Section 1: 10-K (10-K)

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

FORM 10-K

(Mark One)

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

For the fiscal year ended: December 31, 2016

OR

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

For the transition period from to

Commission File Number: 0-24260

AMEDISYS, INC.

(Exact Name of Registrant as Specified in its Charter)

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

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

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

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

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

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

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

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

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☑ No ☐

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company.

See the definitions of “large accelerated filer,” “accelerated filer” and “smaller reporting company” in Rule 12b-2 of the Exchange Act.

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

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 30, 2016 (the last business day of the registrant’s most recently completed second fiscal quarter) was $1.0 billion. For purposes of this determination shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 24, 2017, the registrant had 33,607,420 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant’s definitive Proxy Statement for its 2017 Annual Meeting of Stockholders (the “2017 Proxy Statement”) to be filed pursuant to the Securities Exchange Act of 1934 with the Securities and Exchange Commission within 120 days of December 31, 2016 are incorporated herein by reference into Part III of this Annual Report on Form 10-K.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

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

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

Unless otherwise provided, "Amedisys," "we," "us," "our," and the "Company" refer to Amedisys, Inc. and our consolidated subsidiaries and when we refer to 2016, 2015 and 2014, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2016 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the "Investors" page under the "SEC Filings" link.

PART I

ITEM 1. BUSINESS

Overview

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

We are among the largest, best established and most advanced providers of home health and hospice care in the United States, with 420 care centers in 34 states. Our 16,000 employees deliver the highest quality of care to the doorsteps of patients in need, making more than 7.5 million patient visits to 385,000 patients annually. Over 2,200 hospitals and 61,900 physicians nationwide have chosen us as a partner in post-acute care.

Our services are primarily paid for by Medicare due to the age demographics of our patient base (average age 81). Medicare represented approximately 78% to 82% of our net service revenue over the last three years. We remain focused on maintaining a profitable and strategically important managed care contract portfolio.

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

Our strategy is to become the best choice for care wherever our patients call home by excelling in clinical distinction, operational excellence and efficiency and growth. Our mission is to provide compassionate home health, hospice and personal care services that apply the most advanced clinical practices toward allowing our patients to maintain a sense of independence, quality of life and dignity. We believe that focusing on providing excellent care and becoming an employer of choice across the United States will differentiate us from our competitors.

Our Home Health Segment:

Amedisys Home Health provides experienced, compassionate healthcare to help our patients recover from surgery or illness, live with chronic diseases, and prevent avoidable hospital readmissions with 327 care centers located in 32 states. Our care team includes skilled nurses who are trained and certified to administer medications, care for wounds, monitor vital signs and provide a wide range of other nursing services; therapists specialized in physical, speech and occupational therapy; and aides who assist our patients with completing important personal tasks.

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

This commitment to clinical distinction is evident in our clinical performance measures such as Star Ratings. In the Center for Medicare and Medicaid Services (“CMS”) preview reports for the April 2017 release, the Quality of Patient Care star average across all Amedisys providers is 4.03. This number is subject to change for the final release, and CMS has indicated proposed changes that may impact star scores starting with the July 2017 release. Our goal is to have all of our care centers achieve a 4.0 Quality Star Rating, and we are implementing targeted action plans to continue to improve the quality of care we deliver for our patients across the country. Our Patient Satisfaction average as of the last known release was 3.76, outperforming the industry average of 3.67.

Our Hospice Segment:

Hospice is a special form of care that is designed to provide comfort and support for those who are dealing with a terminal illness. It is a compassionate form of care that promotes dignity and affirms quality of life for the patient, family members and other loved ones. We operate 79 hospice care centers in 21 states.

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

At Amedisys Hospice, our focus is on building and retaining an exceptional team, delivering the highest quality care and service to our patients and their families, and establishing Amedisys as the preferred and preeminent hospice provider in each community we serve. In order to realize these goals, we invest in tailored training, development, and recognition programs for our employees, with specific focus in 2016 on the implementation of a new electronic medical record, employee skills training and leadership development. This has led to our team's consistent achievement at or above the national average in family satisfaction results and quality scores, as well as the trust of the healthcare community driving a 17% increase in new patient admissions and a 16% increase in census.

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

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

Our Personal Care Segment:

On March 1, 2016, Amedisys acquired its first personal care company – an important step in executing our strategy of improving the continuity of care our patients receive as their clinical needs change. Our new segment was further expanded when we purchased the assets of Professional Profiles, Inc. on September 1, 2016. We now operate 14 personal-care care centers in Massachusetts.

Personal care provides assistance with the essential activities of daily living. We believe that personal care services are highly synergistic with our core skilled home health and hospice businesses, and that by acquiring these capabilities in one of our most successful regions we will realize these benefits quickly.

Responding to Changing Regulatory and Reimbursement Environment:

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

Homecare Homebase Implementation:

During 2015, we made the strategic decision to discontinue AMS3, our third generation, proprietary operating system, and transition to Homecare Homebase ("HCHB"), a leading home health and hospice platform. We completed our rollout of HCHB during 2016 with all our care centers fully transitioned to our new platform as of November 1, 2016.

Acquisitions:

On March 1, 2016, we acquired Associated Home Care for a total purchase price of $27.7 million. Associated Home Care owned and operated nine personal-care care centers servicing the state of Massachusetts.

On September 1, 2016, we acquired the assets of four personal-care care centers in Massachusetts for a total purchase price of $4.4 million.

On October 20, 2016, we acquired the assets of a home health care center in New York for a total purchase price of $4.6 million.

Financial Information:

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

Our Employees

As of February 24, 2017, we employed approximately 16,000 employees, consisting of approximately 10,800 home health care employees, 2,800 hospice care employees, 1,800 personal care employees and 600 corporate and divisional support employees.

Payment for Our Services

Home Health Medicare

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

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

Period	Base episode payment
January 1, 2014 through December 31, 2014	$ 2,869
January 1, 2015 through December 31, 2015	$ 2,961
January 1, 2016 through December 31, 2016	$ 2,965
January 1, 2017 through December 31, 2017	$ 2,990

Payments can be adjusted for: (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before an episode was complete; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) a payment adjustment if we are unable to perform periodic therapy assessments; (f) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (g) changes in the base episode payments established by the Medicare program; (h) adjustments to the base

episode payments for case mix and geographic wages; and (i) recoveries of overpayments. Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. In addition, we make adjustments to Medicare revenue if we find that we are unable to obtain appropriate billing documentation, authorizations or face to face documentation.

Home Health Non-Medicare

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

Hospice Medicare

The Medicare hospice benefit is also available to Medicare-eligible patients with terminal illnesses, certified by a physician, where life expectancy is six months or less. Medicare rates are based on standard prospective rates for delivering care over a base 90-day or 60-day period (90-day episodes of care for the first two episodes and 60-day episodes of care for any subsequent episodes). Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Rates are set based on specific levels of care, are adjusted by a wage index to reflect health care labor costs across the country and are established annually through federal legislation. We make adjustments to Medicare revenue when we find we are unable to obtain appropriate billing documentation, authorizations or face to face documentation and other reasons unrelated to credit risk. The levels of care are routine care, general inpatient care, continuous home care and respite care. Beginning January 1, 2016, CMS has provided for two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, on January 1, 2016, Medicare also began reimbursing for a service intensity add-on (“SIA”). The SIA is based on visits made in the last seven days of life by a registered nurse (“RN”) or medical social worker (“MSW”) for patients in a routine level of care.

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

The two caps are detailed below:

- ***Inpatient Cap.*** When we provide hospice care on an inpatient basis, the payments that we are entitled to receive at the higher inpatient reimbursement rate are subject to a cap. This cap limits the number of days that are paid at the inpatient care rate (both respite and general) under a provider number to 20% of the total number of days of hospice care (both inpatient and in-home) that is furnished to all Medicare patients served by the provider. The daily Medicare payment rate for any inpatient days of service that exceed the cap is at the routine home care rate, and the provider is required to reimburse Medicare for any amounts it receives in excess of the cap; and
- ***Overall Payment Cap.*** This cap is calculated by the Medicare fiscal intermediary at the end of each hospice cap period to determine the maximum allowable payments per provider number. We estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation.

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

Hospice Non-Medicare

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

Personal Care Non-Medicare

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

Controls over Our Business System Infrastructure

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

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

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

Our Regulatory Environment

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

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

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

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

Home health and hospice care centers operate under licenses granted by the health authorities of their respective states. Additionally, certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or demonstrative usage of additional providers. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting either from population increases or a reduction in competing providers. These states ration the entry of new providers or services and the expansion of existing providers or services in their markets through a CON process, which is periodically evaluated and updated as required by applicable state law. Currently, state health authorities in 17 states and the District of Columbia require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health care center, and state health authorities in 12 states and the District of Columbia require a CON to operate a hospice care center.

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

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

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

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

Medicare Participation

Our care centers must comply with regulations promulgated by the United States Department of Health and Human Services and CMS in order to participate in the Medicare program and receive Medicare payments. Among other things, these regulations, known as "conditions of participation ("COPs")," relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with state and local laws and regulations. CMS has adopted alternative sanction enforcement options which allow CMS (i) effective as of July 1, 2013, to impose temporary management, direct plans of correction, or direct training, and (ii) effective as of July 1, 2014, to impose payment suspensions and civil monetary penalties in each case on providers out of compliance with the conditions of participation. CMS issued a proposed rule on October 9, 2014, revising the current home health conditions of participation. We provided public comments on the proposed changes. On January 12, 2017, CMS finalized the new COPs and published them in the Federal Register. The new COPs are currently scheduled to go into effect on July 13, 2017, though that could be further delayed.

