the Lake Heath System, Inc., as purchaser.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.28
†21.1	Subsidiaries of the Registrant			
†23.1	Consent of KPMG LLP			
†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 Gary D. Willis, 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 Gary D. Willis, 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			

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
†101.DEF	XBRL Taxonomy Extension Definition Linkbase			
†101.LAB	XBRL Taxonomy Extension Labels Linkbase Document			
†101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document			

Exhibit 31.1

CERTIFICATION

I, Paul B. Kusserow, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 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(s) 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(s) 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 the 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: March 1, 2017

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

Exhibit 31.2

CERTIFICATION

I, Gary D. Willis, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 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(s) 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(s) 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 the 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: March 1, 2017

/S/ Gary D. Willis
Gary D. Willis
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 Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 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 results of operations of the Company.

Date: March 1, 2017

/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 Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2016 (the "Report"), I, Gary D. Willis, 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 results of operations of the Company.

Date: March 1, 2017

/S/ Gary D. Willis

Gary D. Willis
Chief Financial Officer
(Principal Financial Officer)

COMPANY LEADERSHIP

BOARD OF DIRECTORS

Donald A. Washburn
Non-Executive Chairman of the Board
Private Investments

Linda J. Hall
Entrepreneur-in-Residence
Carlson School of Business at the University of Minnesota

Julie D. Klapstein
Former CEO
Availity

Paul B. Kusserow
President and Chief Executive Officer
Amedisys, Inc.

Richard A. Lechleiter
President
Catholic Education Foundation
Retired Executive Vice President and Chief Financial Officer, Kindred Healthcare, Inc.

Jake L. Netterville
Chairman, Emeritus, of the Board of Directors
Postlethwaite & Netterville, A Professional Accounting Corporation

Bruce D. Perkins
Former President of Healthcare Services
Humana

Jeffrey A. Rideout, M.D., M.A., FACP
President and CEO
the Integrated Healthcare Association

Nathaniel M. Zilkha
Head of Credit and Global
Co-Head of Special Situations
KKR

EXECUTIVE OFFICERS

Paul B. Kusserow
President and Chief Executive Officer

Christopher T. Gerard
Chief Operating Officer

Scott G. Ginn
Chief Accounting Officer

David L. Kemmerly
General Counsel

Michael P. North
Chief Information Officer

David Pearce
Chief Compliance Officer

Larry R. Pernosky
Chief Human Resources Officer

Stephen E. Seim
Chief Strategy Officer

Susan Sender
Chief Clinical Operations Officer

Gary D. Willis
Chief Financial Officer

Performance Graph

A performance graph comparing the cumulative total stockholder return on our common stock for the five-year period ended December 31, 2016, with the cumulative total return on the NASDAQ composite index and peer-group index over the same period is included in the Form 10-K.

Independent Accountants

KPMG LLP
Baton Rouge, Louisiana

Annual Meeting

The annual meeting of stockholders will take place on June 8, 2017, at 1:00 p.m. (CDT) at the Nashville office, 209 10th Avenue South, Suite 512, Nashville, TN 37203.

Stock Listing

The company's common stock is listed on the NASDAQ Global Select Market under the symbol "AMED."

Transfer Agent and Registrar

American Stock Transfer & Trust Company, LLC
6201 15th Avenue
Brooklyn, New York 11219
800.937.5449

Form 10-K Exhibits

A copy of all exhibits to the company's Annual Report on Form 10-K as filed with the Securities and Exchange Commission is available free of charge on our website at www.amedisys.com or by contacting:

Amedisys, Inc.
3854 American Way, Suite A,
Baton Rouge, LA 70816
Investor@amedisys.com

Amedisys on the Internet

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, presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled "Investors" on our website home page. Visitors to our website can also register to receive automatic e-mail and other notifications alerting them when new information is made available on the "Investors" subpage of our website. In addition, we make available on the "Investors" 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, Nominating and Corporate Governance, Quality of Care and Compliance and Ethics Committees of our Board are also available on the "Investors" subpage of our website (under the link "Corporate Governance").

Forward-Looking Statements

When included in this document, 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 healthcare industry, our ability to integrate our personal care segment into our business efficiently, 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 an economic downturn and deficit spending by federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate, manage and keep our information systems secure, our ability to comply with the requirements stipulated in our corporate integrity agreement, and changes in law or developments with respect to any litigation relating 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 Part I, Item 1A—"Risk Factors" and Part II, Item 7—"Critical Accounting Policies" within "Management's Discussion and Analysis of Financial Condition and Results of Operations" set forth in our Annual Report on Form 10-K for the year ended December 31, 2016.



www.amedisys.com

EXHIBIT 16

Medicare Visit Rates – Westminster 5005

HHA	$102.00
MSW	$359.00
OT	$247.00
PT	$245.00
SN	$224.00
ST	$266.00

EXHIBIT 17

The Pines
Genesis HealthCare℠
610 Dutchman's Lane
Easton, MD 21601-3346
Tel 410-822-4000
Fax 410-820-9768

October 21, 2015

To whom it may concern:

The social workers here at The Pines of Genesis HealthCare are aware that Amedisys home health care takes referrals for patients who do not have health insurance, otherwise known as charity cases.

Thank you,

Carolyn Treptow, LGSW

Carolyn Treptow, LGSW
Social Worker
Genesis HealthCare – The Pines
410-822-4000 ext. 139

☐ University of Maryland Shore Medical Center at Dorchester 300 Byrn Street Cambridge, MD 21613	☐ Shore Home Care 121 Federal Street, Suite #3 Easton, MD 21601
☒ University of Maryland Shore Medical Center at Easton 219 South Washington Street Easton, MD 21601	☐ Shore Medical Group 607 A Dutchman's Lane Easton, MD 21601

Date: 10-23-15 Total Pages (including cover): 2

To: Wendy

Company: AmeriSys

Fax Number: 1-855-914-2133 Telephone: _____

From: DONNA MARTIN, RN CASE SPECIALIST

Department: REQUARD CENTER FOR ACUTE REHABILITATION

Address: 219 SOUTH WASHINGTON STREET EASTON,MD. 21601

Fax Number: 410-822-4255 Telephone: 410-822-1000 EXT. 5913

Comments: Letter you requested.

The information contained in this transmission is confidential and is intended only for the individual or entity named above. If you have received this information in error, notify us immediately by calling the individual at the number above. If the reader of this message is not the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication or its contents is strictly prohibited. Shore Health System or any of its affiliates will not be held responsible for such acts.

IM-02
(Attachment 2)

FAX COVER SHEET

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Requard Center for Acute Rehabilitation
at Shore Health System
University of Maryland Medical System

219 South Washington Street
Easton, Maryland 21601
410.822.1000
www.shorehealth.org

October 23, 2015

To whom it may concern,

As a case manager at the Requard Center for Acute Rehab, I frequently use the services of Amedisys Home Health. I am aware that they provide charity care for patients that need home health services. They accepted a patient from Requard this year that did not have insurance and they provided charity care. I have found the staff at Amedisys will do all they can to meet the needs of the patients in this area. If you need further information feel free to contact me.

Sincerely,

Donna Martin RN

Requard Center for Acute Rehab

EXHIBIT 18

Amedisys, Inc. - Active Locations

5/3/2017

Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
1080	25080	South Hospice	AL	20-1071691	*Parent	1080	Horizons Hospice Care, L.L.C. d/b/a Amedisys Hospice of Montgomery 8160 Decker Lane Montgomery, AL 36117-4254 County: Montgomery	P: 334-395-7789 F: 334-395-7882 TF:866-252-1146	Facility ID: E5107	1932152113 (HorizonsHC)	01-1623	Medicaid PIC1623E	Hospice
1054	20143	Alabama	AL	20-1539447	*Parent	1054	AccuMed Health Services, L.L.C. d/b/a Amedisys Home Health Care 273 Azalea Road, Suite 204, Bldg. 2 Mobile, AL 36609-1970 County: Mobile *Relocated from Suite 104 to Suite 204 eff.6/26/15	P: 251-380-0492 F: 251-380-0573 TF:800-239-9192		1750335832 (tlc017020)	01-7020	Medicaid VAN7020A	Home Health
1052	20143	Alabama	AL	20-1539447	*Parent	1052	AccuMed Health Services, L.L.C. d/b/a Amedisys Home Health of Greenville 525 Greenville Bypass Greenville, AL 36037-3732 County: Butler	P: 334-382-2042 F: 334-382-2784 TF:800-239-2042		1104870286 (tlc017072)	01-7072	Medicaid VAN7072A	Home Health
1053	20143	Alabama	AL	20-1539447	*Parent	1053	AccuMed Health Services, L.L.C. d/b/a Amedisys Home Health 4735 Norrel Drive, Suite 125 Trussville, AL 35173-3606 County: Jefferson *Relocated from Irondale 3-26-13	P: 205-655-3707 F: 205-655-4247 TF:866-930-0720		1568416642 (tlc017154)	01-7154	Medicaid ACC7154A	Home Health
1070	25033	South Hospice	AL	27-0078073	*Parent	1070	Amedisys Hospice, LLC d/b/a Amedisys Hospice of Birmingham 2204 Lakeshore Drive, Suite 160 Homewood, AL 35209-6762 County: Jefferson	P: 205-868-9221 F: 205-868-9356 TF:877-387-1150	Facility ID: E3708	1326006651 (1070AL)	01-1527	Medicaid PIC1527E	Hospice
1071	25033	South Hospice	AL	27-0078073	Branch	1070	Amedisys Hospice, LLC d/b/a Amedisys Hospice of Gadsden 115 W. Grand Avenue, Suite 70 Rainbow City, AL 35906-3268 County: Etowah *Relocated from Gadsden 11/18/2009*	P: 256-442-0771 F: 256-442-7254 TF: 866-466-8460	Facility ID: E2805	1326006651 (1070AL) MEDICAID ONLY: 1528237997 (1071AL)	01-1527	Medicaid PIC1040E	Hospice
1075	25033	South Hospice	AL	27-0078073	Branch	1070	Amedisys Hospice, LLC d/b/a Amedisys Hospice Care 250 Chateau Drive SW, Suite 112 Huntsville, AL 35801-3497 County: Madison *Relocated from Brownsboro 10/31/12*	P: 256-881-1433 F: 256-881-8939 TF:866-448-1728	Facility ID: E4513	1326006651 (1070AL) MEDICAID ONLY: 1780853101 (1075ala)	01-1527	Medicaid 105087	Hospice
1074	25033	South Hospice	AL	27-0078073	Branch	1070	Amedisys Hospice, LLC d/b/a Amedisys Hospice of Tuscaloosa 1300 McFarland Blvd. NE, Suite 340 Tuscaloosa, AL 35406-2282 County: Tuscaloosa	P: 205-345-4907 F: 205-345-4713 TF:866-719-6866	Facility ID: E6307	1326006651 (1070AL) MEDICAID ONLY: 1104095512 (1074al)	01-1527	Medicaid 107231	Hospice
1076	25033	South Hospice	AL	27-0078073	Branch	1070	Amedisys Hospice, L.L.C d/b/a Amedisys Hospice Care of Sylacauga 216 North Norton Avenue Sylacauga, AL 35150-2456 County: Talledega *Relocated from 630 Old Birmingham Highway, Sylcauga, AL eff 9/8/16	P: 256-249-0088 F: 256-249-0099 TF:866-994-6932	Facility ID: E6111	1326006651 (1070AL) MEDICAID ONLY: 1801192695 (1076AL)	01-1527	Medicaid: 126970	Hospice
1081	25033	South Hospice	AL	27-0078073	*Parent	1081	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of Florence 412 South Court Street, Suite 302 Florence, AL 35630-5645 County: Lauderdale *Relocated from Ste 401 to Ste 302 eff 1/27/16*	P: 256-760-7877 F: 256-760-7886 TF:877-676-0637	Facility ID: E3911	1104016658 (BluewaterHos)	01-1669	Medicaid ID: 122453	Hospice

Amedisys, Inc. - Active Locations

5/3/2017

Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
1082	20174	Alabama	AL	35-2466166	*Parent	1082	Amedisys Home Health, a Lawrence Medical Center Partner, L.L.C. d/b/a Amedisys Home Health, a Lawrence Medical Center Partner 15190 Court Street, Suite B Moulton, AL 35650-1428 County: Lawrence	P: 256-974-2298 F: 256-974-4215 TF:855-499-5674		1972616258 (GRANNY51)	01-7118	Medicaid 148505	Home Health
1034	20019	Alabama	AL	72-1428475	*Parent	1034	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Florence 412 S. Court Street, Suite 403 Florence, AL 35630-5649 County: Lauderdale	P:-256-766-1817 F:-256-766-1462 TF:866-810-7196		1063612588 (1034AL)	01-7165	Medicaid 103817	Home Health
1008	20019	Alabama	AL	72-1428475	*Parent	1008	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health 68278 Main Street Blountsville, AL 35031-3370 County: Blount Relocated from Oneonta, AL 7/29/2015 *Relocated from Blountsville, AL 6/16/2010 *Relocated from Birmingham, AL 12/28/2006	P: 205-429-4919 F: 205-429-4932 TF:866-486-4919		1649238981 (1008AL)	01-7014	Medicaid AME7014A	Home Health
1003	20019	Alabama	AL	72-1428475	*Parent	1003	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Huntsville 250 Chateau Drive SW, Suite 245 Huntsville, AL 35801-6437 County: Madison *Relocated from 7047 Old Madison Pike, NW, Suite 305, Huntsville on 4/18/13	P: 256-885-1665 F: 256-881-1808 TF:800-317-3454		1013975309 (1003AL)	01-7039	Medicaid AME7039A	Home Health
1019	20019	Alabama	AL	72-1428475	*Parent	1019	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health Lakeshore of Birmingham 2204 Lakeshore Drive, Suite 110 Homewood, AL 35209-6701 County: Jefferson	P: 205-868-0147 F: 205-803-4126 TF:800-977-1859		1245298538 (1019AL)	01-7051	Medicaid BHH7051A	Home Health
1007	20019	Alabama	AL	72-1428475	*Parent	1007	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Foley 1809 N. McKenzie Street Foley, AL 36535-2326 County: Baldwin *Relocated from Fairhope, AL 08/11/2005	P: 251-971-1436 F: 251-971-1437 TF:800-763-6382		1013975572 (1007AL)	01-7069	Medicaid AME7069A	Home Health
1016	20019	Alabama	AL	72-1428475	Branch	1007	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Bay Minette 107 North Hoyle Avenue Bay Minette, AL 36507-4827 County: Baldwin	P: 251-580-8236 F: 251-580-8239 TF:866-206-3214		1013975572 (1007AL)	01-7069 Branch ID: 01Q7069001	Medicaid AME7069A	Home Health
1006	20019	Alabama	AL	72-1428475	*Parent	1006	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Citronelle 19375 N. 3rd St, Ste 101 Citronelle, AL 36522-2048 County: Mobile *Relocated from Mobile 11/05/2010	P: 251-866-3261 F: 251-866-3259 TF:866-307-0985		1790743961 (1006AL)	01-7070	Medicaid AME7070A	Home Health
1011	20019	Alabama	AL	72-1428475	*Parent	1011	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Reform 420 First Avenue West Reform, AL 35481-9779 County: Pickens Mailing: P.O. Box 313, Reform, AL 35481-0313	P: 205-375-9255 F: 205-375-9245 TF:800-277-7445		1326006628 (1011AL)	01-7078	Medicaid AME7078A	Home Health
1028	20019	Alabama	AL	72-1428475	*Parent	1028	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Opelika 3320 Skyway Drive, Suite 804 Opelika, AL 36801-7141 County: Lee	P: 334-887-7234 F: 334-887-7287 TF:866-610-4127		1639137011 (1028AL)	01-7157	Medicaid AME7157A	Home Health
1029	20019	Alabama	AL	72-1428475	*Parent	1029	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Fort Payne 501 Greenhill Blvd NW, Suite 150 Fort Payne, AL 35967-8503 County: Dekalb	P: 256-844-8303 F: 256-844-8373 TF:866-238-9281		1861413890 (1029AL)	01-7158	Medicaid AME7158A	Home Health
1030	20019	Alabama	AL	72-1428475	*Parent	1030	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health 2560 County Road 112 Dothan, AL 36303-0822 County: Dale *Relocated from Ozark, AL eff. 10/28/14 *dba Changed from Amedisys Home Health of Ozark eff. 2/10/15	P: 334-984-2370 F: 334-984-2374 TF:866-205-0818		1871503532 (1030AL)	01-7159	Medicaid AME7159A	Home Health
1031	20019	Alabama	AL	72-1428475	*Sub-Unit	1001	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Monroeville 15 Mayfield Street Monroeville, AL 36460-3009 County: Monroe	P: 251-575-9195 F: 251-575-5449 TF:866-334-0260		1679588446 (1031Al)	01-7163	Medicaid AME7163A	Home Health

Amedisys, Inc. - Active Locations

5/3/2017

Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
1009	20019	Alabama	AL	72-1428475	*Parent	1009	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Tuscaloosa 1300 McFarland Blvd., NE Suite 320 Tuscaloosa, AL 35406-2282 County: Tuscaloosa	P: 205-752-0606 F: 205-758-5244 TF:800-261-4316		1093773319 (1009AL)	01-7300	Medicaid AME7300A	Home Health
1015	20019	Alabama	AL	72-1428475	Branch	1009	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Fayette 228 Temple Avenue North Fayette, AL 35555-2307 County: Fayette *Relocated from 1616 Temple Ave. N. on 8/29/13	P: 205-932-5066 F: 205-932-5074 TF:866-297-8253		1093773319 (1009AL)	01-7300 Branch ID: 01Q7300001	Medicaid AME7300A	Home Health
1022	20019	Alabama	AL	72-1428475	Branch	1009	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Brent 10341 Hwy 5, Suite E Brent, AL 35034-3917 County: Bibb	P: 205-926-6309 F: 205-926-6231 TF:866-926-1564		1093773319 (1009AL)	01-7300 Branch ID: 01Q7300002	Medicaid AME7300A	Home Health
1012	20019	Alabama	AL	72-1428475	*Parent	1012	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Anniston 171 Town Center Drive, MPS-4 Anniston, AL 36205-4101 County: Calhoun Mailing: P.O. Box 5664, Anniston, AL 36205-0664	P: 256-820-2503 F: 256-820-2932 TF:800-261-4318		1245298892 (1012AL)	01-7305	Medicaid AME7305A	Home Health
1021	20019	Alabama	AL	72-1428475	Branch	1012	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Gadsden 1021 South 4th Street Gadsden, AL 35901-5226 County: Etowah *Relocated from Rainbow City 2/23/2011	P: 256-543-1066 F: 256-546-1865 TF:866-543-1077		1245298892 (1012AL)	01-7305 Branch ID: 01Q7305001	Medicaid AME7305A	Home Health
1032	20019	Alabama	AL	72-1428475	Branch	1012	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Sylacauga 395 James Payton Boulevard Sylacauga, AL 35150-8064 County: Talledega	P: 256-245-6224 F: 256-245-0634 TF:866-784-9575		1245298892 (1012AL)	01-7305 Branch ID: 01Q7305002	Medicaid AME7305A	Home Health
1033	20019	Alabama	AL	72-1428475	Branch	1012	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Roanoke 935 Highway 431, Unit 4 Roanoke, AL 36274-7332 County: Randolph	P: 334-863-8770 F: 334-863-8747 TF:866-541-0239		1245298892 (1012AL)	01-7305 Branch ID: 01Q7305003	Medicaid AME7305A	Home Health
1004	20019	Alabama	AL	72-1428475	*Parent	1004	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Montgomery 300 Interstate Park Dr, Suite 324 Montgomery, AL 36109-5468 County: Montgomery	P: 334-272-0313 F: 334-272-0448 TF:800-253-4664		1174581474 (1004AL)	01-7319	Medicaid AME7319A	Home Health
1023	20019	Alabama	AL	72-1428475	Branch	1004	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Clanton 1601 7th Street, North, Suite B Clanton, AL 35045-3942 County: Chilton	P: 205-755-5509 F: 205-755-9980 TF:866-246-5846		1174581474 (1004AL)	01-7319 Branch ID: 01Q7319001	Medicaid AME7319A	Home Health
1001	20019	Alabama	AL	72-1428475	*Parent	1001	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Selma 108 Executive Park Lane Selma, AL 36701-7734 County: Dallas	P: 334-875-2550 F: 334-875-3654 TF:800-647-4663		1033177332 (1001AL)	01-7320	Medicaid AME7320A	Home Health
1002	20019	Alabama	AL	72-1428475	Branch	1001	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Demopolis 1050 Bailey Drive Demopolis, AL 36732-3114 County: Marengo	P: 334-289-5030 F: 334-289-8828 TF:800-442-5030		1033177332 (1001AL)	01-7320 Branch ID: 01Q7320001	Medicaid AME7320A	Home Health
1020	20019	Alabama	AL	72-1428475	Branch	1001	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Thomasville 13 West Front Street North, Suite 101 Thomasville, AL 36784-2045 County: Clarke	P: 334-636-1344 F: 334-636-1347 TF:866-636-1344		1033177332 (1001AL)	01-7320 Branch ID: 01Q7320002	Medicaid AME7320A	Home Health
1024	20019	Alabama	AL	72-1428475	*Sub-Unit	1008	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Walker 100 Highway 78 W. Jasper, AL 35501-3738 County: Walker *Converted from branch agency (1018) of Birmingham, AL to Sub-Unit 08/03/2005	P: 205-295-2434 F: 205-384-6117 TF:877-295-2430		1427016997 (1024AL)	01-7327	Medicaid AME7327A	Home Health

