LHC Group, Inc
Form 10-K
March 18, 2013
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

Form 10-K

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

For the fiscal year ended December 31, 2012

or

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

For the transition period from to

Commission file number: 001-33989

LHC GROUP, INC.

(Exact name of registrant as specified in its charter)

Delaware	71-0918189
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

420 West Pinhook Road, Suite A

Lafayette, Louisiana 70503

(Address of principal executive offices, including zip code)

(337) 233-1307

(Registrant s telephone number, including area code)

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

Common Stock, par value $0.01 per share	NASDAQ Global Select Market
(Title of each class)	(Name of each exchange on which registered)

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

None

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

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

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 x 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 during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes x No ¨

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (117 CFR 229.405) is not contained herein, and will not be contained, to the best of registrant s knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. x

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	x
Non-accelerated filer	¨	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 x

As of June 30, 2012, the aggregate market value of the registrant s common stock held by non-affiliates of the registrant was $273.9 million based on the closing sale price as reported on the NASDAQ Global Select Market. For purposes of this determination shares beneficially owned by officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

There were 17,584,303 shares of common stock, $0.01 par value, issued and outstanding as of March 11, 2013.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Annual Report to stockholders for the fiscal year ended December 31, 2012 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant s Proxy Statement for its 2013 Annual Meeting of Stockholders are incorporated by reference in Part III of this Annual Report on Form 10-K.

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PART I

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K and the information incorporated by reference herein contain certain statements and information that may constitute forward-looking statements within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 (the Exchange Act). Forward-looking statements relate to future plans and strategies, anticipated events or trends, future financial performance and expectations and beliefs concerning matters that are not historical facts or that necessarily depend upon future events. The words may, should, could, would, expect, plan, anticipate, believe, foresee, estimate, predict, potential, intend a intended to identify forward-looking statements. Specifically, this Annual Report on Form 10-K contains, among others, forward-looking statements about:

our expectations regarding financial condition or results of operations for periods after December 31, 2012;

our critical accounting policies;

our business strategies and our ability to grow our business;

our participation in the Medicare and Medicaid programs;

the reimbursement levels of Medicare and other third-party payors;

the prompt receipt of payments from Medicare and other third-party payors;

our future sources of and needs for liquidity and capital resources;

the effect of any changes in market rates on our operating and cash flows;

our ability to obtain financing;

our ability to make payments as they become due;

the outcomes of various routine and non-routine governmental reviews, audits and investigations;

our expansion strategy, the successful integration of recent acquisitions and, if necessary, the ability to relocate or restructure our current facilities;

the value of our proprietary technology;

the impact of legal proceedings;

our insurance coverage;

the costs of medical supplies;

our competitors and our competitive advantages;

our ability to attract and retain valuable employees;

the price of our stock;

our compliance with environmental, health and safety laws and regulations;

our compliance with health care laws and regulations;

our compliance with Securities and Exchange Commission laws and regulations and Sarbanes-Oxley requirements;

the impact of federal and state government regulation on our business; and

the impact of changes in or future interpretations of fraud, anti-kickback or other laws.

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The forward-looking statements included in this report reflect our current views and assumptions only as of the date this report is filed with the Securities and Exchange Commission. Except as required by law, we assume no responsibility and do not intend to release updates or revisions to forward-looking statements after the date they are made, whether as a result of new information, future events or otherwise. The occurrence of any of the events described in Part I, Item 1A. Risk Factors in this Annual Report on Form 10-K or incorporated by reference into this Annual Report on Form 10-K, and other events that we have not predicted or assessed could have a material adverse effect on our earnings, financial condition and business, and any such forward-looking statements should not be relied on as a prediction of future events.

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

You should read this Annual Report on Form 10-K, the information incorporated by reference into this Annual Report on Form 10-K and the documents filed as exhibits to this Annual Report on Form 10-K completely and with the understanding that our actual future results or achievements may differ materially from what we expect or anticipate.

Unless otherwise indicated, LHC Group, we, us, our and the Company refer to LHC Group, Inc. and its consolidated subsidiaries.

Item 1. Business.

Overview

We provide post-acute health care services to patients through our home nursing agencies, hospices and long-term acute care hospitals (LTACHs). As of December 31, 2012, through our wholly- and majority-owned subsidiaries, equity joint ventures and controlled affiliates, we operated in Alabama, Arkansas, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, West Virginia and Washington. We operate in two segments: home-based services and facility-based services. As of December 31, 2012, we owned and operated 274 home-based service locations, with 232 home nursing agency locations, 32 hospices, three specialty agencies and four private duty agencies. As of December 31, 2012, we also managed the operations of three home nursing agencies in which we do not have an ownership interest. Our facility-based services included six long-term acute care hospitals with nine locations, a pharmacy, and a family health center.

We provide home-based post-acute health care services through our home nursing agencies and hospices. Our home nursing locations offer a wide range of services, including skilled nursing, medically-oriented social services and physical, occupational and speech therapy. The nurses, home health aides and therapists in our home nursing agencies work closely with patients and their families to design and implement individualized treatments in accordance with a physician-prescribed plan of care. Our hospices provide end-of-life care to patients with terminal illnesses through interdisciplinary teams of physicians, nurses, home health aides, counselors and volunteers. Of the 274 home-based services locations, 140 are wholly-owned by us, 124 are majority-owned or controlled by us through joint ventures, seven are operated through license lease arrangements, and we manage the operations of three home nursing agencies in which we have no ownership interest.

Our LTACH locations provide services primarily to patients with complex medical conditions who have transitioned out of a hospital intensive care unit but whose conditions remain too severe for treatment in a non-acute setting. As of December 31, 2012, our LTACHs had 220 licensed beds. Of our 11 facility-based services locations, six are wholly-owned by us and five are majority-owned or controlled by us through joint ventures.

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Our net service revenue by segment for the years ended December 31, 2012, 2011 and 2010 was as follows (amounts in thousands):

	Year Ended December 31,		
	2012	2011	2010
Home-Based Services	$ 563,741	$ 557,901	$ 555,110
Facility-Based Services	73,828	75,971	76,457
Consolidated Net Service Revenue	$ 637,569	$ 633,872	$ 631,567

Our founders began operations in September 1994 as St. Landry Home Health, Inc. in Palmetto, Louisiana. After several years of expansion, our founders reorganized their business and began operating as Louisiana Healthcare Group, Inc. in June 2000. In March 2001, Louisiana Healthcare Group, Inc. reorganized and became a wholly owned subsidiary of The Healthcare Group, Inc., a Louisiana business corporation. In December 2002, The Healthcare Group, Inc. merged into LHC Group, LLC, a Louisiana limited liability company, with LHC Group, LLC being the surviving entity. In January 2005, LHC Group, LLC established a wholly owned Delaware subsidiary, LHC Group, Inc. and on February 9, 2005, LHC Group, LLC merged into LHC Group, Inc., a Delaware corporation. Our principal executive offices are located at 420 West Pinhook Road, Suite A, Lafayette, Louisiana, 70503. Our telephone number is (337) 233-1307. Our website is www.lhcgroup.com. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Business Strategy

Our objective is to become the leading provider of post-acute services to Medicare beneficiaries in the United States. To achieve this objective, we intend to:

Drive internal growth in existing markets. We intend to drive internal growth in our current markets by increasing the number of health care providers in each market from whom we receive referrals and by expanding the breadth of our services. We intend to achieve this growth by: (1) continuing to educate health care providers about the benefits of our services; (2) reinforcing the position of our agencies and facilities as community assets; (3) maintaining our emphasis on high-quality medical care for our patients; (4) indentifying related products and services needed by our patients and their communities; and (5) providing a superior work environment for our employees.

Achieve margin improvement through the active management of costs. The majority of our net service revenue is generated under Medicare prospective payment systems (PPS) through which we are paid pre-determined rates based upon the clinical condition and severity of the patients in our care. Because our profitability in a fixed payment system depends upon our ability to manage the costs of providing care, we continue to pursue initiatives to improve our margins and net income.

Expand into new markets. We intend to continue expanding into new markets by utilizing our point of care technology, developing de novo locations and by acquiring existing Medicare-certified home nursing agencies in attractive markets throughout the United States. We will continue our unique strategy of partnering with non-profit hospitals in home health services, as these ventures provide significant return on investment. We also plan to acquire larger freestanding agencies that can serve as growth platforms in markets we do not currently serve in order to support our growth into new markets.

Pursue strategic acquisitions and develop joint ventures. We will continue to identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position, increase our referral base and expand the breadth of services we offer. We endeavor to joint venture with hospitals to provide post-acute services, such as home health and hospice services, in communities served by hospitals already operating Medicare-certified home health agencies.

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Services

We provide post-acute care services in the United States by providing quality cost-effective health care services to patients within the comfort and privacy of their home or place of residence. Our services can be broadly classified into two principal categories: (1) home-based services offered through our home nursing agencies and hospices; and (2) facility-based services offered through our long-term acute care hospitals.

Home-Based Services

Home Nursing. Our registered and licensed practical nurses provide a variety of medically necessary services to homebound patients who are suffering from acute or chronic illness, recovering from injury or surgery, or who otherwise require care, teaching or monitoring. These services include:

- wound care and dressing changes;
- cardiac rehabilitation;
- infusion therapy;
- pain management;
- pharmaceutical administration;
- skilled observation and assessment; and
- patient education.

We have also designed guidelines to treat chronic diseases and conditions, including diabetes, hypertension, arthritis, Alzheimer s disease, low vision, spinal stenosis, Parkinson s disease, osteoporosis, complex wound care and chronic pain. Our home health aides provide assistance with daily living activities such as light housekeeping, simple meal preparation, medication management, bathing and walking. Through our medical social workers, we counsel patients and their families with regard to financial, personal and social concerns that arise from a patient s health-related problems. We provide skilled nursing, ventilator and tracheotomy services, extended care specialties, medication administration and management, and patient and family assistance and education. We also provide management services to third-party home nursing agencies, often as an interim solution until proper state and regulatory approvals for an acquisition can be obtained.

Our physical, occupational and speech therapists provide therapy services to patients in their home. Our therapists coordinate multi-disciplinary treatment plans with physicians, nurses and social workers to restore basic mobility skills such as getting out of bed and walking safely with crutches or a walker. As part of the treatment and rehabilitation process, a therapist will stretch and strengthen muscles, test balance and coordination abilities and teach home exercise programs. Our therapists assist patients and their families with improving and maintaining a patient s ability to perform functional activities of daily living, such as the ability to dress, cook, clean and manage other activities safely in the home environment. Our speech and language therapists provide corrective and rehabilitative treatment to patients who suffer from physical or cognitive deficits or disorders that create difficulty with verbal communication or swallowing.

All of our home nursing agencies offer 24-hour personal emergency response and support services through Philips Lifeline (Lifeline) for qualified patients who require close medical monitoring but who want to maintain an independent lifestyle. These services consist principally of a communicator that connects to the telephone line in the subscriber s home and a personal help button that is worn or carried by the individual subscriber which, when activated, initiates a telephone call from the subscriber s communicator to Lifeline s central monitoring facilities. Lifeline s trained personnel identify the nature and extent of the subscriber s particular need and notify the subscriber s family members, neighbors

and/or emergency personnel, as needed. We believe our use of the Lifeline system increases patient satisfaction and loyalty by providing our patients a point of contact between scheduled nursing visits. As a result, we provide a more complete regimen of care management than our competitors in the markets in which we operate by offering this service to qualified patients as part of their home health plan of care.

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Hospice. Our Medicare-certified hospice operations provide a full range of hospice services designed to meet the individual physical, spiritual and psychosocial needs of terminally ill patients and their families. Our hospice services are primarily provided in a patient s home but can also be provided in a nursing home, assisted living facility or hospital. Key services provided include pain and symptom management accompanied by palliative medication, emotional and spiritual support, inpatient and respite care, homemaker services, dietary counseling, and family bereavement counseling and social worker visits for up to 13 months after a patient s death.

Facility-Based Services

Long-term Acute Care Hospitals. Our LTACHs treat patients with severe medical conditions who require a high-level of care and frequent monitoring by physicians and other clinical personnel. Patients who receive our services in an LTACH are too medically unstable to be treated in a non-acute setting. Examples of these medical conditions include respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds, renal disorders, cancer, head and neck injuries and mental disorders. We also treat patients diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living. As part of our facility-based services, we operate an institutional pharmacy, which focuses on providing a full array of services to our long-term acute care hospitals.

Operations

Financial information relating to the home- and facility-based operating segments of our business including their contributions to our total net service revenue, operating income and total assets for each of the three years in the period ended December 31, 2012, 2011 and 2010, respectively, is found in Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Home-Based Services

Our home nursing agencies are operated in one division that is separated into five geographical regions and further separated into individual operating areas. Each agency is staffed with experienced clinical home health and administrative professionals who provide a wide range of patient care services. Each of our home nursing agencies is licensed and certified by the state and federal governments. As of December 31, 2012, 266 of our 274 agencies were accredited by the Joint Commission, a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. Those not yet accredited are working towards achieving this accreditation, a process which can take up to six months. As we acquire companies, we apply for accreditation 12 to 18 months after acquisition.

Our home nursing agencies use our Service Value Point system, a proprietary clinical resource allocation model and cost management system. The system is a quantitative tool that assigns a target level of resource units to a group of patients based upon their initial assessment and estimated skilled nursing and therapy needs. The Service Value Point system allows the Director of Nursing or Branch Manager to allocate adequate resources throughout the group of patients assigned to his or her care, rather than focusing on the profitability of an individual patient.

Patient care is handled at the home nursing agency level. Centralized functions that are provided by the home office include payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management, pharmacy, information technology and general clinical oversight accomplished by periodic on-site surveys.

Facility-Based Services

Our LTACHs are operated in one division within one geographic region. Our facility-based services follow a clinical approach under which each patient is discussed in weekly, multidisciplinary team meetings. In these meetings, patient progress is assessed and compared to goals and future goals are set. We believe that this model results in higher quality care, predictable discharge patterns and the avoidance of unnecessary delays.

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All coding, medical records, case management, utilization review and medical staff credentialing are provided at the hospital level. Centralized functions that are provided by the home office include payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management, pharmacy, information technology and general clinical oversight accomplished by periodic on-site surveys.

Joint Ventures

As of December 31, 2012, we had 70 equity joint ventures including 62 with hospitals, five with physicians, and three with other parties. We also operate three agency license leasing agreements.

Equity Joint Ventures

A majority of our equity joint ventures are structured as limited liability companies in which we own a majority equity interest and our partners own a minority equity interest. At the time of formation, we and our partners each contribute capital to the equity joint venture in the form of cash or property. We believe that the amount contributed by each party to the equity joint venture represents their pro-rata portion of the fair market value of the equity joint venture. None of our partners are required to make or influence referrals to our equity joint ventures. In fact, each of our hospital joint venture partners must follow the same Medicare discharge planning regulations, which, among other things, requires them to offer each Medicare patient a list of available Medicare-certified home nursing agency options and to allow the patient to choose his or her own provider.

We serve as the manager for our equity joint ventures and oversee their day-to-day operations. From a governance perspective, our equity joint ventures are either manager-managed or board-managed. In our manager-managed joint ventures, we are designated as the manager, and, in our board-managed joint ventures, we hold a majority of the votes required to take action, although a majority of our joint ventures require super majority approvals of certain actions. We possess a majority of the total votes available to be cast by the members of the management committee. However, in three of these joint ventures where we have partnered with not-for-profit hospitals, the hospitals control a majority of the total management committee votes. In such instances we possess the right to withdraw from the equity joint venture at any time upon notice to our partner in exchange for the receipt of a payment in an amount calculated in accordance with a predetermined formula. The members of our equity joint ventures participate in profits and losses in proportion to their equity interests. Distributions from our equity joint ventures are made pro-rata based on percentage ownership interests and are not based on referrals made to the equity joint venture by any of the members.

The 70 equity joint ventures individually contribute between 0.02% and 3.88% of our consolidated net service revenue with only two of the equity joint ventures accounting for greater than 3% of our total net service revenue for the twelve months ended December 31, 2012. LA Extended Care of Lafayette, in which we have a 87.23% ownership interest, contributed 3.77% and Mississippi HomeCare of Jackson, LLC, in which we have a 66.67% ownership interest, contributed 3.88% to our consolidated net service revenue for the year ended December 31, 2012.

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

License Leasing Agreements

As of December 31, 2012, we had three agreements to lease, through our wholly-owned subsidiaries, the right to use the home health licenses necessary to operate our home nursing agencies and hospice agencies. These

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leases are entered into when state law would otherwise prohibit the alienation and sale of home nursing agencies. The table below details the monthly fees and termination dates of the leasing agreements. Two of the agreements are based on net quarterly projections with a cap of $180,000 per year.

