LHC Group, Inc
Form 10-K
March 15, 2012
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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, 2011

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, in any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (Section 232.405) 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 (Section 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 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, 2011, the aggregate market value of the registrant s common stock held by non-affiliates of the registrant was $374.6 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 18,820,380 shares of common stock, $0.01 par value, issued and outstanding as of March 8, 2012.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Annual Report to stockholders for the fiscal year ended December 31, 2011 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant s Proxy Statement for its 2012 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, 2011;

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). Through our wholly and majority owned subsidiaries, equity joint ventures and controlled affiliates, we currently operate 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, 2011, we owned and operated 290 home-based service locations, with 247 home nursing agency locations, 32 hospices, three specialty agencies and four private duty agencies. As of December 31, 2011, we also managed the operations of four 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 290 home-based services locations, 151 are wholly-owned by us, 125 are majority-owned or controlled by us through joint ventures, 10 are operated through license lease arrangements, and we manage the operations of four 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, 2011, our hospitals 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, 2011, 2010 and 2009 was as follows (amounts in thousands):

	Year Ended December 31,		
	2011	2010	2009
Home-Based Services	$ 557,901	$ 555,110	$ 466,736
Facility-Based Services	75,971	76,457	62,510
Consolidated Net Service Revenue	$ 633,872	$ 631,567	$ 529,246

A reclassification has been made to the December 31, 2010 and 2009 Home-Based Services Net Service Revenue to conform to the 2011 presentation. Net service revenue has been decreased by $3.5 million and $2.7 million for the twelve months ended December 31, 2010 and 2009, respectively, related to fees the Company collects and subsequently pays to nursing homes primarily for room and board services provided to our hospice patients.

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 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 states.

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,

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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.

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

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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.

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, spiritual counseling and family bereavement counseling, inpatient and respite care, homemaker services, dietary 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, 2011, 2010 and 2009, 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, and 252 of our 290 agencies are 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.

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Patient care is handled at the home nursing agency level. Functions that are centralized into 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 long term acute care hospitals 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, 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.

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, 2011, we had 70 equity joint ventures including 62 with hospitals, five with physicians, and three with other parties. We also operate four 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. 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 hospital controls 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 0.01% and 4.23% of our consolidated net service revenue with only one of the equity joint ventures accounting for greater than 4% of our total net service revenue for the 12 months ended December 31, 2011. Mississippi HomeCare of Jackson, LLC, in which we have a 66.67% ownership interest, contributed 4.23% to our consolidated net service revenue for the year ended December 31, 2011.

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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, 2011, we have four 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 leases are entered into in instances 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 $160,000 per year.

2011 Current Monthly Fee	Increase in Monthly Fee	Initial Term Dates
Based on net quarterly projections with a cap of $160,000.	None	2010 with a 5 year automatic renewal
$16,000	5% increase every three years	2017 with a 2 year automatic renewal
$5,000	Renegotiated after five years (2013)	2017 with a 5 year automatic renewal

In all four 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, 2011, we have three management services agreements under which we manage the operations of home nursing agencies. We currently have no ownership interest in the agencies subject to these management services agreements. As described in the 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 and reimbursed for operating expenses for one agreement and on 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 parties give 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 11,400 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 are 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

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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 nonprofit hospitals for the ownership and management of home nursing agencies and LTACHs. We are unaware of any competitor with this type of ownership mix.

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

In March 2008, we established the LHC Group Quality Council (The 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.

In 2009, we established the Clinical Quality Committee of the Board of Directors (The Committee). 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.

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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 and facilities and at our 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 performed on each of our agencies and facilities by our home office staff;
- 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 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 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. Although we first established our compliance and ethics program in 1996, in 2009 we redesigned and enhanced several aspects of the program. Our redesign and enhancement of the program involved several initiatives to further our goal of fostering and maintaining 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 company policies and procedures related to compliance and ethics issues;

reviewing, making recommended revisions to, disseminating and tracking attestations to our Code of Conduct and Ethics;

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measuring compliance with our policies and procedures, Code of Conduct and Ethics and legal and regulatory requirements related to the Medicare and Medicaid programs and other government healthcare programs, laws and regulations;

developing and providing compliance-related training and education to all of our employees and, as appropriate, directors, contractors and other representatives and agents, including, new-hire compliance training for all new employees, annual compliance training for all employees, sales compliance training to all members of our sales team, billing compliance training to all members of our billing and revenue cycle team and other job-specific and role-based compliance training of certain employees;

performing an annual company-wide risk assessment;

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

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

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

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

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

All employees are required to report incidents, issues or other concerns that they believe in good faith may be in violation of our Code of Conduct and Ethics, our policies and procedures, applicable legal and regulatory requirements or the requirements of the Medicare and Medicaid programs and other government 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, it 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 use 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

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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, 2011, our home nursing agencies primarily utilize 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. We currently have 73 locations (home health and hospice) on POC and plan to continue adding locations on POC over the next several years.