Amedisys, Inc. - Active Locations

5/3/2017

Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
1027	20019	Alabama	AL	72-1428475	*Sub-Unit	1007	Amedisys Home Health of AL, L.L.C. d/b/a Amedisys Home Health of Brewton 2554 Douglas Avenue Brewton, AL 36426-3552 County: Escambia	P: 251-809-1717 F: 251-809-1715 TF:866-8486831		1356309520 (1027AL)	01-7328	Medicaid AME7328A	Home Health
2501	20005	West/MidWest	AR	55-0832933	*Parent	2501	Amedisys Arkansas, LLC d/b/a Amedisys Home Health Care of Arkansas 2700 Bryan Road, Suite A Van Buren, AR 72956-5059 County: Van Buren	P: 479-474-4892 F: 479-474-4179 TF:866-471-4471	AR4358	1346208758 (2501AR)	04-7010	Medicaid 152238514	Home Health
2507	20005	West/MidWest	AR	55-0832933	*Parent	2507	Amedisys Arkansas, L.L.C. d/b/a Amedisys Home Health 307 W. Stillwell Avenue DeQueen, AR 71832-2860 County: Sevier	P: 870-642-4214 F: 870-642-7782 TF: 888-489-2365	AR4746 AR4746(B)	1093742066 (dqhhai)	04-7056	Medicaid: 182173514	Home Health
2502	20005	West/MidWest	AR	55-0832933	*Parent	2502	Amedisys Arkansas, LLC d/b/a Amedisys Home Health of Searcy 404 Llama Drive Searcy, AR 72143-4785 County: White	P: 501-268-2292 F: 501-305-3132 TF:866-528-2292	AR4971	1821295346 (2502AR)	04-7057	Medicaid 174742514	Home Health
2503	20005	West/MidWest	AR	55-0832933	*Parent	2503	Amedisys Arkansas, L.L.C. d/b/a Amedisys Home Health 2236 Harrison Street Batesville, AR 72501-7417 County: Independence	P: 870-793-1483 F: 870-698-6519 TF:800-960-1483	AR4731 AR4731(B)	1821040312 (jtalburt)	04-7080	Medicaid: 179104514	Home Health
2505	20005	West/MidWest	AR	55-0832933	*Parent	2505	Amedisys Arkansas, L.L.C. d/b/a Amedisys Home Health of Mountain View 609 Sylamore Avenue Mountain View, AR 72560 County: Stone **Mailing:** P.O. Box 2710, Mountain View, AR 72560-2710	P: 870-269-2993 F: 870-269-5375 TF:877-683-2993	AR 4629	1306805924 (jonidiffey)	04-7108	Medicaid: 179097514	Home Health
2711	20049	West/MidWest	AZ	20-5611419	*Parent	2711	Amedisys Arizona, L.L.C. d/b/a Amedisys Home Health 1380 S. Castle Dome Avenue, Suite 107 Yuma, AZ 85365-2024 County: Yuma	P: 928-341-1300 F: 928-344-1454 TF:866-327-4137	HHA4586	1154307924 (YRMC7110)	03-7192	Medicaid: 432050	Home Health
2716 (Formerly 2708)	20191	West/MidWest	AZ	30-0809819	*Parent	2716	Tucson Home Health, LLC d/b/a Amedisys Home Health Care, a Tucson Medical Center Partner 5300 East Erickson Drive Suite 116 Tucson, AZ 85712-2809 County: Pima (Formerly Tender Loving Care Health Care Services Western, L.L.C. , dba: Amedisys Home Health Care) **Relocated from 3443 North Campbell Avenue, Suite 155, Tucson, 85719-2472, eff.8/26/16*	P: 520-325-9056 F: 520-325-9101 TF:800-796-9989	HHA7751	1992745210 (TLCTuscon) Do Not Change Spelling	03-7248	Medicaid: 299000	Home Health
2707	20124	West/MidWest	AZ	73-1709953	*Parent	2707	Tender Loving Care Health Care Services Western, L.L.C. d/b/a Amedisys Home Health Care 5045 North 12th Street, Suite 100 Phoenix, AZ 85014-3302 County: Maricopa **Relocated from 7600 N. 16th Street, Suite 250, Phoenix, 85020 eff. 3/29/16*	P: 602-200-0835 F: 602-200-8465 TF:800-244-2034	HHA3720	1013961267 (TLC037106)	03-7106	Medicaid: 958879	Home Health
3511	20124	West/MidWest	CA	73-1709953	*Parent	3511	Tender Loving Care Health Care Services Western, L.L.C. d/b/a Amedisys Home Health Care 1700 S. Winchester Boulevard, Suite 102 Campbell, CA 95008-1163 **Relocated from San Jose 11/19/2010* *County: Santa Clara*	P: 408-370-3927 F: 408-370-6690 TF:866-834-8434	550001171	1538228218 (tlcsanjose)	05-9122	Medicaid: 1538228218	Home Health
3501	20124	West/MidWest	CA	73-1709953	*Parent	3501	Tender Loving Care Health Care Services Western, L.L.C. d/b/a Amedisys Home Health Care 1350 Bayshore Highway, Suite 777 Burlingame, CA 94010-1816 County: San Mateo **Relocated from 1710 Gilbreth Rd, Ste 301, Burlingame eff. 8/12/15*	P: 650-344-4020 F: 650-344-5011 TF:800-380-3886	220000139	1750335824 (tllc557116)	55-7116	Medicaid: HHA57116G	Home Health
3502	20124	West/MidWest	CA	73-1709953	*Parent	3502	Tender Loving Care Health Care Services Western, L.L.C. d/b/a Amedisys Home Health Care 24301 Southland Drive, Suite 411 Hayward, CA 94545-1551 County: Alameda	P: 510-732-0730 F: 510-732-0731 TF:800-430-0095	020000376	1114971280 (tlc557194)	55-7194	Medicaid: HHA57194G	Home Health

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3504	20124	West/MidWest	CA	73-1709953	Branch	3502	Tender Loving Care Health Care Services Western, L.L.C. d/b/a Amedisys Home Health Care 3478 Buskirk Avenue, Suite 336 Pleasant Hill, CA 94523-7312 County: Contra Costa	P: 925-932-3656 F: 925-932-5039 TF:866-738-9979	020000376	1114971280 (tlc557194)	55-7194 Branch ID: 55Q7194001	Medicaid: HHA57194G	Home Health
4703	20127	Northeast	CT	20-1033012	*Parent	4703	Tender Loving Care Health Care Services of New England, LLC d/b/a Amedisys Home Health 68 Southfield Avenue Suite 215 Stamford, CT 06902-7230 County: Fairfield	P: 203-327-2680 F: 203-327-2932 TF:866-327-5024	0016	1043264112 (tlc077136)	07-7136	Medicaid: 004248036 CT Medicaid Non-Medical Services 008046365	Home Health
4701	20127	Northeast	CT	20-1033012	Branch	4703	Tender Loving Care Health Care Services of New England, LLC d/b/a Amedisys Home Health 30 Main Street, Suite 405 Danbury, CT 06810-3004 County: Fairfield	P: 203-730-9035 F: 203-730-8923 TF:866-327-5778	0016	1043264112 (tlc077136)	07-7136 Branch ID: 07Q7136002	Medicaid: 004248036 CT Medicaid Non-Medical Services 008046365	Home Health
4702	20127	Northeast	CT	20-1033012	Branch	4703	Tender Loving Care Health Care Services of New England,LLC d/b/a Amedisys Home Health 1970 Whitney Avenue, Suite 7 Hamden, CT 06517-1206 County: New Haven **Relocated from New Haven, CT 05/31/2012*	P: 203-248-5053 F: 203-248-5085 TF:866-942-2445	0016	1043264112 (tlc077136)	07-7136 Branch ID: 07Q7136004	Medicaid: 004248036 CT Medicaid Non-Medical Services 008046365	Home Health
4704	20127	Northeast	CT	20-1033012	Branch	4703	Tender Loving Care Health Care Services of New England, LLC d/b/a Amedisys Home Health 12 Progress Drive, Suite 1 Shelton, CT 06484-6216 County: Fairfield **Relocated from Stratford, CT 11/19/1*3	P: 203-929-4155 F: 203-929-4181 TF:866-203-7677	0016	1043264112 (tlc077136)	07-7136 Branch ID: 07Q7136005	Medicaid: 004248036 CT Medicaid Non-Medical Services 008046365	Home Health
4708 **Formerly** **4707**	25171	North Hospice	CT	20-1916796	*Parent	4708	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company 111 Founders Plaza, #1803 East Hartford, CT 06108-8301 County: Hartford *Relocated from Mystic(4707) to East Hartford Branch address and assumed branch location code(4708) eff 7-6-15	P 860-282-0527 F 860-282-4692 TF 855-854-0240	0024	1134203284 (beahos1)	07-1537	Medicaid: 008004079	Hospice
4501	20125	CommonWealth	DC	20-1032665	*Parent	4501	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health 1100 H Street NW, Suite 940 Washington, DC 20005-5498 County: Washington	P: 202-783-7892 F: 202-783-7894 TF:800-964-0746	HCA-0058	1669426730 (tlc097024)	09-7024	Medicaid: 018722600	Home Health
1501	20155	CommonWealth	DE	26-1367795	*Parent	1501	Amedisys Delaware, L.L.C. d/b/a Amedisys Home Health 1221 College Park Drive, Suite 203 Dover, DE 19904-8727 County: Kent	P: 302-678-4764 F: 302-678-8614 T 800-655-9299	HHAS-010A	1801881669 (hhcainc01)	08-7007A	Medicaid: 1801881669	Home Health
1502	20155	CommonWealth	DE	26-1367795	*Sub-Unit	1501	Amedisys Delaware, L.L.C. d/b/a Amedisys Home Health 21309 Berlin Road, Sussex Suites, Unit 9 Georgetown, DE 19947-3185 County: Sussex	P: 302-855-0310 F: 302-855-0840 TF:866-276-2314	HHAS-028A	1417021700 (hhcainc16)	08-7034	Medicaid: 1417021700	Home Health
0464	20133	Florida	FL	20-1031990	*Parent	0464	Tender Loving Care Health Care Services of Broward, L.L.C. d/b/a Amedisys Home Health 4752 W. Commercial Blvd Tamarac, FL 33319-2877 County: Broward *Relocated from Ft. Lauderdale eff 12/30/15	P: 954-730-9863 F: 954-714-0346 TF:800-236-6197	21112096	1164476230 (tlc107360)	10-7360	Medicaid 651114700	Home Health
0411 **(Formerl** **y 0405)**	20024	Florida	FL	59-3678437	*Parent	0411	Amedisys Florida, LLC d/b/a Amedisys Home Health 1125 Bartow Road, Suite 300 Lakeland, FL 33801-5849 County: Polk **Relocated from Winterhaven eff. 12/30/15* **Relocated from Lakeland eff 9/25/14* **(Relocated from Winterhaven, FL eff. 4/30/14 to Lakeland branch's address and assumed Lakeland's loc code)	P: 863-680-3531 F: 863-688-3586 TF:866-686-4874	20729096	1982662276 (0405FL)	10-7007	Medicaid: 028156500	Home Health

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0412	20024	Florida	FL	59-3678437	Branch	0411	Amedisys Florida, LLC d/b/a Amedisys Home Health 11968 Balm Riverview Road Riverview, FL 33569-6601 County: Hillsborough *Relocated from Brandon eff 12/30/15*	P: 813-677-9629 F: 813-671-9637 TF:866-651-4639	299991758	1982662276 (0405FL) MEDICAID ONLY: 1073738886 (0412FL)	10-7007 Branch ID: 10Q7007003	Medicaid: N/A	Home Health
0421	20024	Florida	FL	59-3678437	*Parent	0421	Amedisys Florida, LLC d/b/a Amedisys Home Health 2623 Centennial Blvd Ste 201 Tallahassee, FL 32308-0585 County: Leon *Relocated from 8116 Killearn Plaza Circle, Suite 104 Tallahassee, FL eff. 9/30/16*	P: 850-553-9201 F: 850-553-9205 TF:866-419-8776	21078096	1629129937 (0447FL)	10-7151	Medicaid: N/A	Home Health
0417	20024	Florida	FL	59-3678437	*Parent	0417	Amedisys Florida, LLC d/b/a Amedisys Home Health 4900 Bayou Blvd, Suite 201 Pensacola, FL 32503-2543 County: Escambia	P: 850-477-1082 F: 850-477-9713 TF:866-237-0874	299992312	1679685085 (0417FL)	10-8309	Medicaid: 6517005 00	Home Health
0420	20024	Florida	FL	59-3678437	Branch	0417	Amedisys Florida, LLC d/b/a Amedisys Home Health 1008 Airport Road, Suite C Destin, FL 32541-2822 County: Okaloosa *Relocated from Ste B to Ste C Eff. 1/27/16*	P: 850 650-6377 F: 850 654-8066 TF:866-776-9604	299992680	1679685085 (0417FL) MEDICAID ONLY: 1447427547 (0420FLA)	10-8309 Branch ID: 10Q8309003	Medicaid: N/A	Home Health
0419	20024	Florida	FL	59-3678437	Branch	0417	Amedisys Florida, LLC d/b/a Amedisys Home Health 751 N. Ferdon Blvd. Crestview, FL 32536-2113 County: Okaloosa **Relocated from 575 Brookmeade Drive,Crestview eff 4/24/15	P: 850 682-1803 F: 850 682-1831 TF:866-479-2436	299992759	1679685085 (0417FL) MEDICAID ONLY: 1235306325 (0419FL)	10-8309 Branch ID: 10Q8309002	Medicaid: N/A	Home Health
5449 (Formerly 5451)	20062	Florida	FL	62-1179055	*Parent	5449	Housecall Home Health, LLC d/b/a Amedisys Home Health 1515 Herbert Street, Suite 210 Port Orange, FL 32129-6105 County: Volusia **(Relocated from 5451.St. Augustine, FL eff. 4/30/14 to Port Oranges' address and assumed Port Orange's-5449- loc code)	P: 386-788-8313 F: 386-788-6246 TF:866-355-6894	210050961	1184672958 (5451FL)	10-7179	Medicaid: N/A	Home Health
5452	20062	Florida	FL	62-1179055	Branch	5449	Housecall Home Health, LLC d/b/a Amedisys Home Health 4863 Palm Coast Parkway, NW Unit 3 Palm Coast, FL 32137-3665 County: Flagler	P: 386-446-2377 F: 386-986-3440 TF:866-355-8752	299991860	1184672958 (5451FL) MEDICAID & PRIVATE INS. ONLY: 1225345812 (5452FL)	10-7179 Branch ID: 10Q7179005	Medicaid: N/A	Home Health
5442	20062	Florida	FL	62-1179055	*Parent	5442	Housecall Home Health, LLC d/b/a Amedisys Home Health 1300 North Semoran Blvd, Suite 195 Orlando, FL 32807-3599 County: Orange *Relocated from Winter Park, FL 09/20/2007*	P: 407-282-2926 F: 407-282-2186 TF:866-361-0139	210110961	1063460889 (5442FL)	10-7302	Medicaid: N/A	Home Health
5445	20062	Florida	FL	62-1179055	Branch	5442	Housecall Home Health, LLC d/b/a Amedisys Home Health 6905 N Wickham Road, Suite 303 Melbourne, FL 32940-7551 County: Brevard *Relocated from 3962 W. Eau Gallie Blvd, Suite C , Melbourne,32934-3294 eff. 3/25/16	P: 321-751-1901 F: 321-751-9137 TF:866-355-7332	21556096	1063460889 (5442FL) MEDICAID & PRIVATE INS. ONLY: 1689981243 (5445FL)	10-7302 Branch ID: 10Q7302001	Medicaid: N/A	Home Health
5435 (Formerly 5429)	20062	Florida	FL	62-1179055	*Parent	5435	Housecall Home Health, LLC d/b/a Amedisys Home Health 1045 Old Mill Run The Villages, FL 32162-1680 County: Sumter ** *(Relocated from Spring Hill eff 2/22/13 to The Villages branch's address and assumed The Villages' loc code)* *Relocated from Brooksville 4/23/2010* *Relocated from Spring Hill 5/08/2007*	P: 352-391-1416 F: 352-391-1422 TF:866-355-7331	21106096	1053369025 (5429FL)	10-7403	Medicaid: N/A	Home Health
5423 (Formerly 5422)	20062	Florida	FL	62-1179055	*Parent	5423	Housecall Home Health, LLC d/b/a Amedisys Home Health 223 East Oak Street, Suite 2 Arcadia, FL 34266-4445 County: Desoto *Relocated from Port Charlotte eff 12/30/15* *(Relocated from Sarasota eff 12/16/13 to the Port Charlotte branch's address and assumed Port Charlotte's loc code)*	P: 863-993-1038 F: 863-993-1063 TF:866-362-2047	217790961	1992753768 (5422FL)	10-7522	Medicaid: N/A	Home Health
5482	20180	Florida	FL	20-5152080	*Parent	5482	Infinity Home Care of Port Charlotte, LLC d/b/a Amedisys Home Health 4161 Tamiami Trail, Building 8, Unit 801A Port Charlotte, FL 33952-9299 County: Charlotte	P: 941-629-1600 F: 941-629-1606	299991998	1043392038 (INFINITYPC)	10-8270	Applied for	Home Health
5484	20180	Florida	FL	20-5152080	Branch	5482	Infinity Home Care of Port Charlotte, LLC d/b/a Amedisys Home Health 6732 Lone Oak Blvd., Building 1 Naples, FL 34109-6834 County: Collier	P: 239-261-2746 F: 239-261-8606	299993326	1043392038	10-8270 Branch ID: 10Q8270001	Applied for	Home Health

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5485	20180	Florida	FL	20-5152080	Branch	5482	Infinity Home Care of Port Charlotte, LLC d/b/a Amedisys Home Health 1749 NE 10th Terrace , Suite 7 Cape Coral, FL 33909-1713 County: Lee	P: 239-242-0541 F: 239-242-0581	299993039	1043392038	10-8270 Branch ID: 10Q8270002	Applied for	Home Health
5483	20180	Florida	FL	20-5152080	Branch	5482	Infinity Home Care of Port Charlotte, LLC 5969 Cattleridge Boulevard, Suite 104 d/b/a Amedisys Home Health Sarasota, FL 34232-6050 County: Sarasota	P: 941-379-5014 F: 941-379-5032	299993236	1043392038	10-8270 Branch ID: 10Q8270003	Applied for	Home Health
5486	20180	Florida	FL	20-5152080	Branch	5482	Infinity Home Care of Port Charlotte, LLC d/b/a Amedisys Home Health 195A Center Road, Suite A Venice, FL 34285-5572 County: Sarasota	P: 941-484-7292 F: 941-484-7195	299993862	1043392038	10-8270 Branch ID: 10Q8270004	Applied for	Home Health
5487	20183	Florida	FL	20-5782871	*Parent	5487	Infinity Home Care of Lakeland, LLC d/b/a Amedisys Home Health 70 Fourth Street NW Winter Haven, FL 33881-4667 County: Polk	P: 863-686-6790 F: 863-686-6957	299992644	1598891079 ituttle	10-8488	Applied for	Home Health
5488	20183	Florida	FL	20-5782871	Branch	5487	Infinity Home Care of Lakeland, LLC d/b/a Amedisys Home Health 1003 8th Avenue Suite 102 Bradenton, FL 34205-7709 County: Manatee *Relocated from 5959 17th Avenue West, Bradenton eff. 12/7/16	P: 941-792-4500 F: 941-756-7476	299993323	1598891079	10-8488 Branch ID: 10Q8488001	Applied for	Home Health
5489	20183	Florida	FL	20-5782871	Branch	5487	Infinity Home Care of Lakeland, LLC d/b/a Amedisys Home Health 5909 Hampton Oaks Parkway, Ste D Tampa, FL 33610-9581 County: Hillsborough	P: 813-635-0168 F: 813-635-0197	299993369	1598891079	10-8488 Branch ID: 10Q8488002	Applied for	Home Health
5490	20184	Florida	FL	26-1520067	*Parent	5490	Infinity Home Care of Broward, LLC d/b/a Amedisys Home Health 600 W. Hillsboro, Suite 210 Deerfield Beach, FL 33441-1610 County: Broward	P: 954-714-0556 F: 954-714-0553	299992331	1750568648 (Infinitybrow)	10-8342	Applied for	Home Health
5491	20185	Florida	FL	26-1520109	*Parent	5491	Infinity Homecare of District 9, LLC d/b/a Amedisys Home Health 1700 W Woolbright Road, Suite 7 Boynton Beach, FL 33426-6346 County: Palm Beach	P: 561-810-4142 F: 561-810-4170	299992647	1902084759 Infinitypalm	10-8439	Applied for	Home Health
5492	20185	Florida	FL	26-1520109	Branch	5491	Infinity Home Care of District 9, LLC d/b/a Amedisys Home Health 525 NW Lake Whitney Place, Suite 201 Port St. Lucie, FL 34986-1605 County: St. Lucie *Relocated from Vero Beach 4/25/16*	P: 772-204-8967 F: 772-337-4758	299993643	1902084759 Infinitypalm	10-8439 Branch ID: 10Q8439001	Applied for	Home Health
5493	20186	Florida	FL	26-1578514	*Parent	5493	Infinity Home Care of Pinellas , LLC d/b/a Amedisys Home Health 2189 Cleveland Street, Suite 266 Clearwater, FL 33765-3242 County: Pinellas *Relocated from 2963 Gulf to Bay Boulevard, Suite 210 effective 4-29-16	P: 727-538-7716 F: 727-538-4424	299993361	1962665695 (Infinitypin1)	10-9302	Applied for	Home Health
5494	20187	Florida	FL	27-0380782	*Parent	5494	Infinity Home Care of Ocala, LLC d/b/a Amedisys Home Health 7750 SW 60th Ave Suite C Ocala, FL 34476-6472 County: Marion	P: 352-794-3861 F: 352-794-3866	299993640	1346472511 (Ocala547)	10-9669	Applied for	Home Health
5495	20188	Florida	FL	59-3584808	*Parent	5495	Hi-Tech Care, Inc. d/b/a Amedisys Home Health 940 Centre Circle, Suite 3006 Altamonte Springs, FL 32714-7243 County: Seminole	P: 407-464-0194 F: 407-464-0327	299991339	1831192616 (CAHHC01)	10-7660	Applied for	Home Health
3370	25065	South Hospice	GA	02-0674282	*Parent	3370	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice of Dalton 1510 N Thornton Ave, Suite 200 Dalton, GA 30720-8517 County: Whitfield	P: 706-259-2518 F: 706-259-3159 TF:866-353-5915	000-167-H	1255380663 (3370GAH)	11-1643	Medicaid: 000921962B	Hospice

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3371	25065	South Hospice	GA	02-0674282	*Parent	3371	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice of Lawrenceville 595 Hurricane Shoals Road, NW, Suite 201 Lawrenceville, GA 30046-8762 County: Gwinnett	P: 678-442-7338 F: 678-442-7410 TF:866-693-6866	067-0294-H	1427173699 (3371GA)	11-1665	Medicaid: 000921962C	Hospice
8315	20132	South Georgia	GA	20-1032823	*Parent	8315	Tender Loving Care Health Care Services of Georgia, L.L.C. d/b/a Staff Builders Home Health, an Amedisys Company 3505 Duluth Park Lane, Suite 300 Duluth, GA 30096-3203 County: Gwinnett *Relocated from Alpharetta, GA 6/29/2010*	P: 678-417-1033 F: 770-622-9870 TF:866-738-9981	067-305-H	1235182767 (rdelessio)	11-7083	Medicaid: 003124560A	Home Health
8316	20132	South Georgia	GA	20-1032823	Branch	8315	Tender Loving Care Health Care Services of Georgia, L.L.C. d/b/a Staff Builders Home Health, an Amedisys Company 2314 Sullivan Road, Suite 120 College Park, GA 30337-6313 County: Fulton *Relocated from 3848 Northwest Drive, Suite 170 College Park, GA eff 3/8/17* *Relocated from East Point, GA 8/20/2009*	P: 404-684-1932 F: 404-763-1610 TF:866-941-8299	067-305-H	1235182767 (rdelessio) MEDICAID ONLY: 1710134267 (8316GA)	11-7083 Branch ID: 11Q7083001	Medicaid: 000281905H	Home Health
3392	25033	South Hospice	GA	27-0078073	*Parent	3392	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care of Newnan 1825 Highway 34 East, Suite 2200 Newnan, GA 30265-6420 County: Coweta	P: 770-502-3667 F: 770-502-3657 TF:866-694-5374	038-0311-H	1528257169 (3375gah)	11-1685	Medicaid: 003101244A	Hospice
3393	25033	South Hospice	GA	27-0078073	*Parent	3393	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care of Kennesaw 4255 Wade Green Road, NW Bldg 300, Ste. 320 Kennesaw, GA 30144-1762 County: Cobb *Relocated from 1701 Barrett Lakes Boulevard, Suite 280 12/4/2014*	P: 770-423-1316 F: 770-426-7453 TF:866-921-1668	033-0312-H	1396938015 (3374GA)	11-1686	Medicaid: 538644165A	Hospice
3391	25033	South Hospice	GA	27-0078073	*Parent	3391	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care of Cartersville 12 Felton Place, Suite B Cartersville, GA 30120-2165 County: Bartow *Relocated from 1217 Joe Frank Harris Parkway SE, Cartersville eff 3/28/12*	P:770-382-0114 F: 770-382-1393 TF:866-313-1217	008-0308-H	1699968727 (3372GA)	11-1687	Medicaid: 003101278A	Hospice
8326	25033	South Hospice	GA	27-0078073	*Parent	8326	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice 53 Rock Drive Toccoa, GA 30577-3972 County: Stephens	P 706-827-0020 F 706-827-0084 TF:877-234-9881	127-0365-H	1063718211 (8326GA)	11-1718	Medicaid: 003119607A	Hospice
8314	20144	South Georgia	GA	52-2363705	*Parent	8314	AccuMed Home Health of Georgia, L.L.C. d/b/a Community Home Health, an Amedisys Company 400 Churchill Court, Suite 440 Woodstock, GA 30188-6871 County: Cherokee	P: 770-926-9525 F: 770-926-9581 TF:877-622-1909	033-263-H	1003861824 (tlc117130)	11-7130	Medicaid 000964708F	Home Health
3335	20023	North Georgia	GA	58-2567724	*Parent	3335	Amedisys Northwest, LLC d/b/a Amedisys Home Health of Griffin 244 Odell Rd, Unit 1 Griffin, GA 30224-4787 County: Rockdale	P: 770-229-4962 F: 770-412-8767 TF:866-877-5064	126-278-H	1336197003 (3335GA)	11-7045	Medicaid: 00183961A CCSP: 000183961D (Withdrew 6/13/05)	Home Health
3347	20023	North Georgia	GA	58-2567724	Branch	3335	Amedisys Northwest, LLC d/b/a Amedisys Home Health of Thomaston 113 Crawley Street Thomaston, GA 30286-3576 County: Upson	P: 706-648-1148 F: 706-648-1120 TF:866-401-2953	126-278-H	1336197003 (3335GA) MEDICAID ONLY: 1558586347 (3347GA)	11-7045 Branch ID: 11Q7045001	Medicaid: 00183961E	Home Health
3329	20023	North Georgia	GA	58-2567724	*Parent	3329	Amedisys Northwest, LLC d/b/a Amedisys Northwest Home Health 91 Sammy McGhee Blvd, Suite 104 Jasper, GA 30143-7704 County: Pickens	P: 706-692-3491 F: 706-692-0007 TF:800-637-8793	112-095	1588612188 (3329GA)	11-7064	Medicaid 00208007A Source: 00208007F CCSP: (Withdrew 9/1/03)	Home Health
3330	20023	North Georgia	GA	58-2567724	Branch	3329	Amedisys Northwest, LLC d/b/a Amedisys Northwest Home Health 101 Riverstone Vista, Suite 213 Blue Ridge, GA 30513-6648 County: Fanin	P: 706-632-5043 F: 706-632-6160 TF:855-856-3039	112-095	1588612188 (3329GA) MEDICAID ONLY: 1952528259 (3330GA)	11-7064 Branch ID: 11Q7064001	Medicaid 00208007G Source: 00208007F CCSP: (Withdrew 9/1/03)	Home Health