Number of agreements	2012 Current Monthly Fee	Increase in Monthly Fee	Initial Term Dates
1	$17,500	5% increase every three years	2017 with a 2 year automatic renewal
2	Based on net quarterly projections with a cap of $180,000.	None	2010 with a 5 year automatic renewal

In all three leasing arrangements, we have a right of first refusal in the event that the lessor intends to sell the leased agency to a third party.

Management Services Agreements

As of December 31, 2012, we had three management services agreements under which we manage the operations of home nursing agencies. We do not have ownership interest in the agencies subject to these management services agreements. We provide billing, management and other consulting services suited to and designed for the efficient operation of the applicable home nursing agency. We are responsible for the costs associated with the locations and personnel required for the provision of services. We are compensated based on a percentage of cash collections for one agreement and reimbursed for operating expenses plus a percentage of operating net income for the remaining two agreements. The term of these arrangements is typically five years, with an option to renew for an additional five-year term. All management services agreements will automatically renew annually unless either party gives written notice of termination.

We record management services revenue as services are provided in accordance with the various management services agreements.

Competition

The home health care market is highly fragmented. According to MedPac, there were approximately 11,654 Medicare-certified home nursing agencies in the United States in 2010. In 2009 MedPac estimated that approximately 32% of Medicare-certified home health agencies were hospital-based or not-for-profit, freestanding agencies and 19% of home nursing agencies were located in rural markets. We believe we are well positioned to build and maintain long-term relationships with local hospitals, physicians and other health care providers and to become the highest quality post-acute provider in our markets. In our experience, because most rural areas have the population size to support only one or two general acute care hospitals, the local hospital often plays a significant role in rural market health care delivery systems. Rural patients who require home nursing frequently receive care from a small home care agency or an agency that, while owned and run by the hospital, is not an area of focus for that hospital. Similarly, patients in these markets who require services typically offered by long-term acute care hospitals are more likely to remain in the community hospital because it is often the only local facility equipped to deal with severe, complex medical conditions. By entering these markets through affiliations with local hospitals, competition for the services we provide is minimal.

As we expand into new markets, we may encounter public companies that have greater resources or greater access to capital. Competition in our markets comes primarily from small local and regional providers. These providers include facility- and hospital-based providers, visiting nurse associations and nurse registries. We are unaware of any competitor offering our breadth of services and focusing on the needs of rural markets.

We have also entered into various joint ventures with non-profit hospitals for the ownership and management of home nursing agencies and LTACHs. We are unaware of any competitor with this type of ownership mix.

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Although several public and private national and regional companies own or manage long-term acute care hospitals, they generally do not operate in the rural markets that we serve. Generally, the competition in our markets comes from local health care providers. We believe our principal competitive advantages over these local providers are our diverse service offerings, our collaborative approach to working with health care providers, our focus on rural markets and our patient-oriented operating model.

Quality Control

The LHC Group Quality Council (The Council) is responsible for formulating quality of care indicators, identifying performance improvement priorities, and facilitating best-practices for quality care. As part of this council, we adopted the Plan, Do, Check, Act methodology. We also set forth a quality platform for home care that reviews the following:

- performance improvement audits;
- Joint Commission accreditation;
- state and regulatory surveys;
- Home Health Compare scores; and
- patient perception of care.

The Council also has the responsibility to ensure that the infrastructure of the quality initiatives throughout the Company is appropriate, to oversee and evaluate the effectiveness of the quality plans and initiatives and to recommend appropriate quality and performance improvement initiatives.

The Clinical Quality Committee of the Board of Directors (The Committee) is responsible for advising the Company s clinical leadership, monitoring the performance of our locations based on internal and external benchmarks, overseeing and evaluating the effectiveness of the performance improvement and quality plans, facilitating best practices based on internal and external comparisons and fostering enhanced awareness of clinical performance by the Board of Directors.

As part of our ongoing quality control, internal auditing and monitoring programs, we conduct internal regulatory audits and mock surveys at each of our agencies and facilities at least once a year. If an agency or facility does not achieve a satisfactory rating, we require that it prepare and implement a plan of correction. We then follow-up to verify that all deficiencies identified in the initial audit and survey have been corrected.

As required under the Medicare conditions of participation, we have a continuous quality improvement program, which involves:

- ongoing education of staff and quarterly continuous quality improvement meetings at each of our agencies, facilities and home office;
- monthly comprehensive audits of patient charts performed at each of our agencies and facilities;
- at least annually, a comprehensive audit of patient charts is performed on each of our agencies and facilities;

review of Home Health Compare scores;

assessment of patient s and/or family member s perception of care using Press Ganey, Deyton or Thomson Reuters; and

assessment of infection control practices and risk events.

We continually expand and refine our quality improvement programs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring activities, have been

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prepared and implemented to address the functional and operational aspects of our business. Our programs also address specific problem areas identified through regulatory interpretation and enforcement activities. We believe our consistent focus on continuous quality improvement programs provide us with a competitive advantage in the market.

Compliance

We have established and continually maintain a comprehensive compliance and ethics program that is designed to assist all of our employees to meet or exceed applicable standards established by federal and state laws and regulations and industry practice. Our goal is to foster and maintain the highest standards of compliance, ethics, integrity and professionalism in every aspect of our business dealings.

The purpose of our compliance and ethics program is to focus on compliance with applicable legal and regulatory requirements; the requirements of the Medicare and Medicaid programs and other government healthcare programs; industry standards; our Code of Conduct and Ethics; and our policies and procedures that support and enhance overall compliance within our Company. The primary focus of our compliance and ethics program is on regulations related to the federal False Claims Act, Stark Law, Anti-Kickback Law, billing and overall adherence to health care regulations.

To ensure the independence of our compliance department staff, the following measures have been implemented:

- our Chief Compliance Officer reports to and has direct oversight by the Audit Committee of our Board of Directors;
- the compliance department has its own operating budget; and
- the compliance department has the authority to independently investigate any compliance or ethical concerns, including, when deemed necessary, the authority to interview any company personnel, access any company property (including electronic communications) and engage counsel to assist in any investigation.

Among other activities, our compliance department staff is responsible for the following activities:

- drafting and revising the Company s policies and procedures related to compliance and ethics issues;
- reviewing, making recommended revisions, disseminating and tracking attestations to our Code of Conduct and Ethics;
- measuring compliance with our policies and procedures, Code of Conduct and Ethics and legal and regulatory requirements related to the Medicare and Medicaid programs and other government healthcare programs, laws and regulations;
- developing and providing compliance-related training and education to all of our employees and, as appropriate, directors, contractors and other representatives and agents, including new-hire compliance training for all new employees, annual compliance training for all employees, sales compliance training to all members of our sales team, billing compliance training to all members of our billing and revenue cycle team and other job-specific and role-based compliance training of certain employees;
- performing an annual company-wide risk assessment;

implementing an annual compliance auditing and monitoring work plan and performing and following up on various risk-based auditing and monitoring activities, including both clinical and non-clinical auditing and monitoring activities at the corporate level and at the local agency/facility level;

developing, implementing and overseeing our Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy and security compliance program;

monitoring, responding to and overseeing the resolution of issues and concerns raised through our anonymous compliance hotline;

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monitoring, responding to and resolving all compliance and ethics-related issues and concerns raised through any other form of communication; and

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

All employees are required to report incidents, issues or other concerns that they believe in good faith may be in violation of our Code of Conduct and Ethics, our policies and procedures, applicable legal and regulatory requirements or the requirements of the Medicare and Medicaid programs and other government healthcare programs. All employees are encouraged to either contact our Chief Compliance Officer directly or to contact our 24-hour toll-free compliance hotline when they have questions or concerns about any compliance or ethics issues. All reports to our compliance hotline are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. In cases reported to our compliance hotline that involve a compliance or ethics issue or any possible violation of law or regulation, the matter is referred to the compliance department for investigation. Retaliation against employees in connection with reporting compliance or ethical concerns is considered a serious violation of our Code of Conduct and Ethics, and, if it occurs, will result in discipline, up to and including termination of employment.

We continually expand and refine our compliance and ethics programs. We promote a culture of compliance, ethics, integrity and professionalism within our company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures. We believe our consistent focus on our compliance and ethics programs provides us with a competitive advantage in the markets we serve.

Technology and Intellectual Property

Our Service Value Point system is a proprietary information system that assists us in, among other things, monitoring clinical utilization and other cost factors, supporting our health care management techniques, internal benchmarking, clinical analysis, outcomes monitoring and claims generation, revenue cycle management and revenue reporting.

Our patent for our Service Value Point system was finalized during 2009 by the U.S. Patent and Trademark Office. This proprietary home nursing clinical resource and cost management system is a quantitative tool that assigns a target level of resource units to each patient based upon his or her initial assessment and estimated skilled nursing and therapy needs. We designed this system to empower our direct care employees to make appropriate day-to-day clinical care decisions while also allowing us to manage the quality and delivery of care across our system and to monitor the cost of providing that care both on a patient-specific and agency-specific basis.

In addition to our Service Value Point system, our business is substantially dependent on non-proprietary software. We utilize a third-party software information system for billing and maintaining patient claim receivables for our LTACHs. As of December 31, 2012, our home nursing agencies primarily utilized two billing and patient claim systems.

We continue to implement, evaluate and refine our point of care (POC) roll out strategy. POC allows a visiting clinician access to records and other information from the patient s home or at the point of care. This access also allows the clinician to complete required documentation at the point of care and submit it electronically into our patient record. As of December 31, 2012, we had 125 locations (home health and hospice) on POC. We plan to continue converting our locations to POC and expect to be completed by 2014.

Technology plays a key role in our organization s ability to expand operations and maintain effective managerial control. The software we use is based on client-server technology and is highly scalable. We believe our software and systems are flexible, easy-to-use and allow us to accommodate growth without difficulty. We believe that building and enhancing our information and software systems provides us with a competitive advantage that allows us to grow our business in a more cost-efficient manner and results in better patient care.

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Reimbursement

Medicare

The federal government s Medicare program, governed by the Social Security Act of 1965, reimburses health care providers for services furnished to Medicare beneficiaries. These beneficiaries generally include persons age 65 and older and those who are chronically disabled. The program is primarily administered by the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS). Medicare payments accounted for 77.9%, 79.7% and 80.5% of our net service revenue for the years ended December 31, 2012, 2011 and 2010, respectively. Medicare reimburses us based upon the setting in which we provide our services or the Medicare category in which those services fall.

In 2011, sequestration was used in the Budget Control Act of 2011(BCA, P.L. 112-25) as a tool in federal budget control. Sequestration is a procedure in United States law that limits the size of the federal budget. Sequestration involves setting a hard cap on the amount of government spending within broadly-defined categories; if Congress enacts annual appropriations legislation that exceeds these caps, an across-the-board spending cut is automatically imposed on these categories, affecting all departments and programs by an equal percentage. This 2011 act authorized an increase in the debt ceiling in exchange for $2.4 trillion in deficit reduction over the following ten years. This total included $1.2 trillion in spending cuts identified specifically in the legislation, with an additional $1.2 trillion in cuts that were to be determined by a bipartisan group of Senators and Representatives known as the Super Committee or officially as the United States Congress Joint Select Committee on Deficit Reduction. The Super Committee failed to reach an agreement. In that event, a trigger mechanism in the bill was activated to implement across-the-board reductions in the rate of increase in spending known as sequestration. Sequestration was triggered on March 1, 2013 for non-exempted spending other than Medicare. Due to the Congressional Budget Act, sequestration s impact on Medicare spending is triggered on the first day of the first month after the order is put into effect. The sequestration cut to Medicare will begin on April 1, 2013 and will reduce Medicare payments for patients whose service dates end on or after April 1, 2013 by 2%.

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

We receive a standard prospective Medicare payment for delivering care over a base 60-day period, referred to as an episode of care. There is no limit to the number of episodes a beneficiary may receive as long as he or she remains eligible. Most patients complete treatment within two payment episodes. The base episode payment, established through federal legislation, is a flat rate that is adjusted upward or downward based upon differences in the expected resource needs of individual patients as indicated by clinical severity, functional severity and service utilization. The magnitude of the adjustment is determined by each patient s categorization into one of 153 payment groups, known as Home Health Resource Groups and the costliness of care for patients in each group relative to the average patient. Our payment is further adjusted for differences in local labor costs using the hospital wage index. We bill and are reimbursed for services in two stages: an initial request for advance payment when the episode commences and a final claim when it is completed. We submit all Medicare claims through the Medicare Administrative Contractors for the federal government. We receive 60% of the estimated payment for a patient s initial episode up-front (after the initial assessment is completed and upon initial billing) and the remaining 40% upon completion of the episode and after all final treatment orders are signed by the physician. In the event of subsequent episodes, reimbursement timing is 50% up-front and 50% upon completion of the episode. Final payments may reflect one of four retroactive adjustments to ensure the adequacy and

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effectiveness of the total reimbursement: (1) an outlier payment if the patient s care was unusually costly; (2) a low utilization adjustment if the number of visits was fewer than five; (3) a partial payment if the patient transferred to another provider before completing the episode; or (4) a payment adjustment based upon the level of therapy services required in the population base. Because such adjustments are determined upon the completion date of the episode, retroactive adjustments could impact our financial results.

In 2011, CMS finalized two provisions of the Patient Protection and Affordable Care Act (the PPACA): (1) a face-to-face encounter requirement for home health and hospice; and (2) changes in the therapy assessment schedule. As a condition for Medicare payment, the PPACA mandates that prior to certifying a patient s eligibility for home health services, the certifying physician must document that he or she, or a non-physician practitioner that meets the requirements of the rule, has had a face-to-face encounter with the patient that relates to the condition for which the patient receives home health services. The encounter must occur within 90 days prior to the start of care or 30 days after the start of care. Documentation regarding these encounters must be present on certifications.

In addition to the face-to-face encounter requirements, CMS made important changes to therapy assessment requirements. A professional qualified therapist assessment must take place at least once every 30 days during a therapy patient s course of treatment. For those eligible patients needing 13 or 19 therapy visits, a qualified therapist must perform the therapy service required, assess the patient, and measure and document effectiveness of the 13th visit and the 19th visit for all therapy disciplines caring for the patient.

We verify a patient s eligibility for home health benefits at the time of admission. Through the verification process we are able to determine the payor source and eligibility for reimbursement of each patient. Accordingly, we do not have any material reimbursement amounts that are pending approval based on the eligibility of a patient to receive reimbursement from the applicable payor program. Further, we provide only limited services to patients who are ineligible for reimbursement from a third party payor. Therefore, we do not have any material reimbursement from patients who are self-pay.

The base payment rate for Medicare home nursing was $2,138.52, $2,192.07 and $2,312.94 per 60 day episode for the calendar years of 2012, 2011 and 2010, respectively. In 2013, the base payment rate for Medicare home nursing per 60 day episode is $2,137.73. The base payment rate does not include the 2% reduction to Medicare payment through sequestration as mandated by the Congressional Budget Act.

The standard federal rate is increased or decreased based on each Medicare patient s case mix index which measures the severity of the patient s condition. Since the inception of the prospective payment system in October 2000, the base episode payment rate has varied due to both the impact of annual market-basket based increases and Medicare-related legislation. Home health payment rates are updated annually by either the full home health market basket percentage, or by the home health market basket percentage as adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

The Office of Inspector General (OIG) of HHS has a responsibility to report both to the Secretary of HHS and to Congress any program or management problems related to programs such as Medicare. The OIG s duties are carried out through a nationwide network of audits, investigations and inspections. The OIG has undertaken a study with respect to Medicare reimbursement for home health services. No estimate can be made at this time regarding the impact, if any, of the OIG s findings.

Hospice. In order for a Medicare beneficiary to qualify for the Medicare hospice benefit, two physicians must certify that, in the best judgment of the physician or medical director, the beneficiary has less than six months to live, assuming the beneficiary s disease runs its normal course. In addition, the Medicare beneficiary must affirmatively elect hospice care and waive any rights to other Medicare benefits related to his or her terminal illness. For each benefit period, a physician must recertify that the Medicare beneficiary s life expectancy is six months or less in order for the beneficiary to continue to qualify for and to receive the Medicare

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hospice benefit. The first two benefit periods are measured at 90-day intervals and subsequent benefit periods are measured at 60-day intervals. A Medicare beneficiary may revoke his or her election at any time and resume receiving traditional Medicare benefits. There is no limit on how long a Medicare beneficiary can receive hospice benefits and services, provided that the beneficiary continues to meet Medicare hospice eligibility criteria.

Medicare reimburses for hospice care using a prospective payment system. Under that system, we receive one of four predetermined daily or hourly rates based upon the level of care we furnish to the beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations. Our base Medicare rates depend upon which of the following four levels of care we provide:

Routine Care. This level of care includes care that is not classified under any of the other levels of care, such as the work of social workers or home health aides.

General Inpatient Care. This level of care is available for pain control or acute or chronic symptom management that cannot be managed in a setting other than an inpatient Medicare certified facility, such as a hospital, skilled nursing facility or hospice inpatient facility.