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.

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 79.7%, 80.5% and 82.2% of our net service revenue for the years ended December 31, 2011, 2010 and 2009, respectively. Medicare reimburses us based upon the setting in which we provide our services or the Medicare category in which those services fall.

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 one payment episode. 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

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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 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.

CMS finalized two provisions of the Affordable Care Act: (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 Affordable Care Act 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 $2,192.07, $2,312.94 and $2,271.92 per 60 day episode for the calendar years of 2011, 2010 and 2009 respectively. In 2012, the base payment rate for Medicare home nursing per 60 day episode is $2,138.52.

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 recently 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

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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 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 2010 or 2009. We have not received notification that any of our hospices have exceeded the cap on inpatient care services during 2011.

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 1st through October 31st of the following year. We have not received notification that any of our hospices have exceeded the cap on per beneficiary limits during 2011.

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, 2010 to September 27, 2011 by a statutory amount that is indexed for inflation. The per beneficiary cap

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amount was $24,528 for the twelve-month period ended October 31, 2011 and $23,875 for the twelve month period ended October 31, 2010. There will be a cap liability if actual payments per the Provider Statistical and Reimbursement report for the period of November 1, 2010 to October 31, 2011 exceed the beneficiary cap amount.

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. 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 inpatient prospective payment system, or IPPS, that 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 annual update. The final rule adopted a 15-month rate update for fiscal year 2009 and moves 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.

In 2004, CMS published a final regulation applicable to LTACHs that are operated as hospital within hospitals or as satellites. We collectively refer to hospital within hospitals and satellites as HwHs, and we refer to the CMS final regulations as the final regulations. HwHs are separate hospitals located in space leased from, and located in or on the same campus of another hospital. We refer to such other hospitals as host hospitals. Effective for hospital cost reporting periods beginning on or after October 1, 2004, subject to certain exceptions, the final regulations provided lower rates of reimbursement to HwHs for those Medicare patients admitted from their host hospitals that are in excess of a specified percentage threshold. For HwHs opened after October 1, 2004, the Medicare admissions threshold was established at 25% except for HwHs located in rural areas or co-located with MSA dominant hospitals or single urban hospitals where the percentage is no more than 50%, nor less than 25%.

May 2007 Final Rule. On May 11, 2007, CMS published its annual payment rate update for the 2008 LTACH-PPS rate year, or RY 2008 (affecting discharges and cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008). The May 2007 final rule made several changes to LTACH-PPS payment methodologies and amounts during RY 2008 although, as described below, many of these changes have been postponed for a three year period by the SCHIP Extension Act.

For cost reporting periods beginning on or after July 1, 2007, the May 2007 final rule expanded the Medicare HwH admissions threshold to apply to Medicare patients admitted from any individual hospital. Previously, the admissions threshold was applicable only to Medicare HwH admissions from hospitals co-located with an LTACH or satellite of an LTACH. Under the May 2007 final rule, free-standing LTACHs and grandfathered HwHs would be subject to the Medicare admission thresholds, as well as HwHs and satellites that admit Medicare patients from non-co-located hospitals. 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 would be 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 discharging hospital would not count toward the limit and would be paid under LTACH-PPS. CMS estimated the impact of the expansion of the Medicare admission thresholds would result in a reduction of 2.2% of the aggregate payments to all LTACHs in RY 2008.

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The applicable percentage threshold is generally 25% after the completion of the phase-in period described below. The percentage threshold for LTACH discharges from a referring hospital that is an MSA dominant hospital or a single urban hospital is the percentage of total Medicare discharges in the MSA that are from the referring hospital, but no less than 25% nor more than 50%. For Medicare discharges from LTACHs or LTACH satellites located in rural areas, as defined by the Office of Management and Budget, the percentage threshold is 50% from any individual referring hospital. The expanded 25% rule is being phased in over a three year period. The three year transition period starts with cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008, when the threshold is the lesser of 75% or the percentage of the LTACH s or LTACH satellite s admissions discharged from the referring hospital during its cost reporting period beginning on or after July 1, 2004 and before July 1, 2005, or RY 2005. For cost reporting periods beginning on or after July 1, 2008 and before July 1, 2009, the threshold is the lesser of 50% or the percentage of the LTACH s or LTACH satellite s admissions from the referring hospital, during its RY 2005 cost reporting period. For cost reporting periods

beginning on or after July 1, 2009, all LTACHs will be subject to the 25% threshold (or applicable threshold for rural, urban-single, or MSA dominant hospitals). 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 stated above, to those Medicare patients discharged from an LTACH HwH or HwH satellite that were admitted from a non-co-located hospital. The SCHIP Extension Act only postpones the expansion of the admission threshold in the May 2007 final rule to free-standing LTACHs and grandfathered HwHs.