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Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
3355	20023	North Georgia	GA	58-2567724	Branch	3329	Amedisys Northwest, LLC d/b/a Amedisys Northwest Home Health 111 Mountain Vista Blvd, Ste.145 Canton, GA 30115-1301 County: Cherokee *Relocated from 147 Reinhardt College Pkwy, Suite 3 , 5-22-14*	P: 770-345-3630 F: 770-345-3655 TF:866-918-2707	112-095	1588612188 (3329GA) MEDICAID ONLY: 1982822623 (3355GA)	11-7064 Branch ID: 11Q7064002	Medicaid 00208007H	Home Health
3309	20018	South Georgia	GA	72-1428476	*Parent	3309	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1990 Lakeside Parkway, Suite 210 Tucker, GA 30084-5868 County: Dekalb *Relocated from Decatur, GA 12/15/2004*	P: 770-938-9611 F: 770-938-9564 TF:866-236-3849	044-252-H	1477501179 (3309GA)	11-7026	Medicaid 00832444A PSS: 00863145B CCSP: 00863145A (Withdrew 9/1/03)	Home Health
3310	20018	South Georgia	GA	72-1428476	Branch	3309	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 595 Hurricane Shoals Road NW, Suite 200 Lawrenceville, GA 30046-8762 County: Gwinnett	P: 770-995-7802 F: 770-995-8019 TF:866-246-3062	044-252-H	1477501179 (3309GA) MEDICAID ONLY: 1851516629 (3310GA)	11-7026 Branch ID: 11Q7026001	Medicaid 00832444C CCSP: 00863189A (Withdrew 9/1/03)	Home Health
3343	20018	South Georgia	GA	72-1428476	Branch	3309	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 30 Piedmont Drive Winder, GA 30680-8117 County: Barrow	P: 770-868-0078 F: 770-868-0079 TF:866-725-2854	044-252-H	1477501179 (3309GA) MEDICAID ONLY: 1043437346 (3343GA)	11-7026 Branch ID: 11Q7026002	Medicaid 00832444B	Home Health
3394	20018	South Georgia	GA	72-1428476	Branch	3309	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1501 Milstead Road NE Suite 180 Conyers, GA 30012-3850 County: Rockdale Mailing: P.O. Box 1118, Conyers, GA 30012-1118	P: 770-483-7404 F: 770-483-7499 TF:866-377-5262	044-252-H	1477501179 (3309GA) MEDICAID ONLY: 1982849907 (3394GA)	11-7026 Branch ID: 11Q7026003	Medicaid: 000832444D	Home Health
3317	20018	North Georgia	GA	72-1428476	*Parent	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 122 Battlefield Crossing Court Ringgold, GA 30736-5176 County: Catoosa *Relocated from Ft. Oglethorpe 2/27/2008*	P: 706-861-5940 F: 706-861-1237 TF:800-233-0958	023-052	1548218290 (3317GA)	11-7028	Medicai 00826009A CCSP: 00863156C (Withdrew 9/1/03)	Home Health
3363	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 1422 Green Road, Suite F Chatsworth, GA 30705-6998 County: Murray	P 706-517-1600 F 706-517-1606 TF:855-269-1600	023-052	1548218290 (3317GA) MEDICAID ONLY: 1710283205 (3363GA)	11-7028 Branch ID: 11Q7028006	Medicaid 000336894J	Home Health
3318	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 11632 Highway 27 Summerville, GA 30747-5873 County: Chattooga	P: 706-857-7433 F: 706-857-5184 TF:800-874-6433	023-052	1548218290 (3317GA) MEDICAID ONLY: 1003033564 (3318GA)	11-7028 Branch ID: 11Q7028001	Medicaid 00826009D CCSP: 00863156E (Withdrew 9/1/03)	Home Health
3319	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 1575 Chattanooga Avenue, Suite 4 Dalton, GA 30720-2671 County: Whitfield	P: 706-226-1170 F: 706-226-2103 TF:800-742-5972	023-052	1548218290 (3317GA) MEDICAID ONLY: 1437376985 (3319GA)	11-7028 Branch ID: 11Q7028002	Medicaid 00826009E CCSP: 00863156D (Withdrew 9/1/03)	Home Health
3344	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 11804 South Main Street Trenton, GA 30752-2834 County: Dade *Relocated from 5006 Hwy.136 West on 5-24-13*	P: 706-657-6924 F: 706-657-8071 TF:866-610-4113	023-052	1548218290 (3317GA) MEDICAID ONLY: 1821215385 (3344GA)	11-7028 Branch ID: 11Q7028003	Medicaid 00826009B	Home Health
3352	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 202 Professional Court, SE, Suite A Calhoun, GA 30701-7020 County: Gordon	P: 706-629-3447 F: 706-629-3142 TF:866-253-2442	023-052	1548218290 (3317GA) MEDICAID ONLY: 1790903433 (3352GA)	11-7028 Branch ID: 11Q7028004	Medicaid 00826009F CCSP: 00863156E (Withdrew 09/01/03)	Home Health
8320	20018	North Georgia	GA	72-1428476	Branch	3317	Amedisys Georgia, L.L.C. d/b/a North Georgia Home Health Agency, an Amedisys Company 1408 N. Main Street LaFayette, GA 30728-6434 County: Walker	P:706.638.0103 F: 706.639.4925 TF:866-327-6806	023-052	1548218290 (3317GA) MEDICAID ONLY: 1639400286 (8320GAL)	11-7028 Branch ID: 11Q7028005	Medicaid 000827802J	Home Health
3311	20018	North Georgia	GA	72-1428476	*Parent	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 12915 Jones Street Lavonia, GA 30553-1158 County: Franklin	P: 706-356-8480 F: 706-356-2928 TF:800-342-9241	059-240-H	1235187980 (3311GA)	11-7036	Medicaid 00824909A Black Lung: 700317 PSS: 00863123B CCSP: 00863123A (Withdrew 9/1/03)	Home Health
3334	20018	North Georgia	GA	72-1428476	Branch	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 691 441 Historic Highway North, Suite 6 Demorest, GA 30535-4569 County: Habersham *Relocated from 865 Austin Drive, Suite C eff. 6-5-14*	P: 706-839-7037 F: 706-839-7038 TF:866-839-9124	059-240-H	1235187980 (3311GA) MEDICAID ONLY: 1003032475 (3334GA)	11-7036 Branch ID: 11Q7036001	Medicaid: 00824909C CCSP: (Withdrew 9/1/03)	Home Health

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3313	20018	North Georgia	GA	72-1428476	Branch	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 53 Rock Drive Toccoa, GA 30577-3972 County: Stephens	P: 706-886-5442 F: 706-886-4048 TF:800-706-1901	059-240-H	1235187980 (3311GA) MEDICAID ONLY: 1346467750 (3313GA)	11-7036 Branch ID: 11Q7036002	Medicaid 000189109F Black Lung: 700317 CCSP: 00863167A (Withdrew 9/1/03)	Home Health
3312	20018	North Georgia	GA	72-1428476	Branch	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 75 N. Main Street, Suite 105 Clayton, GA 30525-4264 County: Rabun	P: 706-782-4982 F: 706-782-7357 TF:800-348-2852	059-240-H	1235187980 (3311GA) MEDICAID ONLY: 1740406156 (3312GA)	11-7036 Branch ID: 11Q7036003	Medicaid: 000189164F Black Lung: 700317 CCSP: 00863211A (Withdrew 9/1/03)	Home Health
3342	20018	North Georgia	GA	72-1428476	Branch	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 308 E. Howell Street, Suite 100 Hartwell, GA 30643-1999 County: Hart	P: 706-376-4591 F: 706-376-8684 TF:866-862-8534	059-240-H	1235187980 (3311GA) MEDICAID ONLY: 1437376845 (3342GA)	11-7036 Branch ID: 11Q7036004	Medicaid 00824909B Black Lung: 700317	Home Health
3306	20018	South Georgia	GA	72-1428476	*Parent	3306	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 2000 Riveredge Parkway, NW Suite GL200 Atlanta, GA 30328-4694 County: Fulton	P: 770-953-8570 F: 770-916-1850 TF:866-485-3446	060-246-H	1831147529 (3306GA)	11-7039	Medicaid 00824931A PSS: 00863156B CCSP: 00863156A (Withdrew 9/1/03)	Home Health
3308	20018	South Georgia	GA	72-1428476	Branch	3306	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 4255 Wade Green Road, NW,Bldg 300 Suite 310 Kennesaw, GA 30144-1244 County: Cobb **Bldg number 300 was added and suite number chgd from 420 to 310 eff 1/21/15* **Relocated from Cartersville, GA 08/17/2000*	P: 770-424-3595 F: 770-424-1584 TF:866-321-5650	060-246-H	1831147529 (3306GA) MEDICAID ONLY: 1073635660 (3308GA)	11-7039 Branch ID: 11Q7039001	Medicaid 00824931D CCSP: 00863156I (Withdrew 9/1/03)	Home Health
3307	20018	South Georgia	GA	72-1428476	Branch	3306	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1590 Adamson Parkway, Suite 360 Morrow, GA 30260-1755 County: Clayton **Relocated from Atlanta, GA 09/24/2010* **Relocated from College Park, GA 08/23/2004* **Relocated from Forest Park, GA 07/24/2001*	P: 678-422-1051 F: 678-422-6439 TF:855-386-0243	060-246-H	1831147529 (3306GA) MEDICAID ONLY: 1457472250 (3307GA)	11-7039 Branch ID: 11Q7039002	Medicaid: 00824931C CCSP: 00863178A (Withdrew 9/1/03)	Home Health
3353	20018	South Georgia	GA	72-1428476	Branch	3306	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 515 E. Crossville Road, Suite 310 Roswell, GA 30075-3093 County: Fulton *Relocated from Hebbree Road to E. Crossville 10-30-2012	P: 770-993-1059 F: 770-993-1821 TF:866-302-0002	060-246-H	1831147529 (3306GA) MEDICAID ONLY: 1477761351 (3353GA)	11-7039 Branch ID: 11Q7039004	Medicaid 00824931E	Home Health
3320	20018	North Georgia	GA	72-1428476	*Parent	3320	Amedisys Georgia, L.L.C. d/b/a Coosa Valley Home Health, an Amedisys Company 160 Three Rivers Drive, NE, Suite 1100 Rome, GA 30161-2306 County: Floyd	P: 706-291-8867 F: 706-290-0461 F:800-227-6808	057-249-H	1285682955 (3320GEO)	11-7041	Medicaid 00828429A CCSP: 00863156F (Withdrew 9/1/03)	Home Health
3322	20018	North Georgia	GA	72-1428476	Branch	3320	Amedisys Georgia, L.L.C. d/b/a Coosa Valley Home Health, an Amedisys Company 12 Felton Place, Suite E Cartersville, GA 30120-2165 County: Bartow	P: 770-382-8801 F: 770-382-8808 TF:800-831-4138	057-249-H	1285682955 (3320GEO) MEDICAID ONLY: 1548485477 (3322GA)	11-7041 Branch ID: 11Q7041001	Medicaid 00828429B CCSP: 00863156H (Withdrew 9/1/03)	Home Health
3321	20018	North Georgia	GA	72-1428476	Branch	3320	Amedisys Georgia, L.L.C. d/b/a Coosa Valley Home Health, an Amedisys Company 1573 Rome Highway Cedartown, GA 30125-4402 County: Polk **Relocated from 401 N. Main Street* *Cedartown, GA eff 3/31/17* Mailing: P.O. Box 226, Cedartown, GA 30125-0226	P: 770-748-9318 F: 770-748-9898 TF:800-831-5180	057-249-H	1285682955 (3320GEO) MEDICAID ONLY: 1982829826 (3321GA)	11-7041 Branch ID: 11Q7041002	Medicaid 000828429C CCSP: 00863156G (Withdrew 9/1/03)	Home Health
3303	20018	North Georgia	GA	72-1428476	*Parent	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 3009 Chapel Hill Road, Suite C Douglasville, GA 30135-1777 County: Douglas	P: 770-942-1609 F: 770-942-2632 TF:866-488-1643	048-241-H	1437117090 (3303GA)	11-7050	Medicaid 00824942A PSS: 000863222A CCSP: 00863222A (Withdrew 9/1/03)	Home Health
3305	20018	North Georgia	GA	72-1428476	Branch	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1240 Highway 54 W, Suite 601, Bldg. 600 Fayetteville, GA 30214-4562 County: Fayette	P: 770-719-9155 F: 770-719-2441 TF:866-225-4828	048-241-H	1437117090 (3303GA) MEDICAID ONLY: 1467675900 (3305GA)	11-7050 Branch ID: 11Q7050001	Medicaid: 00824942B CCSP: 00863156J (Withdrew 9/1/03)	Home Health
3350	20018	North Georgia	GA	72-1428476	Branch	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 250 Village Center Pkwy, Suite 200 Stockbridge, GA 30281-9044 County: Henry	P: 770-506-4112 F: 770-506-1783 TF:866-776-9598	048-241-H	1437117090 (3303GA) MEDICAID ONLY: 1306063706 (3350GA)	11-7050 Branch ID: 11Q7050003	Medicaid 00824942D	Home Health
3351	20018	North Georgia	GA	72-1428476	Branch	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 105 Village Walk, Suite 282 Dallas, GA 30132-5506 County: Paulding	P: 770-445-2402 F: 770-445-5464 TF:866-393-8915	048-241-H	1437117090 (3303GA) MEDICAID ONLY: 1538281688 (3351GA)	11-7050 Branch ID: 11Q7050004	Medicaid 00824942E	Home Health

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3356	20018	North Georgia	GA	72-1428476	Branch	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1825 Highway 34 East, Suite 2400 Newnan, GA 30265-6411 County: Coweta	P: 678-423-9171 F: 678-423-9182 TF:866-664-9232	048-241-H	1437117090 (3303GA) MEDICAID ONLY: 1609094341 (3356GA)	11-7050 Branch ID: 11Q7050005	Medicaid 000824942G	Home Health
3354	20018	North Georgia	GA	72-1428476	Branch	3303	Amedisys Georgia, L.L.C. d/b/a Central Home Health Care, an Amedisys Company 1124 N. Park St, Suite I Carrollton, GA 30117-2282 County: Carroll	P: 770-832-9310 F: 770-832-9425 TF:888-832-9310	048-241-H	1437117090 (3303GA) MEDICAID ONLY: 1609069756 (3354GA)	11-7050 Branch ID: 11Q7050006	Medicaid 000824942F	Home Health
3302	20018	South Georgia	GA	72-1428476	*Parent	3302	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Covington 4162 Baker Street NE Covington, GA 30014-1404 County: Newton	P: 770-787-1796 F: 770-787-6743 TF:800-834-5927	107-242-H	1134177835 (3302GEO)	11-7065	Medicaid: 00828418A PSS: 000863134A CCSP: 00863134A (Withdrew 9/1/03)	Home Health
3337	20018	South Georgia	GA	72-1428476	Branch	3302	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health Care 500 Great Oaks Drive, Suite 3 Monroe, GA 30655-8228 County: Walton *Relocated from Madison, GA 09/16/2010*	P: 770-207-0790 F: 770-207-0812 TF:866-342-9335	107-242-H	1134177835 (3302GEO) MEDICAID ONLY: 1629190244 (3337GA)	11-7065 Branch ID: 11Q7065001	Medicaid 00828418B	Home Health
3362	20018	South Georgia	GA	72-1428476	Branch	3302	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Athens 1061 Dowdy Road, Suite 205 Athens, GA 30606-5700 County: Clarke Mailing: P.O. Box 607, Athens, GA 30604-6307	P: 706-353-4004 F: 706-353-3866 TF:866-738-0576	107-242-H	1134177835 (3302GEO) MEDICAID ONLY: 1780813576 (3362GA)	11-7065 Branch ID: 11Q7065002	Medicaid 000824909G	Home Health
8303	20018	South Georgia	GA	72-1428476	*Parent	8303	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 201 Maple Drive Vidalia, GA 30474-8906 County: Toombs	P: 912-537-9004 F: 912-537-8586 TF:800-533-2094	138-112	1366627986 (8303GA)	11-7075	Medicaid: 000336894A	Home Health
8304	20018	South Georgia	GA	72-1428476	Branch	8303	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 1022 Hillcrest Pkwy, Suite 302 Dublin, GA 31021-4226 County: Laurens *Relocated from Bellevue Rd, Dublin 6/22/12*	P: 478-272-4261 F: 478-272-4671 TF:866-666-6932	138-112	1366627986 (8303GA) MEDICAID ONLY: 1962665224 (8304GA)	11-7075 Branch ID: 11Q7075002	Medicaid: 000336894H	Home Health
8305	20018	South Georgia	GA	72-1428476	*Parent	8305	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 203 Albany Avenue Waycross, GA 31501-3504 County: Ware	P: 912-285-2222 F: 912-287-1179 TF:800-822-5003	148-110	1316120322 (8305GA)	11-7076	Medicaid 000826009I	Home Health
8324	20018	South Georgia	GA	72-1428476	Branch	8305	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 190 Westside Drive, Suite E Douglas, GA 31533-3534 County: Coffee	P:912.383.0840 F: 912.383.0838 TF:866-204-8071	148-110	1316120322 (8305GA) MEDICAID ONLY: 1457682007 (8324GA)	11-7076 Branch ID: 11Q7076001	Medicaid: 000826009J	Home Health
8302	20018	South Georgia	GA	72-1428476	*Parent	8302	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 72 Kent Road, Suite 3 Tifton, GA 31794-1694 County: Tift	P: 229-386-0665 F: 229-386-5384 TF:800-786-0454	137-111	1356524359 (8302GA)	11-7077	Medicaid: 000336872A	Home Health
8318	20018	South Georgia	GA	72-1428476	Branch	8302	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 220 GA Highway 33 S, Unit 7 Moultrie, GA 31788-0579 County: Colquitt	P: 229-502-4260 F: 229-502-9954 TF:866-327-4194	137-111	1356524359 (8302GA) MEDICAID ONLY: 1649501297 (8318GA)	11-7077 Branch ID: 11Q7077001	Medicaid: 000826009K	Home Health
8301	20018	South Georgia	GA	72-1428476	*Parent	8301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 17 Park of Commerce Boulevard, Suite 100 Savannah, GA 31405-7470 County: Chatham	P: 912-233-9800 F: 912-233-9050 TF:800-272-1667	025-145	1942483920 (8301GA)	11-7078	Medicaid 000336883A	Home Health
8323	20018	South Georgia	GA	72-1428476	Branch	8301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 513 West Oglethorpe Hwy Hinesville, GA 31313-4412 County: Liberty	P: 912-877-3844 F:912-877-3850 TF:866-205-6759	025-145	1942483920 (8301GA) MEDICAID ONLY: 1578895405 (8323GAH)	11-7078 Branch ID: 11Q7078001	Medicaid: 000336883H	Home Health
8322	20018	South Georgia	GA	72-1428476	Branch	8301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health 907 Lisa Street, Suite A Rincon, GA 31326-5184 County: Effingham	P:912-826-5884 F:912-826-6352 TF:866-204-3028	025-145	1942483920 (8301GA) MEDICAID ONLY: 1902137565 (8322GAR)	11-7078 Branch ID: 11Q7078002	Medicaid: 000336883F	Home Health
3340	20018	South Georgia	GA	72-1428476	*Parent	3340	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health Care 3633 Wheeler Road, Suite 200 Augusta, GA 30909-6551 County: Richmond	P: 706-860-0772 F: 706-860-7048 TF:866-359-6570	121-282-H	1952359705 (3340GA)	11-7081	Medicaid 00917683A	Home Health
3301	20018	North Georgia	GA	72-1428476	*Parent	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Macon 6040 Lakeside Commons Drive, Suite B Macon, GA 31210-5794 County: Bibb	P: 478-476-0181 F: 478-477-1317 TF:800-675-1073	011-243-H	1356399018 (3301GA)	11-7093	Medicaid: 00827802A PSS: 0863178A CCSP: 00863178B (Withdrew 9/1/03)	Home Health