Continuous Home Care. This level of care is provided when a patient is experiencing a medical crisis and requires nursing services to achieve palliation and symptom control. For services to qualify for this level of care, the agency must provide a minimum of eight hours of care within a 24-hour period.

Respite Care. This level of care is provided on a short-term, inpatient basis to give temporary relief to the person who regularly provides care to the patient.

Medicare limits the reimbursement we may receive for inpatient care services of hospice patients. Under the 80-20 rule, if the number of inpatient care days furnished by us to Medicare beneficiaries exceeds 20% of the total days of hospice care furnished by us to Medicare beneficiaries, Medicare payments to us for inpatient care days exceeding the inpatient cap will be reduced to the routine home care rate. This determination is made annually based on the 12-month period beginning on November 1st each year. This limit is computed on a program-by-program basis. Our hospices did not exceed the cap on inpatient care services during 2011 or 2010. We have not received notification that any of our hospices have exceeded the cap on inpatient care services during 2012.

Our Medicare hospice reimbursement is also subject to a cap amount calculated by the Medicare fiscal intermediary at the end of the hospice cap period, which runs from November 1 through October 31 of the following year. We have not received notification that any of our hospices have exceeded the cap on per beneficiary limits during 2012.

The two caps include an inpatient cap and overall payment cap, detailed below:

Inpatient Cap. This cap limits the number of days of inpatient care (both respite and general) under a provider number to 20% of the total number of days of hospice care (both inpatient and in-home) furnished to all patients served. The daily payment rate for any inpatient days of service in excess of the cap amount is calculated at the routine home care rate, with excess amounts due back to Medicare; 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.

On a monthly and quarterly basis, 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 from September 28, 2011 to September 27, 2012 by a statutory amount that is indexed for inflation. The per beneficiary cap amount was $25,377 for the twelve-month period ended October 31, 2012 and $24,528 for the twelve month period ended October 31, 2011. There will be a cap liability if actual payments per the Provider Statistical and Reimbursement report for the period of November 1, 2011 to October 31, 2012

exceed the beneficiary cap amount.

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In 2011, CMS finalized a face-to-face encounter requirement applicable to hospice. This requirement mandated that a physician or nurse practitioner must have a face-to-face encounter with the patient no later than the 30 day period prior to the 180th-day recertification (third benefit period) and each subsequent recertification in order to gather clinical findings that support continued hospice care, and that the certifying hospice physician must attest that such a visit took place.

Long-Term Acute Care Hospitals. All Medicare payments to our LTACHs are made in accordance with a prospective payment system specifically applicable to long-term acute care hospitals, referred to as LTACH-PPS. There have been significant regulatory changes over the last few years, including reimbursement changes, which have affected our net operating revenues and, in some cases, caused us to change our operating model and business strategies.

The LTACH-PPS is based on a prospective payment system specifically applicable to LTACHs. It was established by CMS final regulations published on August 30, 2002, and applies to LTACHs for cost reporting periods beginning on or after October 1, 2002. Under the LTACH-PPS, each patient discharged from an LTACH was assigned a distinct LTC-DRG and an LTACH is generally paid a pre-determined fixed amount applicable to the assigned LTC-DRG (adjusted for area wage differences), subject to exceptions for short stay and high cost outlier patients (described below). Beginning with discharges on or after October 1, 2007, CMS implemented a new patient classification system with categories referred to as MS-LTC-DRGs. The new classification categories take into account the severity of the patient s condition. The payment amount for each MS-LTC-DRG is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in an LTACH.

Standard Federal Rate

Payment under the LTACH-PPS is dependent on determining the patient classification, that is, the assignment of the case to a particular MS-LTC-DRG, the weight of the MS-LTC-DRG and the standard federal payment rate. There is a single standard federal rate that encompasses both the inpatient operating costs, which includes a labor and non-labor component, and capital-related costs that CMS updates on an annual basis. LTACH-PPS also includes special payment policies that adjust the payments for some patients based on the patient s length of stay, the facility s costs, whether the patient was discharged and readmitted and other factors.

Short Stay Outlier Policy

CMS established a different payment methodology for Medicare patients with a length of stay less than or equal to five-sixths of the geometric average length of stay for that particular MS-LTC-DRG, referred to as a short stay outlier, or SSO. When LTACH-PPS was established, SSO cases were paid based on the lesser of (1) 120% of the average cost of the case; (2) 120% of the LTC-DRG specific per diem amount multiplied by the patient s length of stay; or (3) the full LTC-DRG payment. CMS modified the payment methodology for discharges occurring on or after July 1, 2006, which changed the limitation in clause (1) above to reduce payment for SSO cases to 100% (rather than 120%) of the average cost of the case, and also added a fourth limitation, potentially further limiting payment for SSO cases at a per diem rate derived from blending 120% of the MS-LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital inpatient prospective payment system, or IPPS . Under this methodology, as a patient s length of stay increases, the percentage of the per diem amount based upon the IPPS component will decrease and the percentage based on the MS-LTC-DRG component will increase.

Modification of Short Stay Outlier Policy

Effective December 29, 2012, the SSO rule was further revised adding a category referred to as a very short stay outlier for discharges. For cases with a length of stay that is less than the average length of stay plus one standard deviation for the same MS-DRG under IPPS, referred to as the so-called IPPS comparable threshold, the rule lowers the LTACH payment to a rate based on the general acute care hospital IPPS per diem. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the SSO payment policy.

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High Cost Outliers

Some cases are extraordinarily costly, producing losses that may be too large for hospitals to offset. Cases with unusually high costs, referred to as high cost outliers, receive a payment adjustment to reflect the additional resources utilized. CMS provides an additional payment if the estimated costs for the patient exceed the adjusted MS-LTC-DRG payment plus a fixed-loss amount that is established in the annual payment rate update.

Interrupted Stays

An interrupted stay is defined as a case in which an LTACH patient is admitted upon discharge to a general acute care hospital, IRF, skilled nursing facility or a swing-bed hospital and returns to the same LTACH within a specified period of time. If the length of stay at the receiving provider is equal to or less than the applicable fixed period of time, it is considered to be an interrupted stay case and is treated as a single discharge for the purposes of payment to the LTACH.

Freestanding, HwH and Satellite LTACHs

LTACHs may be organized and operated as freestanding facilities or as a hospital within a hospital, or HwH . An HwH is an LTACH that is located on the campus of another hospital. In this case, campus means the physical area immediately adjacent to a hospital s main buildings, other areas and structures that are not strictly contiguous to a hospital s main buildings but are located within 250 yards of its main buildings, and any other areas determined, on an individual case basis by the applicable CMS regional office, to be part of a hospital s campus. An LTACH, whether freestanding or an HwH, that uses the same Medicare provider number of an affiliated primary site LTACH is known as a satellite. Under Medicare policy, a satellite LTACH must be located within 35 miles of its primary site LTACH and be administered by such primary site LTACH. A primary site LTACH may have more than one satellite LTACH. CMS sometimes refers to a satellite LTACH that is freestanding as a remote location. As of December 31, 2012, we had a total of nine LTACH facilities, with 220 licensed beds. Eight of our LTACH facilities were classified as HwHs and one as freestanding. Of the eight HwH facilities, three were located in Metropolitan Statistical Area (MSA) or urban areas and five were located in non-MSA or rural areas. One of our HwH facilities was a satellite location of a parent hospital located in an MSA and one was a satellite location of a parent hospital located in a non-MSA. Our single freestanding location was a freestanding remote site of a parent located in an MSA.

LTACH Certification Criteria

The LTACH-PPS regulations define the criteria that must be met in order for a hospital to be certified as an LTACH. To be eligible for payment under the LTACH-PPS, a hospital must be primarily engaged in providing inpatient services to Medicare beneficiaries with medically complex conditions that require a long hospital stay. In addition, by definition, LTACHs must meet certain facility criteria, including (1) instituting a review process that screens patients for appropriateness of an admission and validates the patient criteria within 48 hours of each patient s admission, evaluates regularly their patients for continuation of care and assesses the available discharge options; (2) having active physician involvement with patient care that includes a physician available on-site daily and additional consulting physicians on call; and (3) having an interdisciplinary team of healthcare professionals to prepare and carry out an individualized treatment plan for each patient.

An LTACH must have an average inpatient length of stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days. LTACHs that fail to exceed an average length of stay of 25 days during any cost reporting period may be paid under the general acute care hospital IPPS if not corrected within established timeframes. CMS, through its contractors, determines whether an LTACH has maintained an average length of stay of greater than 25 days during each annual cost reporting period. In the preamble to the final rule for fiscal year 2012, CMS clarified its policy on the calculation of the average length of stay by specifying that all data on all Medicare inpatient days, including Medicare Advantage days, must be included in the average length of stay calculation effective for cost reporting periods beginning on or after January 1, 2012.

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25 Percent Rule

The 25 Percent Rule is a downward payment adjustment that applies to Medicare patients discharged from LTACHs who were admitted from a co-located hospital or a non-co-located hospital and caused the LTACH to exceed the applicable percentage thresholds of discharged Medicare patients. To the extent that any LTACH s or LTACH satellite facility s discharges that are admitted from an individual hospital (regardless of whether the referring hospital is co-located with the LTACH or LTACH satellite) exceed the applicable percentage threshold during a particular cost reporting period, the payment rate for those discharges would be subject to a downward payment adjustment. Cases admitted in excess of the applicable threshold are reimbursed at a rate comparable to that under general acute care IPPS, which is generally lower than LTACH-PPS rates. Cases that reach outlier status in the referring hospital do not count toward the limit and are paid under LTACH-PPS.

For HwHs that meet specified criteria and were in existence as of October 1, 2004, the Medicare percentage thresholds were phased in over a four year period starting with hospital cost reporting periods that began on or after October 1, 2004. For HwHs opened after October 1, 2004, the Medicare percentage threshold has been established at 25% except for HwHs located in rural areas or co-located with an MSA dominant hospital or single urban hospital (as defined by current regulations) where the percentage is no more than 50%, nor less than 25%. All of our LTACH s are in rural areas or are collocated with an MSA dominant hospital.

The SCHIP Extension Act (as amended by the American Recovery and Reinvestment Act, or the ARRA, see below) and the PPACA has limited the application of the Medicare percentage threshold to HwHs in existence on October 1, 2004 and subject to the four year phase in described above. For these HwHs, the percentage threshold is no lower than 50% for a five year period to commence on an LTACH s first cost reporting period to begin on or after October 1, 2007, except for HwHs located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals, in which cases the percentage threshold is no more than 75% during the same five cost reporting years.

For cost reporting periods beginning on or after July 1, 2007, CMS expanded the 25 Percent Rule to apply a payment adjustment to Medicare patients admitted from any individual hospital in excess of the specified percentage threshold. Previously, the percentage threshold payment adjustment was applicable only to Medicare admissions from hospitals co-located with an LTACH or satellite of an LTACH. The expanded 25 Percent Rule subjects free-standing LTACHs, grandfathered HwHs and grandfathered satellites to the Medicare percentage threshold payment adjustment, as well as HwHs that admit Medicare patients from non-co-located hospitals. Two of our LTACH facilities are grandfathered HwH s.

The SCHIP Extension Act, as amended by the ARRA, postponed the application of the percentage threshold to all free-standing and grandfathered HwHs for a three year period commencing on an LTACH s first cost reporting period on or after July 1, 2007. However, the SCHIP Extension Act did not postpone the application of the percentage threshold, or the transition period, to those Medicare patients discharged from an LTACH HwH or satellite that were admitted from a non-co-located hospital. The ARRA limits application of the percentage threshold to no more than 50% of Medicare admissions to grandfathered satellites from a co-located hospital for a three year period commencing on the first cost reporting period beginning on or after July 1, 2007. The PPACA included a two-year extension of the limits placed on the 25 Percent Rule by the SCHIP Extension Act, as amended by the ARRA.

The 25 Percent Rule is highly complex and CMS has issued only limited guidance. Based on our discussions with CMS, we believe each of our satellite and remote locations will be viewed as being located in a non-MSA regardless of the location of its parent hospital and will be treated independently from its parent for purposes of calculating its compliance with the admissions limitations. If the 25 Percent Rule is extended, as planned, to freestanding LTACHs after the three-year delay (established in the MMSEA), our current freestanding facility would not likely be affected because we currently do not receive more than 25% of our Medicare admissions from any single referring hospital.

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For the 12 months ended December 31, 2012, on an individual basis, our LTACH admissions were under the proper threshold as of the current cost report year date of August 31, 2012. We acquired LTACHs in 2010 and 2009 both of which were grandfathered LTACHs and, therefore, have no limitations under MMSEA with respect to the number of patients that can be admitted from the host hospital. One LTACH is not subject to these limits on host hospital referrals because it is not an HwH. All of our LTACHs maintain compliance with non-co-located hospital referral thresholds.

After the expiration of the regulatory relief provided by the SCHIP Extension Act, the ARRA and the PPACA, as described above, our LTACHs (whether freestanding, HwH or satellite) will be subject to a downward payment adjustment for any Medicare patients who were admitted from a co-located or a non-co-located hospital and that exceed the applicable percentage threshold of all Medicare patients discharged from the LTACH during the cost reporting period. If the 25 Percent Rule, as originally adopted by CMS, becomes effective after the expiration of the applicable provisions of the SCHIP Extension Act, the ARRA and the PPACA, these regulatory changes will collectively cause an adverse effect on our operating revenues and profitability in 2013 and beyond. However, this adverse effect could be partially mitigated if we are able to implement certain operational changes.

Extension of Changes Made by the Medicare, Medicaid, and SCHIP Extension Act of 2007

On March 23, 2010, President Obama signed into law the PPACA. The PPACA adopts significant changes to the Medicare program that are particularly relevant to our LTACHs. Among other changes, the PPACA applies a market basket payment adjustment to LTACHs. In addition, the PPACA includes a two-year extension to sections of the SCHIP Extension Act, as amended by the ARRA. The two-year extension applies the relief granted to the 25 Percent Rule payment adjustment, the one-time budget neutrality adjustment and the very short stay outlier payment adjustment. The two-year extension also applies to the moratorium on new LTACHs and new LTACH beds adopted in the SCHIP Extension Act.

Medicare Market Basket Adjustments

The PPACA instituted a market basket payment adjustment to LTACHs. In fiscal year 2010, LTACHs were subject to a market basket reduction of 0.25% for discharges occurring after April 1, 2010 through September 30, 2010. In fiscal year 2011, LTACHs were subject to a market basket reduction of 0.5%. There will be a slightly smaller 0.1% market basket reduction for LTACHs in fiscal years 2012 and 2013. In fiscal year 2014, the market basket update will be reduced by 0.3%. Fiscal years 2015 and 2016 the market basket update will be reduced by 0.2%. Finally, in fiscal years 2017 through 2019, the market basket update will be reduced by 0.75%. The PPACA specifically allows these market basket reductions to result in less than a 0% payment update and payment rates that are less than the prior year.

Hospital Wage Index

The PPACA calls for CMS to abandon the current system of calculating the hospital wage index based on data submitted in hospital cost reports, which currently has a four year lag in data. In its place, CMS is required to develop and present to Congress a comprehensive reform plan using Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved. Although the PPACA addresses the hospital wage index generally, this change presumably applies to LTACHs given that the LTACH-PPS wage index is computed using wage data from general acute care hospitals.

Recent changes to the LTACH prospective pay system

Proposed rules specifically related to LTACHs are generally published in January, finalized in May and effective on July 1st of each year. Additionally, LTACHs are subject to annual updates to the rules related to the IPPS, which are typically proposed in May, finalized in August and effective on October 1st of each year. In the annual payment rate update for the 2010 fiscal year, CMS consolidated the two historical annual updates into one

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annual update. The final rule adopted a 15-month rate update for fiscal year 2009 and moved the LTACH-PPS from a July-June update cycle to an October-September cycle. Beginning fiscal year 2010 the LTACH rate year will begin October 1, coinciding with the start of the federal fiscal year.

The following is a summary of significant changes to the Medicare LTACH-PPS that has occurred during several years.

The American Recovery and Reinvestment Act of 2009. On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009, the ARRA. The ARRA makes several technical corrections to the SCHIP Extension Act, including a clarification that, during the moratorium period established by the SCHIP Extension Act, the percentage threshold for grandfathered satellites is set at 50% and not phased in to the 25% level for admissions from a co-located hospital. In addition, the ARRA clarifies that the application of the percentage threshold is postponed for a LTACH HwH or satellite that was co-located with a provider-based, off-campus location of an IPPS hospital that did not deliver services payable under IPPS. The ARRA also provides that the postponement of the percentage threshold established in the SCHIP Extension Act will be effective for cost reporting periods beginning on or after July 1, 2007 for freestanding LTACHs and grandfathered HwHs and satellites and on or after October 1, 2007 for other LTACH HwHs and satellites.