The May 2007 final rule further revised the payment adjustment formula for short stay outlier, or SSO cases. Beginning with discharges on or after July 1, 2007, for cases with a length of stay that is less than the average length of stay plus one standard deviation for the same DRG under IPPS, referred to as the so-called IPPS comparable threshold, the rule effectively lowers the LTACH payment to a rate based on the general acute care hospital IPPS. SSO cases with covered lengths of stay that exceed the IPPS comparable threshold would continue to be paid under the SSO payment policy described above under the May 2006 final rule. Cases with a covered length of stay less than or equal to the IPPS comparable threshold and less than five-sixths of the geometric average length of stay for that LTC-DRG would be paid at an amount comparable to the IPPS per diem. The SCHIP Extension Act also postponed, for the three year period beginning on December 29, 2007, the SSO policy changes made in the May 2007 final rule.

The May 2007 final rule increased the standard federal rate by 0.71% for RY 2008. As a result, the federal rate for RY 2008 is equal to $38,356.45, compared to $38,086.04 for RY 2007. Subsequently, the SCHIP Extension Act eliminated the update to the standard federal rate that occurred for RY 2008 effective April 1, 2008. This adjustment to the standard federal rate was applied prospectively on April 1, 2008 and reduced the federal rate back to $38,086.04. In a technical correction to the May 2007 final rule, CMS increased the fixed-loss amount for high cost outlier in RY 2008 to $20,738, compared to $14,887 in RY 2007. CMS projected an estimated 0.4% decrease in LTACH payments in RY 2008 due to this change in the fixed-loss amount and the overall impact of the May 2007 final rule to be a 1.2% decrease in total estimated LTACH-PPS payments for RY 2008.

The May 2007 final rule provided that beginning with the annual payment rate updates to the LTC-DRG classifications and relative weights for the fiscal year 2008, or FY 2008 (affecting discharges beginning on or after October 1, 2007 and before September 30, 2008), annual updates to the LTC-DRG classification and relative weights are to have a budget neutral impact. Under the May 2007 final rule, future LTC-DRG reclassification and recalibrations, by themselves, should neither increase nor decrease the estimated aggregated LTACH-PPS payments.

The May 2007 final rule is complex and the SCHIP Extension Act postponed the implementation of certain portions of the May 2007 final rule. While we cannot predict the ultimate long-term impact of LTACH-PPS because the payment system remains subject to significant change, if the May 2007 final rule becomes effective

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as currently written, after the expiration of the applicable provisions of the SCHIP Extension Act, our future net operating revenues and profitability could be adversely affected.

August 2007 Final Rule. On August 22, 2007, CMS published the IPPS final rule for FY 2008, which created a new patient classification system with categories referred to as MS-DRGs and MS-LTC-DRGs, respectively, for hospitals reimbursed under IPPS and LTACH-PPS. Beginning with discharges on or after October 1, 2007, the new classification categories take into account the severity of the patient s condition. CMS assigned proposed relative weights to each MS-DRG and MS-LTC-DRG to reflect their relative use of medical care resources.

The August 2007 final rule published a budget neutral update to the MS-LTC-DRG classification and relative weights. In the preamble to the IPPS final rule for FY 2008 CMS restated that it intends to continue to

update the LTC-DRG weights annually in the IPPS rulemaking and those weights would be modified by a budget neutrality adjustment factor to ensure that estimated aggregate LTACH payments after reweighting are equal to estimated aggregate LTACH payments before reweighting.

Medicare, Medicaid, and SCHIP Extension Act of 2007. On December 29, 2007, President Bush signed into law the SCHIP Extension Act. Among other changes in the federal health care programs, the SCHIP Extension Act makes significant changes to Medicare policy for LTACHs including a new statutory definition of an LTACH, a report to Congress on new LTACH patient criteria, relief from certain LTACH-PPS payment policies for three years, a three year moratorium on the establishment and classification of new LTACHs and LTACH beds, elimination of the payment update for the last quarter of RY 2008 and new medical necessity reviews by Medicare contractors through at least October 1, 2010.