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Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
3339	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Milledgeville 571 Hammock Road NW, Suite 114 Milledgeville, GA 31061-7185 County: Baldwin	P: 478-454-2012 F: 478-454-5253 TF:866-454-2041	011-243-H	1356399018 (3301GA) MEDICAID ONLY: 1851518252 (3339GA)	11-7093 Branch ID: 11Q7093001	Medicaid: 00827802B	Home Health
3341	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Butler 13 South Broad Street Butler, GA 31006-5519 County: Taylor *Relocated from Ellaville, GA 07/13/2006 Mailing: P.O. Box 247, Butler, GA 31006-0247	P: 478-862-3102 F: 478-862-3129 TF:866-771-9537	011-243-H	1356399018 (3301GA) MEDICAID ONLY: 1649497108 (3341GA)	11-7093 Branch ID: 11Q7093002	Medicaid: 00827802C	Home Health
3348	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Columbus 1117 20th St., Suite 200 Columbus, GA 31901-1643 County: Muscogee	P: 706-327-9334 F: 706-327-9306 TF:866-487-4844	011-243-H	1356399018 (3301GA) MEDICAID ONLY: 1003031907 (3348GA)	11-7093 Branch ID: 11Q7093003	Medicaid: 00827802D	Home Health
3358	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Hawkinsville 32 341 Bypass Hawkinsville, GA 31036-4840 County: Pulaski	P: 478-892-0444 F: 478-892-0449 TF:866-448-2615	011-243-H	1356399018 (3301GA) MEDICAID ONLY: 1568643773 (3358GA3)	11-7093 Branch ID: 11Q7093004	Medicaid: 000827802H	Home Health
3360	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Americus 1206 Crawford St. Suite A Americus, GA 31709-3278 County: Sumter	P: 229-928-3483 F: 229-928-4326 TF:877-355-0002	011-243-H	1356399018 (3301GA) MEDICAID ONLY : 1568607513 (3360GA)	11-7093 Branch ID: 11Q7093005	Medicaid: 000827802G	Home Health
3359	20018	North Georgia	GA	72-1428476	Branch	3301	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Gray 4274 Gray Highway Suite C Gray, GA 31032-5938 County: Jones	P: 478-986-5550 F: 478-986-5553 TF:866-276-3406	011-243-H	1356399018 (3301GA) MEDICAID ONLY 1043455074 (3359GA)	11-7093 Branch ID: 11Q7093006	Medicaid: 000827802F	Home Health
3333	20018	South Georgia	GA	72-1428476	*Parent	3333	Amedisys Georgia, L.L.C. d/b/a Amedisys Home Health of Valdosta 2947 North Ashley Street, Suite C Valdosta, GA 31602-1712 County: Lowndes	P: 229-245-0646 F: 229-245-8946 TF:866-268-3535	092-204	1720036494 (3333GA)	11-7114	Medicaid 000748712A	Home Health
3315	20018	North Georgia	GA	72-1428476	*Sub-Unit	3311	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 2565 Thompson Bridge Rd, Suite 204-205 Gainesville, GA 30501-1723 County: Hall	P: 770-532-2013 F: 770-532-4177 TF:800-992-9701	069-247-H	1912955667 (3315GA)	11-7305	Medicaid 00832455A Black Lung: 700318 PSS: 000863233B CCSP: 00863233A (Withdrew 9/1/03)	Home Health
3316	20018	North Georgia	GA	72-1428476	Branch	3315	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 1100 Turner Road, Suite A Cumming, GA 30041-5303 County: Forsyth	P: 678-455-5207 F: 678-455-5300 TF:888-554-1716	069-247-H	1912955667 (3315GA) MEDICAID ONLY: 1548485501 (3316GA)	11-7305 Branch ID: 11Q7305001	Medicaid 00832455C Black Lung: 700318 CCSP: 00863233A (Withdrew 9/1/03)	Home Health
3338	20018	North Georgia	GA	72-1428476	Branch	3315	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 417 Blue Ridge Street, Suite K Blairsville, GA 30512-3778 County: Union	P: 706-781-1093 F: 706-781-1246 TF:866-896-0042	069-247-H	1912955667 (3315GA) MEDICAID ONLY: 1427275825 (3338GA)	11-7305 Branch ID: 11Q7305002	Medicaid 00832455B Black Lung: 700318	Home Health
3357	20018	North Georgia	GA	72-1428476	Branch	3315	Amedisys Georgia, L.L.C. d/b/a Tugaloo Home Health Agency, an Amedisys Company 135 Tipton Drive Dahlonega, GA 30533-1604 County: Lumpkin	P: 706-864-1000 F: 706-864-1012 TF:866-448-1686	069-247-H	1912955667 (3315GA) MEDICAID ONLY: 1437341849 (3357GA)	11-7305 Branch ID: 11Q7305003	Medicaid 000826009G Black Lung: 700318	Home Health
2401	20098	West/MidWest	IL	20-8349848	*Parent	2401	Amedisys Illinois, LLC d/b/a Amedisys Home Health 765 Ela Road, Suite 105 Lake Zurich, IL 60047-2339 County: Lake *Relocated from Hinsdale 6/4/2010* *Relocated from Tinley Park 12/16/13* *Relocated from Algonquin 02/27/14*	P: 847-438-4805 F: 847-438-4870 TF:866-298-2542	1010804	1861667115 (2401IL)	14-7407	Medicaid: 364576454007	Home Health
2406	20098	West/MidWest	IL	20-8349848	*Parent	2406	Amedisys Illinois, LLC. d/b/a Amedisys Home Health 624 Pierce Blvd, Suite 100 O'Fallon, IL 62269-2579 County: St. Clair *Relocated from Belleville 6/28/2012	P: 618-622-8854 F: 618-622-9528 TF:888-825-0170	1010794	1447474895 (2406IL)	14-8004	Medicaid: 364576454006	Home Health
1821	20092	CommonWealth	IN	20-3217967	*Parent	1821	Amedisys Sp-IN, LLC d/b/a Amedisys Home Health 303 Quartermaster Court Jeffersonville, IN 47130-3670 County: Clark	P: 812-284-3030 F: 812-284-6449 TF:800-719-3030	16-006000-1	1164470373 (1821IN)	15-7221	Medicaid 200804850A	Home Health
1824	20092	West/MidWest	IN	20-3217967	*Parent	1824	Amedisys Sp-IN, LLC d/b/a Amedisys Home Health 1332 West Arch Haven Ave, Suite E Bloomington, IN 47403-2078 County: Monroe	P: 812-333-7018 F: 812-333-7094 TF:866-493-5748	16-004926-1	1003937269 (1824IN)	15-7578	Medicaid: 200836910A	Home Health

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1828	20092	West/MidWest	IN	20-3217967	Branch	1824	Amedisys Sp-IN, LLC d/b/a Amedisys Home Health 4134 S. 7th St Terre Haute, IN 47802-4123 County: Vigo	P: 812-234-1850 F: 812-232-5686 TF:866-635-2478	16-004926-1	1003937269 (1824IN) MEDICAID ONLY: 1306037932 (1828IN)	15-7578 Branch ID: 15Q7578001	Medicaid: 200836910B	Home Health
1823	20092	West/MidWest	IN	20-3217967	*Parent	1823	Amedisys Sp-IN, LLC d/b/a Amedisys Home Health 2200 Lake Ave, Suite 150 Fort Wayne, IN 46805-5347 County: Allen	P: 260-422-8900 F: 260-422-8911 TF:866-841-2214	16-011110-1	1437103199 (1823IN)	15-7583	Medicaid: 200841710A	Home Health
1840	20088	West/MidWest	IN	20-8718537	*Parent	1840	Amedisys Indiana, LLC d/b/a Amedisys Home Health 931 Ridge Road, Suites E & F Munster, IN 46321-1756 County: Lake	P: 219-836-4979 F: 219-836-4976 TF:866-315-2809	16-010149-1	1427223684 (1840in)	15-7521	Medicaid: 200914990A	Home Health
1872	25033	North Hospice	IN	27-0078073	*Parent	1872	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice 305 Quartermaster Court Jeffersonville, IN 47130-3670 County: Clark	P 812-284-4630 F 812-284-4656 TF:866-867-6803	17-012308-1	1932437779 (1872IN)	15-1605	Medicaid 201011750A	Hospice
1612	25074	South Hospice	KS	20-8307808	*Parent	1612	Amedisys Kansas, LLC d/b/a Amedisys Hospice of Wichita 250 W. Douglas Ave, Suite 110 Wichita, KS 67202-3113 County: Sedgwick	P: 316-945-0459 F: 316-945-9897 TF:866-334-7790		1801089859 (1612KS)	17-1548	Medicaid: KMAP ID Number: 200533600B	Hospice
1611	20074	West/MidWest	KS	20-8307808	*Parent	1611	Amedisys Kansas, LLC d/b/a Amedisys Home Health Care 250 W. Douglas Ave, Suite 101 Wichita, KS 67202-3113 County: Sedgwick	P: 316-945-9797 F: 316-945-8896 TF:800-759-0501	A087024	1609068204 (1161KS)	17-7170A	Medicaid 200533600A	Home Health
2123	20093	CommonWealth	KY	20-3217688	*Parent	2123	Amedisys Sp-OH, L.L.C. d/b/a Amedisys Home Health of Kentucky 533 Centre View Blvd. Crestview Hills, KY 41017-3444 County: Kenton *Relocated from: 2670 Chancellor Drive, Suite 120, eff. 11/18/14*	P: 859-441-7999 F: 859-441-5606 TF:866-841-2064	150184	1215940093 (2123KY)	18-7179	Medicaid: 7100031060	Home Health
2121	20094	CommonWealth	KY	20-3217889	*Parent	2121	Amedisys Sp-KY, LLC d/b/a Amedisys Home Health Care Services 101 Bruce Professional Plaza Mt. Sterling, KY 40353-8502 County: Montgomery	P: 859-498-5199 F: 859-498-7814 TF:888-798-5199	150091	1326096140 (2121KY)	18-7093	Medicaid 34000281	Home Health
2120	20094	CommonWealth	KY	20-3217889	*Parent	2120	Amedisys Sp-KY, LLC d/b/a Amedisys Home Health Care Services 9000 Wessex Place, Suite 304 Louisville, KY 40222-5071 County: Jefferson *Relocated from Ste. 100 to Ste. 304 eff 04/28/15	P: 502-429-4550 F: 502-426-1887 TF:800-982-4550	150084	1013965979 (2120KY)	18-7143	Medicaid: 34000299	Home Health
2122	20094	CommonWealth	KY	20-3217889	*Parent	2122	Amedisys Sp-KY, LLC d/b/a Amedisys Home Health Care Services 833 Valley College Drive, Suite 5 Louisville, KY 40272-2791 County: Jefferson	P:502-933-1311 F:502-933-1745 TF:800-982-4550	150154	1104875749 (2122KY)	18-7171	Medicaid: 7100107770	Home Health
2140	20122	Tennessee	KY	62-1151058	*Sub-Unit	0540	Comprehensive Home Healthcare Services, L.L.C. d/b/a Amedisys Home Health Care 123 N. 19th Street, Suite 5 Middlesboro, KY 40965-2865 County: Bell **Mailing:** P.O.Box 236, Middlesboro, KY 40965-0236	P: 606-248-1062 F: 606-242-1224 TF:800-528-4029	150129	1942250592 (CBRANDEN12)	18-7306	Medicaid 7100126150 Medicaid Waiver: 7100163110 EPSDT Waiver: 7100163150	Home Health
2101	20062	CommonWealth	KY	62-1179055	*Parent	2101	Housecall Home Health, LLC d/b/a Amedisys Home Health Services 13101 Magisterial Drive, Suite 101 Louisville, KY 40223-5138 County: Jefferson	P: 502-244-5441 F: 502-244-5627 TF:888-582-3200	150045	1043268881 (2101KY)	18-7059	Medicaid 34026567	Home Health
2150	20121	CommonWealth	KY	62-1282368	*Parent	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 937 Campbellsville Road, Suite 903 Columbia, KY 42728-2265 County: Columbia **Mailing:** P. O. Box 1089, Columbia, KY 42728-6089	P: 270-384-6411 F: 270-384-3928 TF:800-861-8601	150108	1891765723 (CBRANDEN)	18-7119	Medicaid 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2156	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 1724 Rockingham Avenue, Suite 300 Bowling Green, KY 42104-5842 County: Warren	P: 270-842-4500 F: 270-842-0900 TF:866-770-4500	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119004	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health

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2153	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 1332 North Race Street Glasgow, KY 42141-3455 County: Barren *Relocated from 216C North Race Street,Glasgow eff 10/14/15	P: 270-651-7640 F: 270-651-9644 TF:877-949-0990	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119005	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2160	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 124 Foothills Avenue Albany, KY 42602-1090 County: Clinton **Mailing**: P.O. Box 184, Albany, KY 42602-0184	P: 606-387-6661 F: 606-387-6670 TF:800-861-8603	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119006	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2151	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 102 South Main Street Greensburg, KY 42743-1527 County: Green	P: 270-932-7791 F: 270-932-5229 TF:800-861-8605	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119007	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2157	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 40 Turpen Court, Suite A Somerset, KY 42503-3464 County: Pulaski	P: 606-679-8555 F: 606-678-4548 TF:877-346-0210	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119009	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2152	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 175 West Bear Track Road Campbellsville, KY 42718-8709 County: Taylor	P: 270-465-4978 F: 270-465-5330 TF:800-861-8606	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119010	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2155	20121	CommonWealth	KY	62-1282368	Branch	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 1690 Ring Road, Suite 200 Elizabethtown, KY 42701-4411 County: Hardin	P: 270-766-1297 F: 270-766-1649 TF:800-647-0775	150108	1891765723 (CBRANDEN)	18-7119 Branch ID: 18Q7119015	Medicaid: 7100162880 H&C Based Waiver: 7100162920 Model 2 Waiver: 7100162950 EPSDT Waiver 7100162960	Home Health
2143	20121	CommonWealth	KY	62-1282368	*Sub-Unit	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 2480 Fortune Drive, Suite 120 Lexington, KY 40509-4168 County: Fayette *Relocated from Georgetown, 7-23-13	P: 859-271-0611 F: 859-271-0751 TF:866-841-2067	150170	1568432433 (CBRANDEN3)	18-7163	Medicaid: 7100123960 H&C Based Waiver: 7100163030 Model 2 Waiver: 7100163000	Home Health
2149	20121	CommonWealth	KY	62-1282368	*Sub-Unit	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 2200 East Parrish Avenue, Suite 103E Owensboro, KY 42303-1450 County: Daviess	P: 270-852-4811 F: 270-852-4812 TF:800-910-1412	150176	1285604140 (CBRANDEN2)	18-7168	Medicaid: 7100123910 H&C Based Waiver: 7100162990	Home Health
2142	20121	Northeast	KY	62-1282368	*Sub-Unit	2150	Family Home Health Care, L.L.C. d/b/a Amedisys Home Health 1200 Bath Avenue, Suite 301 Ashland, KY 41101-2665 County: Boyd	P: 606-324-2491 F: 606-324-7676 TF:888-882-6300	150164	1740250133 (CBRANDEN4)	18-7302	Medicaid: 7100163050 H&C Based Waiver: 7100163080 Model 2 Waiver: 7100163100	Home Health
1211	25033	South Hospice	LA	27-0078073	*Parent	1211	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice 425 Ashley Ridge Blvd., Suite 240 Shreveport, LA 71106-7226 Parish: Caddo *Relocated from 8508 Line Avenue, Suite A--8-15-13	P: 318-868-8788 F: 318-868-9788 TF:800-856-4307	2203781755 STATE ID: HP0001772	1366443830 (ohc048la)	19-1533	Medicaid 1580627	Hospice
1212	25033	South Hospice	LA	27-0078073	*Parent	1212	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice 4017 Common Street Lake Charles, LA 70607-2942 Parish: Calcasieu *Relocated from 814 W. McNeese St, St.100 5-24-13	P: 337-562-3200 F: 337-478-9501 TF:855-594-7264	2203781671 STATE ID: HP0001773	1649271016 (ohc056la)	19-1534	Medicaid 1580732	Hospice
1280	25033	South Hospice	LA	27-0078073	*Parent	1280	Amedisys Hospice, LLC d/b/a Amedisys Hospice 13702 Coursey Blvd, Suite 1B Baton Rouge, LA 70817-1370 Parish: East Baton Rouge *Relocated from Ste. 6A to Ste. 1B--07-30-13	P: 225-751-4599 F: 225-751-4579 TF:866-334 7786	2203781730 STATE ID: HP0004886	1790743086 (1280LOU)	19-1607	Medicaid 1583880	Hospice

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1284	25033	South Hospice	LA	27-0078073	*Parent	1284	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice 4021B Ambassador Caffery Pkwy, Suite 101 Lafayette, LA 70503-5262 Parish: Lafayette *Relocated from 100 Asma Boulevard, Suite 265 Lafayette, eff 8/26/15*	P 337-988-9778 F 337-988-9782 TF877-922-3724	2203782436 STATE ID: HP0010560	1780984732 (1284LA)	19-1674	Medicaid: 2173235	Hospice
1210	20013	La/Miss	LA	72-1225546	*Parent	1210	Home Health of Alexandria, L.L.C. d/b/a Amedisys Home Health Services 5803 Coliseum Boulevard, Suite C Alexandria, LA 71303-3579 Parish: Rapides *Relocated from Boyce, LA 12/08/2010*	P: 318-445-2846 F: 318-445-8719 TF:800-442-3106	1189 STATE ID: HH0001295	1992763148 (1210LA)	19-7504	Medicaid 1403695	Home Health
1291	20016	La/Miss	LA	72-1429887	*Parent	1291	Amedisys Louisiana, LLC d/b/a Amedisys Home Health 1403 St. Charles Street, Suite 101 Houma, LA 70360-3964 Parish: Terrrebonne	P: 985-872-1955 F: 985-580-4233 TF:866-877-8050	1079 STATE ID: HH0001257	1760430441 (1291LA)	19-7167	Medicaid 1401676	Home Health
1207	20016	La/Miss	LA	72-1429887	*Parent	1207	Amedisys Louisiana, L.L.C. d/b/a Amedisys Home Health 425 Ashley Ridge Blvd., Suite 246 Shreveport, LA 71106-7226 Parish: Caddo *Relocated from 920 Pierremont Road, Suite 520 8-15-13*	P: 318-865-8865 F: 318-865-0104 TF:855-594-7265	2203781752 STATE ID: HH0001295	1871523902 (gentivahh152)	19-7242	Medicaid: 1402346	Home Health
1253	20016	La/Miss	LA	72-1429887	*Parent	1253	Amedisys Louisiana, LLC d/b/a Amedisys Home Health 4021B Ambassador Caffery Pkwy, Suite 100 Lafayette, LA 70503-5262 Parish: Lafayette *Relocated from 1201 Camellia Blvd., Suite 201, Lafayette eff. 8/28/15*	P: 337-989-6913 F: 337-989-6972 TF:800-489-1143	2203782441 STATE ID: HH0001308	1588612261 (1253LA)	19-7263	Medicaid 1402508	Home Health
1292	20016	La/Miss	LA	72-1429887	Branch	1253	Amedisys Louisiana, LLC d/b/a Amedisys Home Health 2341 Larkspur Lane, Suite 3 Opelousas, LA 70570-8664 Parish: St. Landry	P: 337-948-3223 F: 337-948-3930 TF:866-848-3122	2203782441-B STATE ID: HH0001308	1588612261 (1253LA)	19-7263 Branch ID: 19Q7263001	Medicaid 1402508	Home Health
1251	20016	La/Miss	LA	72-1429887	*Parent	1251	Amedisys Louisiana, LLC d/b/a Amedisys Home Health 13702 Coursey Blvd, Suite 1A Baton Rouge, LA 70817-1370 Parish: East Baton Rouge	P: 225-751-8201 F: 225-751-2230 TF:800-943-7095	919 STATE ID: HH0001374	1588612360 (1251LA)	19-7437	Medicaid 1403334	Home Health
1298	20016	La/Miss	LA	72-1429887	*Parent	1298	Amedisys Louisiana, L.L.C. d/b/a Amedisys Home Health 4015 Common Street Lake Charles, LA 70607-2942 Parish: Calcasieu	P:337-477-9820 F:337-477-5175 TF855-594-7263	2203781684 STATE ID: HH0001378	1750609384 gentivahh379	19-7443	Medicaid 1403423	Home Health
1271	20004	La/Miss	LA	91-2197557	*Parent	1271	Amedisys LA Acquisitions, LLC d/b/a Amedisys Home Health Care 1007 W. Thomas St., Suite L Hammond, LA 70401-3062 Parish: Tangipahoa	P: 985-902-9922 F: 985-902-9006 TF:855-849-7198	1107 STATE ID: HH0001283	1003864794 (1271LA)	19-7216	Medicaid 1402125	Home Health
1276	20004	La/Miss	LA	91-2197557	*Parent	1276	Amedisys LA Acquisitions, LLC d/b/a Amedisys Home Health Care 3501 N. Causeway Blvd, Suite 200 Metairie, LA 70002-3617 Parish: Jefferson	P: 504-838-7080 F: 504-838-8038 TF:877-486-7080	1011 STATE ID: HH0001360	1336107663 (1276LA)	19-7765	Medicaid 1406678	Home Health
1275	20004	La/Miss	LA	91-2197557	Branch	1276	Amedisys LA Acquisitions, LLC d/b/a Amedisys Home Health Care 525 Justin Street Lockport, LA 70374-2740 Parish: Lafourche *Relocated from Larose, LA to Lockport, LA eff 10/28/14*	P: 985-532-6508 F: 985-532-7178 TF:800-349-9182	1011-E	1336107663 (1276LA)	19-7765 Branch ID: 19Q7765003	Medicaid 1406678	Home Health
4414 **(Formerl** **y 4402)**	20127	Northeast	MA	20-1033012	*Parent	4414	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care 529 Main Street, Suite 101 Charlestown, MA 02129-1122 County: Suffolk (Waltham (4402) relocated eff. 5/2/14 to Charlestown (4414) Branch address and assumed Charlestown's loc. code)	P: 617-241-0003 F: 617-241-0008 TF:877-885 0108		1407800584 (tlc227211) MEDICAID BILLING ONLY: 1134420748 (MA4402)	22-7211	Medicaid: 110080794B	Home Health

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4410	20127	Northeast	MA	20-1033012	Branch	4414	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care 182 North Main Street, Suite A Fall River, MA 02720-2107 County: Bristol *Relocated from 1 Father DeValles Blvd. Suite 302 Fall River, MA eff. 5/13/14	P: 508-235-0425 F: 508-675-3894 TF:866-994-6931		1407800584 (tlc227211) MEDICAID ONLY 1013249101 (4410MA)	22-7211 Branch ID: 22Q7211002	Medicaid: 110080794H	Home Health
4405	20127	Northeast	MA	20-1033012	Branch	4414	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care One Parker Street, Suite 2A Lawrence, MA 01843-1548 County: Essex	P:978-685-2818 F:978-738-5071 TF:877-806-3997		1407800584 (tlc227211) MEDICAID ONLY 1851623946 (4405MA)	22-7211 Branch ID: 22Q7211005	Medicaid: 110080794F	Home Health
4401	20127	Northeast	MA	20-1033012	*Parent	4401	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care 67 Hunt Street, Suite 102 Agawam, MA 01001-1913 County: Hampden	P: 413-789-0027 F: 413-789-0322 TF:800-379-5795		1770537847 (tlc227288) MEDICAID BILLING ONLY: 1316248925 (MA4401)	22-7288	Medicaid: 110080794A	Home Health
4408	20127	Northeast	MA	20-1033012	Branch	4401	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care 7 North Street, Suite 300 Pittsfield, MA 01201-5162 County: Berkshire	P: 413-236-8500 F: 413-236-8501 TF:877-370-3573		1770537847 (tlc227288) MEDICAID ONLY 1285864579 (4401MA)	22-7288 Branch ID: 22Q7288003	Medicaid: 110080794D	Home Health
4419	25171	North Hospice	MA	20-1916796	*Parent	4419	Beacon Hospice,L.L.C d/b/a Beacon Hospice, an Amedisys Company 529 Main Street, Suite 126 Charlestown, MA 02129-1248 County: Suffolk	P 617-242-8370 F 617-241-2880 TF: 877-242-8394	7237	1932283694 (beahos4)	22-1544A	Medicaid: 110024514C	Hospice
4418	25171	North Hospice	MA	20-1916796	Branch	4419	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 100 Cummings Center, Suite 222C Beverly, MA 01915-6113 County: Essex	P 978-524-9510 F 978-524-9514 TF: 800-981-4743	7237	1932283694 (beahos4)	22-1544A	Medicaid: 110024514A	Hospice
4420	25171	North Hospice	MA	20-1916796	Branch	4419	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 182 North Main Street Fall River, MA 02720-2107 County: Bristol	P 508-324-1900 P 508-324-4672 TF:800-981-4631	7237	1932283694 (beahos4)	22-1544A	Medicaid: 110024514B	Hospice
4423	25171	North Hospice	MA	20-1916796	Branch	4419	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 13 Branch Street, Suite 100 Methuen, MA 01844-1975 County: Essex *Relocated from Haverhill 04/06/2012*	P: 978-837-3333 F: 978-837-3330 TF: 800-981-4805	7237	1932283694 (beahos4)	22-1544A	Medicaid: 110024514K	Hospice
4424	25171	North Hospice	MA	20-1916796	Branch	4419	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 68 Center Street, Suite 19 Hyannis, MA 02601-5575 County: Barnstable *Relocated from Yarmouth Port 2/24/2012*	P: 508-778-1622 F: 508-778-1625 TF: 800-981-8794	7237	1932283694 (beahos4)	22-1544A	110024514E	Hospice
4425	25171	North Hospice	MA	20-1916796	Branch	4419	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 32 Resnik Road, Suite 3 Plymouth, MA 02360-7255 County: Plymouth	P: 508-747-7222 F: 508-747-7252 TF: 800-981-4643	7237	1932283694 (beahos4)	22-1544A	110024514D	Hospice
4426	25171	North Hospice	MA	20-1916796	*Parent	4426	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 815 Worcester Street Springfield, MA 01151-1001 County: Hampden	P: 413-543-3133 F: 413-543-3137 TF:855-897-7846	7KNQ	1508012204 (spring02)	22-1573	110024514I	Hospice
4421	25171	North Hospice	MA	20-1916796	*Parent	4421	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 36 Williams Street Leominster, MA 01453-3276 County: Worcester	P: 978-466-7890 F: 978-466-7893 TF:855-897-7848	77YW	1386839520 (leominster02)	22-1580	110024514G	Hospice