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

Federal and State Anti-Fraud and Anti-Kickback Laws

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

Stark Laws

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

Federal and State Privacy and Security Laws

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

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

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

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

The False Claims Act

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

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

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

In June 2016, the Department of Justice issued a rule that more than doubles civil monetary penalties under the False Claims Act. These increases took effect on August 1, 2016 and apply to False Claims Act violations after November 2, 2015.

In addition to the False Claims Act, the Federal Government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the Federal Government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act. As part of the Deficit

Reduction Act of 2005 (the "DRA"), Congress provided states an incentive to adopt state false claims acts consistent with the Federal False Claims Act. Additionally, the DRA required providers who receive $5 million or more annually from Medicaid to include information on Federal and state false claims acts, whistleblower protections and the providers' own policies on detecting and preventing fraud in their written employee policies.

Civil Monetary Penalties

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

FDA Regulation

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

Patient Protection and Affordable Care Act

In March 2010, comprehensive health care reform legislation was signed into law in the United States through the passage of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"). Since the 2016 election, it has been widely discussed that the PPACA will be "repealed and replaced." The effect of any major modification or repeal of the PPACA on our business, operations, or financial condition cannot be predicted at this time.

Even as of December 31, 2016, it is difficult to predict the full impact of PPACA due to the law's complexity and phased in effective dates, as well as our inability to foresee how CMS and other participants in the health care industry will respond to the choices available to them under the law. PPACA calls for a number of changes to be made over time that will likely have a significant impact upon the health care delivery system. For example, PPACA mandates decreases in home health reimbursement rates, including a four-year phased rebasing of the home health payment system that began in 2014 and will continue through 2017. These reimbursement changes are described in detail in Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – Economic and Industry Factors." PPACA has established a number of new requirements impacting our business operations, and promises to give rise to other changes that could significantly impact our businesses in the future. For example, PPACA also mandates the creation of a home health value-based purchasing program, the development of quality measures, and the testing of alternative payment and delivery models, including ACOs and the Bundled Payments for Care Improvement initiative. See Part I, Item 1A, "Risk Factors: Risks Related to Laws and Government Regulations" for a more complete discussion of PPACA and the risks it presents to our businesses.

The Improving Medicare Post-Acute Care Transformation Act

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

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

The Comprehensive Care for Joint Replacement Bundled Payment Program

In November 2015, CMS announced the final Comprehensive Care for Joint Replacement bundled payment program ("CJR Program"). The CJR Program implements a mandatory payment model in which acute care hospitals in 67 metropolitan statistical areas will receive a bundled payment for all inpatient care provided in connection with a lower extremity joint replacement or reattachment procedure, as well as for all related care provided within a 90-day episode of care following discharge from such hospital. The bundled payment will be in lieu of separate payments provided to post-acute healthcare providers for services provided within such 90-day episode of care. The CJR Program will test this payment model over five performance periods between April 1, 2016 and December 31, 2020 to see if Medicare expenditures can be reduced while at the same time improving care coordination and preserving or enhancing the quality of care provided to Medicare beneficiaries.

Pre-Claim Review Demonstration for Home Health Services

On June 8, 2016, CMS announced the implementation of a three year Medicare pre-claim review demonstration for home health services provided to beneficiaries in the states of Illinois, Florida, Texas, Michigan and Massachusetts. The demonstration began in Illinois in August 2016 and will expand to Florida for home health services that begin on or after April 1, 2017. CMS is expected to announce staggered start dates for the other states in the coming months. The pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. The pre-claim review demonstration may result in an increase in administrative costs or reimbursement delays related to home health services in such states, which could have an adverse effect on our results of operations and cash flow.

Home Health Groupings Model

In the Calendar Year 2017 Home Health Proposed Rule, released in July 2016, CMS provided information regarding potential changes to the Home Health Prospective Payment System ("HHPPS"), known as the Home Health Groupings Model ("HHGM"). Among a number of major differences from the current payment system, the HHGM would distinguish between referrals from institutions and those from the community, with

community referrals receiving lower payments. In addition, a 60-day episode would consist of two 30-day periods, each paid separately, with the initial 30-day period paid higher than any other period. CMS did not solicit comments at that time but noted that a more detailed Technical Report would be released with additional research and analysis conducted on the HHGM. The HHGM Technical Report was issued in December 2016. We are closely monitoring this potential change to the HHPPS and have joined industry stakeholders in directly engaging CMS on this concept and its impact on home health agencies. CMS has not indicated if HHGM will be included in the Calendar Year 2018 Home Health Proposed Rule which will be released in mid-summer 2017. At this time we are unable to determine the impact this potential change in reimbursement methodology might have on Amedisys.

Our Competitors

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

Available Information

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

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

ITEM 1A. RISK FACTORS

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

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

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

Risks Related to Reimbursement

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

Our net service revenue is primarily derived from Medicare, which accounted for 78%, 80% and 82% of our revenue during 2016, 2015 and 2014, respectively. Payments received from Medicare are subject to changes made through federal legislation. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. These changes, as further detailed in Part I, Item 1, "Business: Payment for Our Services," can include changes to base episode payments and adjustments for home health services, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility and documentation requirements or changes designed to restrict utilization. Any such changes, including retroactive adjustments, adopted in the future by the Center for Medicare and Medicaid Services ("CMS") could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

On September 1, 2016, CMS published annual changes in Medicaid hospice payment rates. As finalized, CMS estimates hospices will see a 2.1% ($350 million) increase in Medicare payments for fiscal year 2017, which reflects a market basket update of 2.7%, reduced by 0.6% as required by PPACA. CMS will reimburse hospice providers with two routine home care rates, to provide separate payment rates for the first 60 days of care and care beyond 60 days, a change that was instituted in 2016. In addition, the rule finalizes changes to the hospice quality reporting program, including new quality measures. The final rule also describes a potential future enhanced data collection instrument as well as plans to publicly display quality measures and other hospice data beginning in the middle of 2017. As of December 31, 2016, we estimate our impact of the 2017 final rule to be an increase of approximately 2%.

In October 2016, CMS issued a final rule to update and revise Medicare home health reimbursement rates for calendar year 2017. The final rule implements the final year of the four-year phase-in of the rebasing adjustments

to the home health prospective payment system rates as required by the PPACA. CMS also provides an update to the Home Health Quality Reporting Program. CMS estimates that the net impact of the payment provisions of the final rule will result in a decrease of 0.7% in reimbursement to home health providers. The decrease is the result of a 2.8% market basket increase minus 0.3% for productivity, a 2.3% decrease for the last year in the four-year rebasing cycle and a 0.97% decrease for the second year in a three-year series of cuts for nominal case mix growth. Our impact could differ depending on differences in the wage index and the impact of coding and outlier changes. As of December 31, 2016, we estimate our impact of the 2017 final rule to be a decrease of approximately 2%.

On February 2, 2016 CMS published a final rule adding new requirements for Medicaid home health services. Among other things, the final rule requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician practitioner must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than 6 months prior to the start of services. Although the final rule's stated effective date is July 1, 2016, CMS created an exception for state legislation by giving state agencies that require state legislation to until July 1, 2017 or July 1, 2018 to publish requirements imposed by the rule.

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

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

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

With respect to our hospice operations, overall payments made by Medicare to each provider number (generally corresponding to a hospice care center) are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we may be required to reimburse the Medicare program for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Quality reporting requirements may negatively impact Medicare reimbursement.

Hospice quality reporting was mandated by PPACA, which directs the Secretary to establish quality reporting requirements for hospice programs. For fiscal year 2014, and each subsequent year, failure to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. This quality reporting program is currently "pay-for-reporting," meaning it is the act of submitting data that determines compliance with program requirements.

Similarly, in the Calendar Year 2015 Home Health Final Rule, CMS proposed to establish a new "Pay-for-Reporting Performance Requirement" with which provider compliance with quality reporting program requirements can be measured. Home health agencies that do not submit quality measure data to CMS are subject to a 2.0% reduction in their annual home health payment update percentage. Home health agencies are required to report prescribed quality assessment data for a minimum of 70.0% of all patients with episodes of care that occur on or after July 1, 2015. This compliance threshold increases by 10.0% in each of two subsequent periods--i.e., for episodes beginning on or after July 1, 2016 and before June 30, 2017, home health agencies must score at least 80%, and for episodes beginning on or after July 1, 2017 and thereafter, the required performance level is at least 90%.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act") requires the submission of standardized data by home health agencies and other providers. Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. Failure to report data as required will subject providers to a 2% reduction in market basket prices then in effect. Additionally, reporting activities associated with the IMPACT Act are anticipated to be quite burdensome.

There can be no assurance that all of our agencies will continue to meet quality reporting requirements in the future which may result in one or more of our agencies seeing a reduction in its Medicare reimbursements. Regardless, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

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

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

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

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

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

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

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

Risks Related to Laws and Government Regulations

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

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

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

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

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

With respect to the pending securities class action, we may be obligated to indemnify (and advance legal expenses to) both current and former officers, employees and directors in connection with this matter. We maintain directors' and officers' liability insurance that we believe should cover a portion of the legal costs and potential liability costs associated with this matter. However, such insurance coverage does not extend to all of these expenditures, and the insurance limits may be insufficient even with respect to expenditures that would otherwise be covered. Furthermore, our insurance carriers may seek to deny coverage in this matter, in which case we may have to fund the indemnification amounts owed to such directors and officers ourselves. We do not

maintain any insurance that will cover any part of the class action lawsuits in which we are defendants. If our insurance coverage is denied or is not adequate, it may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

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

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

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

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

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

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

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

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

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

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

We are required to comply with federal and state laws, generally referred to as "anti-kickback laws," that prohibit certain direct and indirect payments or other financial arrangements between health care providers that are

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

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

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

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

Regulations implementing the provisions of the PPACA and related initiatives may similarly increase our costs, decrease our revenues, expose us to expanded liability or require us to revise the ways in which we conduct our business.