The SCHIP Extension Act precludes the Secretary from implementing, during the three year moratorium period, the provisions added by the May 2007 final rule that extended the 25% rule to free-standing LTACHs and grandfathered HwHs. The SCHIP Extension Act also modifies, during the moratorium, the effect of the 25% rule for non-grandfathered LTACH HwHs, non-grandfathered satellites and grandfathered LTACH HwHs, as it applies to admissions from co-located hospitals. For HwHs and satellite facilities, the applicable percentage threshold is set at 50% and not phased in to the 25% level. For those HwHs and satellite facilities located in rural areas and those which receive referrals from MSA dominant hospitals or single urban hospitals, the percentage threshold is set at no more than 75%. The ARRA, as discussed below further revises the SCHIP Extension Act to postpone the percentage limitations established in the SCHIP Extension Act to the three cost reporting periods beginning on or after July 1, 2007 for freestanding LTACHs, grandfathered HwHs and grandfathered satellites and on or after October 1, 2007 for non-grandfathered LTACH HwHs and non-grandfathered satellites.

The SCHIP Extension Act also precludes the Secretary from implementing, for the three year period beginning on December 29, 2007, a one-time adjustment to the LTACH standard federal rate. This rule, established in the original LTACH-PPS regulations, permits CMS to restate the standard federal rate to reflect the effect of changes in coding since the LTACH-PPS base year. In the preamble to the May 2007 final rule, CMS discussed making a one-time prospective adjustment to the LTACH-PPS rates for the 2009 rate year. In addition, the SCHIP Extension Act reduced the Medicare payment update for the portion of RY 2008 from April 1, 2008 to June 30, 2008 to the same base rate applied to LTACH discharges during RY 2007.

For the three calendar years following December 29, 2007, the Secretary must impose a moratorium on the establishment and classification of new LTACHs, LTACH satellite facilities, and LTACH beds in existing LTACH or satellite facilities. This moratorium does not apply to LTACHs that, before the date of enactment, (1) began the qualifying period for payment under the LTACH-PPS, (2) have a written agreement with an unrelated party for the construction, renovation, lease or demolition for a LTACH and have expended at least 10% of the estimated cost of the project or $2,500,000, or (3) have obtained an approved certificate of need.

May 6, 2008 Interim Final Rule. On May 6, 2008, CMS published an interim final rule with comment period, which implemented portions of the SCHIP Extension Act. The May 6, 2008 interim final rule addressed: (1) the payment adjustment for very short-stay outliers, (2) the standard federal rate for the last three months of

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RY 2008, (3) adjustment of the high cost outlier fixed-loss amount for the last three months of RY 2008, and (4) made references to the SCHIP Extension Act in the discussion of the basis and scope of the LTACH-PPS rules.

May 9, 2008 Final Rule. On May 9, 2008, CMS published its annual payment rate update for the 2009 LTACH-PPS rate year, or RY 2009 (affecting discharges and cost reporting periods beginning on or after July 1, 2008). The final rule adopts a 15-month rate update, from July 1, 2008 through September 30, 2009 and moves LTACH-PPS from a July-June update cycle to the same update cycle as the general acute care hospital inpatient rule (October September). For RY 2009, the rule establishes a 2.7% update to the standard federal rate. The rule increases the fixed-loss amount for high cost outlier cases to $22,960, which is $2,222 higher than the 2008 LTACH-PPS rate year. The final rule provides that CMS may make a one-time reduction in the LTACH-PPS rates to reflect a budget neutrality adjustment no earlier than December 29, 2010 and no later than October 1, 2012. CMS estimated this reduction will be approximately 3.75%.

May 22, 2008 Interim Final Rule. On May 22, 2008, CMS published an interim final rule with comment period, which implements portions of the SCHIP Extension Act not addressed in the May 6, 2008 interim final rule. Among other things, the May 22, 2008 interim final rule establishes a definition for free-standing LTACHs as a hospital that: (1) has a Medicare provider agreement, (2) has an average length of stay of greater than 25 days, (3) does not occupy space in a building used by another hospital, (4) does not occupy space in one or more separate or entire buildings located on the same campus as buildings used by another hospital and (5) is not part of a hospital that provides inpatient services in a building also used by another hospital.