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5006	20125	CommonWealth	MD	20-1032665	*Parent	5006	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health Care 19 Newport Drive, Suite 201 Forest Hill, MD 21050-1622 County: Harford *Relocated from Baltimore 09/09/2011*	P: 410-420-6412 F: 410-420-6419 TF:800-988-5024	HH7045	1295789360 (tlc217045)	21-7045	Medicaid: 420716501	Home Health
5009 (Formerly 5008)	20125	CommonWealth	MD	20-1032665	*Parent	5009	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health Care 1401 Mercantile Lane, Suite 351 Largo, MD 20774-4315 County: Largo *(Relocated from Silver Spring eff 04/28/14 to Largo's branch's address and assumed Largo's loc code)	P: 301-322-6023 F: 301-322-6858 TF:866-974-1388	HH7149	1831143908 (tlc217149)	21-7149	Medicaid: 420716500	Home Health
5014	25038	North Hospice	MD	20-2222985	*Parent	5014	Amedisys Maryland, L.L.C. d/b/a Amedisys Hospice of Greater Chesapeake 7106 Ridge Road, Suite 140 Rosedale, MD 21237-3876 County: Baltimore *Suite number changed from 100 to 140 eff 11/1/16*	P: 410-686-5635 F: 410-686-5639 TF:877-370-3612	H1536	1780738757 (CamillePot) PHYSICIAN MEDICAID ONLY: 1679879720 (5014MD)	21-1536	Service Type 71 417528001 Service Type 20 Physician Mediciad 417529800	Hospice
5015	25038	North Hospice	MD	20-2222985	Branch	5014	Amedisys Maryland, L.L.C. d/b/a Amedisys Hospice of Greater Chesapeake 107 Chesapeake Blvd., Suite 134 Elkton, MD 21921-6390 County: Cecil	P: 410-392-3750 F: 410-392-4286 TF:855-494-9108	H1536	1780738757 (CamillePot) PHYSICIAN MEDICAID ONLY: 1679879720 (5014MD)	21-1536	Service Type 71 417528001 Service Type 20 Physician Medicaid: 417529800	Hospice
5005	20038	CommonWealth	MD	20-2222985	*Parent	5005	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 511 Jermor Lane, Suite 200 Westminster, MD 21157-6151 County: Carroll	P: 410-751-9904 F: 410-751-9914 TF:855-343-5386	HH7048	1699701177 (watsobal)	21-7048	Medicaid 414978500	Home Health
5013	20038	CommonWealth	MD	20-2222985	*Parent	5013	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 7106 Ridge Road, Suite 110 Rosedale, MD 21237-3876 County: Baltimore *Relocated from Baltimore, MD 10/18/11*	P: 410-686-8413 F: 410-686-8417 TF: 877-640-1809	HH7094	1548229834 (Camille08)	21-7094A	Medicaid: 4169654 00	Home Health
5001	20038	CommonWealth	MD	20-2222985	*Parent	5001	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 811 Cromwell Park Drive, Suite 109 Glen Burnie, MD 21061-2538 County: Anne Arundel	P: 410-590-4926 F: 443-572-5548 TF:866-770-1365	HH7108	1841248697 (5001MD)	21-7108	Medicaid 407725300	Home Health
5011	20038	CommonWealth	MD	20-2222985	*Parent	5011	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 6512 Deer Pointe Drive, Suite B Salisbury, MD 21804-1669 County: Wicomico	P: 410-543-8258 F: 410-742-2004 TF: 800-955-8810	HH7111	1811982069 (hhcainc)	21-7111A	415927600 DE Mcd: 000045714	Home Health
5016	20038	CommonWealth	MD	20-2222985	Branch	5011	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 204 Cedar Street, Suite 101 Cambridge, MD 21613-2312 County: Dorchester	P: 410-228-2170 F: 410-228-2461 TF: 855-548-3648	HH7111	1811982069 (hhcainc)	21-7111A Branch ID: 21Q7111001	Medicaid: 415927600	Home Health
5010	20038	CommonWealth	MD	20-2222985	*Parent	5010	Amedisys Maryland, L.L.C. d/b/a Amedisys Home Health 107 Chesapeake Boulevard, Suite 114 Elkton, MD 21921-6390 County: Cecil	P: 410-398-4733 F: 410-620-2723 TF: 800-342-2040	HH7151	1235203324 (hhcainc17)	21-7151	Medicaid: 415928400	Home Health
4806	25171	North Hospice	ME	20-1916796	*Parent	4806	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company 54 Atlantic Place South Portland, ME 04106-2316 County: Cumberland	P: 207-772-0929 F: 207-772-7779 TF: 800-981-4770	38312	1437236551 (beahos5)	20-1516	431853300	Hospice
4805	25171	North Hospice	ME	20-1916796	*Parent	4805	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company 245 Center Street, Suite 10 A Auburn , ME 04210-6169 County: Androscoggin *Relocated from Lewiston 3/28/2012*	P: 207-784-4242 F: 207-784-4233 TF:800-981-4635	38374	1083798938 (beahos3)	20-1517	431853301	Hospice
4803	25171	North Hospice	ME	20-1916796	Branch	4805	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company 45 Commerce Drive, Suite 12 Augusta, ME 04330-7889 County: Kennebec	P: 207-621-1212 F: 207-621-1215 TF:877-621-1217	38374	1083798938 (beahos3)	20-1517	431853301	Hospice

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4804	25171	North Hospice	ME	20-1916796	*Parent	4804	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 289 State Street, Suite B Bangor, ME 04401-5528 County: Penobscot *Relocated from 304 Hancock Street, Suite 3A,Bangor, eff. 7/15/14*	P: 207-942-2920 F: 207-942-3026 TF:855-897-7844	38375	1245444280 (2BEACON123)	20-1520	431853304	Hospice
4801	20152	Northeast	ME	26-1477601	*Parent	4801	Amedisys Maine, P.L.L.C. Amedisys Home Health 34 Atlantic Place S. Portland, ME 04106-2316 County: Cumberland *Relocated from Portland, ME eff 1/30/17*	P:207-772-7520 F:207-772-7545 TF:800-558-0076	38543	1366617680 (ME4801)	20-7073	Medicaid: 1366617680	Home Health
4802	20152	Northeast	ME	26-1477601	*Parent	4802	Amedisys Maine, P.L.L.C. d/b/a Amedisys Home Health 289 State Street, Suite A Bangor, ME 04401-5528 County: Penobscot *Relocated from 23 Water Street, Suite 208,Bangor,ME eff. 6/26/14*	P: 207-990-0029 F: 207-990-0035 TF:877-816-2808	38541	1316171796 (4802MN)	20-7075	Medicaid: 1316171796 (For services 8/16/10 through 8/30/10 use 436317200)	Home Health
1309	20096	West/MidWest	MO	20-3333939	*Parent	1309	Amedisys Missouri, L.L.C. d/b/a Amedisys Home Health of Missouri 2955 Kanell Boulevard Poplar Bluff, MO 63901-4008 County: Butler	P: 573-727-9687 F: 573-727-9715 TF:800-448-7172	804-8HH	1679745251 (1309MO)	26-7151	Medicaid: 1679745251	Home Health
1301	20096	West/MidWest	MO	20-3333939	*Parent	1301	Amedisys Missouri, LLC d/b/a Amedisys Home Health of Missouri 10675 Business 21 Hillsboro, MO 63050-5094 County: Jefferson	P: 636-789-4715 F: 636-797-5876 TF:800-660-7271	786-9HH	1164433041 (1301MO)	26-7270	Medicaid 582496402	Home Health
1302	20096	West/MidWest	MO	20-3333939	Branch	1301	Amedisys Missouri, LLC d/b/a Amedisys Home Health of Missouri 10805 Sunset Office Drive, Suite L101 St. Louis, MO 63127-1025 County: St. Louis	P: 314-821-7679 F: 314-821-7699 TF:866-708-8582	786-9HH	1164433041 (1301MO)	26-7270 Branch ID: 26Q7270001	Medicaid 582496402	Home Health
1304	20096	West/MidWest	MO	20-3333939	*Parent	1304	Amedisys Missouri, LLC d/b/a Amedisys Home Health of Missouri 1027 South Main Street, Suite 6 Joplin, MO 64801-4527 County: Jasper *Relocated from 3230 Wisconsin Avenue,Suite H on 5-15-13*	P: 417-206-6500 F: 417-206-4003 TF:866-299-2911	885-10HH	1043361959 (1304MO)	26-7606	Medicaid 586304305	Home Health
1303	20096	West/MidWest	MO	20-3333939	*Parent	1303	Amedisys Missouri, LLC d/b/a Amedisys Home Health of Missouri 3050 S. National Avenue, Suite 106 Springfield, MO 65804-4242 County: Greene	P: 417-877-7474 F: 417-877-1256 TF:866-203-6863	785-10HH	1053464651 (1303MO)	26-7607	Medicaid 586304206	Home Health
1307	20096	West/MidWest	MO	20-3333939	*Parent	1307	Amedisys Missouri, LLC d/b/a Amedisys Home Health of Missouri 100 NE Missouri Road, Suite 202 Lees Summit, MO 64086-4702 County: Jackson	P: 816-524-7355 F: 816-524-7354 TF: 866-343-2123	827-4HH	1215191598 (1307MO)	26-7623	Medicaid: 1215191598	Home Health
1407	20036	La/Miss	MS	27-0078077	*Parent	1407	Amedisys Mississippi, LLC d/b/a Amedisys Home Health of Collins 18 Melody Lane Collins, MS 39428-9002 County: Covinton	P: 601-765-8316 F: 601-765-8298 TF:866-526-5590	2381	1467400168 (1407MS)	25-7087	Medicaid 00070587 Homemaker Services: 01983097	Home Health
1409	20036	La/Miss	MS	27-0078077	Branch	1407	Amedisys Mississippi, LLC d/b/a Amedisys Home Health of Hattiesburg 132 Mayfair Road, Suite 1 Hattiesburg, MS 39402-1463 County: Lamar *Relocated from 6184 US HWY 98, ste 130 eff. 2/26/16*	P: 601-296-9710 F: 601-296-9688 TF:866-401-2904	2381	1467400168 (1407MS) BCBS Only: 1982936670 (1409MS)	25-7087 Branch ID: 25Q7087001	Medicaid 00070587 Homemaker Services: 01983097	Home Health
1405	20036	La/Miss	MS	27-0078077	*Parent	1405	Amedisys Mississippi, LLC d/b/a Amedisys Home Health of Biloxi 925 Tommy Munro Dr, Suite K Biloxi, MS 39532-2134 County: Harrison	P: 228-388-4144 F: 228-385-7704 TF:800-273-5212	9595	1093763773 (1405MS)	25-7100	Medicaid 00770086 Homemaker Services: 07626363	Home Health
1414	20036	La/Miss	MS	27-0078077	Branch	1405	Amedisys Mississippi, LLC d/b/a Amedisys Home Health 2012 Highway 90 Gautier, MS 39553-5306 County: Jackson *Relocated from 4211 Hospital St, Suite 309, Pascagoula,MS 39581-5318 effective 4/15/216* *D/B/A changed from Amedisys Home Health of Pascagoula effective 4/15/16*	P:228-497-0193 F:228-497-8089 TF:866-511-0336	9595	1093763773 (1405MS) BCBS Only: 1821320516 (1414MS)	25-7100 Branch ID: 25Q7100001	Medicaid 00770086 Homemaker Services: 07626363	Home Health
1411	20036	La/Miss	MS	27-0078077	Branch	1405	Amedisys Mississippi, LLC d/b/a Amedisys Home Health of Picayune 509 Highway 11 N, Suite B Picayune, MS 39466-3349 County: Pearl River	P: 601-799-2626 F: 601-799-0839 TF:866-910-0353	9595	1093763773 (1405MS) BCBS Only: 1619209301 (1411MS)	25-7100 Branch ID: 25Q7100002	Medicaid 00770086 Homemaker Services: 07626363	Home Health
1406	20036	La/Miss	MS	27-0078077	*Parent	1406	Amedisys Mississippi, LLC d/b/a Amedisys Home Health of Vicksburg 2080 South Frontage Road, Suite 105 Vicksburg, MS 39180-5328 County: Warren	P: 601-619-3670 F: 601-619-3672 TF:866-332-6340	7394	1245288943 (1406MS)	25-7103	Medicaid 00770548	Home Health

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1408	20036	La/Miss	MS	27-0078077	Branch	1406	Amedisys Mississippi, LLC d/b/a Amedisys Home Health 310 Byram Place, Suite E Byram, MS 39272-8750 County: Hinds *Relocated from Jackson eff. 8/23/2007*	P: 601-371-9051 F: 601-371-7459 TF:800-298-7810	7394	1245288943 (1406MS) BCBS Only: 1346572039 (1408MS)	25-7103 Branch ID: 25Q7103001	Medicaid 00770548	Home Health
1415	20036	La/Miss	MS	27-0078077	Branch	1406	Amedisys Mississippi, LLC d/b/a Amedisys Home Health 4294 Lakeland Drive, Suite 200 Flowood, MS 39232-9518 County: Rankin *Relocated from Jackson 8/23/2007* *Relocated from Hazelhurst 11/18/2009*	P: 601-420-2056 F: 601-420-4874 TF:866-448-2357	7394	1245288943 (1406MS) BCBS Only: 1437481124 (1415MS)	25-7103 Branch ID: 25Q7103002	Medicaid 00770548	Home Health
1428	20036	La/Miss	MS	27-0078077	*Parent	1428	Amedisys Mississippi, L.L.C. d/b/a Amedisys Home Health 2900 North Hills Street Meridian, MS 39305-2645 County: Lauderdale	P: 601-484-3293 F: 601-484-3133 TF:866-327-5017	9985	1427220649 (1428MS)	25-7121	Medicaid 00770267	Home Health
1421	20147	La/Miss	MS	52-2363676	*Parent	1421	Nine Palms 2 LLP d/b/a Tender Loving Care, an Amedisys Company 11010 Highway 49, Suite 4 Gulfport, MS 39503-4191 County: Harrison	P: 228-831-9821 F: 228-831-9826 TF:866-898-7970	12384	1104871094 (tlc257143)	25-7143	Medicaid 00770616	Home Health
3225	25125	North Hospice	NC	20-1032665	*Parent	3225	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Hospice 3320 US 1 Highway, Suite B Franklinton, NC 27525-8438 County: Franklin	P: 919-494-3773 F: 919-494-2585 TF:800-377-5827	HOS3826	1215976436 (tlc341560)	34-1560	Medicaid 1215976436	Hospice
3226	25125	North Hospice	NC	20-1032665	Branch	3225	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Hospice 220 New Fidelity Court Garner, NC 27529-2896 County: Wake	P: 919-773-4865 F: 919-773-4985 TF:866-773-8797	HOS3147	1215976436 (tlc341560)	34-1560	Medicaid 1215976436	Hospice
3229	25125	North Hospice	NC	20-1032665	Branch	3225	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Hospice 2929 Crouse LN, Suite E Burlington, NC 27215-8316 County: Alamance *Relocated from 1111 Huffman Mill Road, Suite 102A,Burlington eff. 07/30/15	P: 336-584-4440 F: 336-584-4404 TF:800-377-5829	HOS3823	1215976436 (tlc341560)	34-1560	Medicaid 1215976436	Hospice
3223	20125	Carolinas	NC	20-1032665	*Parent	3223	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health 1005 Slater Road, Suite 105 Durham, NC 27703-8471 County: Durham	P: 919-941-5793 F: 919-941-9012 TF:800-682-6670	HC0145	1083669873 (tlc347110)	34-7110	Medicaid 1083669873	Home Health
3227	20125	Carolinas	NC	20-1032665	Branch	3223	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health 3320 US 1 Highway, Suite C Franklinton, NC 27525-8438 County: Franklin *Relocated form Louisburg, NC 02/04/2009*	P: 919-494-2462 F: 919-494-5251 TF:866-327-4195	HC0078	1083669873 (tlc347110)	34-7110 Branch ID: 34Q7110001	Medicaid 1083669873	Home Health
3222	20125	Carolinas	NC	20-1032665	Branch	3223	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health 2929 Crouse LN, Suite F Burlington, NC 27215-8316 County: Alamance *Relocated from 1111 Huffman Mill Road, Suite 102,Burlington eff. 07/30/15*	P: 336-524-0127 F: 336-524-0257 TF:800-377-5829	HC0134	1083669873 (tlc347110)	34-7110 Branch ID: 34Q7110002	Medicaid 1083669873	Home Health
3215	25033	North Hospice	NC	27-0078073	*Parent	3215	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care 56 Three Hunts Drive, Bldg 3 Pembroke, NC 28372-8998 County: Robeson *Relocated from 30 Three Hunts Drive Ste C, Pembroke eff 9/9/16*	P: 910-521-8211 F: 910-521-8298 TF:855-641-1982	HC4027	1154652428 (elocklear30)	34-1596	Medicaid: 1154652428	Hospice
3216	25033	North Hospice	NC	27-0078073	Branch	3215	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care 1729 Southport Supply Road, Unit A Bolivia, NC 28422-7679 County: Brunswick *Relocated from Sunset Beach eff. 7-30-14*	P: 910-253-6687 F: 910-253-9486 TF:855-809-0997	HOS4018	1154652428 (elocklear30)	34-1596	Medicaid: 1154652428	Hospice

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3230	25033	North Hospice	NC	27-0078073	*Parent	3230	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care 1072 US Highway 64 W Plymouth, NC 27962-9396 County: Washington	P: 252-791-0490 F: 252-791-0545 TF:855-808-4202	HOS4596	1518205277 (3230NC)	34-1598	Medicaid: 1518205277	Hospice
3221	20150	Carolinas	NC	56-1697708	*Parent	3221	Emerald Care, L.L.C. d/b/a Amedisys Home Health Care 1050 Xray Drive Gastonia, NC 28054-7488 County: Gaston	P: 704-867-1141 F: 704-868-2267 TF:800-427-1143	HC0353	1154376028 (tlc347099)	34-7099	Medicaid 1154376028	Home Health
3208	20020	Carolinas	NC	72-1428474	*Parent	3208	Amedisys North Carolina, LLC d/b/a Amedisys Home Health of Chapel Hill 120 Providence Road, Suite 200 Chapel Hill, NC 27514-2273 County: Orange	P: 919-401-3000 F: 919-402-1952 TF:800-672-5905	HC0166	1326096074 (3208NC)	34-7030	Medicaid 1326096074 CAP: 3409117	Home Health
3212	20020	Carolinas	NC	72-1428474	*Parent	3212	Amedisys North Carolina, LLC d/b/a Amedisys Home Health Care 1630 Liberty Drive Suite 100 Thomasville, NC 27360-5365 County: Davidson *Relocated from 524 Turner Street eff 3/1/17*	P: 336-472-4449 F: 336-475-4449 TF:866-233-0690	HC0495	1124076872 (3212NC)	34-7094	Medicaid 1124076872	Home Health
3213	20020	Carolinas	NC	72-1428474	*Parent	3213	Amedisys North Carolina, LLC d/b/a Amedisys Home Health of Fayetteville 2021 Valleygate Drive, Suite 201 Fayetteville, NC 28304-3763 County: Cumberland	P: 910-483-8153 F: 910-483-4473 TF:866-381-5703	HC0292	1548205487 (3213NC)	34-7132	Medicaid 1548205487	Home Health
3211	20020	Carolinas	NC	72-1428474	*Parent	3211	Amedisys North Carolina, LLC d/b/a Amedisys Home Health of Winston-Salem 1100 South Stratford Road, Suite 531 Winston-Salem, NC 27103-3217 County: Forsyth	P: 336-768-7200 F: 336-768-7272 TF:866-724-4542	HC1304	1558319202 (3211NC)	34-7212	Medicaid: 1558319202	Home Health
0912	90110	North Hospice	NH	03-0443397	*Parent	0912	Wentworth Home Care and Hospice, LLC d/b/a Wentworth Home Care and Hospice, an Amedisys Partner 9 Andrews Road Somersworth, NH 03878-1042 County: Strafford *Relocated from 121 Broadway, Suite 117 Dover, NH eff 9/30/16	P: 603-692-0220 F: 603-692-0232 TF:866-835-3390	03717 (NH) 38303 (ME)	1831163211 (WentworthHHH)	30-1512	Medicaid 3077141 MaineCare: 1831163211-001	Hospice
0911	90110	Northeast	NH	03-0443397	*Parent	0911	Wentworth Home Care and Hospice, LLC d/b/a Wentworth Home Care and Hospice, an Amedisys Partner 9 Andrews Road Somersworth, NH 03878-1042 County: Strafford *Relocated from 121 Broadway, Suite 115 Dover, NH eff 9/30/16	P: 603-692-0200 F: 603-692-0154 TF:888-742-7921	03718 (NH) 38635 (ME)	1568436194 (WentworthHH) MEDICAID WAIVER ONLY: 1598066102 (NH0911)	30-7014	Medicaid 3076668 Medicaid Waiver: 3079038 MainCare: 1568436194-001	Home Health
0917 (Formerly 0914)	25171	North Hospice	NH	20-1916796	*Parent	0917	Beacon Hospice, L.L.C d/b/a Beacon Hospice, an Amedisys Company 25 New Hampshire Avenue Suite 272 Portsmouth, NH Portsmouth, NH 03801-2923 County: Rockingham **(Relocated from Concord, NH to Portsmouth, NH eff. 05/01/14 to Portsmouth's branch address and assumed Portsmouth's loc code) *Relocated from 95 Brewery Lane, Unit 10 Portsmouth, NH eff. 12/09/16*	P: 603-433-2480 F: 603-433-4185 TF:800-416-9207	38255 (ME) 03277 (NH)	1023193703 (beahos7)	30-1526	Medicaid 3077135 MaineCare: 1023193703-003	Hospice
0902	25106	North Hospice	NH	26-0590826	*Parent	0902	Amedisys New Hampshire, LLC d/b/a Amedisys Hospice Care 1 E Commons Drive, Unit 33 Londonderry, NH 03053-3478 County: Rockingham *Relocated from Portsmouth, NH 10/31/2010*	P: 603-421-0414 F: 603-421-0548 TF:866-230-3143	03315 (NH)	1710170204 (0902NH)	30-1507	Medicaid 3076670	Hospice