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

In addition, various health care reform proposals similar to the federal reforms described above have also emerged at the state level, including in several states which we operate. We cannot predict with certainty what health care initiatives, if any, will be implemented at the state level, or what the ultimate effect of federal health care reform or any future legislation or regulation may have on us or on our business and consolidated financial condition, results of operations and cash flows.

In addition to impacting our Medicare businesses, PPACA may also significantly affect our non-Medicare businesses. PPACA makes many changes to the underwriting and marketing practices of private payors. The resulting economic pressures could prompt these payors to seek to lower their rates of reimbursement for the services we provide. At this time, it is not possible to estimate what impact PPACA may have on our non-Medicare businesses.

Finally, efforts to repeal or substantially modify provisions of the PPACA continue in Congress. The ultimate outcomes of legislative efforts to repeal, substantially amend, eliminate or reduce funding for the PPACA is unknown. While these attempts have not been successful to date, the results of the Presidential and Congressional elections in 2016 could have a significant impact on future efforts to amend or repeal PPACA. In addition to the prospect for legislative repeal or revision, the President and members of his administration hostile to the PPACA could seek to impose substantial changes upon the PPACA through administrative action, including revised regulation and other Executive Branch action. The effect of any major modification or repeal of the PPACA on our business, operations, or financial condition cannot be predicted, but could be materially adverse.

Risks Related to our Growth Strategies

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

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

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

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

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

Changes in federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, PPACA authorized CMS to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. The moratoria on new enrollments may be applied to categories of providers or to specific geographic regions. In 2012, the OIG released a report that concluded Medicare had overpaid home health agencies due to inappropriate and questionable billing practices. Citing this report, in 2014, CMS adopted a temporary moratorium on new home health agencies and home health agency subunits in certain regions of Texas, Michigan, Florida and Illinois. On July 29, 2016, CMS announced it was extending such moratorium for an additional six months, and that the moratorium would be expanded statewide in each targeted state. If a moratorium is imposed on the enrollment of new home health or hospice providers in a geographic area we desire to service, it could have a material impact on our ability to open new care centers. Additionally, in 2010,

CMS implemented and amended a regulation known as the "36 Month Rule" that is applicable to home health care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health care centers – those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition – from assuming the Medicare billing privileges of the acquired care center. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy.

We could face a variety of risks by expanding into our personal care line of business.

We established a personal care segment of our business with the acquisition of Associated Home Care, which closed on March 1, 2016. Risks of our entry into the new personal care segment include, without limitation: (i) potential diversion of management's time and other resources from our existing home health and hospice businesses; (ii) unanticipated liabilities or contingencies; (iii) the need for additional capital and other resources to expand into this new line of business; and (iv) inefficient integration of operational and management systems and controls. Entry into a new line of business may also subject us to new laws and regulations with which we are not familiar, and may lead to increased litigation and regulatory risk. If we are unable to successfully implement our growth strategies, our revenue and profitability may not grow as we expect, our competitiveness may be materially and adversely affected, and our reputation and business may be harmed.

Risks Related to our Operations

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

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

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

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

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

Managed care organizations and other third party payors continue to consolidate, which enhances their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if these organizations terminate us as

a provider and/or engage our competitors as a preferred or exclusive provider. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was approximately $289.0 million as of December 31, 2016 and if we make additional acquisitions, it is likely that we will record additional intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment and other identifiable intangible assets of $83.8 million as of December 31, 2016, which we review both on a periodic basis for indefinite lived intangible assets as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our consolidated financial condition and results of operations.

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

We compete for qualified personnel with other healthcare providers. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there

are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with attractive benefit packages than we originally anticipated which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our care center employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

The services we offer involve an inherent risk of professional liability and related substantial damage awards. As of February 24, 2017, we had approximately 16,000 employees (10,800 home health, 2,800 hospice, 1,800 personal care and 600 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their acts or omissions. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits, or multiple claims requiring us to pay deductibles, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

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

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

Our operations could be impacted by natural disasters.

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

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

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

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

CMS is implementing a three-year pre-claim review demonstration for home health services in the states of Illinois, Florida, Michigan, Massachusetts, and Texas, which will be phased in during 2016 and 2017, depending on the state. CMS is testing whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud occurring among home health agencies providing services to Medicare beneficiaries. Additionally, CMS is testing whether the demonstration helps reduce expenditures while maintaining or improving quality of care. The pre-claim review demonstration for home health services does not create new clinical documentation requirements. CMS has indicated that home health agencies will submit the same information they currently submit for payment, but will do so earlier in the process. CMS has further indicated that this demonstration should not delay care to Medicare beneficiaries and does not alter the Medicare home health benefit. However, this process could result in increased administrative costs or delays in reimbursement for home health services in states subject to the demonstration.

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

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

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

are unable to raise the necessary funds on acceptable terms, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

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

As of December 31, 2016, we had total outstanding indebtedness of approximately $95.7 million, comprised mainly of indebtedness incurred in connection with our April 23, 2014 settlement agreement with the U.S. Department of Justice relating to certain of our clinical and business operations. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and impair our ability to fulfill other obligations in several ways, including:

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

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

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

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

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

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

Risks Related to Ownership of Our Common Stock

The price of our common stock may be volatile.

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

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

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

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. “Short sale” is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2016, investors held a short position of approximately 3.2 million shares of our common stock which represented 9.5% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

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

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

	As of December 31, 2016
Common stock outstanding	33,597,215
Preferred stock outstanding	—
Common stock available under 2008 Omnibus Incentive Compensation Plan	1,204,572
Stock options outstanding	1,008,157
Stock options exercisable	281,458
Non-vested stock outstanding	209,378
Non-vested stock units outstanding	474,286

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

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

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

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

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

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 2. PROPERTIES

Our executive office is located in Nashville, Tennessee in a leased property consisting of 15,825 square feet; our corporate headquarters is located in Baton Rouge, Louisiana in a leased property consisting of 75,243 square feet. We believe we have adequate space to accommodate our corporate staff located in these locations for the foreseeable future.

In addition to our executive office and corporate headquarters, we also lease facilities for our home health, hospice and personal-care care centers. Generally, these leases have an initial term of five years with a three year early termination option, but range from one to seven years. Most of these leases also contain an option to extend the lease period. The following table shows the location of our 327 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers at December 31, 2016:

State	Home Health	Hospice	Personal Care	State	Home Health	Hospice	Personal Care
Alabama	30	7	—	New Jersey	2	1	—
Arkansas	5	—	—	New York	5	—	—
Arizona	3	—	—	New Hampshire	2	2	—
California	4	—	—	North Carolina	8	6	—
Connecticut	4	1	—	Ohio	—	1	—
Delaware	2	—	—	Oklahoma	6	—	—
Florida	28	—	—	Oregon	3	1	—
Georgia	62	6	—	Pennsylvania	7	6	—
Illinois	2	—	—	Rhode Island	1	2	—
Indiana	5	1	—	South Carolina	19	7	—
Kansas	1	1	—	Tennessee	43	11	—
Kentucky	17	—	—	Texas	—	1	—
Louisiana	10	4	—	Virginia	14	1	—
Massachusetts	5	8	14	West Virginia	11	6	—
Maine	2	4	—	Wisconsin	1	—	—
Maryland	8	2	—	Washington, D.C.	1	—	—
Mississippi	10	—	—	Total	327	79	14
Missouri	6	—	—				

ITEM 3. LEGAL PROCEEDINGS

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

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

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

Market Information and Holders

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

	Price Range of Common Stock	
	High	Low
Year Ended December 31, 2016:		
First Quarter	$48.48	$31.16
Second Quarter	54.42	46.12
Third Quarter	55.16	45.48
Fourth Quarter	48.13	34.58
Year Ended December 31, 2015:		
First Quarter	$31.27	$25.83
Second Quarter	43.61	24.81
Third Quarter	48.34	36.11
Fourth Quarter	45.00	34.72

As of February 24, 2017, there were approximately 513 holders of record of our common stock.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors as our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends; provided, however, that we may pay (i) dividends payable solely in our equity securities and (ii) dividends if (1) no default or event of default under the Credit Agreement shall have occurred and be continuing at the time of such dividend or would result therefrom, (2) we demonstrate that, upon giving pro forma effect to such dividend, our consolidated leverage ratio (as defined in the Credit Agreement) is less than 2.00 to 1.0 and (3) we demonstrate a minimum liquidity of $50 million upon giving effect to such dividend.