June 3, 2009 Interim Final Rule. On June 3, 2009, CMS published an interim final rule in which CMS adopted a new table of MS-LTC-DRG relative weights that applied to the remainder of fiscal year 2009 (through September 30, 2009). This interim final rule revises the MS-LTC-DRG relative weights for payment under the LTACH-PPS for fiscal year 2009 due to CMS s misapplication of its established methodology in the calculation of the budget neutrality factor. This error resulted in relative weights that are higher, by approximately 3.9% for all of fiscal year 2009 (October 1, 2008 through September 30, 2009) which has the effect of reducing reimbursement by approximately 3.9%. However, CMS only applied the corrected weights to the period from June 3, 2009 through September 30, 2009.

July 31, 2009 Final Rule. On July 31, 2009, CMS released its annual payment rate update for the LTACH-PPS for fiscal year 2010 (affecting discharges and cost reporting periods beginning on or after October 1, 2009 and before September 30, 2010). For fiscal year 2010 CMS adopted a 2.5% increase in payments under the LTACH-PPS. As a result, the standard federal rate for fiscal year 2010 is set at $39,897, an increase from $39,114 in fiscal year 2009. The increase in the standard federal rate uses a 2.0% update factor based on the market basket update of 2.5% less an adjustment of 0.5% to account for changes in documentation and coding practices. The fixed loss amount for high cost outlier cases is set at $18,425. This is a decrease from the fixed loss amount in the 2009 rate year of $22,960.

The July 31, 2009 annual payment rate update also included an interim final rule with comment period implementing provisions of the ARRA discussed above, including amendments to provisions of the SCHIP Extension Act relating to payments to LTACHs and LTACH satellite facilities and increases in beds in existing LTACHs and LTACH satellite facilities under the LTACH-PPS.

In the same federal register, CMS finalized three interim final rules. First, CMS finalized the June 3, 2009 interim final rule that adopted a new table of MS-LTC-DRG relative weights for the period between June 3, 2009 and September 30, 2009. Second, CMS finalized the May 6, 2008 interim final rule that implemented changes to LTACH-PPS mandated by the SCHIP Extension Act addressing: (1) payment adjustments for certain short-stay outliers, (2) the federal standard rate for the last three months of rate year 2008, and (3) adjustment of the high cost outlier fixed-loss amount. Finally, CMS finalized the May 22, 2008 interim final rule that implemented changes to LTACH-PPS mandated by the SCHIP Extension Act modifying the percentage threshold policy for certain LTACHs and addressing the three-year moratorium on the establishment of new LTACHs and bed increases at existing LTACHs and LTACH satellites.

On June 2, 2010, CMS published a notice of changes to the payment rates for LTACH-PPS during the portion of fiscal year 2010 occurring on or after April 1, 2010. The standard federal rate for discharges occurring

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on or after April 1, 2010 was revised downward to $39,795 from $39,897 established in the original final rule for fiscal year 2010. This change to the LTACH-PPS standard federal rate for the remainder of fiscal year 2010 was based on an additional market basket reduction of 0.25% as mandated by the PPACA. The notice revised the fixed-loss amount for high cost outlier cases for fiscal year 2010 discharges occurring on or after April 1, 2010 to $18,615, which was higher than the fixed-loss amount of $18,425 in effect from October 1, 2009 to March 31, 2010.

Fiscal Year 2011 On August 16, 2010, CMS published the policies and payment rates for LTACH-PPS for fiscal year 2011 (affecting discharges and cost reporting periods beginning on or after October 1, 2010 through September 30, 2011). The standard federal rate for fiscal year 2011 is $39,600, which is a decrease from the fiscal year 2010 standard federal rate of $39,897 in effect from October 1, 2009 to March 31, 2010 and the fiscal year 2010 standard federal rate of $39,795 that went into effect on April 1, 2010. This update to the LTACH-PPS standard federal rate for fiscal year 2011 is based on a market basket increase of 2.5% less a reduction of 2.5% to account for what CMS attributes as an increase in case-mix in prior periods that resulted from changes in documentation and coding practices less an additional reduction of 0.5% as mandated by the PPACA. The final rule establishes a fixed-loss amount for high cost outlier cases for fiscal year 2011 of $18,785, which is higher than the fiscal year 2010 fixed-loss amount of $18,425 in effect from October 1, 2009 to March 31, 2010 and the $18,615 that went into effect on April 1, 2010. The final rule also included revisions to the relative weights for each of the MS-LTC-DRGs for fiscal year 2011.

Fiscal Year 2012 On August 18, 2011, CMS published the policies and payment rates for LTACH-PPS for fiscal year 2012 (affecting discharges and cost reporting periods beginning on or after October 1, 2011 through September 30, 2012). The standard federal rate for fiscal year 2012 was $40,222, an increase from the fiscal year 2011 standard federal rate of $39,600. The final rule established a fixed-loss amount for high cost outlier cases for fiscal year 2012 of $17,931, which is a decrease from the fixed loss amount in the 2011 fiscal year of $18,785.

Fiscal Year 2013 On August 1, 2012 CMS released its final rule for LTACH Medicare reimbursement for fiscal year 2013 which spans from October 1, 2012 through September 30, 2013. In aggregate, payments for fiscal year 2013 will increase by 1.8% over fiscal year 2012 rates. The 1.8% increase consists of a 2.6% inflationary market basket update offset by a 0.7% reduction for the productivity adjustment, a 0.1% reduction to the market basket as defined by the PPACA. LTACH payment rates will also be reduced by approximately 1.3% to 0.5% for the one-time budget neutrality adjustment for discharges on or after December 29, 2012. The 0.5% does not include the 2% reduction to Medicare payments caused by sequestration.

The fiscal year 2013 rule also includes:

* A one-year extension of the existing moratorium on the 25 percent threshold policy, pending results of an on-going research initiative to re-define the role of LTACHs in the Medicare program.

* A reduction to Medicare payments for very short stay cases in LTACHs to the Inpatient Prospective Payment System comparable per diem amount payment option for discharges occurring on or after December 29, 2012 and an increase to the high cost outlier payment.

The labor-related share of the LTACH-PPS standard federal rate is adjusted annually to account for geographic differences in area wage levels by applying the applicable LTACH-PPS wage index. CMS adopted a decrease in the labor-related share from 75.271% to 70.199% under the LTACH-PPS for fiscal year 2012.

In addition, CMS applied an area wage level budget neutrality factor to the standard federal rate to make annual changes to the area wage level adjustment budget neutral. Previously, there was no statutory or regulatory requirement that these adjustments to the area wage level be made in a budget neutral manner. The final rule creates a regulatory requirement that any adjustments or updates to the area wage level adjustment be made in a budget neutral manner such that estimated aggregate LTACH-PPS payments are not affected.

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An LTACH must have an average inpatient length of stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days. In the preamble to the final rule for fiscal year 2012, CMS clarified its policy on the calculation of the average length of stay by specifying that all data on all Medicare inpatient days, including Medicare Advantage days, must be included in the average length of stay calculation effective for cost reporting periods beginning on or after January 1, 2012.

Medicaid

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

Non-Governmental Payors

Payments from non-governmental payor sources are based on episodic-based rates or per visit basis depending upon the terms and conditions of the payor. Examples of non-governmental payor sources are insurance companies, workers compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as patients directly.

Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs and the non-governmental payors, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations on patients has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. Because the majority of our billed services are paid in full by Medicare, Medicaid or private insurance, co-payments from patients do not represent a material portion of our billed revenue and corresponding accounts receivable. To further reduce their health care costs, most insurance companies, health maintenance organizations, preferred provider organizations and other managed care companies have negotiated discounted fee structures or fixed amounts for services performed, rather than paying health care providers the amounts billed.

In response to the challenges associated with collecting from commercial payors we began negotiating higher reimbursement rates with a majority of our commercial payors. As of December 31, 2012, our Managed Care contracts included 93 different payors between all our divisions, six of those were national contracts, 19 were regional contracts and 68 were state and local contracts/standing letters of agreement. However, if we are unable to continue negotiating higher reimbursement rates with commercial payors or if commercial payors continue to reduce health care costs through reduction in home health reimbursement, it could have a material adverse impact on our financial results.

Government Regulations

General

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

Medicare and Medicaid participation and reimbursement;

the federal Anti-Kickback Statute and similar state laws;

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the federal Stark Law and similar state laws;

false and other improper claims;

the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

civil monetary penalties;

environmental health and safety laws;

licensing; and

certificates of need and permits of approval.

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

Office of Inspector General

The Department of Health and Human Services OIG has a responsibility to report any program or management problems related to programs such as Medicare to the Secretary of HHS and Congress. The OIG s duties are carried out through a nationwide network of audits, investigations and inspections. Each year, the OIG outlines areas it intends to review relating to a wide range of providers. As part of its annual process, the OIG describes topics relating to, among others, home health, hospice and long-term care hospitals. No estimate can be made at this time regarding the impact, if any, of the OIG s findings.

Medicare Participation

During the years ended December 31, 2012, 2011 and 2010, we received 77.9, 79.7% and 80.5%, respectively, of our consolidated net service revenue from Medicare. We expect to continue to receive the majority of our consolidated net service revenue from serving Medicare beneficiaries. Medicare is a federally funded and administered health insurance program, primarily for individuals who are 65 or older or who are disabled. To participate in the Medicare program and receive Medicare payments, our agencies and facilities must comply with regulations promulgated by CMS. Among other things, these requirements, known as conditions of participation, relate to the type of facility, its personnel and its standards of medical care. Although we intend to continue to participate in the Medicare reimbursement programs, we cannot guarantee that our agencies, facilities and programs will continue to qualify for participation.

Under Medicare rules, the designation provider-based refers to circumstances in which a subordinate facility (e.g., a separately-certified Medicare provider, a department of a provider or a satellite facility) is treated as part of another provider, called the main provider, for Medicare payment purposes. In these cases, the services of the subordinate facility are included in the main provider s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that such costs are shared. We operate LTACHs that are treated as provider-based satellites of certain of our other facilities. We also provide contract rehabilitation and management services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status. Although we intend to continue to operate these facilities as provider-based, we cannot guarantee that they will continue to qualify as provider-based entities.

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Anti-Kickback Statute

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

The OIG has published numerous safe harbors that exempt some practices from enforcement action under the federal Anti-Kickback Statute. These safe harbors exempt specified activities, including bona-fide employment relationships, contracts for the rental of space or equipment, personal service arrangements and management contracts, so long as all of the requirements of the safe harbor are met. The OIG has recognized that the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback Statute. Instead, each arrangement is analyzed on a case-by-case basis, which is very fact specific. We cannot guarantee that all our arrangements will satisfy a safe harbor or will ultimately be viewed as being compliant with the Anti-Kickback Statute.

We are required under the Medicare conditions of participation and some state licensing laws to contract with numerous health care providers and practitioners, including physicians, hospitals and nursing homes and to arrange for these individuals or entities to provide services to our patients. In addition, we have contracts with other suppliers, including pharmacies, ambulance services and medical equipment companies. We have also entered into various joint ventures with hospitals and physicians for the ownership and management of home nursing agencies and LTACHs. Some of these individuals or entities may refer, or be in a position to refer, patients to us and we may refer, or be in a position to refer, patients to these individuals or entities. We attempt to structure these arrangements in a manner that meets the requirements of a safe harbor. However, some of these arrangements may not meet all of the requirements of a safe harbor. We believe that our contracts and arrangements with providers, practitioners and suppliers do not violate the Anti-Kickback Statute or similar state laws. We cannot guarantee, however, that governmental agencies and bodies will interpret these laws in the same manner as we do.

From time to time, various federal and state agencies, such as CMS and DHHS, issue pronouncements, including fraud alerts, that identify practices that may be subject to heightened scrutiny. For example, the OIG s fiscal year 2013 Work Plan describes, among other things, the government s intention to examine the compliance with Face to Face requirements, monitor the employment of home health aides with criminal convictions, Medicare oversight for timeliness of recertification and complaint surveys conducted by the state, review the OASIS data to ensure submitted accurately and that billing codes on the claim are consistent with the OASIS data, review compliance with documentation required in support of the claims paid by Medicare, and review cost report data to analyze home health agency revenue and expense trends against PPS to determine whether the payment methodology should be adjusted.

In June 1995, the OIG issued a special fraud alert that focused on the home nursing industry and identified some of the illegal practices the OIG has uncovered. In March 1998, the OIG issued a special fraud alert titled, *Fraud and Abuse in Nursing Home Arrangements with Hospices.* This special fraud alert focused on payments received by nursing homes from hospices. We believe, but cannot assure, that our operations comply with the principles expressed by the OIG in these special fraud alerts.

We endeavor to conduct our operations in compliance with federal and state health care fraud and abuse laws, including the Anti-Kickback Statute and similar state laws. However, our practices may be challenged in the future and the fraud and abuse laws may be interpreted in a way that finds us in violation of these laws. If we

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are found to be in violation of the Anti-Kickback Statute, we could be subject to civil and criminal penalties and we could be excluded from participating in federal health care programs such as Medicare and Medicaid. The occurrence of any of these events could significantly harm our business and financial condition.

Stark Law

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

The term financial relationship is defined very broadly to include most types of ownership or compensation relationships. The Stark Law also prohibits the entity receiving the referral from seeking payment under the Medicare and Medicaid programs for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties and could be excluded from participating in the Medicare or Medicaid programs. If an arrangement is covered by the Stark Law, the requirements of a Stark Law exception must be met for the physician to be able to make referrals to the entity for designated health services and for the entity to be able to bill for these services.

Designated health services under the Stark Law is defined to include clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The Stark Law defines a financial relationship to include: (1) a physician s ownership or investment interest in an entity and (2) a compensation relationship between a physician and an entity. Under the Stark Law, financial relationships include both direct and indirect relationships.

Physicians refer patients to us for several Stark Law designated health services, including home health services, inpatient and outpatient hospital services and physical therapy services. We have compensation arrangements with some of these physicians or their professional practices in the form of medical director and consulting agreements. We also have operations owned by joint ventures in which physicians have an investment interest. In addition, other physicians who refer patients to our agencies and facilities may own our stock. As a result of these relationships, we could be deemed to have a financial relationship with physicians who refer patients to our facilities and agencies for designated health services. If so, the Stark Law would prohibit the physicians from making those referrals and would prohibit us from billing for the services unless a Stark Law exception applies.

The Stark Law contains exceptions for certain physician ownership or investment interests in and certain physician compensation arrangements with entities. If a compensation arrangement or investment relationship between a physician, or a physician s immediate family member, and an entity satisfies all requirements for a Stark Law exception, the Stark Law will not prohibit the physician from referring patients to the entity for designated health services. The exceptions for compensation arrangements cover employment relationships, personal services contracts and space and equipment leases, among others. The exceptions for a physician investment relationship include ownership in an entire hospital and ownership in rural providers. We believe our compensation arrangements with referring physicians and our physician investment relationships meet the requirements for an exception under the Stark Law and that our operations comply with the Stark Law.

The Stark Law also includes an exception for a physician s ownership or investment interest in certain entities through the ownership of stock. If a physician owns stock in an entity and the stock is listed on a national exchange or is quoted on NASDAQ and the ownership meets certain other requirements, the Stark Law will not apply to prohibit the physician from referring to the entity for designated health services. The requirements for

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this Stark Law exception include a requirement that the entity issuing the stock have at least $75.0 million in stockholders equity at the end of its most recent fiscal year or on average during the previous three fiscal years. As of December 31, 2012, 2011 and 2010, we have exceeded $75.0 million in stockholders equity.

If an entity violates the Stark Law, it could be subject to civil penalties of up to $15,000 per prohibited claim and up to $100,000 for knowingly entering into certain prohibited referral schemes. The entity also may be excluded from participating in federal health care programs (including Medicare and Medicaid). There are no criminal penalties for violations of Stark Law. If the Stark Law was found to apply to our relationships with referring physicians and those relationships did not meet the requirement of an exception under the Stark Law, we would be required to restructure these relationships or refuse to accept referrals for designated health services from these physicians. If we were found to have submitted claims to Medicare or Medicaid for services provided pursuant to a referral prohibited by the Stark Law, we would be required to repay any amounts we received from Medicare for those services and could be subject to civil monetary penalties. Further, we could be excluded from participating in Medicare and Medicaid. If we were required to repay any amounts to Medicare, subjected to fines, or excluded from the Medicare and Medicaid Programs, our business and financial condition would be harmed significantly.

Many states have physician relationship and referral statutes that are similar to the Stark Law. Some of these laws generally apply regardless of payor. We believe that our operations are structured to comply with applicable state laws with respect to physician relationships and referrals. However, any finding that we are not in compliance with these state laws could require us to change our operations or could subject us to penalties. This, in turn, could have a negative impact on our operations.