August 2008 Final Rule. On August 19, 2008, CMS published the IPPS final rule for FY 2009 (affecting discharges and cost reports beginning on or after October 1, 2008 and before October 1, 2009), which made limited revisions to the classifications of cases in MS-LTC-DRGs. The final rule also includes a number of hospital ownership and physician referral provisions, including expansion of a hospital s disclosure obligations by requiring physician-owned hospitals to disclose ownership or investment interests held by immediate family members of a referring physician. The final rule requires physician-owned hospitals to furnish to patients, on request, a list of physicians or immediate family members who own or invest in the hospital. Moreover, a physician-owned hospital must require all physician owners or investors who are also active members of the hospital s medical staff to disclose in writing their ownership or investment interests in the hospital to all patients they refer to the hospital. CMS can terminate the Medicare provider agreement of a physician-owned hospital if it fails to comply with these disclosure provisions or with the requirement that a hospital disclose in writing to all patients whether there is a physician on-site at the hospital 24 hours per day, 7 days per week.

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 will apply 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 FY 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 FY 2009 (October 1, 2008 through September 30, 2009) which has the effect

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of reducing reimbursement by approximately 3.9%. However, CMS is only applying the corrected weights to the remainder of fiscal year 2009 (that is, 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 FY 2010 (affecting discharges and cost reporting periods beginning on or after October 1, 2009 and before September 30, 2010). For FY 2010 CMS adopted a 2.5% increase in payments under the LTACH PPS. As a result, the standard federal rate for FY 2010 is set at $39,896.65, an increase from $39,114.36 in FY 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 with comment period that it previously published but had yet to respond to public comment. 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.

We currently have a total of nine LTACH facilities, with 220 licensed beds. Eight of our LTACH facilities are classified as HwHs and one as freestanding. Of the eight HwH facilities, five are located in rural or non-MSAs. Three of our eight HwH facilities are located in MSA or urban areas. Of these eight locations classified as HwHs, one facility is a satellite location of a parent hospital located in an MSA and one facility is a satellite location of a parent hospital located in a non-MSA. We also have one location that is a freestanding remote site of a parent located in an MSA. 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% 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.

For the 12 months ended December 31, 2011, on an individual basis, the admission of our LTACHs were under the proper threshold as of the current cost report year date of August 31, 2011. Our new LTACHs acquired in 2010 and 2009 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. Our remaining LTACH is not an HwH; therefore, it is not subject to these limits on host hospital referrals, but maintains compliance with non-co-located hospital referral thresholds.

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

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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. Our Managed Care contracts include 80 different payors between all our divisions, 5 of those are national contracts, 10 are regional contracts and 65 are 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;
- 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.

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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 study relating to a wide range of providers. In fiscal year 2011, the OIG indicated its intent to study 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, 2011, 2010 and 2009, we received 79.7%, 80.5% and 82.2%, 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.

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

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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 HHS and CMS, issue pronouncements, including fraud alerts, that identify practices that may be subject to heightened scrutiny. For example, the OIG s FY 2009 Work Plan describes, among other things, the government s intention to examine Medicare Part B payments for therapy services, accuracy of claims coding for Medicare home health resources groups, examining trends in utilization patterns and Medicare reimbursement for services ordered by referring physicians, the incidence of Medicare home health services outlier payments for insulin injections, and analysis of Home Health Agency claims under CMS Comprehensive Error Rate Testing Program to determine whether payments for services and items were adequately documented, medically necessary and coded correctly.

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 you, 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 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

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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 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, 2011, 2010 and 2009, 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

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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 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

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to our relationships with those payors. Because many of our payors might not have been able to accept transactions in the format required by the Transaction Standards rule by the original compliance date, we filed a timely compliance extension plan with HHS. 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;

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;

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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 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.

These regulatory requirements impose significant administrative and financial obligations on companies like us that use or disclose electronic health information. We have implemented policies and procedures to comply with the security 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.

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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 2011.

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 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 2011.

Accreditation

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, 2011, the Joint Commission had accredited 252 of our 290 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.

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 2012.

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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.

Employees

As of December 31, 2011 we had 7,571 employees, of which 5,130 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 Louisiana, Mississippi, Alabama, Arkansas, Texas, Tennessee, Georgia, Florida, Kentucky, Missouri, Oklahoma, Virginia, West Virginia, Oregon, North Carolina, Maryland and Idaho. 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 $25.0 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 $25.0 million, with an additional $5.0 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.

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.

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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 Patient Protection and Affordable Care Act 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.

We derive more than 75% 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, 2011, 2010 and 2009, we received 79.7%, 80.5% and 82.2%, 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 2011 we experienced an approximate 5.22% cut in home health reimbursement for our Medicare patients and expect an additional 2.4% cut in 2012. 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.

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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.