Purchases of Equity Securities

The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2016:

Period	(a) Total Number of Shares (or Units) Purchased	(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs
October 1, 2016 to October 31, 2016	676	$ 43.86	—	$ —
November 1, 2016 to November 30, 2016	—	—	—	—
December 1, 2016 to December 31, 2016	11,472	42.85	—	—
	12,148(1)	$ 42.91	—	$ —

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

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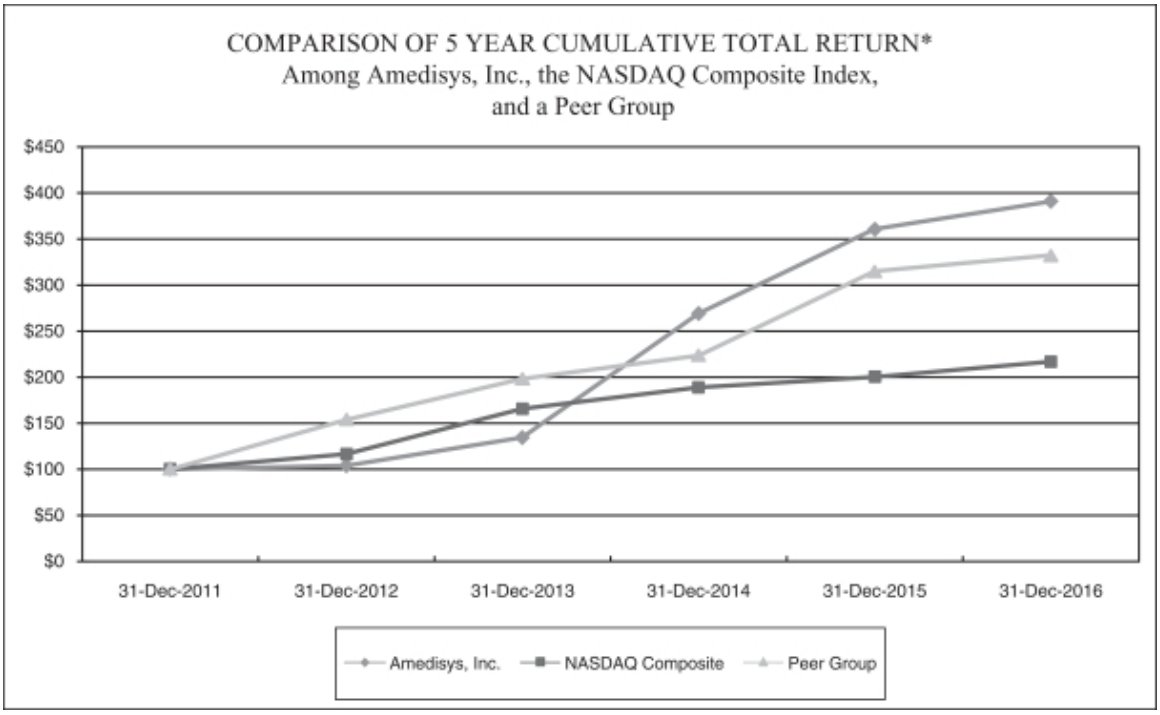
Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2016, with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group) on December 31, 2011 and the reinvestment of dividends. The peer group we selected is comprised of: LHC Group, Inc. ("LHCG") and Almost Family, Inc. ("AFAM"). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been paid on our common stock.



	12/31/2011	12/31/2012	12/31/2013	12/31/2014	12/31/2015	12/31/2016
Amedisys, Inc.	$ 100.00	$ 103.64	$ 134.10	$ 269.02	$ 360.40	$ 390.74
NASDAQ Composite	$ 100.00	$ 116.41	$ 165.47	$ 188.69	$ 200.32	$ 216.54
Peer Group	$ 100.00	$ 153.62	$ 198.06	$ 223.44	$ 314.73	$ 331.94

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

ITEM 6. SELECTED FINANCIAL DATA

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for the five-year period ended December 31, 2016, based on our continuing operations. The financial data for the years ended December 31, 2016, 2015 and 2014 should be read together with our consolidated financial statements and related notes included in Item 8, "Financial Statements and Supplementary Data" and the information included in Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations" herein.

	2016 (1)	2015 (2)	2014 (3)	2013 (4)	2012 (5)
	(Amounts in thousands, except per share data)				
Income Statement Data:					
Net service revenue	$ 1,437,454	$ 1,280,541	$ 1,204,554	$ 1,249,344	$ 1,440,836
Operating income (loss) from continuing operations	$ 57,340	$ (9,166)	$ 24,047	$ (154,971)	$ (108,855)
Net income (loss) from continuing operations attributable to Amedisys, Inc.	$ 37,261	$ (3,021)	$ 12,992	$ (93,105)	$ (80,262)
Net income (loss) from continuing operations attributable to Amedisys, Inc. per basic share	$ 1.12	$ (0.09)	$ 0.40	$ (2.98)	$ (2.68)
Net income (loss) from continuing operations attributable to Amedisys, Inc. per diluted share	$ 1.10	$ (0.09)	$ 0.40	$ (2.98)	$ (2.68)

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

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

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

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

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

	2016	2015	2014	2013	2012
	(Amounts in thousands)				
Balance Sheet Data:					
Total assets (1)	$ 734,029	$ 681,715	$ 666,956	$ 724,237	$ 728,132
Total debt, including current portion (1)	$ 93,029	$ 96,630	$ 113,586	$ 44,735	$ 100,248
Total Amedisys, Inc. stockholders' equity	$ 460,203	$ 409,568	$ 397,167	$ 372,201	$ 452,340
Cash dividends declared per common share	$ —	$ —	$ —	$ —	$ —

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

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

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2016, 2015 and 2014. This discussion should be read in conjunction with our audited financial statements included in Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1, "Business" of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues, operating results and expectations. See "Special Caution Concerning Forward-Looking Statements" for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A, "Risk Factors."

Overview

We are a provider of high-quality in-home healthcare and related services to the chronic, co-morbid, aging American population, with approximately 78%, 80% and 82% of our revenue derived from Medicare for 2016, 2015 and 2014, respectively.

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgery. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. Our personal care segment provides patients assistance with the essential activities of daily living. As of December 31, 2016, we owned and operated 327 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers in 34 states within the United States and the District of Columbia.

2016 Developments

- Completed the rollout of Homecare Homebase ("HCHB"), a leading platform for home health and hospice companies, to all of our care centers.
- Integrated Infinity HomeCare which we acquired on December 31, 2015.
- Closed the acquisition of Associated Home Care on March 1, 2016, which resulted in the establishment of our personal care segment which was further expanded with the purchase of the assets of Professional Profiles, Inc. on September 1, 2016.

2017 Strategy

- Continue to focus on growth through acquisitions in all three segments and increased volumes in existing care centers.
- Continue to focus on commitment to clinical distinction with a goal of all care centers achieving a 4.0 Quality Star Rating.
- Gain operating efficiencies from investments in infrastructure, including HCHB.
- Focus on recruitment and retention of world class employees while fostering a culture of engagement to become the employer of choice in the industry.

Financial Performance

The year ended December 31, 2016 continued our focus on operational improvements that began during 2014 despite the disruption related to the conversion from our proprietary operating system to HCHB.

Our home health care centers experienced same store revenue and admissions growth in 2016. The home health segment saw an increase in non-Medicare revenue and Medicare revenue per episode offset by increases in cost per visit and other operating expenses which resulted in a $2 million reduction in our operating income over the year ended December 31, 2015 (see “Results of Operations”).

Our hospice segment achieved significant growth in admissions and average daily census combined with strong cost controls in 2016, all of which helped deliver an $8 million improvement in our operating income over the year ended December 31, 2015 (see “Results of Operations”).

Care Centers Summary

	Home Health	Hospice	Personal Care
At December 31, 2013	367	92	—
Closed/Consolidated/Sold	(51)	(12)	—
At December 31, 2014	316	80	—
Acquisitions	15	1	—
Closed/Consolidated/Sold	(2)	(2)	—
At December 31, 2015	329	79	—
Acquisitions/Start-Ups	1	—	14
Closed/Consolidated	(3)	—	—
At December 31, 2016	327	79	14

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

Economic and Industry Factors

Home health, hospice and personal care services are a highly fragmented and highly competitive industry. The degree of competiveness varies based upon whether our care centers operate in states that require a certificate of need (CON) or permit of approval (POA). In such states, expansion by existing providers or entry into the market by new providers is permitted only where determination is made by state health authorities that a given amount of unmet healthcare need exists. Currently, 68% and 40% of our home health and hospice care centers, respectively operate in CON/POA states.

As the Federal government continues to debate a reduction in expenditures and a reform of the Medicare system, our industry continues to face reimbursement pressures. The Centers for Medicare and Medicaid Services (“CMS”) instituted a rebasing cut of approximately $81 per episode (2.7%) per year for 2014 – 2017; however,

we do expect some offset from a market basket update in each of these years. The following payment adjustments are effective for the years indicated based on CMS's final rules relative to Medicare reimbursement:

	Home Health			Hospice		
	2017 (1)	2016	2015	2017 (2)	2016	2015
Market Basket Update	2.8 %	2.3 %	2.6 %	2.7 %	2.4 %	2.9 %
Rebasing	(2.3)	(2.4)	(2.8)	—	—	—
50/50 Blend of Wage Index	—	—	—	—	0.2	—
Nominal Case Mix Adjustment	(0.9)	(0.9)	—	—	—	—
PPACA Adjustment	—	—	—	(0.3)	(0.3)	(0.3)
Budget Neutrality Adjustment Factor	—	—	0.4	—	(0.7)	(0.7)
Productivity Adjustment	(0.3)	(0.4)	(0.5)	(0.3)	(0.5)	(0.5)
	(0.7)%	(1.4)%	(0.3)%	2.1 %	1.1 %	1.4 %

(1) Effective for episodes scheduled to be completed on or after January 1, 2017.
(2) Effective for services provided from October 1, 2016 to September 30, 2017.

Our company-specific impact of the final rules could differ depending on differences in the wage index and the impact of coding and outlier changes.

As part of the 2016 final rule issued in October 2015, CMS finalized their proposal to implement a Home Health Value-Based Purchasing model in nine states that seeks to test whether incentives for better care can improve outcomes in the delivery of home health services. Financial impacts from this change, either positive or negative, would begin January 1, 2018, applied to that calendar year based on 2015 performance data. Care centers operating in the states included in the proposed model account for approximately 31% of our 2016 home health Medicare revenue.