False and Improper Claims

The submission of claims to a federal or state health care program for items and services that are not provided as claimed may lead to the imposition of civil monetary penalties, criminal fines and imprisonment and/or exclusion from participation in state and federally funded health care programs, including the Medicare and Medicaid programs. These false claims statutes include the Federal False Claims Act. Under the Federal False Claims Act, actions against a provider can be initiated by the federal government or by a private party on behalf of the federal government. These private parties are often referred to as qui tam relators, and relators are entitled to share in any amounts recovered by the government. Both direct enforcement activity by the government and qui tam actions have increased significantly in recent years. This development has increased the risk that a health care company like us will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation arising out of false claims laws. Many states have enacted similar laws providing for the imposition of civil and criminal penalties for the filing of fraudulent claims. Because of the complexity of the government regulations applicable to our industry, we cannot assure that we will not be the subject of an action under the Federal False Claims Act or similar state law.

Anti-fraud Provisions of the HIPAA

In an effort to combat health care fraud, Congress included several anti-fraud measures in HIPAA. Among other things, HIPAA broadened the scope of certain fraud and abuse laws, extended criminal penalties for Medicare and Medicaid fraud to other federal health care programs and expanded the authority of the OIG to exclude persons and entities from participating in the Medicare and Medicaid programs. HIPAA also extended the Medicare and Medicaid civil monetary penalty provisions to other federal health care programs, increased the amounts of civil monetary penalties and established a criminal health care fraud statute.

Federal health care offenses under HIPAA include health care fraud and making false statements relating to health care matters. Under HIPAA, among other things, any person or entity that knowingly and willfully defrauds or attempts to defraud a health care benefit program is subject to a fine, imprisonment or both. Also under HIPAA, any person or entity that knowingly and willfully falsifies or conceals or covers up a material fact

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or makes any materially false or fraudulent statements in connection with the delivery of or payment of health care services by a health care benefit plan is subject to a fine, imprisonment or both. HIPAA applies not only to governmental plans but also to private payors.

Administrative Simplification Provisions of HIPAA

HHS s final regulations governing electronic transactions involving health information are part of the administrative simplification provisions of HIPAA, commonly referred to as the Transaction Standards rule. The rule establishes standards for eight of the most common health care transactions by reference to technical standards promulgated by recognized standards publishing organizations. Under the standards, any party transmitting or receiving health transactions electronically must send and receive data in a single format, rather than the large number of different data formats currently used. This rule applies to us in connection with submitting and processing health claims. The Transaction Standards rule also applies to many of our payors and to our relationships with those payors. We believe that our operations materially comply with the Transaction Standards rule.

HHS also has final regulations implementing HIPAA that set forth standards for the privacy of individually-identifiable health information, referred to as protected health information. These regulations cover health care providers, health care clearinghouses and health plans. The privacy regulations require companies covered by the regulations to use and disclose protected health information only as allowed by the privacy regulations. Specifically, the privacy regulations require companies, including us, to do the following, among other things:

obtain patient authorization prior to certain uses or disclosures of protected health information;

provide notice of privacy practices to patients and obtain an acknowledgement that the patient has received the notice;

respond to requests from patients for access to or to obtain a copy of their protected health information;

respond to patient requests for amendments of their protected health information;

provide an accounting to patients of certain disclosure of their protected health information;

enter into agreements with the companies business associates through which the business associates agree to use and disclose protected health information only as permitted by the agreement and the requirements of the privacy regulations;

train the companies workforce in privacy compliance;

designate a privacy officer;

use and disclose only the minimum necessary information to accomplish a particular purpose; and

establish policies and procedures with respect to uses and disclosures of protected health information.

These regulatory requirements impose significant administrative and financial obligations on companies that use or disclose individually identifiable health information relating to the health of a patient. We have implemented policies and procedures to maintain patient privacy and comply with HIPAA s privacy regulations. However, the privacy regulations are extensive, and we may need to change some of our practices to comply with them as they are interpreted.

In February 2003, HHS published the final security regulations implementing HIPAA that govern the security of health information. The compliance date for the security regulations was April 21, 2005. The security regulations require the implementation of policies and procedures that establish administrative, physical and technical safeguards for electronic protected health information. Companies covered by the security regulations are required to ensure the confidentiality, integrity and availability of electronic protected health information. Specifically, among others things, companies subject to the security regulations, including us, are required to:

- conduct a thorough assessment of the potential risks and vulnerabilities to confidentiality, integrity and availability of electronic protected health information and to reduce the risks and vulnerabilities to a reasonable and appropriate level as required by the security regulations;

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designate a security officer;

establish policies relating to access by the companies workforce to electronic protected health information;

enter into agreements with the companies business associates whereby business associates agree to establish administrative, physical and technical safeguards for electronic protected health information received from or on behalf of the companies;

create a disaster and contingency plan to ensure the availability of electronic protected health information;

train the companies workforce in security compliance;

establish physical controls for electronic devices and media containing or transmitting electronic protected health information;

establish policies and procedures regarding the use of workstations with access to electronic protected health information; and

establish technical controls for the information systems maintaining or transmitting electronic protected health information.

In addition, in 2009, the Health Information Technology for Economic and Clinical Health (HITECH) Act (enacted as part of the American Reinvestment and Recovery Act of 2009) expanded some of our obligations under the existing HIPAA privacy and security provisions, including:

requirements to notify individuals and governmental agencies when security breaches occur with respect to unsecured information;

limitations on our ability to use or disclose protected health information for marketing or soliciting charitable contributions;

expansion of certain privacy and security requirements to our vendors and business associates; and

requirements for providing an accounting of disclosures of electronic health records.

In January 2013, HHS published a Final Rule implementing provisions of the HITECH Act addressing the privacy and security requirements for health information established under HIPAA.

The significant changes in the Final Rule include:

expansion of the HIPAA privacy and security regulations to business associates (contractors and subcontractors) of providers that receive protected health information, and provides a timeline for amendment of existing contracts to ensure compliance;

increased penalties for noncompliance based on four levels of negligence with a maximum penalty of $1.5 million per violation;

clarification of the circumstances under which breaches of unsecured health information must be reported to HHS;

expansion of individual rights to request copies of electronic records in electronic form;

modifies authorization requirements for specific records relating to research, immunizations and decedents;

limiting use and disclosure of information for marketing and fundraising purposes;

prohibiting the sale of individuals health information without their permission; and

extends privacy rule protections to genetic information, and prohibits most health plans from using or disclosing genetic information for underwriting purposes.

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These regulatory requirements impose significant administrative and financial obligations on companies like us that use or disclose electronic health information. We are modifying our existing HIPAA privacy and security policies and procedures to comply with the new regulations.

Civil Monetary Penalties

The Secretary of HHS may impose civil monetary penalties on any person or entity that presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies depending on the offense, from $2,000 to $50,000 per violation, plus treble damages for the amount at issue and may include exclusion from federal health care programs (including Medicare and Medicaid).

HHS also can impose penalties on a person or entity who offers inducements to beneficiaries for program services, who violates rules regarding the assignment of payments, or who knowingly gives false or misleading information that could reasonably influence the discharge of patients from a hospital. Persons who have been excluded from a federal health care program and who retain ownership in a participating entity and persons who contract with excluded persons may be penalized.

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

- for physician services that the person or entity knew or should have known were rendered by a person who was unlicensed, or by a person who misrepresented either (1) his or her qualifications in obtaining his or her license or (2) his or her certification in a medical specialty;
- for services furnished by a person who was, at the time the claim was made, excluded from the program to which the claim was made; or
- that show a pattern of medically unnecessary items or services.

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

Environmental Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, use and disposal of materials and waste products. Although we believe that our safety procedures for storing, handling and disposing of these hazardous materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management s attention to comply with current or future environmental laws and regulations. We do not have any violations related to compliance with environmental, health and safety laws through 2012.

Licensing

Our agencies and facilities are subject to state and local licensing regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. To assure continued compliance with these various regulations, governmental and other authorities periodically inspect our agencies and facilities. Additionally, health care professionals at our agencies and facilities are required to be individually licensed or certified under applicable state law. We take steps to ensure that our employees and agents possess all necessary licenses and certifications.

The institutional pharmacy operations within our facility-based services segment are also subject to regulation by the various states in which we conduct the pharmacy business, as well as by the federal

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government. The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the United States Food and Drug Administration. Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, administered by the United States Drug Enforcement Administration, dispensers of controlled substances must register with the Drug Enforcement Administration, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties. We do not have any violations related to the Comprehensive Drug Abuse Prevention and Control Act of 1970 through 2012.

Certificate of Need and Permit of Approval Laws

In addition to state licensing laws, some states require a provider to obtain a certificate of need or permit of approval prior to establishing or expanding certain health services or facilities. States with certificate of need or permit of approval laws place limits on both the construction and acquisition of health care facilities and operations and the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding certain amounts that involve certain facilities or services, including home nursing agencies. The certificate of need or permit of approval issued by the state determines the service areas for the applicable agency or program. The following states issue certificates of need or permits of approval: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, South Carolina, Tennessee, Vermont, Washington, West Virginia and the District of Columbia. In addition, the state of Louisiana has imposed a moratorium on the issuance of new licenses for home nursing agencies that we expect to remain in effect for 2013.

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

Accreditations

The Joint Commission is a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of health care organizations. Currently, Joint Commission accreditation of home nursing and hospice agencies is voluntary. However, some managed care organizations use Joint Commission accreditation as a credentialing standard for regional and state contracts. As of December 31, 2012, the Joint Commission had accredited 266 of our 274 agencies. Those not yet accredited are working towards achieving this accreditation. As we acquire companies, we apply for accreditation 12 to 18 months after acquisition.

Employees

As of December 31, 2012, we had 7,903 employees, of which 5,201 were full-time. None of our employees are subject to a collective bargaining agreement. We consider our relationships with our employees and independent contractors to be good.

Insurance

We are subject to claims and legal actions in the ordinary course of our business. To cover claims that may arise, we maintain professional malpractice liability insurance, general liability insurance, automobile liability insurance and workers compensation/employer s liability insurance in amounts that we believe are appropriate and sufficient for our operations. We maintain professional malpractice and general liability insurance that provide primary coverage on a claims-made basis of $1.0 million per incident and $3.0 million in annual aggregate amounts. We maintain workers compensation insurance that meets state statutory requirements with a primary employer liability limit of $1.0 million for Alabama, Arkansas, Florida, Georgia, Idaho, Kentucky,

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Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, Oregon, Tennessee, Texas, Virginia, and West Virginia. There are no limits to employer liability in Ohio and Washington. The Company is self-insured for the first $350,000 in workers compensation liability. We maintain automobile liability insurance for all owned, hired and non-owned autos with a primary limit of $1.0 million. In addition, we currently maintain multiple layers of umbrella coverage in the aggregate amount of $40.0 million that provides excess coverage for professional malpractice, general liability, automobile liability and employer s liability. We maintain directors and officers liability insurance in the aggregate amount of $45.0 million, with an additional $10.0 million of Side A coverage. The cost and availability of insurance coverage has varied widely in recent years. While we believe that our insurance policies and coverage are adequate for a business enterprise of our type, we cannot guarantee that our insurance coverage is sufficient to cover all future claims or that it will continue to be available in adequate amounts or at a reasonable cost.

Available Information

Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements and amendments to those reports are available free of charge on our internet website at www.lhcgroup.com as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission (SEC). The SEC also maintains an internet site at www.sec.gov that contains such reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. These reports may also be obtained at the SEC s Public Reference Room at 100 F Street NE, Washington, D.C. 20549. Information on the operation of the Public Reference Room is available by calling the SEC at (800) SEC-0330. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Item 1A. Risk Factors.

The risks and uncertainties described below and elsewhere in this Annual Report on Form 10-K could cause our actual results to differ materially from past or expected results and are not the only ones we face. Other risks and uncertainties that we have not predicted or assessed may also adversely affect us.

If any of the following risks occur, our earnings, financial condition or business could be materially harmed and the trading price of our common stock could decline, resulting in the loss of all or part of stockholders investments.

Risk Factors Related to Reimbursement and Government Regulation

We cannot predict the effect that health care reform and other changes in government programs may have on our business, financial condition or results of operations.

The PPACA and the Health Care Education Reconciliation Act of 2010 (collectively, the Acts) were signed into law by President Obama on March 23, 2010, and March 30, 2010, respectively. The Acts dramatically alter the United States health care system and are intended to decrease the number of uninsured Americans and reduce overall health care costs. The Acts attempt to achieve these goals by, among other things, requiring most Americans to obtain health insurance, expanding Medicare and Medicaid eligibility, reducing Medicare and Medicaid payments, and tying reimbursement to the satisfaction of certain quality criteria. The Acts also contain a number of measures that are intended to reduce fraud and abuse in the Medicare and Medicaid programs. Because a majority of the measures contained in the Acts have not yet taken effect, it is difficult to predict the impact the Acts will have on our operations. However, depending on how they are ultimately interpreted and implemented, the Acts could have an adverse effect on our business and its financial condition and results of operations.

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We derive a majority of our consolidated net service revenue from Medicare. If there are changes in Medicare rates or methods governing Medicare payments for our services, or if we are unable to control our costs, our results of operations and cash flows could decline materially.

For the years ended December 31, 2012, 2011 and 2010, we received 77.9%, 79.7% and 80.5%, respectively, of our net service revenue from Medicare. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our net service revenue and net income to decline, perhaps materially. Reductions in Medicare reimbursement could be caused by many factors, including:

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

We receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure category of the Consumer Price Index, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. In 2012 we experienced an approximate 2.4% cut in home health reimbursement for our Medicare patients and expect an additional 1.1% cut in 2013. Also beginning on April 1, 2013 Medicare reimbursement will be cut an additional 2% through sequestration as mandated by the Congressional Budget Act. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted.

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

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

- licensure and certificates of need and permits of approval;
- coding and billing for services;

conduct of operations, including financial relationships among health care providers, Medicare fraud and abuse and physician self-referral;

maintenance and protection of records, including HIPAA;

environmental protection, health and safety;

certification of additional agencies or facilities by the Medicare program; and

payment for services.

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The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer and our interactions with patients and other providers. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws, regulations, their interpretations or the enactment of new laws or regulations could increase our costs of doing business and cause our net income to decline. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state reimbursement programs.

We are also subject to various routine and non-routine governmental reviews, audits and investigations. These audits include those conducted through the recovery audit contractor program, in which third party firms engaged by CMS conduct extensive reviews of claims data and non-medical and other records to identify potential improper payments under the Medicare Program. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including with respect to referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Although we have invested substantial time and effort in implementing policies and procedures to comply with laws and regulations, we could be subject to liabilities arising from violations. A violation of the laws governing our operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs or the suspension or revocation of our licenses to operate. If we become subject to material fines or if other sanctions or other corrective actions are imposed upon us, we may suffer a substantial reduction in net income.

Current economic conditions and continued decline in spending by the Federal and State governments could adversely affect our results of operations and cash flows.

Worldwide economic conditions have significantly declined and will likely remain depressed for the foreseeable future. While our services are not typically sensitive to general declines in the federal and state economies, the erosion in the tax base caused by the general economic downturn has caused, and will likely continue to cause, restrictions on the federal and state governments ability to obtain financing and a decline in spending. As a result, we may face reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payors, which could adversely impact our results of operations and cash flows.

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

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

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

If our LTACHs fail to meet or maintain the standards for Medicare certification as LTACHs, such as for average minimum length of patient stay, they will receive reimbursement under the prospective payment system applicable to general acute care hospitals rather than the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our LTACHs receiving less Medicare reimbursement than they currently receive for their patient services. Moreover, all but one of our LTACHs are subject to additional Medicare criteria because they operate as separate hospitals located in space leased from and located in a general acute care hospital, known as a host hospital. This is known as a hospital within a hospital model. These additional criteria include requirements concerning financial and operational separateness from the host hospital. If any of our LTACHs were subject to payment as general acute care hospitals or failed to comply with the separateness requirements, our net service revenue and net income would decline.

CMS has adopted regulations that could materially and adversely affect the results of operations and cash flows of our long-term acute care hospitals.

In a final rule released on May 1, 2007, CMS expanded the Medicare admissions threshold to apply not only to long-term acute care HwHs and satellites but also to freestanding LTACHs and grandfathered LTACHs. The policy also applies to HwHs and satellites that admit Medicare patients from non-co-located hospitals. While this policy change was supposed to take effect for cost reporting periods beginning on or after July 1, 2007, the MMSEA delayed the implementation of the policy initially for three years and then for an additional two years with respect to freestanding LTACHs and grandfathered LTACHs. Further, the MMSEA set the percentage threshold at 50% for three years for HwHs and satellites located in urban areas that would otherwise be subject to a transition period and it established a 75% ceiling for HwHs and satellite facilities located in rural areas and those that receive referrals from MSA dominant hospitals or urban single hospitals. The fiscal year 2013 IPPS/LTACH-PPS final rule extended the 25% thresholds established under MMSEA for cost reporting periods beginning on or after October 1, 2012 and before October 1, 2013.