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0901	20106	Northeast	NH	26-0590826	*Parent	0901	Amedisys New Hampshire, LLC d/b/a Amedisys Home Health 25 New Hampshire Avenue Suite 270 Portsmouth, NH 03801-2923 County: Rockingham **Relocated from 95 Brewery Lane, Unit 11 Portsmouth, NH eff. 12/9/16*	P: 603-436-0815 F: 603-431-5457 TF:888-870-6952	03314 (NH) 38695 (ME)	1326230251 (0901NH) MEDICAID WAIVER ONLY: 1730480534 (NH0901)	30-7006	Medicaid: 3077867 Medicaid Waiver: 3076340	Home Health
0905	20106	Northeast	NH	26-0590826	Branch	0901	Amedisys New Hampshire, LLC d/b/a Amedisys Home Health 1 E Commons Drive, Unit 32 Londonderry, NH 03053-3478 County: Rockingham	P: 603-437-9443 F: 603-437-9445 TF:877-810-6018	03314 (NH) 38491 (ME)	1326230251 (0901NH)	30-7006 Branch ID: 30Q7006001	Medicaid: 3077867 Medicaid Waiver: 3076340	Home Health
4203	25161	North Hospice	NJ	27-0797096	*Parent	4203	Amedisys New Jersey, L.L.C. d/b/a Hospice Care of Hackensack, an Amedisys Company 21 Main Street, Suite 253 Hackensack, NJ 07601-7086 County: Bergen **Relocated from 25 E. Salem Street, 2nd Floor, Hackensack, NJ eff.10/24/14*	P: 201-342-7766 F: 201-487-1982 TF:855-690-9770	22614	1033216338 (humc2014c)	31-1510	Medicaid 0292044	Hospice
4201	20161	Northeast	NJ	27-0797096	*Parent	4201	Amedisys New Jersey, L.L.C. d/b/a Home Health Services of Hackensack, an Amedisys Company 21 Main Street, Suite 252 Hackensack, NJ 07601-7086 County: Bergen **Relocated from 25 E. Salem Street, 2nd Floor, Hackensack, NJ eff.10/24/14*	P: 201-342-6311 F: 201-678-9670 TF:877-816-8790	70202	1952402737 (humc2014b)	31-7047	Medicaid: 0249114	Home Health
4202	20161	Northeast	NJ	27-0797096	Branch	4201	Amedisys New Jersey, L.L.C. d/b/a Amedisys Home Health One Harmon Plaza, Suite 804 Secaucus, NJ 07094-2803 County: Hudson	P: 201-902-1490 F: 201-902-1495 TF:877-478-5628	70202	1952402737 (humc2014b) MEDICAID ONLY: 1962791756 (4202NJ)	31-7047 Branch ID: 31Q7047002	Medicaid 0261653	Home Health
5104	20137	Northeast	NY	20-1519257	*Parent	5104	Tender Loving Care Health Care Services of Nassau Suffolk, L.L.C. d/b/a Tender Loving Care, an Amedisys Company 960 South Broadway, Suite 110A Hicksville, NY 11801-5028 County: Nassau	P: 516-935-3737 F: 516-932-5337 TF:866-738-0579	2952603	1699715961 (tlc337260)	33-7260	Medicaid 02640095	Home Health
5105	20137	Northeast	NY	20-1519257	Branch	5104	Tender Loving Care Health Care Services of Nassau Suffolk, L.L.C. d/b/a Tender Loving Care, an Amedisys Company 1721 North Ocean Avenue , Suite A Medford, NY 11763-2684 County: Suffolk	P: 631-447-2020 F: 631-447-7243	2952603	1699715961 (tlc337260)	33-7260 Branch ID: 33Q7260001	Medicaid 02640095	Home Health
5101	20134	Northeast	NY	20-1522536	*Parent	5101	Tender Loving Care Health Care Services of Erie Niagara, L.L.C. d/b/a Amedisys Home Health Care 1127 Wehrle Drive, Suite 50 Amherst, NY 14221-7700 County: Erie	P: 716-632-6420 F: 716-633-7642 TF:800-876-2913	1401614	1730134529 (tlc337248)	33-7248	Medicaid 02640086	Home Health
5103	20134	Northeast	NY	20-1522536	Branch	5101	Tender Loving Care Health Care Services of Erie Niagara, L.L.C. d/b/a Amedisys Home Health Care 6932 Williams Road, Suite 1200 Niagara Falls, NY 14304-3071 County: Niagara **Relocated from North Tonanwanda 8/31/2010* ****Previously referred to internally as "Wheatfield"****	P: 716-297-3310 F: 716-298-3534 TF:877-807-9399	1401614	1730134529 (tlc337248)	33-7248 Branch ID: 33Q7248002	Medicaid: 2640086	Home Health
5111	20137	Northeast	NY	20-1519257	*Parent	5111	Tender Loving Care Health Care Services of Nassau Suffolk, L.L.C Tender Loving Care, an Amedisys Company 100 Garden City Plaza, Suite 100 Garden City, NY 11530-3201 County: Nassau	P: 516-739-1270 F: 516-739-1284 TF:800-237-0884	2905601	1932262383 (lauricchio)	33-7143	Medicaid 02998089	Home Health
4333	25126	North Hospice	OH	20-1032641	*Parent	4333	Tender Loving Care Health Care Services of West Virginia, LLC d/b/a Amedisys Hospice 52171 National Road E., Suite 1 St. Clairsville, OH 43950-8398 County: Belmont	P: 740-526-0970 F: 740-526-0971 TF:877-568-8572	0176HSP	1679767743 (stclairhospi)	36-1652	Medicaid: 3095127	Hospice

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4331	90118	North Hospice	OH	26-1480799	*Parent	4331	Marietta Home Health and Hospice, L.L.C. d/b/a Marietta Home Health and Hospice, an Amedisys Partner 450 Pike Street, Suite I-1 Marietta, OH 45750-3375 County: Washington *Relocated from 210 N. Seventh St, STE 400 eff 6/8/12*	P: 740-374-9100 F: 740-374-9105 TF:800-822-2165	0188HSP	1043489156 (4331HO)	36-1650	Medicaid 3073178	Hospice
4330	90018	Northeast	OH	26-1480799	*Parent	4330	Marietta Home Health and Hospice, LLC d/b/a Marietta Home Health and Hospice, an Amedisys Partner 450 Pike Street, Suite I-2 Marietta, OH 45750-3375 County: Washington *Relocated from 210 N. Seventh St, STE 300 eff 6/8/12*	P: 740 373-8549 F: 740 373-3995 TF:800-822-2165		1265600571 (4330HH)	36-8230	Medicaid 2936041	Home Health
2037	20017	West/MidWest	OK	62-1752120	*Parent	2037	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 1637 S. Main Street Grove, OK 74344-5368 County: Delaware	P: 918-787-9496 F: 918-787-9497 TF:866-787-9496	7210	1417905175 (2037OK)	37-7072	Medicaid 100260420I	Home Health
2033	20017	West/MidWest	OK	62-1752120	*Parent	2033	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 10108 E. 79th Street, Suite A Tulsa, OK 74133-4539 County: Tulsa *Relocated from Claremore to Tulsa 5/01/1999* *Relocated to current address in Tulsa 6/30/2010*	P: 918-294-3902 F: 918-294-3432 TF:866-256-8200	7191	1598723140 (2033okla)	37-7180	Medicaid: 100260420C Advantage Personal Care: 100260420F (Withdrew 7/1/03) Advantage Skilled Home: 100260420G (Withdrew 7/1/03)	Home Health
2023	20017	West/MidWest	OK	62-1752120	Branch	2033	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 206 West Blue Starr Drive Claremore, OK 74017-4228 County: Rogers *Parent agency relocated to Tulsa, OK 05/01/1999 and Claremore, OK converted to branch agency.*	P: 918-341-9255 F: 918-342-4520 TF:800-246-9255	7191	1598723140 (2033okla)	37-7180 Branch ID: 37Q7180001	Medicaid: 100260420C Advantage Personal Care: 100260420F (Withdrew 7/1/03) Advantage Skilled Home: 100260420G (Withdrew 7/1/03)	Home Health
2045	20017	West/MidWest	OK	62-1752120	Branch	2033	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 2503 SE Washington Blvd, Suite 104 Bartlesville, OK 74006-7606 County: Washington *Relocated from Oklahoma City, OK (2035) on 07/31/2006*	P: 918-333-2802 F: 918-333-3325 TF:866-841-2068	7191	1598723140 (2033okla)	37-7180 Branch ID: 37Q7180002	Medicaid 100260420C	Home Health
2038	20017	West/MidWest	OK	62-1752120	*Parent	2038	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 14201 Caliber Drive, Suite 110 Oklahoma City, OK 73134-1027 County: Oklahoma	P: 405-748-7104 F: 405-748-7285 TF:800-891-7010	7711	1255380275 (2038OK)	37-7642	Medicaid 100260420A	Home Health
2043	20017	West/MidWest	OK	62-1752120	Branch	2038	Amedisys Oklahoma, LLC d/b/a Amedisys Home Health 404 West Main St Stroud, OK 74079-3614 County: Lincoln **Mailing:** P.O. Box 530, Stroud, OK 74079-0530	P: 918-968-1179 F: 918-968-1182 TF:866-334-8400	7711	1255380275 (2038OK)	37-7642 Branch ID: 37Q7642006	Medicaid 100260420A	Home Health
3902	25108	South Hospice	OR	26-0528775	*Parent	3902	Amedisys Oregon, LLC d/b/a Amedisys Hospice Care 1820 NW Mulholland Drive Roseburg, OR 97470-1945 County: Douglas *Relocated from 2510 NW Edenbower Blvd, Suite 112 on 06/28/13*	P: 541- 440-2583 F:541- 440-2530 TF:800-556-7457	16-1048	1083807101 (3902OR)	38-1518	Medicaid 218450	Hospice
3905 (Formerly 3904)	20108	West/MidWest	OR	26-0528775	*Parent	3905	Amedisys Oregon, LLC d/b/a Amedisys Home Health Care 12021 NE Glenn Widing Drive Bldg G Portland, OR 97220-9550 County: Multomomah *Relocated from 16083 SW Upper Boones Ferry Road, Suite 100, Portland, OR 97224-7736 on 07/29/16*	P: 503-253-5155 F: 503-253-8097 TF:877-259-1074	13-1395	1134311988 (3904OR)	38-7003	Medicaid 007146	Home Health

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3903	20108	West/MidWest	OR	26-0528775	*Parent	3903	Amedisys Oregon, LLC d/b/a Amedisys Home Health Care 3220 State Street, Suite 100 Salem, OR 97301-6868 County: Marion *Relocated from McMinnville, OR 01/06/2011*	P: 503-364-9850 F: 503-364-1874 TF:877-263-0066	13-1367	1639362742 (3903OR)	38-7136A	Medicaid 007142	Home Health
3901	20108	West/MidWest	OR	26-0528775	*Sub-Unit	3903	Amedisys Oregon, LLC d/b/a Amedisys Home Health Care 1820 NW Mulholland Drive Roseburg, OR 97470-1945 County: Douglas *Relocated from 2510 NW Edenbower Blvd, Suite 112 on 06/28/13	P: 541-440-3052 F: 541-440-8964 TF:877-816-8789	13-1368	1093908725 (3901OR)	38-7311	Medicaid 007147	Home Health
2619	25148	North Hospice	PA	20-1031909	*Parent	2619	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Hospice of PA 1368 Mall Run Road, Suite 624 Uniontown, PA 15401-7512 County: Fayette	P: 724-439-4440 F: 724-438-2072 TF:800-245-4144	154499	1629015250 (AGHC391544)	39-1544	Medicaid: 1014856420015	Hospice
2613	25148	North Hospice	PA	20-1031909	Branch	2619	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Hospice of PA 109 Crossroads Road, Suite 400 Scottdale, PA 15683-2458 County: Westmoreland *Relocated from Connelsville on 07/02/2009	P: 724-887-3161 F: 724-887-3548 TF:887-370-3572	154499	1629015250 (AGHC391544) MEDICAID ONLY 1366763724 (2613PA)	39-1544	Medicaid: 1014856420018	Hospice
2615	25148	North Hospice	PA	20-1031909	Branch	2619	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Hospice of PA 2183 McClellantown Road Masontown, PA 15461-2593 County: Fayette	P: 724-583-2680 F: 724-583-2685 TF:866-583-9675	154499	1629015250 (AGHC391544) MEDICAID ONLY 1467773820 (2615PA)	39-1544	Medicaid: 101485642 0011	Hospice
2617	25148	North Hospice	PA	20-1031909	Branch	2619	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Hospice of PA 100 Stoops Drive, Suite 300 Monongahela, PA 15063-3553 County: Washington	P: 724-483-4109 F: 724-483-4015 TF:877-895-8739	154499	1629015250 (AGHC391544) MEDICAID ONLY 1194046557 (2617PA)	39-1544	Medicaid: 1014856420009	Hospice
2621	25148	North Hospice	PA	20-1031909	Branch	2619	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Hospice of PA 480 Johnson Road Suite 230 Washington, PA 15301-8936 County: Washington *Relocated from Washington on 06/12/2009* *Relocated from Canonsburg on 08/30/2012* *Relocated from 275 Meadowlands Boulevard eff 11/4/16*	P: 724-746-6581 F: 724-222-2637 TF:877-896-5620	154499	1629015250 (AGHC391544) MEDICAID ONLY 1538480991 (2621PA)	39-1544	Medicaid: 1014856420019	Hospice
2618	20148	Northeast	PA	20-1031909	*Parent	2618	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Home Health of PA 1368 Mall Run Road, Suite 628 Uniontown, PA 15401-7512 County: Fayette	P: 724-438-6660 F: 724-438-3858 TF:800-255-6221	713905	1598719379 (AGHC397139)	39-7139	Medicaid: 1014856420023	Home Health
2616	20148	Northeast	PA	20-1031909	Branch	2618	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Home Health of PA 100 Stoops Drive Monongahela, PA 15063-3553 County: Washington	P: 724-483-4183 F: 724-483-0537 TF:800-860-4445	713905	1598719379 (AGHC397139) MEDICAID ONLY 1457672677 (2616PA)	39-7139 Branch ID: 39Q7139003	Medicaid: 1014856420012	Home Health
2614	20148	Northeast	PA	20-1031909	Branch	2618	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Home Health of PA 2181 McClellandtown Road Masontown, PA 15461-2593 County: Fayette	P: 724-583-0414 F: 724-583-2085 TF:877-895-1020	713905	1598719379 (AGHC397139) MEDICAID ONLY 1538480751 (2614PA)	39-7139 Branch ID: 39Q7139007	Medicaid: 1014856420004	Home Health
2620	20148	Northeast	PA	20-1031909	Branch	2618	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Home Health of PA 480 Johnson Road Suite 200 Washington, PA 15301-8936 County: Washington *Relocated to Washington 11/2/2010* *Relocated from Washington on 6/4/2009* *Relocated from 275 Meadowlands Boulevard eff 11/4/16*	P: 724-873-7325 F: 724-222-2836 TF:877-746-1258	713905	1598719379 (AGHC397139) MEDICAID ONLY 1477874832 (2620PA)	39-7139 Branch ID: 39Q7139008	Medicaid: 1014856420016	Home Health
2612	20148	Northeast	PA	20-1031909	Branch	2618	Albert Gallatin Home Care and Hospice Services, L.L.C. d/b/a Amedisys Home Health of PA 109 Crossroads Road, Suite 400 Scottdale, PA 15683-2458 County: Westmoreland	P:724-887-3846 F:724-887-3549 TF:877-370-3572	713905	1598719379 (AGHC397139) MEDICAID ONLY 1518288976 (2612PA)	39-7139 Branch ID: 39Q7139009	Medicaid: 1014856420017	Home Health

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2601	20102	Northeast	PA	20-8619703	*Parent	2601	Amedisys Pennsylvania, LLC d/b/a Amedisys Home Health 480 New Holland Avenue, Building 8, Suite 8101 Lancaster, PA 17602-2292 County: Lancaster	P: 717-291-8396 F: 717-291-6788 TF:866-305-4135	740105	1780889402 (2601PA)	39-7401C	Medicaid: 1020418560013	Home Health
2634	20102	Northeast	PA	20-8619703	*Parent	2634	Amedisys Pennsylvania, L.L.C. d/b/a Amedisys Home Health 240 Pullman Square, Suite 255 Butler, PA 16001- 5654 County: Butler	P:724-284-4663 F: 724-284-1034 TF:800-361-1551	04110501	1407177322 (2634PA)	39-8146	Medicaid: 1020418560016	Home Health
2635	25033	North Hospice	PA	27-0078073	*Parent	2635	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice Care 240 Pullman Square Suite 255 Butler, PA 16001-5654 County: Butler	P: 724-431-4170 F: 724-431-4175 TF: 877-274-9306	17261601	1932431400 (2635PA)	39-1726	Medicaid: 1023769740002	Hospice
4901	20127	Northeast	RI	20-1033012	*Parent	4901	Tender Loving Care Health Care Services of New England, L.L.C. d/b/a Amedisys Home Health Care 300 Centerville Road STE 202 East Warwick, RI 02886-0200 County: Kent *Relocated from Providence, RI eff. 5/26/16	P: 401-737-4236 F: 401-738-1618 TF:800-649-2280	HNC02384	1770537854 (tlc417036)	41-7036	Medicaid: TL56604 Waivers #'s: TL57249 TL57250	Home Health
4902	25171	North Hospice	RI	20-1916796	*Parent	4902	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company 1 Catamore Boulevard East Providence, RI 02914-1228 County: Providence	P: 401-438-0008 F: 401-438-2252 TF: 800-981-8791	HSP01626	1558445569 (beahos2)	41-1510	BH55689	Hospice
4903	25171	North Hospice	RI	20-1916796	Branch	4902	Beacon Hospice, L.L.C. d/b/a Beacon Hospice, an Amedisys Company Meadows Professional Office Park 1130 Ten Rod Road, Suite C104 North Kingstown, RI 02852-4127 County: Washington	P: 401-294-6204 F: 401-294-6452 TF: 855-876-6687	HSP01626-01	1558445569 (beahos2)	41-1510	BH55689	Hospice
2207	20037	Carolinas	SC	20-1968800	*Parent	2207	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Charleston East 1027 Physicians Drive, Suite 210 Charleston, SC 29414-5352 County: Charleston	P: 843-556-0200 F: 843-556-0202 TF:800-951-6877	HHA-0191	1447218748 (2207SC)	42-7027	Medicaid HHA191	Home Health
2208	20037	Carolinas	SC	20-1968800	Branch	2207	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Walterboro 305 Robertson Blvd. Walterboro, SC 29488-5712 County: Colleton *Relocated from 402 Robertson Blvd. Eff. 06/24/14*	P: 843-542-9020 F: 843-549-3236 TF:888-952-6877	HHA-0191	1447218748 (2207SC)	42-7027 Branch ID: 42Q7027001	Medicaid HHA191	Home Health
2209	20037	Carolinas	SC	20-1968800	Branch	2207	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Mount Pleasant 950 Houston Northcutt Blvd, Suite 105 Mt. Pleasant, SC 29464-5648 County: Charleston	P: 843-972-0416 F: 843-972-0421 TF:866-972-0416	HHA-0191	1447218748 (2207SC)	42-7027 Branch ID: 42Q7027002	Medicaid HHA191	Home Health
2216	20037	Carolinas	SC	20-1968800	*Parent	2216	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Camden 1110 Broad Street, Suite B Camden, SC 29020-3624 County: Kershaw *Relocated from West Columbia, SC Eff. 06/26/2006*	P: 803-713-9774 F: 803-713-9264 TF:888-318-7323	HHA-0194	1699733246 (2216SC)	42-7036	Medicaid HHA194	Home Health
2225	20037	Carolinas	SC	20-1968800	Branch	2216	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Columbia 3227 Sunset Boulevard, Suite F101 West Columbia, SC 29169-3201 County: Lexington	P: 803-739-5881 F: 803-739-5886 TF:866-231-8731	HHA-0194	1699733246 (2216SC)	42-7036 Branch ID: 42Q7036002	Medicaid HHA194	Home Health
2211	20037	Carolinas	SC	20-1968800	*Parent	2211	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Lexington 714 South Lake Drive, Suite 250 Lexington, SC 29072-3462 County: Lexington *Relocated from West Columbia Eff. 3/11/2008*	P: 803-359-2253 F: 803-356-7136 TF:866-318-7323	HHA-0190	1760430375 (2211SC)	42-7039	Medicaid HHA190	Home Health
2214	20037	Carolinas	SC	20-1968800	Branch	2211	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Sumter 3481 Declaration Blvd Sumter, SC 29154-8140 County: Sumter	P: 803-905-5240 F: 803-905-5244 TF:877-284-6630	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039001	Medicaid HHA190	Home Health
2212	20037	Carolinas	SC	20-1968800	Branch	2211	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Newberry 184 Commerce Dr. Newberry, SC 29108-2964 County: Newberry	P: 803-276-9359 F: 803-276-9560 TF:866-276-9359	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039004	Medicaid HHA190	Home Health