Governmental Inquiries and Investigations and Other Litigation

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

On April 23, 2014, with no admission of liability on our part, we entered into a settlement agreement to resolve the U.S. Department of Justice investigation which began with a Civil Investigative Demand ("CID") issued by the U.S. Department of Justice on September 27, 2010 and the Stark Law Self-Referral Matter disclosed to CMS in May 2012. Pursuant to the settlement agreement, on May 2, 2014, we paid the United States an initial payment in the amount of $116.5 million representing the first installment of $115 million plus interest thereon due under the settlement agreement, and on October 23, 2014, we paid the United States an additional payment in the amount of $35.8 million, representing the second and final installment of $35 million plus interest thereon due under the settlement agreement.

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

In connection with the settlement agreement, on April 23, 2014, we entered into a corporate integrity agreement ("CIA") with the Office of Inspector General-HHS ("OIG"). The CIA formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the CIA requires us to maintain our existing compliance program, executive compliance committee and compliance committee of the Board of Directors; provide certain compliance training; continue screening new and current employees to ensure they are eligible to participate in federal health care programs; engage an independent review organization to perform certain auditing and reviews and prepare certain reports regarding our compliance with federal health care

programs, our billing submissions to federal health care programs and our compliance and risk mitigation programs; and provide certain reports and management certifications to the OIG. Additionally, the CIA specifically requires that we report substantial overpayments that we discover we have received from federal health care programs, as well as probable violations of federal health care laws. Upon breach of the CIA, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. The CIA has a term of five years. We expect the CIA to impact operating expenses by approximately $1 to $2 million annually.

May 2015 Subpoena Duces Tecum Issued by the U.S. Department of Justice

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

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

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

June 2016 Civil Investigative Demand Issued by the U.S. Department of Justice

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

See Item 8, Note 10 – Commitments and Contingencies to our consolidated financial statements for additional information regarding our April 2014 CIA, the May 2015 Subpoena issued by the U.S. Department of Justice, the November 2015 CID issued by the U.S. Department of Justice, the June 2016 CID issued by the U.S. Department of Justice and for a discussion of and updates regarding class action litigation we are involved in. No assurances can be given as to the timing or outcome of these items.

Results of Operations

Consolidated

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

	For the Years Ended December 31,		
	2016	2015	2014
Net service revenue	$1,437.4	$1,280.5	$1,204.5
Gross margin, excluding depreciation and amortization	604.4	554.6	513.4
% of revenue	42.0%	43.3%	42.6%
Other operating expenses	542.7	486.5	486.3
% of revenue	37.7%	38.0%	40.4%
Asset impairment charge	4.4	77.3	3.1
Operating income (loss)	57.3	(9.2)	24.0
Total other income (expense), net	4.2	8.9	(3.1)
Income tax expense	(23.9)	(2.0)	(7.7)
Effective income tax rate	38.9%	650.6%	36.6%
Income (loss) from continuing operations	37.6	(2.3)	13.3
Net loss from discontinued operations	—	—	(0.2)
Net income attributable to noncontrolling interests	(0.4)	(0.7)	(0.3)
Net income (loss) attributable to Amedisys, Inc.	$ 37.3	$ (3.0)	$ 12.8

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Our 2016 operating results include the results of Infinity HomeCare (“Infinity”), Associated Home Care and Professional Profiles beginning on the date of their acquisition. These three acquisitions accounted for $85 million of our $157 million increase in revenue and $35 million of our $56 million increase in other operating expenses. Our operating results were also impacted by an increase of approximately $21 million in costs associated with our move to HCHB. Approximately $8 million relates to implementation services provided by a third party while $4 million is the result of a non-cash charge to write off assets (primarily laptops) not compatible with our new platform. The remaining $9 million is related to disruption in care center operations as well as additional corporate resources to support multiple systems. In addition to the $21 million related to HCHB, we experienced an increase of $5 million in bad debt and contractual reserves due to increased write-offs and accounts receivable aging due to the HCHB disruption. While we anticipated these costs to continue as we completed the roll-out, our care centers generally return to normal operating results approximately 60 to 90 days after implementation; we completed the HCHB roll-out during the three-month period ended December 31, 2016. Additionally, our results were impacted by approximately $12 million as a result of the 2016 CMS rate cut.

Total other income (expense), net decreased $1 million in 2016 from 2015 after considering the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2016	2015
Legal settlements	$ 2.3	$ 7.4
Equity in earnings from equity method investment	3.5	6.7
Interest expense related to tax audit reserve	(0.6)	—
Life insurance proceeds	—	1.0
Debt refinance costs	—	(3.2)
Interest expense related to long-term obligations	(4.5)	(7.6)
Gain (loss) on disposal of property and equipment or sale of care centers	—	0.2
	$ 0.7	$ 4.5

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

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

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

	For the Year Ended December 31, 2014			
	Home Health	Hospice	Corporate	Total
Severance (a)	$ 2.0	$ 0.1	$ —	$ 2.1
Restructuring severance	2.1	0.6	3.0	5.7
Lease terminations	1.9	0.2	—	2.1
Other intangibles impairment	1.6	1.5	—	3.1
Exit and restructuring activities cost	7.6	2.4	3.0	13.0
U.S. Department of Justice Settlement/Relator Fees	—	—	3.9	3.9
Total	$ 7.6	$ 2.4	$ 6.9	$16.9

(a) Includes $0.8 million and $0.1 million for severance included in cost of service for home health and hospice, respectively.

Our operating results were impacted by the sale, closure and consolidation of numerous care centers as mentioned above. Accordingly, our results for the year ended December 31, 2015 were not fully comparable to the year ended December 31, 2014.

Our operating income, excluding the $77 million asset impairment charges in 2015 and the $17 million in costs incurred in 2014 noted above, increased $27 million as our home health operating income increased $29 million, our hospice operating income increased $13 million and our corporate operating expense increased $15 million.

The primary drivers of our improvement in performance were the closure/consolidation of care centers that had a negative operating contribution, an increase in our revenue per episode, an increase in non-Medicare revenue, growth in hospice census and a reduction in operating expenses. The increase in corporate operating expenses was primarily due to the $6 million Wage and Hour Litigation settlement accrual and HCHB maintenance and hosting and implementation costs of $8 million. The increase in HCHB maintenance and hosting was offset by a $4 million decrease in depreciation and amortization as we moved from our proprietary software to HCHB.

Total other income (expense), net decreased $1 million in 2015 from 2014 after considering the impact of the following items (amounts in millions):

	For the Years Ended December 31,	
	2015	2014
Legal settlements	$ 7.4	$ 1.1
Equity in earnings from equity method investment	6.7	—
Life insurance proceeds	1.0	—
Debt refinance costs	(3.2)	(0.5)
Gain (loss) on disposal of property and equipment or sale of care centers	0.2	0.7
	$ 12.1	$ 1.3

The difference in income tax expense in 2015 and 2014 was driven primarily by the decrease in income before income taxes. Additionally, the effective tax rate for the year ended December 31, 2015 does not provide a meaningful comparison to other periods. The effective tax rate for the year was influenced by the relationship of the amount of “effective tax rate drivers” (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to (loss) income before income taxes. A significant asset impairment was recorded during the three-month period ended March 31, 2015, resulting in a scenario where the company’s (loss) income before income taxes for 2015 was near zero. Consequently, for 2015, the relationship between the “effective tax rate drivers” and (loss) income before income taxes was distorted.

Home Health Division

The following table summarizes our home health segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions)*:			
Medicare	$ 822.4	$ 761.4	$ 751.5
Non-Medicare	263.1	243.7	205.4
Net service revenue	1,085.5	1,005.1	956.9
Cost of service	643.7	584.2	559.4
Gross margin	441.8	420.9	397.5
Other operating expenses	303.2	280.6	294.4
Operating income	$ 138.6	$ 140.3	$ 103.1
Key Statistical Data:			
Medicare:			
Same Store (1):			
Revenue	2%	3%	1%
Admissions	3%	3%	0%
Recertifications	0%	(1%)	1%
Total (2):			
Admissions	194,662	178,226	177,243
Recertifications	103,193	99,762	102,263
Completed episodes	289,862	269,227	272,864
Visits	5,124,002	4,797,734	4,794,609
Average revenue per completed episode (3)	$ 2,839	$ 2,825	$ 2,768
Visits per completed episode (4)	17.5	17.5	17.3
Non-Medicare:			
Same Store (1):			
Revenue	8%	21%	19%
Admissions	2%	18%	17%
Recertifications	8%	14%	13%
Total (2):			
Admissions	98,448	96,934	83,940
Recertifications	38,618	35,870	32,074
Visits	2,050,975	1,954,543	1,651,745
Total (2):			
Visiting Clinician Cost per Visit	$ 81.18	$ 78.23	$ 78.47
Clinical Manager Cost per Visit	$ 8.53	$ 8.29	$ 8.30
Total Cost per Visit	$ 89.71	$ 86.52	$ 86.77
Visits	7,174,977	6,752,277	6,446,354

(1) Same store information represents the percent increase (decrease) in our Medicare and Non-Medicare revenue, admissions or recertifications for the period as a percent of the Medicare and Non-Medicare revenue, admissions or recertifications of the prior period.
(2) Total includes acquisitions; based on continuing operations for all periods presented.
(3) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care.
(4) Medicare visits per completed episode are the home health Medicare visits on completed episodes divided by the home health Medicare episodes completed during the period.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Overall, our operating income decreased $2 million on a $21 million increase in gross margin offset by a $23 million increase in other operating expenses. These results are inclusive of Infinity which accounted for $49 million of our total revenue increase and $18 million of other operating expenses. Our results have been negatively impacted by approximately $12 million related to the CMS rate cut which became effective January 1, 2016 and approximately $6 million as the result of disruptions associated with the roll-out of HCHB.