As of December 31, 2012, we had a total of nine LTACH locations; eight of our LTACHs were classified as HwHs and one was freestanding. Of the eight HwH facilities, five were located in rural or non-MSAs and were, therefore, subject to a final admission percentage of 50% at the end of the phase-in period. Three of our HwH facilities were located in MSA or urban areas and will be subject to a final admission percentage of 25% at the end of the phase-in period. Of the eight locations classified as HwHs, one facility was a satellite location of a parent hospital located in an MSA and one was a satellite location of a parent hospital located in a non-MSA. Based on our discussions with CMS, we believe each of these satellite locations will be viewed as being located in a non-MSA regardless of the location of its parent hospital and will be treated independently from its parent for purposes of calculating its compliance with the admissions limitations. If the 25 Percent Rule is extended, as planned, to freestanding LTACHs after the implementation delay established in the MMSEA, our current freestanding facility would not likely be affected because we currently do not receive more than 25% of our Medicare admissions from any single referring hospital.

For the 12 months ended December 31, 2012, on an individual basis, all of our LTACHs that are classified as HwHs admitted between 56% and 72% of their patients from their host hospitals. These hospitals came under the proper thresholds as of their respective cost report year end date in 2012. Our new LTACHs acquired in 2010 and 2009 are grandfathered and, consequently, have no limitations under MMSEA with respect to the number of patients that can be admitted from the host hospital. Our remaining LTACH is not an HwH; therefore, it is not subject to these limits on host hospital referrals.

Our ability to quantify the potential reduction in our reimbursement rates resulting from the implementation of these new regulations is contingent upon a variety of factors, such as our ability to reduce the percentage of admissions that are derived from our host hospitals and, if necessary, our ability to relocate our existing long-term

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acute care hospitals to freestanding locations. We may not be able to successfully restructure or relocate these operations without incurring significant expense or in a manner that avoids reimbursement reductions. If these new regulations result in lower reimbursement rates, our net service revenue and net income could decline. As a result of these new rules, we do not intend to expand the number of HwH long-term acute care hospitals that we operate.

We are reimbursed by Medicare for services we provide in our long-term acute care hospitals based on the long-term care diagnosis-related group assigned to each patient. CMS establishes these long-term care diagnosis-related groups by grouping diseases by diagnosis to reflect the amount of resources needed to treat a given disease. The May 2007 CMS final rules reclassifies certain long-term care diagnosis-related groups, which could result in a decrease in reimbursement rates. Further, the rule kept in place the financial penalties associated with the failure to limit the total number of Medicare patients discharged from a host hospital and subsequently readmitted to a long-term acute care hospital located within the host hospital to no greater than 5.0%. If we fail to comply with these readmission rates or if our reimbursement rates decline due to the reclassification of certain long-term care diagnosis-related groups, our net service revenue and net income could decline.

If the structures or operations of our joint ventures are found to violate the law, it could have a material adverse impact on our financial condition and consolidated results of operations.

Several of our joint ventures are with hospitals and physicians, which are governed by the Anti-Kickback Statute and similar state laws. These anti-kickback statutes prohibit the payment or receipt of anything of value in return for referrals of patients or services covered by governmental health care programs, such as Medicare. The OIG has published numerous safe harbors that exempt qualifying arrangements from enforcement under the Anti-Kickback Statute. We have sought to satisfy as many safe harbor requirements as possible in structuring our joint ventures. For example, each of our equity joint ventures with hospitals and physicians is structured in accordance with the following principles:

- the investment interest offered is not based upon actual or expected referrals by the hospital or physician;
- our joint venture partners are not required to make or influence referrals to the joint venture;
- at the time the joint venture is formed, each hospital or physician joint venture partner is required to make an actual capital contribution to the joint venture equal to the fair market value of his or her investment interest and is at risk to lose its investment;
- neither we nor the joint venture entity lends funds to or guarantees a loan to acquire interests in the joint venture for a hospital or physician; and
- distributions to our joint venture partners are based solely on their equity interests and are not affected by referrals from the hospital or physician.

Despite our efforts to meet the safe harbor requirements where possible, our joint ventures may not satisfy all elements of the safe harbor requirements.

If any of our joint ventures were found to be in violation of federal or state anti-kickback or physician referral laws, we could be required to restructure them or refuse to accept referrals from the physicians or hospitals with which we have entered into a joint venture. We also could be required to repay to Medicare amounts we have received pursuant to any prohibited referrals, and we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs. If any of our joint ventures were subject to any of these penalties, our business could be materially adversely affected. If the structure of any of our joint ventures were found to violate federal or state anti-kickback statutes or physician referral laws, we may be unable to implement our growth strategy, which could have an adverse impact on our future net income and consolidated results of operations.

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The application of state certificate of need and permit of approval regulations and compliance with federal and state licensing requirements could substantially limit our ability to operate and grow our business.

Our ability to expand operations in a state will depend on our ability to obtain a state license to operate. States may have a limit on the number of licenses they issue. For example, Louisiana currently has a moratorium on the issuance of new home nursing agency licenses. We cannot predict whether this moratorium will be extended beyond this date or whether any other states in which we operate, or may wish to operate in the future, may adopt a similar moratorium.

As of December 31, 2012, we operated in 10 states that require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. The states that currently issue certificates of need or permits of approval are: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, South Carolina, Tennessee, Vermont, Washington, West Virginia and the District of Columbia. In granting approval, these states consider the need in the service area for additional or expanded health care facilities or services. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

Risk Factors Related to Capital and Liquidity

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

Financial markets experienced significant disruptions over the past few years. These disruptions have impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. Despite the instability over the past few years within the financial markets nationally and globally, we have not experienced any individual lender limitations to extend credit under our revolving credit facility. However, the obligations of each of the lending institutions in our revolving credit facility are separate and the availability of future borrowings under our revolving credit facility could be impacted by further volatility and disruptions in the financial credit markets or other events. Our inability to access our revolving credit facility or refinance the revolving credit facility would have a material adverse effect on our business, financial positions, results of operations and liquidity.

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

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

The agreement and instruments governing our outstanding credit facility, and the agreements and instruments governing future debt agreements may contain various restrictive covenants that, among other things, require us to comply with or maintain certain financial tests and ratios that may restrict our ability to:

- incur more debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;

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create liens;

enter into transactions with affiliates;

make unapproved acquisitions;

merge or consolidate;

transfer or sell 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 and maintain such financial tests and ratios. Any failure by us to comply with or maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to our credit facility or any other future debt agreements. An event of default could lead to the acceleration of the maturity of any outstanding loans and the termination of the commitments to make further extensions of credit. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business at our sole discretion could harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

Our net service revenue is concentrated in a small number of states, which makes us sensitive to regulatory and economic changes in those states.

As of December 31, 2012, the Company s facilities in Louisiana, Alabama, Mississippi, Tennessee, and Kentucky accounted for approximately 64.9% of net service revenue. Accordingly, any changes in the current demographic, economic, competitive, or regulatory conditions in these states could have an adverse effect on our business, financial condition, results of operations and cash flows. Medicaid changes in these states could also have a material adverse effect on our results of operations or cash flows.

Hurricanes or other adverse weather events could negatively affect the local economies in which we operate or disrupt our operations, which could have an adverse effect on our business or results of operations.

Our operations along coastal areas in the southern United States are particularly susceptible to hurricanes. Such weather events can disrupt our operations, result in damage to our properties and negatively affect the local economies in which we operate. Future hurricanes could affect our operations or the economies in those market areas and result in damage to certain of our facilities, the equipment located at such facilities or equipment rented to patients in those areas. Our business or results of operations may be adversely affected by these and other negative effects of future hurricanes. Although we maintain insurance coverage, we cannot guarantee that our insurance coverage will be adequate to cover any losses or that we will be able to maintain insurance at a reasonable cost in the future. If our losses from business interruption or property damage exceed the amount for which we are insured, our results of operations and financial condition would be adversely affected.

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we request payment for our services to the time we receive reimbursement or payment. A portion of our estimated reimbursement (60.0% for an initial episode of care and 50.0% for subsequent episodes of care) for each Medicare episode is billed at the commencement of the episode and, we typically receive payment within approximately seven days. The remaining reimbursement is billed upon completion of the episode and is typically paid within 14 to 17 days from the billing date. If we have information system problems or issues arise with Medicare or other payors, we may encounter further delays in our payment cycle. For example, in the past we have experienced delays resulting from problems arising out of the implementation by Medicare of new or modified reimbursement methodologies or as a result of natural disasters, such as hurricanes. We have also experienced delays in reimbursement resulting from our implementation of new information systems related to our accounts receivable and billing functions. Any future timing delay may cause working capital shortages. As a result, working capital

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management, including prompt and diligent billing and collection, is an important factor in our consolidated results of operations and liquidity. Our working capital management procedures may not successfully negate this risk. Significant delays in payment or reimbursement could have an adverse impact on our liquidity and financial condition.

Risk Factors Related to Operations and our Growth Strategy

We could be required to record a material non-cash charge to income if our recorded goodwill or intangible assets are impaired.

Goodwill and other intangibles represent a significant portion of the assets on our balance sheet and are assessed for impairment annually. The goodwill assessment includes comparing the fair value of each reporting unit to the carrying value of the assets assigned to the reporting unit. If the carrying value of the reporting unit were to exceed our estimate of fair value of the reporting unit, we would be required to estimate the fair value of the individual assets and liabilities within the reporting unit to ascertain the fair value of goodwill. If we determine that the fair value is less than our book value, we could be required to record a non-cash impairment charge to our consolidated statements of operations, which could have a material adverse effect on our earnings, debt covenants and ability to access capital.

We assess other intangible assets, such as trade names and licenses, individually based on expected revenue and cash flows to be generated by those assets. Specific economic factors and conditions attributed to local agencies could cause these expected revenue and cash flows to decrease. If we determine that the fair value is less than the carrying value, we could be required to record material non-cash impairment charges, which could have a material adverse effect on our earnings, debt covenants and ability to access capital.

Our allowance for contractual adjustments and doubtful accounts may not be sufficient to cover uncollectible amounts.

On an ongoing basis, we estimate the amount of Medicare, Medicaid and private insurance receivables that we will not be able to collect. This allows us to calculate the expected loss on our receivables for the period we are reporting. Our allowance for contractual adjustments and doubtful accounts may underestimate actual unpaid receivables for various reasons, including:

- adverse changes in our estimates as a result of changes in payor mix and related collection rates;
- inability to collect funds due to missed filing deadlines or inability to prove that timely filings were made;
- adverse changes in the economy generally exceeding our expectations; or
- unanticipated changes in reimbursement from Medicare, Medicaid and private insurance companies.

If our allowance for contractual adjustments and doubtful accounts is insufficient to cover losses on our receivables, our business, financial position and results of operations could be materially adversely affected.

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

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

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

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

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

Upon the occurrence of fundamental changes to the laws and regulations applicable to our joint ventures, or if a substantial number of our joint venture partners were to exercise the buy/sell provisions contained in many of our joint venture agreements, we may be obligated to purchase or sell the equity interests held by us or our joint venture partners. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the partners but will be subject to a fair market valuation process. In the event the buy/sell provisions are exercised and we lack sufficient capital to purchase the interest of our joint venture partners, we may be obligated to sell our equity interest in these joint ventures. If we are forced to sell our equity interest, we will lose the benefit of those particular joint venture operations. If these buy/sell provisions are exercised and we choose to purchase the interest of our joint venture partners, we may be obligated to expend significant capital in order to complete such acquisitions. If either of these events occurs, our net service revenue and net income could decline or we may not have sufficient capital necessary to implement our growth strategy.

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

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

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

We compete with local and regional home nursing and hospice companies, hospitals and other businesses that provide post-acute health care services, some of which are large established companies that have significantly greater resources than we do. Our primary competition comes from local operators in each of our markets. We expect our competitors to develop joint ventures with providers, referral sources and payors, which could result in increased competition. The introduction by our competitors of new and enhanced service offerings, in combination with industry consolidation and the development of competitive joint ventures, could cause a decline in net service revenue, loss of market acceptance of our services or make our services less attractive. Future increases in competition from existing competitors or new entrants may limit our ability to

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maintain or increase our market share. We may not be able to compete successfully against current or future competitors and competitive pressures may have a material adverse impact on our business, financial condition and results of operations.

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

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

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

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

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

We intend to continue growing through the acquisition of additional home nursing agencies and the formation of joint ventures with hospitals for the operation of home nursing agencies. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher prices for our acquisitions and joint ventures. We cannot guarantee that we will be able to identify suitable acquisition or joint venture opportunities in the future or that any such opportunities, if identified, will be consummated on favorable terms, if at all. Without successful acquisitions or joint ventures, our future growth rate could decline. In addition, we cannot guarantee that any future acquisitions or joint ventures, if consummated, will result in further growth.

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

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

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We are the subject of an inquiry by the federal government, which could have an adverse impact on our financial condition and operations.

We operate in a highly regulated industry and are the subject of an inquiry by the federal government. We are cooperating with the government agency with respect to the inquiry and producing the requested records. Any negative findings could have a material adverse impact on our operations and financial condition. Although we cannot predict when this matter may be resolved, it is not unusual for an investigation such as this one to continue for a considerable period of time. Responding to this inquiry will continue to require management s attention and significant legal expense. See Part I. Item 3. Legal Proceedings in this Annual Report on Form 10-K for additional information regarding these inquiries.

We are subject to a corporate integrity agreement and could be subject to substantial monetary penalties or suspension of participation in Federal health care programs for noncompliance.

On September 29, 2011, we entered into a corporate integrity agreement (CIA) with the Office of Inspector General of the Department of Health and Human Services. The CIA imposes certain auditing, self-reporting and training requirements that we must comply with. Failure to comply with certain obligations may lead to the imposition of monetary penalties and/or exclusion from participation in the Federal health care programs. The imposition of monetary penalties would adversely affect our profitability. An exclusion from participation in the Federal health care programs would have a material adverse effect on our financial condition as substantially all of our net service revenue is attributable to payments received under the Medicare and Medicaid programs.

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

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

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

In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software. We utilize a third-party software information system for billing and maintaining patient claim receivables for our LTACHs. Our various home nursing agency databases are fully consolidated into an enterprise-wide system. Problems with, or the failure of, these systems could negatively impact our clinical performance and our management and reporting capabilities. Any such problems or failure could materially and adversely affect our operations and reputation, result in significant costs to us, cause delays in our ability to bill Medicare or other payors for our services, or impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems with regard to our proprietary and non-proprietary software may be substantial and could adversely affect our net income.

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Our information systems are networked via public network infrastructure and standards based encryption tools that meet regulatory requirements for transmission of protected health care information over such networks. However, threats from computer viruses, instability of the public network on which our data transit relies, or other instances that might render those networks unstable or disabled would create operational difficulties for us, including difficulties effectively transmitting claims and maintaining efficient clinical oversight of our patients, as well as disrupting revenue reporting and billing and collections management, which could adversely affect our business or operations. If personal or protected information of our patients, employees or others with whom we do business is tampered with, stolen or otherwise improperly accessed, we may incur additional fines and penalties associated with the breach of security or take other action with respect to judicial or regulatory actions arising out of the incident, including under HIPAA or other judicial acts, as applicable.

Risk Factors Related to our Ownership and Management

Start-up agencies can be delayed from opening in a timely manner due to processing or regulatory approvals.

There can be delays associated with opening a de novo agency. These delays are the result of processing delays with the state regulatory bodies as well as processing delays by the associated fiscal intermediaries that serve as billing liaisons between the agency and CMS. To initiate operations at a de novo agency, we must submit the necessary applications along with the required documentation to the appropriate state and Federal regulatory bodies. However, CMS has issued a memorandum which prioritizes the initial surveys for new Medicare providers as lowest priority for the state regulatory bodies. Moreover, depending on state requirements, the fiscal intermediary may need to receive the state license before the approval process can move forward. Once the necessary application and documentation has been submitted to the state and Federal regulatory bodies, there is a testing period of transmitting data from the applicant to CMS. Once complete, the agency receives a provider agreement and corresponding number and can begin billing. If we are unable to obtain regulatory approval for our de novo agencies in a timely manner, such delays could have a material adverse effect on our business and our consolidated financial condition, results of operations and cash flows.

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

We are a holding company with no material assets or operations of our own. Accordingly, our ability to service our debt and pay dividends, if any, is dependent upon the earnings from the business conducted by our subsidiaries. The distributions of those earnings or advances or other distributions of funds by these subsidiaries to us are contingent upon the subsidiaries earnings and are subject to various business considerations. In addition, distributions by subsidiaries could be subject to statutory restrictions, including state laws requiring that the subsidiary be solvent, or contractual restrictions. If our subsidiaries are unable to make sufficient distributions or advances to us, we may not have the cash resources necessary to service our debt or pay dividends.