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2213	20037	Carolinas	SC	20-1968800	Branch	2211	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Orangeburg 1704 Village Park Drive Orangeburg, SC 29118-2401 County: Orangeburg	P: 803-534-2022 F: 803-534-3731 TF:888-534-2022	HHA-0190	1760430375 (2211SC)	42-7039 Branch ID: 42Q7039005	Medicaid HHA190	Home Health
2224	20008	Carolinas	SC	20-1968800	*Parent	2224	Amedisys SC, L.L.C d/b/a Amedisys Home Health of Bluffton 59 Sheridan Park Circle, Ste. A Bluffton, SC 29910-6029 County: Beaufort *Relocated from 23 Plantation Park Dr. Eff. 1/15/16*	P: 843-815-8088 F: 843-815-8090 TF:800-697-5235	HHA -0203	1215110226 (2224SC)	42-7048	Medicaid HHA203	Home Health
2226	20037	Carolinas	SC	20-1968800	*Parent	2226	Amedisys SC, L.L.C. d/b/a Neighbors Care Home Health Agency, an Amedisys Company 1645 JA Cochran Bypass, Suite I Chester, SC 29706-3101 County: Chester	P: 803-581-6775 F: 803-581-8915 TF:866-327-3205	HHA-0198	1629245808 (2226SC)	42-7063	Medicaid HHA301	Home Health
2210	20037	Carolinas	SC	20-1968800	*Parent	2210	Amedisys SC, L.L.C. d/b/a Amedisys Home Health of Beaufort 35 Professional Village Circle Lady's Island, SC 29907-1575 County: Beaufort *Relocated from Beaufort Eff. 4/12/17* *Relocated from Hilton Head Eff. 1/26/2012*	P: 843-379-2320 F: 843-379-2321 TF:800-300-9559	HHA-0189	1043278542 (2210SC)	42-7304	Medicaid HHA189	Home Health
2227	25033	South Hospice	SC	27-0078073	*Parent	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 500 Pamplico Highway, Suite D Florence, SC 29505-6051 County: Florence	P: 843-656-0820 F: 843-669-7957 TF:877-656-0820	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2228	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 1027 Physicians Drive, Suite 240 Charleston, SC 29414-5352 County: Charleston	P: 843-554-7161 F: 843-554-7830 TF:866-554-7161	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2229	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 305 Robertson Boulevard, Suite A Walterboro, SC 29488-5712 County: Colleton *Relocated from 203-A & 203-B Eddie Chasteen Drive, Walterboro,SC eff. 06/26/14*	P: 843-549-5166 F: 843-549-5177 TF:866-549-5166	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2231	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 198 E. Wesmark Blvd., Suite 2 Sumter, SC 29150-2020 *County: Sumter *Relocated from 2555 Lin Do Court, Suite B, eff 9/25/15*	P: 803-774-4036 F: 803-774-7011 TF:800-463-4349	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2232	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 1900 Sunset Blvd. Suite 103 West Columbia,SC 29169-5959 County: Lexington *Relocated from 220 Stoneridge Drive, Suite 105 Columbia, SC eff. 10/21/16*	P: 803-251-2287 F: 803-796-9150 TF:877-794-2515	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2233	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 250 Commonwealth Drive, Suite 105 Greenville, SC 29615-4846 County: Greenville	P: 864-335-0455 F: 864-335-0456 TF:866-381-2085	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2235	25033	South Hospice	SC	27-0078073	Branch	2227	Amedisys Hospice, L.L.C. d/b/a Amedisys Hospice of South Carolina 391 Seaboard Street, Unit 6 Myrtle Beach, SC 29577-9635 County: Georgetown *Relocated from Pawley's Island eff. 01-16-16*	P: 843-839-2505 F: 843-839-1615 TF:877-652-0093	HPC-0091	1437160058 (Winyah137)	42-1555	Medicaid: HSP111	Hospice
2245 (Formerly 2205)	20176	Carolinas	SC	36-4754427	*Parent	2245	Georgetown Hospital Home Health, L.L.C. d/b/a Amedisys Home Health of Georgetown 2503 Highmarket Street Georgetown, SC 29440-2900 County: Georgetown *Relocated from 1105 Church Street, Georgetown, SC eff. 06-26-14*	P: 843-546-1730 F: 843-545-9260 TF: 800-946-9244	HHA-0192	1760430334 (2205SC)	42-7065	Medicaid HHA310	Home Health
2246 (Formerly 2206)	20176	Carolinas	SC	36-4754427	*Parent	2246	Georgetown Hospital Home Health, L.L.C. d/b/a Amedisys Home Health of Myrtle Beach 1309 Professional Drive, Suite 100 Myrtle Beach, SC 29577-5701 County: Horry	P: 843-916-0931 F: 843-916-0985 TF: 866-604-1172	HHA-0187	1811955065 (2206SC)	42-7067	Medicaid HHA312	Home Health

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2241 (Formerly 2221)	20176	Carolinas	SC	36-4754427	*Parent	2241	Georgetown Hospital Home Health, L.L.C. d/b/a Amedisys Home Health Care 127 E Mill Street Kingstree, SC 29556-3427 County: Williamsburg	P: 843-355-5103 F: 843-355-6617 TF:800-816-6668	HHA-0188	1255399747 (2221SC)	42-7068	Medicaid HHA311	Home Health
2203	20008	Carolinas	SC	57-1119857	*Parent	2203	Amedisys Home Health, Inc. of South Carolina d/b/a Amedisys Home Health of Charleston 2675 Lake Park Drive North Charleston, SC 29406-9100 County: Charleston	P: 843-553-1263 F: 843-553-0651 TF:800-849-2421	HHA-0172	1033177290 (2203SC)	42-7005	Medicaid HHA172	Home Health
2222	20008	Carolinas	SC	57-1119857	*Parent	2222	Amedisys Home Health, Inc. of South Carolina d/b/a Amedisys Home Health of Conway 176 Waccamaw Medical Park Court Conway, SC 29526-8965 County: Horry	P: 843-347-5899 F: 843-347-5885 TF:866-205-4247	HHA-0195	1316905573 (2222SC)	42-7112	Medicaid HHA195	Home Health
2204	20008	Carolinas	SC	57-1119857	*Parent	2204	Amedisys Home Health, Inc. of South Carolina d/b/a Amedisys Home Health of Clinton 210 Physicians Park Dr, Suite U Clinton, SC 29325-7565 County: Laurens	P: 864-833-3212 F: 864-833-3234 TF:866-833-3210	HHA-0186	1679531156 (2204SC)	42-7116	Medicaid HHA186	Home Health
2223	20008	Carolinas	SC	57-1119857	Branch	2204	Amedisys Home Health, Inc. of South Carolina d/b/a Amedisys Home Health of Greenville 440 Roper Mountain Road, Suite G-1 Greenville, SC 29615-4235 County: Greenville	P: 864-288-9441 F: 864-288-7705 TF:866-299-2890	HHA-0186	1679531156 (2204SC)	42-7116 Branch ID: 42Q7116001	Medicaid HHA186	Home Health
5529	25065	South Hospice	TN	02-0674282	*Parent	5529	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 1420 Dutch Valley Road, Suite C Knoxville, TN 37918-1424 County: Knox	P: 865-689-7123 F: 865-689-8445 TF:866-462-7182	0000000344	1053379214 (5529TN)	44-1525	Medicaid: 0441525	Hospice
5523	25065	South Hospice	TN	02-0674282	Branch	5529	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 1423 West Morris Blvd, Suite C Morristown, TN 37813-2975 County: Hamblen	P: 423-587-9484 F: 423-587-9408 TF:800-659-2633	0000000344	1053379214 (5529TN)	44-1525	Medicaid: 0441525	Hospice
5559	25065	South Hospice	TN	02-0674282	Branch	5529	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 665 New Highway 68, Suite B Sweetwater, TN 37874-1908 County: Monroe	P: 423-351-0233 F: 423-351-0238 TF:877-370-3477	0000000344	1053379214 (5529TN)	44-1525	Medicaid: 0441525	Hospice
5543	25065	South Hospice	TN	02-0674282	*Parent	5543	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 7205 Lee Hwy. Suite B Chattanooga, TN 37421-6801 County: Hamilton *Relocated from: 7161 Lee Hwy Suite 400 --11/20/13*	P: 423-499-0018 F: 423-499-4342 TF:800-951-2561	0000000343	1104884493 (5543TN)	44-1533	Medicaid: 0441533	Hospice
5544	25065	South Hospice	TN	02-0674282	Branch	5543	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 614 Congress Parkway N Athens, TN 37303-1618 County: McMinn *Relocated from 744 Tell Street, Athens 4/13/09*	P: 423-507-8755 F: 423-507-8748 TF:866-890-2977	0000000343	1104884493 (5543TN)	44-1533	Medicaid: 0441533	Hospice
5545	25065	Tennessee	TN	02-0674282	Branch	5543	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 310 Kimball Crossing, Suite 3 & 4 Kimball, TN 37347-5644 County: Marion *Relocated from Monteagle eff 6/24/15 *Relocated from South Pittsburg 8/18/2010*	P: 423-837-3636 F: 423-837-3640 TF:866-890-2981	0000000343	1104884493 (5543TN)	44-1533	Medicaid: 0441533	Hospice

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5539	25065	South Hospice	TN	02-0674282	*Parent	5539	Adventa Hospice, L.L.C d/b/a Amedisys Hospice, an Adventa Company 1500 West Elk Ave., Suite 202 Elizabethton, TN 37643-2655 County: Carter	P: 423-547-0852 F: 423-543-6449 TF:800-774-1404	0000000353	1518925783 (5539TN)	44-1534	Medicaid: 0441534	Hospice
5540	25065	South Hospice	TN	02-0674282	Branch	5539	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 116 Jack White Drive, Suite 6 Kingsport, TN 37664-2379 County: Sullivan *Relocated from 200 Professional Park Pvt. Drive on 7-30-13	P: 423-288-9777 F: 423-288-9781 TF:866-462-7180	0000000353	1518925783 (5539TN)	44-1534	Medicaid: 0441534	Hospice
5541	25065	South Hospice	TN	02-0674282	Branch	5539	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice, an Adventa Company 127 Serral Drive, Suite 1 Greeneville, TN 37745-3111 County: Greene	P: 423-638-2707 F: 423-638-4732 TF:866-462-7167	0000000353	1518925783 (5539TN)	44-1534	Medicaid: 0441534	Hospice
0547	25065	South Hospice	TN	02-0674282	*Parent	0547	Adventa Hospice, L.L.C. Amedisys Hospice, an Adventa Company 400 Royal Parkway Nashville, TN 37214-3636 County: Davidson	P: 615-231-7113 F: 615-886-7296 TF:844-269-3912	326	1942685565 0547TN	44-1602	Medicaid Q020750	Hospice
0545	20125	Tennessee	TN	20-1032665	*Parent	0545	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Care 8245 Tournament Drive, Suite 255 Memphis, TN 38125-8873 County: Shelby *Relocated from 6263 Poplar Avenue, Suite 1000 Memphis, TN 38119-4738 eff 8/30/16	P: 901-748-9121 F:901-748-9125 TF:877-896-5612	0000000239	1629018999 (tlc4457538)	44-7538	Medicaid: 0447538	Home Health
0551	20095	Tennessee	TN	20-3218056	*Parent	0551	Amedisys Sp-TN, LLC d/b/a Amedisys Home Health Services 900 Conference Drive, Suite 1A Goodlettsville, TN 37072-1925 County: Davidson *Relocated from Nashville East to Hermitage 01/16/2008* *Relocated from Hermitage to Nashville 02/02/2012* *Relocated from Nashville (230 Cumberland Bend) eff.10/7/13*	P: 615-851-3881 F: 615-851-3896 TF:866-610-4079	0000000068	1356399752 (0551TN)	44-7558	Medicaid: 0447558	Home Health
0570	25033	South Hospice	TN	27-0078073	*Parent	0570	Amedisys Hospice, LLC d/b/a Amedisys Hospice Care 1355 Lynnfield Road, Suite 120 Memphis, TN 38119-5832 County: Shelby	P: 901-680-0378 F: 901-818-4894 TF:866-877-2396	0000000376	1265490726 (0570TN)	44-1506	Medicaid 0441506 TLC # 29753	Hospice
5517	20061	Tennessee	TN	62-1139940	*Parent	5517	HHC, LLC. d/b/a Amedisys Home Health Care 1423 W. Morris Blvd., Suite B Morristown, TN 37813-2975 County: Hamblen	P: 423-586-0106 F: 423-581-8391 TF:866-586-0106	0000000091	1639127319 (5517TN)	44-7190	Medicaid: 0447190	Home Health
5520	20061	Tennessee	TN	62-1139940	Branch	5517	HHC, LLC. d/b/a Amedisys Home Health Care 170 Beech Street, Suite 3 Harrogate, TN 37752-8515 County: Claiborne **Mailing:** P.O. Box 4177, Harrogate, TN 37752-4177	P: 423-869-3977 F: 423-869-3738 TF:866-864-1379	0000000091	1639127319 (5517TN)	44-7190 Branch ID: 44Q7190001	Medicaid: 0447190	Home Health

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5521	20061	Tennessee	TN	62-1139940	Branch	5517	HHC, LLC. d/b/a Amedisys Home Health Care 109 Apple Lane, Suite A Rogersville, TN 37857-2943 County: Hawkins	P: 423-272-4484 F: 423-272-4485 TF:866-864-2075	0000000091	1639127319 (5517TN)	44-7190 Branch ID: 44Q7190002	Medicaid: 0447190	Home Health
5518	20061	Tennessee	TN	62-1139940	Branch	5517	HHC, LLC. d/b/a Amedisys Home Health Care 154 Campbell Drive, Suite A Sneedville, TN 37869-3900 County: Hancock **Mailing:** P.O. Box 428, Sneedville, TN 37869-0428	P: 423-733-2441 F: 423-733-2443	0000000091	1639127319 (5517TN)	44-7190 Branch ID: 44Q7190003	Medicaid: 0447190	Home Health
5522	20061	Tennessee	TN	62-1139940	Branch	5517	HHC, LLC. d/b/a Amedisys Home Health Care 404 E. Bernard Avenue Suite B Greeneville, TN 37745-5123 County: Greene *Relocated from 1350 East Andrew Johnson Highway, Greenville eff 12-2-2016	P: 423-638-7389 F: 423-639-9386 TF:866-864-1376	0000000091	1639127319 (5517TN)	44-7190 Branch ID: 44Q7190005	Medicaid: 0447190	Home Health
5507	20061	Tennessee	TN	62-1139940	*Parent	5507	HHC, LLC. d/b/a Amedisys Home Health Care 8 Stonebridge Boulevard, Suite L Jackson, TN 38305-2178 County: Madison *Other d/b/a: Housecall Home Healthcare	P: 731-664-2264 F: 731-668-9490 TF:800-261-2264	0000000177	1851349559 (5507TN)	44-7278	Medicaid: 0447278	Home Health
5508	20061	Tennessee	TN	62-1139940	Branch	5507	HHC, LLC. d/b/a Amedisys Home Health Care 2490 Parr Avenue, Suite 1 Dyersburg, TN 38024-2030 County: Dyer *Other d/b/a: Housecall Home Healthcare	P: 731-286-2097 F: 731-286-2253 TF:877-255-2097	0000000177	1851349559 (5507TN)	44-7278 Branch ID: 44Q7278001	Medicaid: 0447278	Home Health
5553	20061	Tennessee	TN	62-1139940	Branch	5507	HHC, LLC. d/b/a Amedisys Home Health Care 331 Jim Adams Drive, Suite A Paris, TN 38242-5037 County: Henry *Other d/b/a: Housecall Home Healthcare	P: 731-644-0723 F: 731-644-7964 TF:866-355-3101	0000000177	1851349559 (5507TN)	44-7278 Branch ID: 44Q7278002	Medicaid: 0447278	Home Health

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5556	20061	Tennessee	TN	62-1139940	Branch	5507	HHC, LLC. d/b/a Amedisys Home Health Care 880 Pickwick Street, Unit 1 Savannah, TN 38372-3071 County: Hardin *Other d/b/a: Housecall Home Healthcare	P: 731-926-2371 F: 731-926-3979 TF:866-472-8086	0000000177	1851349559 (5507TN)	44-7278 Branch ID: 44Q7278003	Medicaid: 0447278	Home Health
5557	20061	Tennessee	TN	62-1139940	Branch	5507	HHC, LLC. d/b/a Amedisys Home Health Care 1110 Bishop Street Union City, TN 38261-5402 County: Obion *Other d/b/a: Housecall Home Healthcare	P: 731-886-1113 F: 731-886-0224 TF:866-516-1113	0000000177	1851349559 (5507TN)	44-7278 Branch ID: 44Q7278004	Medicaid: 0447278	Home Health
5524	20061	Tennessee	TN	62-1139940	*Parent	5524	HHC, LLC. d/b/a Amedisys Home Health Care 1420 Dutch Valley Road, Suite A Knoxville, TN 37918-1424 County: Knox	P: 865-688-7500 F: 865-689-2804 TF:866-864-1381	0000000150	1710935408 (5524TN)	44-7312	Medicaid: 0447312	Home Health
5533	20061	Tennessee	TN	62-1139940	Branch	5524	HHC, LLC. d/b/a Amedisys Home Health Care 1855 Tanner Way, Suite 230 Harriman, TN 37748-8331 County: Roane	P: 865-376-6207 F: 865-376-7183 TF:866-864-1377	0000000150	1710935408 (5524TN)	44-7312 Branch ID: 44Q7312001	Medicaid: 0447312	Home Health
5532	20061	Tennessee	TN	62-1139940	Branch	5524	HHC, LLC. d/b/a Amedisys Home Health Care 1229 Fox Meadows Blvd, Suite 1 Sevierville, TN 37862-6923 County: Sevier	P: 865-428-2510 F: 865-429-4402 TF:866-666-6595	0000000150	1710935408 (5524TN)	44-7312 Branch ID: 44Q7312003	Medicaid: 0447312	Home Health
5527	20061	Tennessee	TN	62-1139940	Branch	5524	HHC, LLC. d/b/a Amedisys Home Health Care 1713 North Highway 92 Jefferson City, TN 37760-5220 County: Jefferson	P: 865-475-6400 F: 865-471-0919 TF:866-864-1380	0000000150	1710935408 (5524TN)	44-7312 Branch ID: 44Q7312004	Medicaid: 0447312	Home Health

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5526	20061	Tennessee	TN	62-1139940	Branch	5524	HHC, LLC. d/b/a Amedisys Home Health Care 611 West Broadway Newport, TN 37821-9032 County: Cocke	P: 423-623-6540 F: 423-625-2040 TF:866-864-2069	0000000150	1710935408 (5524TN)	44-7312 Branch ID: 44Q7312005	Medicaid: 0447312	Home Health
5530	20061	Tennessee	TN	62-1139940	Branch	5524	HHC, LLC. d/b/a Amedisys Home Health Care 575 Oak Ridge Turnpike, Suite 130 Oak Ridge, TN 37830-7173 County: Anderson	P: 865-481-3434 F: 865-481-3601 TF:866-610-4116	0000000150	1710935408 (5524TN)	44-7312 Branch ID: 44Q7312006	Medicaid: 0447312	Home Health
5509	20061	Tennessee	TN	62-1139940	*Parent	5509	HHC, LLC. d/b/a Amedisys Home Health Care 1655 Wynne Road, Suite 101 Cordova, TN 38016-4905 County: Shelby *Relocated from Bartlett-6/22/12 *Other d/b/a: Housecall Home Healthcare	P: 901-388-3335 F: 901-388-3866 TF:866-666-6950	0000000215	1134177983 (5509TN)	44-7451	Medicaid: 0447451	Home Health
5535	20061	Tennessee	TN	62-1139940	*Parent	5535	HHC, LLC. d/b/a Amedisys Home Health Care 1500 W. Elk Ave. Ste.201 Elizabethton, TN 37643-2655 County: Carter *Other d/b/a: Housecall Home Healthcare	P: 423-547-2310 F: 423-547-2319 TF:800-897-8975	0000000023	1487602488 (5535TN)	44-7505	Medicaid: 0447505	Home Health
5536	20061	Tennessee	TN	62-1139940	Branch	5535	HHC, LLC. d/b/a Amedisys Home Health Care 203 Forge Creek Road Mountain City, TN 37683-2057 County: Johnson *Other d/b/a: Housecall Home Healthcare	P: 423-727-2130 F: 423-727-2134 TF:800-231-1513	0000000023	1487602488 (5535TN)	44-7505 Branch ID: 44Q7505002	Medicaid: 0447505	Home Health
5506	20061	Tennessee	TN	62-1139940	*Parent	5506	HHC, LLC. d/b/a Amedisys Home Health Care 537 Stonecrest Parkway, Suite 109 Smyrna, TN 37167-6889 County: Rutherford *Other d/b/a: Housecall Home Healthcare* *Relocated from Murfreesboro 02/24/2010*	P: 615-220-8417 F: 615-220-8422 TF:866-666-7053	0000000005	1437107133 (5505TN)	44-7563	Medicaid: 0447563	Home Health
5552	20061	Tennessee	TN	62-1139940	Branch	5506	HHC, LLC. d/b/a Amedisys Home Health Care 1127 E. College Street Suite B Pulaski, TN 38478-4520 County: Giles *Other d/b/a: Housecall Home Healthcare	P: 931-363-9039 F: 931-366-9066 TF:866-401-2978	0000000005	1437107133 (5505TN)	44-7563 Branch ID: 44Q7563001	Medicaid: 0447563	Home Health

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5555	20061	Tennessee	TN	62-1139940	Branch	5506	HHC, LLC. d/b/a Amedisys Home Health Care 220 Town Center Parkway, Suite 201 Spring Hill, TN 37174-2406 County: Maury *Other d/b/a: Housecall Home Healthcare	P: 931-486-1911 F: 931-486-3129 TF:866-335-9319	0000000005	1437107133 (5505TN)	44-7563 Branch ID: 44Q7563002	Medicaid: 0447563	Home Health
0540	20122	Tennessee	TN	62-1151058	*Parent	0540	Comprehensive Home Healthcare Services, L.L.C. d/b/a Amedisys Home Health of Tennessee 1006 Old Knoxville Road Tazewell, TN 37879-4138 County: Claiborne	P: 423-626-2405 F: 423-626-2407 TF:866-666-6597	0000000025	1639149586 (CBRANDEN1)	44-7188	KY Medicaid 34620070 KY Mcd Waiver: 42620013 KY EPSDT: 45345642 TennCare: 0447188	Home Health
0541	20122	Tennessee	TN	62-1151058	Branch	0540	Comprehensive Home Healthcare Services, L.L.C. d/b/a Amedisys Home Health of Tennessee 2435 Jacksboro Pike, Suite 4 La Follette, TN 37766-2908 County: Campbell	P: 423-563-0038 F: 423-563-0021 TF:866-563-0038	0000000025	1639149586 (CBRANDEN1)	44-7188 Branch ID: 44Q7188003	Medicaid: 0447188	Home Health
0535	20021	Tennessee	TN	62-1755344	*Parent	0535	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 2000 Glen Echo Road, Suite 115 Nashville, TN 37215-2877 County: Davidson *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 615-298-3931 F: 615-298-3163 TF:866-505-0345	0000000038	1972551794 (0535TN)	44-7107	Medicaid 0447107	Home Health
0546	20021	Tennessee	TN	62-1755344	Branch	0535	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 2690 Madison Street, Suite 200 Clarksville, TN 37043-5498 County: Montgomery **Mailing:** P.O. Box 3215, Clarksville, TN 37043-3215	P:931- 358-9063 F:931- 358-9064 TF:866-326-0069	0000000038	1972551794 (0535TN)	44-7107 Branch ID: 44Q7107003	Medicaid: 0447107	Home Health
0512	20021	Tennessee	TN	62-1755344	*Parent	0512	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 7205 Lee Highway, Suite A Chattanooga, TN 37421-6801 County: Hamilton *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 423-490-1100 F: 423-490-1111 TF:800-903-8426	0000000113	1326096009 (0512TN)	44-7156	Medicaid 0447156 MR/DD Medicaid Waiver: 00736 Homemaker Services: 0445786	Home Health
0517	20021	Tennessee	TN	62-1755344	Branch	0512	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 3055 Rhea County Highway, Suite 330 Dayton, TN 37321-5840 County: Rhea *Relocated from Pikeville, TN eff. 7-30-13* *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 423-775-2739 F: 423-775-4354 TF:800-891-1450	0000000113	1326096009 (0512TN)	44-7156 Branch ID: 44Q7156001	Medicaid: 0447156	Home Health
0513	20021	Tennessee	TN	62-1755344	Branch	0512	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 616 Congress Parkway North Athens, TN 37303-1618 County: McMinn *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 423-744-8404 F: 423-744-3590 TF:800-756-8404	0000000113	1326096009 (0512TN)	44-7156 Branch ID: 44Q7156002	Medicaid: 0447156	Home Health
0506	20021	Tennessee	TN	62-1755344	*Parent	0506	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 209 10th Avenue South, Suite 408 Nashville, TN 37203-0766 County: Davidson *Relocated from 230 Cumberland Bend, Ste D eff 2/17/2017* *Relocated 12/01/99 from Hendersonville, TN.* *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee *Prior Nashville, TN parent closed 11/30/1999*	P: 615-313-7400 F: 615-313-7410 TF:800-643-5641	0000000254	1689622466 (0506TN)	44-7206	Medicaid: 0447206	Home Health