Net Service Revenue

Our Medicare revenue increased $61 million which is inclusive of $48 million from acquired care centers. The increase in same store revenue is due to higher admission volumes. Our revenue per episode was relatively flat despite the impact of the CMS rate cut in 2016; the increase was due to an increase in patient acuity.

Our non-Medicare revenue increased approximately $19 million, with revenues from episodic payors increasing 16% while our revenue from per visit payors grew 5%. We continue to focus on contract payors with significant concentrations in our markets and those that add incremental margin to our operations as we continue to evaluate our portfolio of managed care contracts.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service increased $59 million primarily as a result of a 6% increase in visits and a 4% increase in cost per visit. The increase in cost per visit is primarily due to higher health insurance expense, planned wage increases and additional costs related to our HCHB roll-out. We believe that the impact of the HCHB roll-out is temporary and will normalize now that the roll-out is complete.

Other Operating Expenses

Other operating expenses increased $23 million due to increases in other care center related expenses, primarily salaries and benefits, travel and training expense and HCHB maintenance and hosting fees. Other operating expense related to care centers acquired from Infinity were approximately $18 million. We have completed the consolidation of our legacy Florida operations with Infinity and the conversion of Infinity to our back office platform.

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

Overall, our operating income excluding the $8 million in exit activity costs in 2014, increased $29 million on a $22 million increase in gross margin and a $7 million decline in other operating expenses. 2014 results included revenue of $16 million and operating losses of $5 million for those care centers that were closed, consolidated or sold.

Net Service Revenue

Our Medicare revenue increase of approximately $10 million consisted of a $16 million increase due to higher revenue per episode offset by $6 million due to lower volumes. The decrease in volumes is primarily due to the sale, closure and consolidation of 51 care centers since December 31, 2013, as we experienced a 3% increase in same store admissions in 2015. Net service revenue included a reduction of $1 million for the estimated impact of the 2016 rate change.

Our non-Medicare revenue increased $38 million as we have focused on contracted payors with significant concentrations in our markets and those that add incremental margin to our operations.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our 2015 results were not fully comparable to the prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,	
	2015	2014
Revenue *(in millions)*:		
Operating care centers	$ 1,005.1	$ 941.2
Closed/Consolidated/Sold care centers	—	15.7
Net service revenue	1,005.1	956.9

Cost of Service, Excluding Depreciation and Amortization

Our cost of service, excluding the $1 million in exit activity costs in 2014, increased $26 million primarily as a result of a 5% increase in visits. Our cost per visit remained relatively flat.

Other Operating Expenses

Other operating expenses, excluding the $7 million in exit activity costs in 2014, decreased $7 million due to decreases in other care center related expenses as a result of our closure and consolidation strategy and the reduction in divisional leadership; the majority of the reductions were in salaries and benefits and rent expense, offset by a $5 million increase in legal expense related to the self-disclosure matter. In addition, our provision for doubtful accounts decreased $3 million and our depreciation and amortization expense decreased $4 million compared to 2014.

Hospice Division

The following table summarizes our hospice segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions)*:			
Medicare	$ 297.7	$ 258.5	$ 232.6
Non-Medicare	18.3	16.9	15.0
Net service revenue	316.0	275.4	247.6
Cost of service	163.1	141.7	131.7
Gross margin	152.9	133.7	115.9
Other operating expenses	77.0	66.0	63.4
Operating income	$ 75.9	$ 67.7	$ 52.5
Key Statistical Data:			
Same Store (1):			
Medicare revenue	15%	13%	(2%)
Non-Medicare revenue	9%	18%	6%
Hospice admissions	17%	16%	(3%)
Average daily census	16%	12%	(4%)
Total (2):			
Hospice admissions	22,526	19,205	17,081
Average daily census	5,912	5,105	4,632
Revenue per day, net	$146.05	$147.78	$146.51
Cost of service per day	$ 75.36	$ 76.06	$ 77.93
Average discharge length of stay	96	92	100

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

(2) Total includes acquisitions; based on continuing operations for all periods presented.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Overall, our operating income increased $8 million on a $19 million increase in gross margin offset by an $11 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased approximately $41 million due to an increase in our average daily census as a result of a 17% increase in hospice admissions. We benefited from a 1.1% hospice rate increase effective October 1, 2015. Beginning January 1, 2016, CMS provided for two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two rates, beginning January 1, 2016, Medicare is also reimbursing for a service intensity add-on (“SIA”). The SIA is based on visits made in the last seven days of life by a registered nurse (“RN”) or medical social worker (“MSW”) for patients in a routine level of care.

Our revenue per day was impacted by an increase in contractual reserves and write-offs which occurred during the HCHB roll-out. We expect to return to normal levels during 2017.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $21 million as the result of a 16% increase in average daily census.

Other Operating Expenses

Other operating expenses increased $11 million due to increases in other care center related expenses, primarily salaries and benefits and HCHB maintenance and hosting fees. We have experienced an increase in days revenue outstanding, net as we transitioned to the HCHB platform. As such, our provision for doubtful accounts increased approximately $4 million, which is reflective of an increase in our accounts receivable aging. We do expect to return to normal days revenue outstanding, net now that we are on one operating platform.

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

Overall, our operating income, excluding the $2 million in exit activity costs in 2014, increased $13 million on an $18 million increase in gross margin offset by a $5 million increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $28 million, primarily as the result of an increase in our average daily census as a result of a 16% increase in hospice admissions. We benefitted from a 1.4% hospice rate increase effective October 1, 2014.

As mentioned above, we have closed numerous care centers since December 31, 2013. Accordingly, our 2015 results were not fully comparable to the prior year. The following table summarizes our net service revenue for our operating care centers and those care centers that were closed, consolidated or sold.

	For the Years Ended December 31,	
	2015	2014
Revenue *(in millions)*:		
Operating care centers	$275.4	$243.4
Closed/Consolidated/Sold care centers	—	4.2
Net service revenue	275.4	247.6

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $10 million as the result of a 10% increase in average daily census offset by a decrease in cost of service per day. We experienced significant improvement in pharmacy and DME cost per day during 2015.

Other Operating Expenses

Other operating expenses, excluding the $2 million in exit activity costs in 2014, increased $5 million due to increases in other care center related expenses, primarily salaries and benefits expense and travel costs.

Personal Care Division

The following table summarizes our personal care segment results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions):*			
Medicare	$ —	$—	—
Non-Medicare	35.9	—	—
Net service revenue	35.9	—	—
Cost of service	26.3	—	—
Gross margin	9.6	—	—
Other operating expenses	8.1	—	—
Operating income	$ 1.5	$—	$—
Key Statistical Data:			
Billable hours	1,539,093	—	—
Clients served	51,520	—	—

Year Ended December 31, 2016

On March 1, 2016, we acquired Associated Home Care, a personal care home health care company with 9 care centers. On September 1, 2016, we acquired the assets of Professional Profiles, Inc. which owned and operated 4 personal-care care centers. In addition, during the three-month period ended September 30, 2016 we opened a start-up personal-care care center. Operating income related to our new personal care division for 2016 was approximately $2 million on net service revenue of $36 million and cost of service of $26 million; other operating expenses were approximately $8 million.

Corporate

The following table summarizes our corporate results from continuing operations:

	For the Years Ended December 31,		
	2016	2015	2014
Financial Information *(in millions):*			
Other operating expenses	$141.9	$126.5	$114.4
Depreciation and amortization	12.4	13.4	17.2
Total operating expenses before asset impairment charge	$154.3	$139.9	$131.6
Asset impairment charge	4.4	77.3	—
Total operating expenses	$158.7	$217.2	$131.6

Corporate expenses consist of costs relating to our executive management and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration.

Year Ended December 31, 2016 Compared to the Year Ended December 31, 2015

Corporate other operating expenses have increased approximately $14 million which is inclusive of approximately $12 million in corporate support expenses related to acquisitions, a $3 million increase in non-cash compensation and a $4 million increase related to HCHB implementation costs offset by decreases of approximately $5 million in various other costs (including a $2 million decrease in legal settlement expenses).

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

Excluding the $77 million asset impairment charge in 2015 and the $7 million in exit and restructuring activities costs and relator fees associated with our U.S. Department of Justice settlement agreement during 2014, corporate other operating expenses increased $15 million which is inclusive of the $6 million Wage and Hour Litigation settlement accrual, $4 million in HCHB maintenance and hosting costs, $4 million related to HCHB implementation and $2 million in severance costs.

Liquidity and Capital Resources

Cash Flows

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

	For the Years Ended December 31,		
	2016	2015	2014
Cash provided by (used in) operating activities	$ 62.2	$107.8	$(65.5)
Cash used in investing activities	(52.0)	(67.4)	(14.3)
Cash (used in) provided by financing activities	(7.5)	(20.9)	70.5
Net increase (decrease) in cash and cash equivalents	2.7	19.5	(9.3)
Cash and cash equivalents at beginning of period	27.5	8.0	17.3
Cash and cash equivalents at end of period	$ 30.2	$ 27.5	$ 8.0

Cash provided by operating activities decreased $45.6 million during 2016 compared to 2015 primarily due to a decrease in our cash collections relative to growth in accounts receivable as our days revenue outstanding, net increased eight days (approximately $41 million) from December 31, 2015. For additional information regarding our operating performance, see “Results of Operations”. Cash provided by operating activities increased $173.3 million during 2015 compared to 2014 primarily due to an increase in our operating performance as compared to 2014 and the payment of the $150.0 million in 2014 under our settlement agreement with the U.S. Department of Justice. The recognition of the asset impairment charge of $77.3 million, which resulted in the net loss for 2015 was a non-cash item and therefore had no impact on our cash flow from operations.