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

Our success depends upon the continued employment of our executive management team and key employees and our ability to retain and motivate these individuals. If we lose the services of one or more of our executive officers or key employees, we may not be able to successfully manage our business, achieve our business goals or replace them with equally qualified personnel. The loss of any of our executive officers or key employees could have a material adverse effect on our operations and financial performance.

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

Our executive officers and directors and individuals or entities affiliated with them, beneficially own an aggregate of approximately 31.8% of our outstanding common stock as of December 31, 2012. The interests of

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these stockholders may differ from other stockholders interests. If they were to act together, these affiliated stockholders would be able to significantly influence all matters that our stockholders vote upon, including the election of directors, business combinations, the amendment of our certificate of incorporation and other significant corporate actions.

Certain provisions of our charter, bylaws, and Delaware law may delay or prevent a change in control of the Company.

Delaware law and our corporate documents contain provisions that may enable our Board of Directors to resist a change in control of the Company. These provisions include:

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

These anti-takeover defenses could discourage, delay or prevent a transaction involving a change in control of the Company. These provisions could also discourage proxy contests and make it more difficult for stockholders to elect directors or cause us to take other corporate actions.

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

Our common stock is thinly traded, which may cause volatility in our stock price, including a decline in value.

We have a relatively low volume of daily trades in our common stock on the NASDAQ Global Select Market (NASDAQ). For example, the average daily trading volume of our common stock on NASDAQ over the three-month trading period ending March 13, 2013 was approximately 57,710 shares per day. Because our common stock is traded infrequently, the price per share of our common stock can fluctuate more significantly from day-to-day than a widely held stock that is actively traded on a daily basis. For example, trading of a large volume of our common stock may have a significant impact on the trading price of our stock. In addition, future issuances of our common stock, including the exercise of any options or the vesting of any restricted stock that we may grant to directors, executive officers and other employees in the future and the issuance of common stock in connection with acquisitions, could have an adverse effect on the market price of our common stock.

If we identify deficiencies in our internal control over financial reporting, our business and our stock price could be adversely affected.

We are required to report on the effectiveness of our internal control over financial reporting as required by Section 404 of Sarbanes-Oxley. Under Section 404, we are required to assess the effectiveness of our internal control over financial reporting and report our conclusion in our annual report. Our independent registered public accounting firm is also required to report its conclusion regarding the effectiveness of our internal control over financial reporting. The existence of one or more material weaknesses would require us and our auditor to conclude that our internal control over financial reporting is not effective. If material weaknesses in our internal control over financial reporting are identified, we could be subject to regulatory scrutiny and a loss of public confidence in our financial reporting, which could have an adverse effect on our business and our stock price.

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Item 1B. Unresolved Staff Comments.

We have no unresolved written comments from the staff of the SEC regarding our periodic or current reports filed under the Exchange Act.

Item 2. Properties.

Our home office facilities are located in two properties in Lafayette, Louisiana. One property is 22,571 square feet of leased office space under a lease that commenced on March 1, 2004 and expires on December 31, 2021. The second property is 25,849 square feet of leased office space under a lease that commenced on December 27, 2008 and expires on February 28, 2014.

Of our 274 owned home-based service locations, five are owned by us and the remaining locations are in leased facilities. Generally, the leases for our home-based service locations have initial terms of one year, but range from one to five years. Most of the leases either contain multiple options to extend the lease period in one-year increments or convert to a month-to-month lease upon the expiration of the initial term. Eight of our LTACHs are hospitals within a hospital, meaning we have a lease or sublease for space with the host hospital. Generally, our leases or subleases for LTACHs have initial terms of five years, but range from three to ten years. Most of our leases and subleases for our LTACHs contain multiple options to extend the term in one-year increments. The following table shows our locations of our home-based and facility-based facilities:

	Home-Based Services	Facility-Based Services
Louisiana	47	11
Alabama	32	
Tennessee	29	
Mississippi	27	
Kentucky	26	
Arkansas	21	
West Virginia	17	
Washington	12	
Texas	11	
Missouri	9	
Idaho	9	
Maryland	9	
Georgia	7	
Oregon	5	
Florida	4	
Virginia	4	
Ohio	2	
North Carolina	2	
Oklahoma	1	
	274	11

Item 3. Legal Proceedings.

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

On July 16, 2010, the Company received a subpoena from the Securities and Exchange Commission (SEC) that included a request for documents related to the Company s participation in the Medicare Home Health Prospective Payment System. The Company produced the documents requested by the initial subpoena,

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produced additional documents requested by the SEC as part of its review, and cooperated fully with the SEC s review. On December 3, 2012, the Company was advised by the SEC that its investigation was complete and that it did not intend to recommend any enforcement action against the Company.

On October 17, 2011, the Company received a subpoena from the Department of Health and Human Services Office of Inspector General (the OIG). The subpoena requested documents related to the Company s agencies in Oregon, Washington and Idaho. The Company has produced all documents requested by the OIG and has fully cooperated with the OIG s review. The Company cannot predict the outcome or effect of this review, if any, on the Company s business.

On June 13, 2012, a putative shareholder securities class action was filed against the Company and its Chairman/CEO in the United States District Court for the Western District of Louisiana, styled City of Omaha Police & Fire Retirement System v. LHC Group, Inc., et al., Case No. 6:12-cv-01609-JTT-CMH. The action was filed on behalf of LHC shareholders who purchased shares between July 30, 2008 and October 26, 2011. Plaintiff generally alleges that the defendants caused false and misleading statements to be issued in violation of Section 10(b) of the Securities Exchange Act of 1934 (Exchange Act) and Rule 10b-5 promulgated thereunder and that the Company s Chairman/CEO is a control person under Section 20(a) of the Exchange Act. On November 2, 2012, Lead Plaintiff City of Omaha Police & Fire Retirement System filed an Amended Complaint for Violations of the Federal Securities Laws (Amended Complaint) on behalf of the same putative class of LHC shareholders as the original Complaint. In addition to claims under Sections 10(b) and 20(a) of the Exchange Act, the Amended Complaint added a claim against the Chairman/CEO for violation of Section 20A of the Exchange Act. The Company believes these claims are without merit and intends to defend this lawsuit vigorously. On December 17, 2012, the Company and the Chairman/CEO filed a motion to dismiss the Amended Complaint, which was denied by Order dated March 15, 2013. The Company cannot predict the outcome or effect of this lawsuit, if any, on the Company s business.

Except as discussed above, the Company is not aware of any pending or threatened investigations involving allegations of potential wrongdoing.

Item 4. Mine Safety Disclosures.

Not applicable.

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PART II

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

Sales of Unregistered Common Stock

None

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market (NASDAQ) under the symbol LHCG. As of March 13, 2013, there were approximately 364 registered holders of record of our common stock.

Dividend Policy

We have not paid any dividends on our common stock since our initial public offering in 2005 and do not anticipate paying dividends in the foreseeable future. We currently intend to retain future earnings, if any, to support the development and growth of our business. Payment of future dividends, if any, will be at the discretion of our Board of Directors and subject to any requirements under our Credit Facility or any future credit facility.

Price Range of Common Stock

The following table provides the high and low prices of our common stock during 2012 and 2011 as quoted by NASDAQ:

	High	Low
2012		
Fourth Quarter	$ 22.12	$ 16.33
Third Quarter	18.70	16.86
Second Quarter	18.87	16.45
First Quarter	19.71	12.57

	High	Low
2011		
Fourth Quarter	$ 18.84	$ 12.35
Third Quarter	23.90	16.15
Second Quarter	30.39	22.48
First Quarter	31.52	26.33

The closing price of our common stock as reported by NASDAQ on March 12, 2013 was $20.09.

Performance Graph

This item is incorporated by reference from our annual report to stockholders for the fiscal year ended December 31, 2012.

Issuer Purchases of Equity Securities

In October 2010, our Board of Directors authorized a program to repurchase shares of our common stock, par value $0.01 per share, from time to time, in an amount not to exceed $50.0 million (Stock Repurchase Program). We anticipate that we will finance the Stock Repurchase Program with cash from general corporate funds or draws under our Credit Facility, the terms of which allow us to purchase up to $50.0 million of our

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common stock without obtaining approval from the bank group. We may repurchase shares of our common stock in open market purchases or in privately negotiated transactions in accordance with applicable securities laws, rules and regulations. The timing and extent to which we repurchase our shares will depend upon market conditions and other corporate considerations.

We account for the repurchase of our common stock under the cost method. We use the average cost method upon the subsequent reissuance of treasury shares. During the twelve months ended December 31, 2012, we repurchased 1,540,813 shares of common stock at an aggregate cost of $27.0 million, including commissions, or an average cost per share of $17.52. During the twelve months ended December 31, 2011, we repurchased 24,159 shares of common stock at an aggregate cost of $577,000, including commissions, or an average cost per share of $23.93. The remaining dollar value of shares authorized to be purchased under the share repurchase program is $22.5 million at December 31, 2012.

The following table summarizes the Company s repurchase activity during the three month period ended December 31, 2012:

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 October 31	238,416	$ 18.10	238,416	$ 26,090,000
November 1 November 30	208,738	$ 17.37	208,738	$ 22,465,000
December 1 December 31				$ 22,465,000
Total for the fourth quarter of 2012	447,154			$ 22,465,000

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Item 6. Selected Financial Data.

The selected consolidated financial data presented below is derived from our audited consolidated financial statements included in this Annual Report on Form 10-K as of and for each of the years ended December 31, 2012, 2011 and 2010. The selected consolidated financial data presented below as of and for each of the years ended December 31, 2009 and 2008 is derived from our audited consolidated financial statements not included in this Annual Report on Form 10-K. The financial data for the years ended December 31, 2012, 2011 and 2010 should be read together with our consolidated financial statements and related notes included in Part II, Item 7. Management s Discussion and Analysis of Financial Condition and Consolidated Results of Operations and Item 8. Financial Statements and Supplementary Data included herein.

	Year Ended December 31,				
	2012	2011	2010	2009	2008
	(In thousands, except share and per share data)				
Consolidated Statements of Operations Data:					
Net service revenue	$ 637,569	$ 633,872	$ 631,567	$ 529,246	$ 381,278
Gross margin	271,817	281,526	305,046	261,465	196,337
Operating income (loss)	54,305	(6,382)	95,602	85,046	60,492
Income (loss) from continuing operations	35,428	(3,651)	64,546	57,900	42,654
Net income (loss) attributable to LHC Group, Inc.	27,440	(13,244)	48,759	43,841	30,202
Change in the redemption value of redeemable noncontrolling interests			41	45	31
Net income (loss) available to LHC Group, Inc. s common stockholders	27,440	(13,244)	$ 48,800	$ 43,886	$ 30,233
Net income (loss) attributable to LHC Group Inc. s common stockholders per basic share:	$ 1.54	$ (0.73)	$ 2.69	$ 2.44	$ 1.69
Net income (loss) attributable to LHC Group Inc. s common stockholders per diluted share:	$ 1.53	$ (0.73)	$ 2.68	$ 2.43	$ 1.69
Weighted average shares outstanding:					
Basic	17,853,321	18,265,118	18,119,183	17,960,376	17,855,634
Diluted	17,899,195	18,265,118	18,226,091	18,069,897	17,899,087

	As of December 31,				
	2012	2011	2010	2009	2008
	(In Thousands)				
Consolidated Balance Sheet Data:					
Cash	$ 9,720	$ 256	$ 288	$ 394	$ 3,511
Total assets	386,894	396,376	357,305	307,615	243,400
Total debt	19,500	34,820		11,802	5,116
Total LHC Group, Inc. stockholders equity	$ 268,181	$ 263,683	$ 273,741	$ 221,172	$ 176,821

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Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis contains forward-looking statements about our future revenues, operating results, plans and expectations. Forward-looking statements are based on a number of assumptions and estimates that are inherently subject to significant risks and uncertainties and our results could differ materially from the results anticipated by our forward-looking statements as a result of many known or unknown factors, including, but not limited to, those factors discussed in Part I, Item 1A. Risk Factors. Also, please read the Cautionary Statements Regarding Forward-Looking Statements set forth at the beginning of this Annual Report on Form 10-K.

Please read the following discussion in conjunction with Part 1 of this Annual Report on Form 10-K as well as our Consolidated Financial Statements and the related notes contained elsewhere in this Annual Report on Form 10-K.

Overview

We provide post-acute health care services primarily to Medicare beneficiaries throughout the United States, through our home nursing agencies, hospices and LTACHs. Our net service revenue increased $3.7 million to $637.6 million for the year ending December 31, 2012 from $633.9 million for the year ending December 31, 2011. During 2012, we acquired three home nursing agencies. As of December 31, 2012, we operated 285 locations in the following 19 states: Alabama, Arkansas, Florida, Georgia, Idaho, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Ohio, Oklahoma, Oregon, Tennessee, Texas, Virginia, West Virginia and Washington.

Segments

We operate in two segments for financial reporting purposes: home-based services and facility-based services. We derived 88.4%, 88.0%, and 87.9% of our net service revenue during the years ended December 31, 2012, 2011 and 2010, respectively, from our home-based services segment and derived the balance from our facility-based services segment.

Through our home-based services segment we offer a wide range of services, including skilled nursing, private duty nursing, physical, occupational and speech therapy, medically-oriented social services and hospice care. As of December 31, 2012, the home-based services segment was comprised of the following locations:

Type of Service	
Home Health	232
Hospice	32
Private Duty	4
Specialty Services	3
Management Companies	3
	274

Of our 274 home-based services locations, 140 are wholly-owned by us, 124 are majority-owned or controlled by us through joint ventures, seven are controlled by us through license lease arrangements and the remaining three are management companies in which we have no ownership interest. We intend to increase the number of home nursing agencies that we operate through continued acquisitions and organic development. As we acquire and develop home nursing agencies, we anticipate the percentage of our net service revenue and operating income derived from our home-based services segment will continue to increase.

We provide facility-based services principally through our LTACHs. As of December 31, 2012, we owned and operated six LTACHs with nine locations, of which all but one are located within host hospitals. We also owned and operated a pharmacy and a health and fitness center. Of these 11 facility-based services locations, six are wholly-owned by us and five are majority-owned or controlled by us through joint ventures.

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Development Activities

The following table provides a summary of our acquisitions, divestitures and internal development activities from January 1, 2010 through December 31, 2012. This table does not include the three management services agreements under which we manage the operations of three home nursing agencies, through our home-based services segment.

	Home-Based Services			Facility-Based Services	
	Home Nursing Agencies	Hospice Agencies	Specialty and Private Duty	Long-Term Acute Care Hospitals	Specialty
Year					
Total at January 1, 2010	230	21	9	8	3
Developed	12				
Acquired	20	6	1	1	
Divested/Merged	(5)	(1)			
Total at January 1, 2011	257	26	10	9	3
Developed	6				
Acquired	5	8			
Divested/Merged	(21)	(2)	(3)		
Total at January 1, 2012	247	32	7	9	3
Developed					
Acquired	3				
Divested/Merged	(18)				(1)
Total at December 31, 2012	232	32	7	9	2

Recent Developments

Home-based services

Home Nursing. In 2010, the PPACA was enacted, which made a number of changes to Medicare payment rates, including the reinstatement of the 3% home health rural add-on, which began on April 1, 2010 (expiring January 1, 2016). Other changes from the PPACA that began on or after January 1, 2011 are:

- a reduction in the market basket adjustment to be determined by CMS for the calendar years 2011, 2012 and 2013 by 1%;
- a full productivity adjustment beginning in 2015; and
- rebasing of the base payment rate for Medicare beginning in 2014 and phasing in over a four year period the amount of the rebasing is uncertain at this time.

On October 31, 2011, CMS issued the final rule covering payment rates for home health services in Calendar Year (CY) 2012. CMS set the base payment rate for Medicare home nursing at $2,138.52 per 60-day episode for CY 2012, a decrease of 2.4% from the CY 2011 base payment rate of $2,192.07. The decrease for CY 2012 includes the following adjustments to the base rate, as compared to the CY 2011 base rate, in accordance with the PPACA: a reduction of 1% to the 2.4% inflation update increase to the market basket and a 3.79% case-mix weight adjustment decrease. These changes are effective for all episodes completed during 2012.

The case-mix weight adjustment reduced Home Health Prospective Payment System (HH PPS) rates 3.79% for CY 2012 and an additional 1.32% reduction for CY 2013.

This rule also finalizes structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes, and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same amount of total aggregate payments.

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Under current Medicare policy, a certifying physician or an allowed non-physician practitioner must see a patient prior to certifying a patient as eligible for the home health benefit. The rule also finalizes added flexibility to allow physicians who cared for the patient in an acute or post-acute facility to inform the certifying physician of their encounters with the patient in order to satisfy the requirement.