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0507	20021	Tennessee	TN	62-1755344	Branch	0506	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 100 Physicians Way, Suite 240 Lebanon, TN 37090-8108 County: Wilson *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee *Relocated from Gordonsville TN 06/27/2008* *Relocated from Carthage, TN 07/31/2000*	P: 615-453-2532 F: 615-547-7480 TF:800-287-6988	0000000254	1689622466 (0506TN)	44-7206 Branch ID: 44Q7206002	Medicaid: 0447206	Home Health
0528	20021	Tennessee	TN	62-1755344	Branch	0506	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 437 Henslee Drive Dickson, TN 37055-2166 County: Dickson *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 615-326-0326 F: 615-326-0369 TF:866-920-4082	0000000254	1689622466 (0506TN)	44-7206 Branch ID: 44Q7206003	Medicaid: 0447206	Home Health
0519	20021	Tennessee	TN	62-1755344	*Parent	0519	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 107 North Porter St, Suite 3 Winchester, TN 37398-1480 County: Franklin *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 931-962-4663 F: 931-962-4251 TF:800-876-8266	0000000082	1730137415 (0519TN)	44-7238	Medicaid: 0447238	Home Health
0523	20021	Tennessee	TN	62-1755344	*Parent	0523	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 508 West Main Street Livingston, TN 38570-1718 County: Overton *Other d/b/a's: Amedisys, Amedisys Home Care, Amedisys Home Health of Tennessee	P: 931-823-2050 F: 931-572-5376 TF:800-844-1515	0000000191	1972551752 (0523TN)	44-7260	Medicaid: 0447260	Home Health
0544	20021	Tennessee	TN	62-1755344	Branch	0523	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 315 N. Washington Ave Ste. 255 Cookeville, TN 38501-2697 County: Putnam	P:931-520-3005 F:931-520-3008 TF:866-377-4427	0000000191	1972551752 (0523TN)	44-7260 Branch ID: 44Q7260004	Medicaid: 0447260	Home Health
0530	20021	Tennessee	TN	62-1755344	Branch	0523	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 342 W. Central Avenue Jamestown, TN 38556-3407 County: Fentress **Mailing:** P.O. Box 607, Jamestown, TN 38556-0607	P: 931-879-9073 F: 931-879-9061 TF:866-877-8290	0000000191	1972551752 (0523TN)	44-7260 Branch ID: 44Q7260001	Medicaid: 0447260	Home Health
0550	20021	Tennessee	TN	62-1755344	*Parent	0550	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 6005 Park Ave, Suite 200B Memphis, TN 38119-5207 County: Shelby	P: 901-685-7231 F: 901-761-5485 TF:866-877-2027	0000000238	1114975539 (0550TN)	44-7277	Medicaid: 0447277	Home Health
0538	20021	Tennessee	TN	62-1755344	Branch	0550	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 1921 Highway 51 South, Unit C Covington, TN 38019-3659 County: Tipton	P: 901-476-0491 F: 901-476-3549 TF:866-610-4128	0000000238	1114975539 (0550TN)	44-7277 Branch ID: 44Q7277001	Medicaid: 0447277	Home Health
0536	20021	Tennessee	TN	62-1755344	*Parent	0536	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 1809 Ward Drive Murfreesboro, TN 37129-0502 County: Rutherford	P: 615-893-0214 F: 615-896-3716 TF:866-893-0018	0000000207	1326096108 (0536TN)	44-7296	Medicaid: 0447296	Home Health
0509	20021	Tennessee	TN	62-1755344	*Parent	0509	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 2913 Boones Creek Road, Ste. 6 Johnson City, TN 37615-4997 County: Washington *Relocated from 136 W. Springbrook Drive, Johnson City, 37604-1758 effective 4-1-16* *Other d/b/a's: Amedisys Home Health of Tennessee, Amedisys, Amedisys Home Care,	P: 423-952-2340 F: 423-952-2313 TF:800-624-6770	0000000273	1942258769 (0509TN)	44-7422	Medicaid: 0447422	Home Health

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0511	20021	Tennessee	TN	62-1755344	Branch	0509	Amedisys Tennessee, LLC d/b/a Amedisys Home Health 116 Jack White Drive, Suite 4 Kingsport, TN 37664-2379 County: Sullivan *Other d/b/a's: Amedisys Home Health of Tennessee, Amedisys, Amedisys Home Care	P: 423-392-5188 F: 423-392-5185 TF:800-842-2350	0000000273	1942258769 (0509TN)	44-7422 Branch ID: 44Q7422002	Medicaid: 0447422	Home Health
0770	25033	South Hospice	TX	27-0078073	*Parent	0770	Amedisys Hospice, LLC d/b/a Amedisys Hospice of San Antonio 5410 Fredericksburg Road, Bldg A, Suite 310 San Antonio, TX 78229-3576 County: Bexar	P: 210-541-0922 F: 210-541-9118 TF:866-549-3804	013242	1336207034 (1738TX)	45-1738	Medicaid 001018661	Hospice
1734	25065	North Hospice	VA	02-0674282	*Parent	1734	Adventa Hospice, L.L.C. d/b/a Amedisys Hospice Care 5221 Valley Park Drive, Suite 2 Roanoke, VA 24019-3004 County: Roanoke *Relocated from Salem, VA 01/30/14* *Relocated from154 W 4th St,Salem, to 1312 W Main St,Salem eff 9/4/09*	P: 540-265-8509 F: 540-265-2510 TF:800-394-8720	Exempt	1174581466 (1734VA)	49-1513	Medicaid: 004910222	Hospice
1754	20125	CommonWealth	VA	20-1032665	*Parent	1754	Tender Loving Care Health Care Services Southeast, L.L.C. d/b/a Amedisys Home Health Care 6353 Center Drive, Building 8, Suite 205 Norfolk, VA 23502-4112 County: Norfolk City	P: 757-466-1340 F: 757-466-1668 TF:866-738-0578	Exempt	1063467801 (tlc497498)	49-7498	Medicaid: 010216982	Home Health
1731	20061	CommonWealth	VA	62-1139940	*Parent	1731	HHC, LLC. d/b/a Amedisys Home Health Care 5221 Valley Park Drive, Suite 1A Roanoke, VA 24019-3004 County: Roanoke *Relocated from Salem, VA 01/17/2007*	P: 540-265-5980 F: 540-265-5985 TF:800-276-3203	Exempt	1164470738 (1731VA)	49-7275	Medicaid 004972759	Home Health
1732	20061	CommonWealth	VA	62-1139940	Branch	1731	HHC, LLC. d/b/a Amedisys Home Health of Martinsville 1077 Spruce Street Martinsville, VA 24112-4506 County: Henry	P: 276-656-2190 F: 276-656-2189 TF:866-666-6778	Exempt	1164470738 (1731VA) MEDICAID ONLY: 1306965538 (1732VA)	49-7275 Branch ID: 49Q7275001	Medicaid 010110424	Home Health
1736	20061	CommonWealth	VA	62-1139940	Branch	1731	HHC, LLC. d/b/a Amedisys Home Health of Lynchburg 2050 Langhorne Road, Suite 103 Lynchburg, VA 24501-1402 County: Lynchburg City *Suite 101 was corrected to be Suite 103 eff 5-4-16*	P: 434-845-7555 F: 434-845-7557 TF:866-768-0956	Exempt	1164470738 (1731VA) MEDICAID ONLY: 1528187853 (1736VA)	49-7275 Branch ID: 49Q7275003	Medicaid 010293669	Home Health
1712	20022	CommonWealth	VA	62-1818333	*Parent	1712	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health of Newport News One Enterprise Parkway, Suite 120 Hampton, VA 23666-5845 County: Hampton City *Relocated from Newport News 2/26/09	P: 757-223-5424 F: 757-223-5447 TF:866-610-4122	Exempt	1578511242 (1712VA)	49-7091	Medicaid 010216222	Home Health
1713	20022	CommonWealth	VA	62-1818333	Branch	1712	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health of Chesapeake 4016 Raintree Road, Suite 340 Chesapeake, VA 23321-3776 County: Chesapeake City	P: 757-465-1400 F: 757-465-8411 TF:866-784-9806	Exempt	1578511242 (1712VA) MEDICAID ONLY: 1659490951 (1713VA)	49-7091 Branch ID: 49Q7091001	Medicaid 010216184	Home Health

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1704	20022	CommonWealth	VA	62-1818333	*Parent	1704	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health 4589 Lifestyle Lane Midlothian, VA 23112-4807 County: Chesterfield *Relocated from Chesterfield, VA 12/28/2006	P: 804-639-7903 F: 804-739-4963 TF:800-313-4353	Exempt	1669420337 (1704VA)	49-7538	Medicaid 010131049	Home Health
1705	20022	CommonWealth	VA	62-1818333	Branch	1704	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health 1602 West Virginia Avenue #12 Crewe, VA 23930-1051 County: Nottoway *Relocated from Jetersville, VA 12/15/2010	P: 434-645-1012 F: 434-645-1021 TF:888-819-1951	Exempt	1669420337 (1704VA) MEDICAID ONLY: 1609994573 (1705VA)	49-7538 Branch ID: 49Q7538001	Medicaid 010131111	Home Health
1706	20022	CommonWealth	VA	62-1818333	Branch	1704	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health 3015 River Road West Goochland, VA 23063-3203 County: Goochland	P: 804-556-7172 F: 804-556-7176 TF:866-556-0297	Exempt	1669420337 (1704VA) MEDICAID ONLY: 1306964168 (1706VA)	49-7538 Branch ID: 49Q7538002	Medicaid 010131090	Home Health
1716	20022	CommonWealth	VA	62-1818333	Branch	1704	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health 200 Executive Center Parkway, Suite 100 Fredericksburg, VA 22401-3177 County: Spotsylvania	P: 540-371-7422 F: 540-371-7466 TF:866-414-3487	Exempt	1669420337 (1704VA) MEDICAID ONLY: 1326166620 (1716VA)	49-7538 Branch ID: 49Q7538006	Medicaid 010293642	Home Health
1702	20022	Tennessee	VA	62-1818333	*Parent	1702	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health Care 16009 Porterfield Highway Abingdon, VA 24210-8471 County: Washington *Was branch agency of Johnson City, TN prior to 12/20/2000. *Relocated from Weber City, VA 01/30/2003 *Relocated from Duffield, VA 12/13/13 *Other d/b/a's: Amedisys Home Health of Duffield	P: 276-619-2532 F: 276-619-2539 TF:866-889-5621	Exempt	1225096886 (1702VA)	49-7566	Medicaid 004970781	Home Health
1721	20022	CommonWealth	VA	62-1818333	*Parent	1721	Amedisys Home Health of Virginia L.L.C. d/b/a Amedisys Home Health Care 729 Richmond Ave., Suite B Staunton, VA 24401-4981 County: Staunton City *Relocated from Harrisonburg,VA 11-13-13 *Other d/b/a's: Amedisys Home Health of Harrisonburg	P: 540-886-2970 F: 540-886-2999 TF:866-231-8425	HCO-09534	1073794863 (1721VA)	49-7646	Medicaid: 1073794863	Home Health
1753	20146	CommonWealth	VA	74-3010642	*Parent	1753	Nine Palms 1, L.L.C. d/b/a Brookside Home Health, an Amedisys Company 460 McLaws Circle, Suite 250 Williamsburg, VA 23185-6428 County: James City	P: 757-253-2536 F: 757-253-8068 TF:800-296-2536	Exempt	1518912377 (tlc497415A)	49-7415	Medicaid: 4971264	Home Health
1752	20146	CommonWealth	VA	74-3010642	Branch	1753	Nine Palms 1, L.L.C. d/b/a Brookside Home Health, an Amedisys Company 18 New Street, Suite102 Saluda, VA 23149-1298 County: Middlesex **Mailing:** P.O. Box 1298, Saluda, VA 23149-1298	P: 804-758-1311 F: 804-758-8817 TF:800-758-3028	Exempt	1518912377 (tlc497415A) MEDICAID ONLY: 1881846087 (1752VA)	49-7415 Branch ID: 49Q7415004	Medicaid: 1881846087	Home Health
0801	90112	West/MidWest	WA	45-0506431	*Parent	0801	Tri-Cities Home Health, LLC d/b/a Tri Cities Home Health 8819 W Victoria Ave, Suite 110 Kennewick, WA 99336-7193 County: Benton *Relocated from 8905 West Gage Boulevard Suite 101, Kennewick eff 4/29/15 *Relocated from Richland 01/22/2009	P: 509-783-1851 F: 509-783-1871 TF:866-946-7725	IHS.FS.00000352	1679547244 (TriCities)	50-7010	Medicaid 9053836	Home Health
4601	20123	West/MidWest	WI	26-1457534	*Parent	4601	Amedisys Wisconsin, L.L.C. d/b/a Amedisys Home Health 2120 South Ridge Road Green Bay, WI 54304-4327 County: Brown	P: 920-497-1234 F: 920-497-1236 TF:866-833-0172	1170	1467602847 (4601WI)	52-7308	Medicaid: 1467602847	Home Health
3021	25126	North Hospice	WV	20-1032641	*Parent	3021	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Hospice Care 5006 Mid Atlantic Drive Morgantown, WV 26508-4290 County: Monongalia *Relocated from 246 Cheat Rd., Ste.3--03-18-13	P: 304-292-4868 F: 304-292-4867 TF:866-934-6229	19	1396799474 (tlc511523)	51-1523	Medicaid 3810019181	Hospice

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Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
3022	25126	North Hospice	WV	20-1032641	Branch	3021	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Hospice Care 67 Casino Drive, Suite 102 Anmoore, WV 26323 County: Harrison *Relocated from Bridgeport, WV 4-28-09 **Mailing:** P.O. Box 366, Anmoore, WV 26323-0366	P: 304-622-1297 F: 304-622-0978 TF:877-277-8574	19	1396799474 (tlc511523) MEDICAID ONLY: 1649422239 (3022WV)	51-1523	Medicaid 3810019151	Hospice
3023	25126	North Hospice	WV	20-1032641	Branch	3021	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Hospice Care 1251 Warwood Avenue, Suite A Wheeling, WV 26003-7129 County: Ohio	P: 304-217-3300 F: 304-217-3306 TF:866-327-3204	19	1396799474 (tlc511523) MEDICAID ONLY 1548412133 (3023WV)	51-1523	Medicaid: 3810019174	Hospice
3017	20126	Northeast	WV	20-1032641	*Parent	3017	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Home Health Care 5007 Mid Atlantic Drive Morgantown, WV 26508-4298 County: Monongalia *Relocated from 246 Cheat Rd., Ste.2--03-18-13	P: 304-296-9898 F: 304-292-5210 TF:800-860-0101		1215976592 (tlc517122)	51-7122	Medicaid 3810003006	Home Health
3016	20126	Northeast	WV	20-1032641	Branch	3017	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Home Health Care 67 Casino Drive, Suite 104 Anmoore, WV 26323 County: Harrison **Mailing:** P.O. Box 315, Anmoore, WV 26323-0315	P: 304-622-1684 F: 304-622-0810 TF:800-321-8316		1215976592 (tlc517122) MEDICAID ONLY: 1083865182 (3016WV)	51-7122 Branch ID: 51Q7122001	Medicaid 3810000004	Home Health
3018	20126	Northeast	WV	20-1032641	Branch	3017	Tender Loving Care Health Care Services of West Virginia, L.L.C. d/b/a Amedisys Home Health Care 1251 Warwood Avenue, Suite B Wheeling, WV 26003-7129 County: Ohio	P: 304-277-1500 F: 304-277-1507 TF:800-295-1501		1215976592 (tlc517122) MEDICAID ONLY: 1457503047 (3018WV)	51-7122 Branch ID: 51Q7122002	Medicaid 3810000003	Home Health
3014	25097	North Hospice	WV	20-4124842	*Parent	3014	Amedisys West Virginia, L.L.C. d/b/a Amedisys Hospice of Bluefield 545 Airport Road Suite 201 Bluefield, WV 24701-7388 County: Mercer *Relocated from 3879 Maple Acres Road eff 3/10/17*	P: 304-327-0600 F: 304-327-0611 TF:866-381-5704	20	1902064892 (3014WV)	51-1524	Medicaid 3810019172	Hospice
3015	25097	North Hospice	WV	20-4124842	*Parent	3015	Amedisys West Virginia, L.L.C. d/b/a Amedisys Hospice of Vienna 2200 Grand Central Ave. Ste 102 Vienna, WV 26105-1300 County: Wood *Relocated from Parkersburg Eff. 1/20/16	P: 304-424-6270 F: 304-424-6274 TF:866-764-3262	21	1366600256 (3015WV)	51-1525	Medicaid 3810019171	Hospice
3010	20097	Northeast	WV	20-4124842	*Parent	3010	Amedisys West Virginia, L.L.C. d/b/a Amedisys Home Health of West Virginia 108 Sunset Drive Beckley, WV 25801-2824 County: Raleigh	P: 304-253-2273 F: 304-256-6359 TF:800-876-1390		1427240183 (3010WV)	51-7054B	Medicaid 3810012504	Home Health
3011	20097	Northeast	WV	20-4124842	Branch	3010	Amedisys West Virginia, L.L.C. d/b/a Amedisys Home Health of West Virginia 545 Airport Road Suite 101 Bluefield, WV 24701-7388 County: Mercer *Relocated from 3887 Maple Acres Road eff 3/10/17*	P: 304-325-0066 F: 304-325-0077 TF:800-390-0017		1427240183 (3010WV) MEDICAID ONLY: 1487823183 (3011WV)	51-7054B Branch ID: 51Q7054001	Medicaid Provider ID: 3810012503 Service ID 1487823183-001	Home Health
3013	20097	Northeast	WV	20-4124842	*Parent	3013	Amedisys West Virginia, L.L.C. d/b/a Amedisys Home Health of West Virginia 2200 Grand Central Ave. Ste 101 Vienna, WV 26105-1300 County: Wood *Relocated from Parkersburg Eff. 1/20/16	P: 304-428-2554 F: 304-428-2518 TF:877-378-2273		1780876441 (3013WV)	51-7074A	Medicaid 3810012506	Home Health
3025	20097	Northeast	WV	20-4124842	Branch	3013	Amedisys West Virginia, L.L.C. d/b/a Amedisys Home Health of West Virginia 208 Stone Street Ripley, WV 25271-1162 County: Jackson	P: 304-372-7590 F: 304-372-7594 TF:877-872-2061		1780876441 (3013WV) MEDICAID ONLY: 1821327511 (3025WV)	51-7074A Branch ID: 51Q7074001	Medicaid 3810018146	Home Health
3001	20097	Northeast	WV	20-4124842	*Parent	3001	Amedisys West Virginia, LLC d/b/a Amedisys Home Health of West Virginia 2345 Chesterfield Avenue, Suite 201 Charleston, WV 25304-1063 County: Kanawha	P: 304-343-2047 F: 304-343-2069 TF:800-377-6736	Exempt	1700834553 (3001VA)	51-7115	Medicaid 3810005125	Home Health
3002	20097	Northeast	WV	20-4124842	Branch	3001	Amedisys West Virginia, LLC d/b/a Amedisys Home Health of West Virginia 5447 Maple Lane, Suite A Fayetteville, WV 25840-6872 County: Fayette *Relocated from Oak Hill, WV eff 10-18-12	P: 304-574-1141 F: 304-574-1151 TF:800-825-7954	Exempt	1700834553 (3001VA) MEDICAID ONLY: 1467655019 (3002WV)	51-7115 Branch ID: 51Q7115001	Medicaid 3810008960	Home Health
3003	20097	Northeast	WV	20-4124842	Branch	3001	Amedisys West Virginia, LLC d/b/a Amedisys Home Health of West Virginia 18 Red Oaks Shopping Center Ronceverte, WV 24970-1348 County: Greenbrier	P: 304-645-7474 F: 304-645-7799 TF:866-401-6527	Exempt	1700834553 (3001VA) MEDICAID ONLY: 1780887331 (3003WV)	51-7115 Branch ID: 51Q7115002	Medicaid Provider ID: 3810008962 Service ID: 1780887331-001	Home Health

Amedisys, Inc. - Active Locations

5/3/2017

Care Center	Business Unit	Region	State	Tax ID #	Status	Parent #	Legal Entity Name d/b/a Agency Name Agency Address	Phone Fax Toll Free	Home Care or Hospice License #	NPI (Login)	Medicare # & Branch ID	Medicaid # & Other Provider #'s	Care Center Type
3004	20097	Northeast	WV	20-4124842	Branch	3001	Amedisys West Virginia, LLC d/b/a Amedisys Home Health of West Virginia 3135 16th Street, Suite 22 Huntington, WV 25701-5247 County: Cabell	P: 304-523-2426 F: 304-523-6183 TF:866-824-6702	Exempt	1700834553 (3001VA) MEDICAID ONLY: 1902000391 (3004WV1)	51-7115 Branch ID: 51Q7115003	Medicaid 3810009786	Home Health
3031	25177	North Hospice	WV	38-3913146	*Parent	3031	Morgantown Hospice, L.L.C. d/b/a Morgantown Hospice, an Amedisys Partner 3596 Collins Ferry Road, Ste 250 Morgantown, WV 26505-2374 County: Monogalia *Relo from 1063 Maple Drive, Ste 2B eff 3/11/16	P: 304-285-2777 F: 304-285-1456 TF:866-317-2777	22	1659461804 (hopkinsr25)	51-1511A	Medicaid: 3810027632	Hospice

EXHIBIT 19

Enforcement Actions – Amedisys, Inc and Subsidiaries (From Form 10Q for Quarterly Period Ended 6/30/16)

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.

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 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.

EXHIBIT 20

Authorization of Amedisys Maryland, LLC

I, Jennifer R. Guckert, on behalf of Amedisys Maryland, LLC, the Applicant for a Certificate of Need to establish a general home health program in Frederick County (the "CON Application"), and its duly qualified officers, and in my capacity as Secretary of Amedisys Maryland, LLC and of its ultimate parent company, Amedisys, Inc. do hereby authorize Geoffrey L. Abraskin, as the Vice President of Operations for Amedisys, Inc., to sign for and act on behalf of Amedisys Maryland, LLC for the project which is the subject of the CON Application and to complete and file the CON Application with the appropriate state authorities in the State of Maryland.

Thus signed and dated this 1st day of May, 2017.

Jennifer R. Guckert

EXHIBIT 21

ACHC

FOR PROVIDERS.
BY PROVIDERS.

September 23, 2014

Amedisys Maryland, L.L.C.
511 Jemor Lane, Suite 200
Westminster, MD 21157-6151
Attention: Iris Rancatore

Dear Amedisys Maryland, L.L.C.:

On behalf of the Accreditation Commission for Health Care, Inc., it is my pleasure to inform you that Amedisys Maryland, L.L.C. has been ***approved for accreditation*** for the Home Health Program. The services approved are Home Health Aide Services, Medical Social Services, Occupational Therapy Services, Physical Therapy Services, Skilled Nursing Services, Speech Therapy Services.

Your accreditation is effective October 1, 2014 through October 1, 2017. Of course, maintaining accreditation is contingent upon continued compliance with ACHC's standards during this period. In granting accreditation, ACHC finds that your company has demonstrated that it operates at a level of quality, integrity and effectiveness consistent with its standards.

If you have any questions about your organization's findings, ACHC's decision, or ACHC's procedures, you should feel free to contact your organization's Accreditation Advisor, Nora Lee Stephen.

Again, ACHC extends its congratulations to Amedisys Maryland, L.L.C. for being awarded accreditation. It is an achievement of which your organization can be proud and one which marks your commitment to quality in the provision of care.

Sincerely,

Matthew D. Hughes
Director Business Development &
Customer Service

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT:

Amedisys Maryland, L.L.C.
d/b/a Amedisys Home Health
WESTMINSTER, MARYLAND

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

HOME HEALTH

FROM *October 1, 2014* THROUGH *October 1, 2017*

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF THE BOARD OF COMMISSIONERS

ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED · ACHC ACCREDITED · ACHC

ACCREDITATION COMMISSION *for* HEALTH CARE