Cash used in investing activities decreased $15.4 million during 2016 compared to 2015 primarily due to decreases in cash paid for acquisitions ($33.6 million), capital expenditures ($5.7 million) and investments ($2.4 million), offset by decreases in proceeds from the sale of property and equipment related to the sale of our former corporate headquarters and in proceeds from the sale of investments. Cash used in investing activities increased $53.1 million during 2015 compared to 2014 primarily due to our acquisition activity ($69.1 million) and an increase in capital expenditures ($9.4 million), offset by proceeds from the sale of property and equipment ($20.0 million) and investments ($5.0 million).

Cash used in financing activities decreased $13.4 million during 2016 compared to 2015 primarily due to tax benefits from stock compensation plans and a decrease in repayments of outstanding borrowings, offset by repurchases of company stock pursuant to our stock repurchase program. Cash used in financing activities increased $91.4 million during 2015 compared to 2014 primarily due to an increase in our borrowings under our long-term obligations partially offset by principal payments.

Liquidity

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

During 2016, we spent $6.8 million in routine capital expenditures compared to $9.3 million and $7.0 million during 2015 and 2014, respectively. Routine capital expenditures primarily include equipment and computer software and hardware. In addition, we spent $8.9 million in non-routine capital expenditures related to leasehold improvements and IT infrastructure upgrades compared to $12.1 million and $5.0 million during 2015 and 2014, respectively, related to enhancements to our point of care software. Our capital expenditures for 2017 are expected to be approximately $10.0 million – $12.0 million.

During 2014, we paid the U.S. government $152.3 million representing the $150 million settlement plus interest thereon due under the settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral Matter.

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million. The net proceeds of the term loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement dated as of October 22, 2012, as amended with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014, with a principal balance of $70 million.

As of December 31, 2016, we had $30.2 million in cash and cash equivalents and $173.3 million in availability under our $200.0 million Revolving Credit Facility. Based on our operating forecasts and our new debt service requirements, we believe we will have sufficient liquidity to fund our operations, capital requirements and debt service requirements.

Outstanding Patient Accounts Receivable

Our patient accounts receivable, net increased $41.0 million from December 31, 2015 to December 31, 2016. Our cash collection as a percentage of revenue was 99% and 100% for December 31, 2016 and 2015, respectively. Our days revenue outstanding, net at December 31, 2016 was 40.2 days which is an increase of 8.3 days from December 31, 2015. We have experienced a slowdown in collections primarily as the result of our shift from our legacy platforms (AMS2 and AMS3) to HCHB. We anticipate further reductions in days revenue outstanding now that we have completed our HCHB implementation and are completely off our legacy system. Our days revenue outstanding, net at December 31, 2015 does not include Infinity HomeCare, which was acquired on December 31, 2015.

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

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

	For the Years Ended December 31, 2016	2015
Provision for estimated revenue adjustments	$ 7.9	$ 6.1
Provision for doubtful accounts	19.5	14.1
Total	$ 27.4	$ 20.2
As a percent of revenue	1.9%	1.6%

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

	0-90	91-180	181-365	Over 365	Total
At December 31, 2016:					
Medicare patient accounts receivable, net (1)	$82.7	$17.1	$ 1.4	$ —	$101.2
Other patient accounts receivable:					
Medicaid	13.6	3.6	3.6	0.2	21.0
Private	39.8	10.4	7.6	3.8	61.6
Total	$53.4	$14.0	$ 11.2	$ 4.0	$ 82.6
Allowance for doubtful accounts (2)					(17.7)
Non-Medicare patient accounts receivable, net					$ 64.9
Total patient accounts receivable, net					$166.1
Days revenue outstanding, net (3)					40.2

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

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

	For the Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 4.0	$ 3.1
Provision for estimated revenue adjustments	7.9	6.1
Write offs	(7.8)	(5.2)
Balance at end of period	$ 4.1	$ 4.0

Our estimated revenue adjustments were 3.9% and 4.8% of our outstanding Medicare patient accounts receivable at December 31, 2016 and December 31, 2015, respectively.

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

	For the Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 16.5	$ 14.3
Provision for doubtful accounts	19.5	14.1
Write offs	(18.3)	(11.9)
Balance at end of period	$ 17.7	$ 16.5

Our allowance for doubtful accounts was 21.5% and 26.9% of our outstanding Medicaid and private patient accounts receivable at December 31, 2016 and 2015, respectively.

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

Indebtedness

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million.

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the “Term Loan”); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the “Revolving Credit Facility”). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our Prior Credit Agreement, dated as of October 22, 2012, as amended (the “Prior Credit Agreement”) with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the “Second Lien Credit Agreement”), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan began amortizing on March 31, 2016 and will continue amortizing over 14 quarterly installments (four remaining quarterly installments of

$1.25 million followed by eight quarterly installments of $2.5 million beginning March 31, 2018, followed by two quarterly installments of $3.1 million beginning March 31, 2020, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and its subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2016, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.5% for 2016 and 2.7% for the period August 28, 2015 to December 31, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 3.5% for 2016.

As of December 31, 2016, our availability under our $200.0 million Revolving Credit Facility was $173.3 million as we had $26.7 million outstanding in letters of credit.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2016, our consolidated leverage ratio was 1.0 and our consolidated fixed charge coverage ratio was 3.8 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guaranties from wholly-owned subsidiaries that in the aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as

of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with the entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet during 2015 which was reclassified to long-term obligations, less current portion during 2016 in accordance with Accounting Standards Update 2015-03, *Interest – Imputation of Interest (Subtopic 835-30): Simplifying the Presentation of Debt Issuance Costs*.

Stock Repurchase Program

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

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

Pursuant to this program, we repurchased 324,141 shares of our common stock at a weighted average price of $37.96 per share and a total cost of approximately $12.3 million during 2016 and 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million during 2015. The repurchased shares are classified as treasury shares. The stock repurchase program expired on September 6, 2016.

Contractual Obligations and Medicare Liabilities

Our future contractual obligations and Medicare liabilities at December 31, 2016 were as follows (amounts in millions):

	Payments Due by Period				
	Total	Less than 1 Year	1-3 Years	4-5 Years	After 5 Years
Long-term obligations	$ 95.7	$ 5.2	$20.5	$70.0	$ —
Interest on long-term obligations (1)	8.3	2.6	4.5	1.2	—
Operating leases	72.0	23.5	30.5	13.4	4.6
Capital commitments	1.2	1.2	—	—	—
Purchase obligations	47.3	14.0	24.8	8.5	—
Uncertain tax positions	4.1	0.3	3.8	—	—
	$228.6	$ 46.8	$84.1	$93.1	$ 4.6

(1) Interest on debt with variable rates was calculated using the current rate of that particular debt instrument at December 31, 2016.

Critical Accounting Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements, which have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP"). The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses and related disclosures of contingent assets and liabilities. On an ongoing basis, we evaluate our estimates, including those related to revenue recognition, collectability of accounts receivable, reserves related to insurance and litigation, goodwill, intangible assets, income taxes and contingencies. We base these estimates on our historical experience and various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results experienced may vary materially and adversely from our estimates. To the extent there are material differences between our estimates and the actual results, our future results of operations may be affected.

We believe the following critical accounting policies represent our most significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenue Recognition

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

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

Home Health Revenue Recognition

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system ("PPS") based on a 60-day episode payment rate that is subject to adjustment based on certain variables. We make adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, and our discovered inability to obtain appropriate billing documentation or authorizations and other reasons unrelated to credit risk. We estimate the impact of such adjustments based on our historical experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record this estimate during the period in which services are rendered as an estimated revenue adjustment and a corresponding reduction to patient accounts receivable. In addition, management evaluates the potential for revenue adjustments and, when appropriate, provides allowances based upon the best available information.

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but

were not completed as of the end of the period. We estimate this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on the number of days elapsed during an episode of care.

Non-Medicare Revenue

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

Non-episodic Based Revenue. Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates, as applicable. Contractual adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue and are also recorded as a reduction to our outstanding patient accounts receivable. In addition, we receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily or hourly rates for each of the four levels of care we deliver. We make adjustments to Medicare revenue for our discovered inability to obtain appropriate billing documentation or authorizations and other reasons unrelated to credit risk. We estimate the impact of these adjustments based on our historical experience, which primarily includes our historical collection rate on Medicare claims, and record it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable.

Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap for each provider number, we monitor these caps and estimate amounts due back to Medicare if a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in other accrued liabilities. Beginning for the cap year ending October 31, 2014, providers are required to self-report and pay their estimated cap liability by March 31st of the following year. As of December 31, 2016, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $0.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016. As of December 31, 2015, we had recorded $1.4 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016.

Hospice Non-Medicare Revenue

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

Personal Care Revenue Recognition

Personal Care Non-Medicare Revenue

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

Patient Accounts Receivable – Allowance for Doubtful Accounts

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. We fully reserve for accounts which are aged at 365 days or greater. We write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible. We do not record an allowance for doubtful accounts for our Medicare patient accounts receivable, which are recorded at their net realizable value after recording estimated revenue adjustments as discussed above.

We believe there is a certain level of credit risk associated with non-Medicare payors. To provide for our non-Medicare patient accounts receivable that could become uncollectible in the future, we establish an allowance for doubtful accounts to reduce the carrying amount to its estimated net realizable value. We estimate an allowance for doubtful accounts based upon our assessment of historical and expected net collections, business and economic conditions, trends in payment and an evaluation of collectability based upon the date that the service was provided. Based upon our best judgment, we believe the allowance for doubtful accounts adequately provides for accounts that will not be collected due to credit risk.