On November 2, 2012, CMS issued the final rule effective January 1, 2013 regarding payment rates for home health services in CY 2013. In the CY 2013 issue, CMS is:

* Decreasing the base payment rate to $2,137.73 in 2013 as compared to $2,138.52 in 2012. The decrease is made up of a market basket increase of 2.3% less a reduction of 1% to the market basket as defined by the PPACA and less a 1.32% case mix adjustment carried over from 2012.

* Rebasing of the wage index and increasing the labor related portion of the base payment rate from 77.082% to 78.535% which decreases payments to the home health industry an aggregate of 0.37%.

* The estimated 0.1% reduction to home health payments does not include the deficit reduction sequester approved earlier by Congress. The sequestration cut to Medicare will begin on April 1, 2013 and will reduce Medicare payments for patients whose service dates end on or after April 1, 2013 by 2%.

* Face to Face CMS will allow non-physician practitioners in an acute or post-acute setting to perform the encounter and inform the certifying physician.

* Therapy CMS will also revise the regulation to state that in cases where multiple therapy disciplines are involved, if the required reassessment visit was missed for any one of the therapy disciplines for which therapy services were being provided, therapy coverage would cease only for that particular therapy discipline. Therefore, as long as the required therapy reassessments were completed timely for the remaining therapy disciplines, therapy services would continue to be covered for those therapy disciplines.

Finally, with respect to the therapy assessments timing, CMS revises the regulations to clarify that in cases where the patient is receiving more than one type of therapy, qualified therapists could complete their reassessment visits during the 11th, 12th, or 13th visit for the required 13th visit reassessment and the 17th, 18th, or 19th visit for the required 19th visit reassessment.

* Sanctions CMS will have additional sanctions for enforcement of survey deficiencies that will include the following: (These are not mutually exclusive. CMS can impose any or all of the following, including termination.) Each of these sanctions requires a prior 15 day notice:

    (a) Civil money penalties;

    (b) Suspension of payment for all new admissions and new payment episodes;

    (c) Temporary management of the HHA;

    (d) Directed plan of correction;

(e) Directed in-service training.

Hospice. The following table shows the hospice Medicare payment rates for fiscal year 2012, which began on October 1, 2011 and ended September 30, 2012:

Description	Rate per patient day
Routine Home Care	$ 151.03
Continuous Home Care	$ 881.46
Full Rate = 24 hours of care $36.73 = hourly rate	
Inpatient Respite Care	$ 156.22
General Inpatient Care	$ 671.84

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On July 29, 2011, CMS issued its final rule for hospice for fiscal year 2012 which increased Medicare reimbursement payments by 2.5%. The 2.5% increase consisted of a 3.0% inflationary market basket update offset by a 0.5% reduction for the third year of CMS seven-year phase-out of its wage index budget neutrality adjustment factor. The final rule also:

- Changed the way CMS counts hospice patients for the 2012 cap accounting year and beyond. The final policy for counting the number of Medicare hospice beneficiaries in care for a given cap year calculates the cap based on the number of days of care the patient received in that cap year for each hospice. This rule also finalized that the new counting method be applied to past cap years in certain instances.

- Allowed hospice providers who do not want a change in their patient counting method to elect to continue using the current method.

- Allowed any hospice physician to perform the face-to-face encounter regardless of whether that same physician recertifies the patient s terminal illness and composes the recertification narrative.

- Implemented a hospice quality reporting program, which includes a timeframe for reporting, as required by section 3004 of the PPACA. The measures that are being adopted in this final rule for the fiscal year 2014 program are one measure endorsed by the National Quality Forum related to pain management and one structural measure that assesses whether a hospice administers a Quality Assessment and Performance Improvement (QAPI) program that contains at least three indicators related to patient care.

On July 24, 2012, CMS issued its final rule for hospice for fiscal year 2013, which increases Medicare reimbursement payments by 0.9% over fiscal year 2012 rates. The 0.9% increase consists of a 2.6% inflationary market basket update offset by a 0.6% reduction for the fourth year of CMS seven-year phase-out of its wage index budget neutrality adjustment factor, a 0.7% reduction for the productivity adjustment, a 0.3% reduction to the market basket as defined by the PPACA, and a 0.1% reduction related to the wage index changes. The 0.9% does not include the deficit reduction sequester approved earlier by Congress. The sequestration cut to Medicare will begin on April 1, 2013 and will reduce Medicare payments for patients whose service dates end on or after April 1, 2013 by 2%.

The final rule also provides:

- Clarification regarding diagnosis reporting on hospice claims:

CMS is concerned that hospices reporting a single diagnosis on claims are not providing an accurate description of the patients conditions, and believes that providers should code and report coexisting or additional diagnoses in order to more fully describe the Medicare patients they are treating.

- Hospice payment reform update:

CMS indicates that it is moving forward with hospice payment reform efforts and will continue to investigate Medicare Payment Advisory Commission, Office of the Inspector General, and Government Accountability Office recommendations, as well as other payment options, as part of this comprehensive effort. CMS does not, however, provide an anticipated timeline for public release of information about proposals to alter the current hospice payment system.

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The following table shows the hospice Medicare payment rates for fiscal year 2013, which began on October 1, 2012 and will end September 30, 2013 (the payment rates do not reflect the 2% sequestration cut):

Description	Rate per patient day
Routine Home Care	$ 153.45
Continuous Home Care	$ 895.56
Full Rate = 24 hours of care $37.32 = hourly rate	
Inpatient Respite Care	$ 158.72
General Inpatient Care	$ 682.59

Facility-Based Services

LTACHs. On August 1, 2011, CMS released its rule for LTACH Medicare reimbursement for fiscal year 2012, which spans from October 1, 2011 through September 30, 2012. In aggregate, payments for fiscal year 2012 increased 2.5% from fiscal year 2011. Included in the final regulations was (1) a 2.9% market basket increase to the standard payment rate; (2) an aggregate reduction in the standard payment rate of 1.1% mandated by the PPACA; and (3) a reduction in the high cost outlier threshold per discharge from $18,785 in fiscal year 2011 to $17,931 in fiscal year 2012. The final rule resulted in a 1.8% increase in average Medicare payments to LTACHs. Some of the other changes in the final rule included:

Three quality measures to begin reporting October 1, 2012 that will affect payment in fiscal year 2014.

Clarification that the 25-day average length of stay (ALOS) calculation includes both traditional Medicare Fee-For-Service and Medicare Advantage stays but this calculation began January 1, 2012.

On August 1, 2012 CMS released its final rule for LTACH Medicare reimbursement for fiscal year 2013 which spans from October 1, 2012 through September 30, 2013. In aggregate, payments for fiscal year 2013 will increase by 1.8% over fiscal year 2012 rates. The 1.8% increase consists of a 2.6% inflationary market basket update offset by a 0.7% reduction for the productivity adjustment, a 0.1% reduction to the market basket as defined by the PPACA. LTACH payment rates will also be reduced by approximately 1.3% to 0.5% for the one-time budget neutrality adjustment for discharges on or after December 29, 2012. The 0.5% does not include the deficit reduction sequester approved earlier by Congress. The sequestration cut to Medicare will begin on April 1, 2013 and will reduce Medicare payments for patients whose service dates end on or after April 1, 2013.

The fiscal year 2013 rule also includes:

* A one-year extension of the existing moratorium on the 25 Percent threshold policy, pending results of an on-going research initiative to re-define the role of LTACHs in the Medicare program.

* A reduction to Medicare payments for very short stay cases in LTACHs to the Inpatient Prospective Payment System comparable per diem amount payment option for discharges occurring on or after December 29, 2012 and an increase to the high cost outlier payment.

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2012 and 2011 Operational Data

The following table sets forth, for the period indicated, data regarding aggregate admissions and Medicare admissions to our home health agencies and patient days for our LTACHs. Certain historical data has been included in order to present a more comparative analysis of the statistical data.

	Three Months Ended March 31, 2012	Three Months Ended June 30, 2012	Three Months Ended September 30, 2012	Three Months Ended December 31, 2012
Home Health Agencies:				
Average census	32,608	32,988	32,605	33,103
Average Medicare census	24,689	24,858	24,279	24,765
Admissions	27,696	26,498	27,301	27,443
Medicare admissions	19,046	17,837	18,415	18,665
LTACHs:				
Patient days	16,191	15,822	15,335	15,552

	Three Months Ended March 31, 2011	Three Months Ended June 30, 2011	Three Months Ended September 30, 2011	Three Months Ended December 31, 2011
Home Health Agencies:				
Average census	34,466	33,937	31,311	31,692
Average Medicare census	26,570	26,192	24,076	24,301
Admissions	26,194	24,935	25,787	25,410
Medicare admissions	18,589	17,477	18,445	17,803
LTACHs:				
Patient days	15,333	15,268	15,385	15,953

Consolidated Results of Operations

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

	Year Ended December 31,		
	2012	2011	2010
Consolidated Services Data:			
Net service revenue	$ 637,569	$ 633,872	$ 631,567
Cost of service revenue	365,752	352,346	326,521
Gross margin	271,817	281,526	305,046
Provision for bad debts	11,875	12,320	7,607
Settlement with government agencies		65,000	
General and administrative expenses	205,637	210,588	201,837
Operating income (loss)	$ 54,305	$ (6,382)	$ 95,602
Interest expense	(1,550)	(1,018)	(134)
Non-operating income , including gain on sales of entities and assets, net	184	1,781	805
Income tax expense (benefit)	17,511	(1,968)	31,727
Income attributable to noncontrolling interests	7,988	9,593	15,787
Redeemable noncontrolling interests			41
Net income (loss) available to LHC Group, Inc. s common stockholders.	$ 27,440	$ (13,244)	$ 48,800

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The following table sets forth the consolidated results of our Company as a percentage of net service revenue, except income tax expense (benefit), which is presented as a percentage of income from continuing operations available to LHC Group, Inc:

	Year Ended December 31,		
	2012	2011	2010
Consolidated Services Data:			
Cost of service revenue	57.4%	55.6%	51.7%
Gross margin	42.6%	44.4%	48.3%
Provision for bad debts	1.9%	1.9%	1.2%
Settlement with government agencies		10.3%	
General and administrative expenses	32.3%	33.2%	32.0%
Operating income (loss)	8.5%	(1.0)%	15.1%
Interest expense	0.2%	0.2%	0.0%
Non-operating income (loss), including gain on sales of entities and assets	0.0%	0.3%	0.1%
Income tax expense (benefit)	39.0%	(12.9)%	39.4%
Income attributable to noncontrolling interests	1.3%	1.5%	2.5%
Net income (loss) available to LHC Group, Inc. s common stockholders	4.3%	(2.1)%	7.7%

Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2012 was $637.6 million compared to $633.9 million in 2011. Net service revenue growth in 2012 was primarily due to an increase in census and increase in admits. Net service revenue was comprised of the following for the periods ending December 31:

	2012	2011
Home-based services	88.4%	88.0%
Facility-based services	11.6	12.0
	100.0%	100.0%

Revenue derived from Medicare represented 77.9% and 79.7% of consolidated net service revenue for the years ended December 31, 2012 and 2011, respectively.

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2012 was $365.8 million compared to $352.3 million in 2011. The increase in cost of service revenue was related to the following factors:

- an increase of costs related to 2012 acquisitions;
- cost of living increases;
- an increase in insurance; and

additional field staff included in our existing home based agencies.

Provision for Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2012 was $11.9 million compared to $12.3 million in 2011. Beginning January 1, 2011, the period allowed to file Medicare claims was reduced to twelve months from the end of episode date. This change resulted in a greater number of Medicare claims being denied for timely filing requirements in 2011.

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General and administrative expenses

Consolidated general and administrative expenses for the year ended December 31, 2012 was $205.6 million compared to $210.6 million in 2011. The decrease was primarily due to our incurring higher legal fees in 2011 associated with the settlement with the United States of America. In addition, we eliminated salaries and benefits, consulting, travel and hotel costs incurred in 2011 related to the conversion of four legacy billing systems to our point of care platform. We accelerated this transition in order to replace the legacy billing systems which remained from previous acquisitions. The accelerated transition was completed in the first quarter of 2011. We also entered into fewer acquisitions and incurred lower acquisition related costs during the twelve months ended December 30, 2012. Finally, cost reduction initiatives begun last year reduced personnel costs and other corporate costs in the twelve months ended December 31, 2012 as compared to the twelve months ended December 31, 2011.

General and administrative expenses consist primarily of the following expenses incurred by our home office and administrative field personnel:

Home office and field administration:

- salaries and related benefits;
- insurance;
- costs associated with advertising and other marketing activities; and
- rent and utilities.

Supplies and services:

- accounting, legal and other professional services; and
- office supplies.

Depreciation;

Other:

- advertising and marketing expenses;
- recruitment;
- operating locations rent; and

taxes.

Non-Operating Income

Consolidated non-operating income for the year ended December 31, 2012 was $184,000 compared to $1.8 million in 2011. In 2011, non-operating income was primarily due to the Medicare Home Health Pay for Performance program. We received $1.2 million in 2011. The program was not available during 2012.

Interest Expense

Consolidated interest expense for the year ended December 31, 2012 was $1.6 million compared to $1.0 million in 2011 and related to balances outstanding on our Credit Facility in each year.

Income Tax Expense

Consolidated income tax expense (benefit) for the year ended December 31, 2012 was $17.5 million compared to $(1.9) million in 2011. In 2011, we recognized a tax benefit on our settlement with the United States of America, reduced by $3.4 million to recognize the uncertainty of deducting the full settlement.

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Net income attributable to noncontrolling interest

Consolidated net income attributable to noncontrolling interest for the year ended December 31, 2012 was $8.0 million compared to $9.6 million in 2011. The overall decrease was due to our purchasing the outstanding membership interest of three joint venture partners, and an overall decrease of operating results of the joint ventures themselves.

Home-Based Services Segment Results of Operations

	Year Ended December 31,		
	2012	2011	2010
	(amounts in thousands, except for statistical data)		
Home-Based Services Data:			
Net service revenue	$ 563,741	$ 557,901	$ 555,110
Cost of service revenue	322,189	307,744	281,013
Gross margin	241,552	250,157	274,097
Provision for bad debts	10,593	11,680	7,078
Settlement with government agencies		65,000	
General and administrative expenses	184,125	190,264	182,750
Operating income (loss)	$ 46,834	$ (16,787)	$ 84,269
Average census	33,834	33,062	32,997
Average Medicare census	25,544	25,713	26,107
Total admissions	113,362	106,323	95,688
Total Medicare admissions	77,969	75,944	69,490

Net service revenue from home-based services for the year ended December 31, 2012 was $563.7 million compared to $557.9 million in 2011. Total admissions increased 6.6% to 113,362 during the year ended December 31, 2012, compared to 106,323 for the same period ended December 31, 2011. Average home-based patient census for the year ended December 31, 2012 increased 2.3% to 33,834 patients as compared with 33,062 patients for the year ended December 31, 2011.

Organic growth includes growth in same store locations, or those locations owned for greater than 12 months, and growth from de novo locations. We calculate organic growth by dividing organic growth generated in a period by total revenue generated in the same period of the prior year. Revenue from acquired agencies contributes to organic growth beginning with the thirteenth month after acquisition.

The following tables detail the home-based services revenue growth and home health agencies census, admissions and episodes growth (amounts in thousands, except statistical data):

	Year Ending December 31, 2012						
	Same Store(1)	De Novo(2)	Organic(3)	Organic Growth%	Acquired(4)	Total	Total Growth %
Revenue	$ 560,165	$	$ 560,165	0.4%	$ 3,576	$ 563,741	1.0%
Revenue Medicare	$ 437,117	$	$ 437,117	(2.4)%	$ 2,012	$ 439,129	(2.0)%
Average Census	32,671		32,671	1.6%	163	32,834	2.1%
Average Medicare Census	24,563		24,563	(1.3)%	76	24,639	(1.0)%
Admissions	107,556		107,556	5.1%	1,382	108,938	6.5%
Medicare Admissions	73,375		73,375	1.5%	588	73,963	2.3%
Episodes	166,457		166,457	(1.6)%	572	167,029	(1.3)%

(1) Same store location that has been in service with the Company for greater than 12 months.
(2) De Novo internally developed location that has been in service with the Company for 12 months or less.

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(3) Organic combination of same store and de novo.
(4) Acquired purchased location that has been in service with the Company for 12 months or less.

	Year Ending December 31, 2011						
	Same Store(1)	De Novo(2)	Organic(3)	Organic Growth%	Acquired(4)	Total	Total Growth %
Revenue	$ 538,135	$ 3,191	$ 541,326	(2.5)%	$ 16,575	$ 557,901	0.5%
Revenue Medicare	$ 431,101	$ 2,793	$ 433,894	(4.3)%	$ 14,120	$ 448,014	(1.2)%
Average Census	31,514	129	31,643	(2.3)%	522	32,165	(0.6)%
Average Medicare Census							