Insurance

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

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the

excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

Each of our operating segments described in the notes to our financial statements is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice and personal-care care centers and have also deemed them to be a single reporting unit.

During 2016, we did not record any goodwill impairment charges and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names and non-compete agreements. We amortize non-compete agreements and acquired names that we do not intend to use in the future on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for acquired names.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2016 and 2015 our net deferred tax assets were $107.9 million and $125.2 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax

jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk from fluctuations in interest rates. Our Revolving Credit Facility and Term Loan carry a floating interest rate which is tied to the Eurodollar rate (*i.e.* LIBOR) or the Prime Rate and therefore, our consolidated statements of operations and our consolidated statements of cash flows are exposed to changes in interest rates. As of December 31, 2016, the total amount of outstanding debt subject to interest rate fluctuations was $95.0 million. A 1.0% interest rate change would cause interest expense to change by approximately $0.9 million annually.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited the accompanying consolidated balance sheets of Amedisys, Inc. and subsidiaries (the Company) as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the consolidated financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Amedisys, Inc. and subsidiaries as of December 31, 2016 and 2015, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2016, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated March 1, 2017, expressed an unqualified opinion on the effectiveness of Amedisys, Inc.'s internal control over financial reporting.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 1, 2017

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

	As of December 31, 2016	As of December 31, 2015
ASSETS		
Current assets:		
Cash and cash equivalents	$ 30,197	$ 27,502
Patient accounts receivable, net of allowance for doubtful accounts of $17,716, and $16,526	166,056	125,010
Prepaid expenses	7,397	8,110
Other current assets	11,260	14,641
Total current assets	214,910	175,263
Property and equipment, net of accumulated depreciation of $138,650 and $141,793	36,999	42,695
Goodwill	288,957	261,663
Intangible assets, net of accumulated amortization of $27,864 and $25,386	46,755	44,047
Deferred income taxes	107,940	125,245
Other assets, net	38,468	32,802
Total assets	$ 734,029	$ 681,715
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 30,358	$ 25,682
Payroll and employee benefits	82,480	72,546
Accrued expenses	63,290	71,965
Current portion of long-term obligations	5,220	5,000
Total current liabilities	181,348	175,193
Long-term obligations, less current portion	87,809	91,630
Other long-term obligations	3,730	4,456
Total liabilities	272,887	271,279
Commitments and Contingencies – Note 10		
Equity:		
Preferred stock, $0.001 par value, 5,000,000 shares authorized; none issued or outstanding	—	—
Common stock, $0.001 par value, 60,000,000 shares authorized; 35,253,577, and 34,786,966 shares issued; and 33,597,215 and 33,607,282 shares outstanding	35	35
Additional paid-in capital	537,472	504,290
Treasury stock at cost 1,656,362, and 1,179,684 shares of common stock	(46,774)	(26,966)
Accumulated other comprehensive income	15	15
Retained earnings	(30,545)	(67,806)
Total Amedisys, Inc. stockholders' equity	460,203	409,568
Noncontrolling interests	939	868
Total equity	461,142	410,436
Total liabilities and equity	$ 734,029	$ 681,715

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

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

	For the Years Ended December 31,		
	2016	2015	2014
Net service revenue	$ 1,437,454	$ 1,280,541	$ 1,204,554
Cost of service, excluding depreciation and amortization	833,055	725,915	691,061
General and administrative expenses:			
Salaries and benefits	306,981	279,425	292,497
Non-cash compensation	16,401	11,824	5,597
Other	180,048	161,186	143,644
Provision for doubtful accounts	19,519	14,053	16,294
Depreciation and amortization	19,678	20,036	28,307
Asset impairment charge	4,432	77,268	3,107
Operating expenses	1,380,114	1,289,707	1,180,507
Operating income (loss)	57,340	(9,166)	24,047
Other income (expense):			
Interest income	75	71	94
Interest expense	(5,164)	(10,783)	(8,217)
Equity in earnings from equity method investments	5,588	9,823	2,991
Miscellaneous, net	3,727	9,747	2,061
Total other income (expense), net	4,226	8,858	(3,071)
Income (loss) before income taxes	61,566	(308)	20,976
Income tax expense	(23,935)	(2,004)	(7,671)
Income (loss) from continuing operations	37,631	(2,312)	13,305
Discontinued operations, net of tax	—	—	(216)
Net income (loss)	37,631	(2,312)	13,089
Net income attributable to noncontrolling interests	(370)	(709)	(313)
Net income (loss) attributable to Amedisys, Inc.	$ 37,261	$ (3,021)	$ 12,776
Basic earnings per common share:			
Income (loss) from continuing operations attributable to Amedisys, Inc. common stockholders	$ 1.12	$ (0.09)	$ 0.40
Discontinued operations, net of tax	—	—	(0.01)
Income (loss) attributable to Amedisys, Inc. common stockholders	$ 1.12	$ (0.09)	$ 0.39
Weighted average shares outstanding	33,198	33,018	32,301
Diluted earnings per common share:			
Income (loss) from continuing operations attributable to Amedisys, Inc. common stockholders	$ 1.10	$ (0.09)	$ 0.40
Discontinued operations, net of tax	—	—	(0.01)
Income (loss) attributable to Amedisys, Inc. common stockholders	$ 1.10	$ (0.09)	$ 0.39
Weighted average shares outstanding	33,741	33,018	32,823
Amounts attributable to Amedisys, Inc. common stockholders:			
Income (loss) from continuing operations	$ 37,261	$ (3,021)	$ 12,992
Discontinued operations, net of tax	—	—	(216)
Net income (loss)	$ 37,261	$ (3,021)	$ 12,776

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME (LOSS)
(Amounts in thousands)

	For the Years Ended December 31,		
	2016	2015	2014
Net income (loss)	$ 37,631	$ (2,312)	$ 13,089
Other comprehensive income (loss)	—	—	—
Comprehensive income (loss)	37,631	(2,312)	13,089
Comprehensive income attributable to non-controlling interests	(370)	(709)	(313)
Comprehensive income (loss) attributable to Amedisys, Inc.	$ 37,261	$ (3,021)	$ 12,776

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands, except common stock shares)

	Total	Common Stock Shares	Common Stock Amount	Additional Paid-in Capital	Treasury Stock	Accumulated Other Comprehensive Loss (Income)	Retained Earnings	Noncontrolling Interests
Balance, December 31, 2013	$372,479	33,413,970	33	467,890	(18,176)	15	(77,561)	278
Issuance of stock – employee stock purchase plan	2,433	176,796	—	2,433	—	—	—	—
Issuance of stock – 401(k) plan	7,062	430,919	1	7,061	—	—	—	—
Exercise of stock options	564	28,229	—	564	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	519,612	1	(1)	—	—	—	—
Non-cash compensation	5,597	—	—	5,597	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(579)	—	—	(579)	—	—	—	—
Surrendered shares	(1,684)	—	—	—	(1,684)	—	—	—
Sale of noncontrolling interest	(1,549)	—	—	(493)	—	—	—	(1,056)
Decrease in noncontrolling interest	350	—	—	(710)	—	—	—	1,060
Net income	13,089	—	—	—	—	—	12,776	313
Balance, December 31, 2014	397,762	34,569,526	35	481,762	(19,860)	15	(64,785)	595
Issuance of stock – employee stock purchase plan	2,204	79,323	—	2,204	—	—	—	—
Issuance of stock – 401(k) plan	6,032	184,412	—	6,032	—	—	—	—
Exercise of stock options	399	15,380	—	399	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	(61,675)	—	—	—	—	—	—
Non-cash compensation	11,824	—	—	11,824	—	—	—	—
Tax benefit from stock options exercised and restricted stock vesting	2,073	—	—	2,073	—	—	—	—
Tax deficit from stock options exercised and restricted stock vesting	(4)	—	—	(4)	—	—	—	—
Surrendered shares	(2,525)	—	—	—	(2,525)	—	—	—
Shares repurchased	(4,581)	—	—	—	(4,581)	—	—	—
Noncontrolling interest distribution	(436)	—	—	—	—	—	—	(436)
Net loss	(2,312)	—	—	—	—	—	(3,021)	709
Balance, December 31, 2015	410,436	34,786,966	35	504,290	(26,966)	15	(67,806)	868
Issuance of stock – employee stock purchase plan	2,483	63,688	—	2,483	—	—	—	—
Issuance of stock – 401(k) plan	6,682	145,660	—	6,682	—	—	—	—
Issuance/(cancellation) of non-vested stock	—	257,263	—	—	—	—	—	—
Non-cash compensation	16,401	—	—	16,401	—	—	—	—
Tax benefit from stock options exercised and restricted stock vesting	7,241	—	—	7,241	—	—	—	—
Surrendered shares	(7,493)	—	—	—	(7,493)	—	—	—
Shares repurchased	(12,315)	—	—	—	(12,315)	—	—	—
Noncontrolling interest distribution	(329)	—	—	—	—	—	—	(329)
Assets contributed to equity investment	405	—	—	375	—	—	—	30
Net income	37,631	—	—	—	—	—	37,261	370
Balance, December 31, 2016	$461,142	35,253,577	$ 35	$ 537,472	$ (46,774)	$ 15	$ (30,545)	$ 939

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

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

	For the Years Ended December 31,		
	2016	2015	2014
Cash Flows from Operating Activities:			
Net income (loss)	$ 37,631	$ (2,312)	$ 13,089
Adjustments to reconcile net income (loss) to net cash provided by (used in) operating activities:			
Depreciation and amortization	19,678	20,036	28,347
Provision for doubtful accounts	19,519	14,053	16,369
Non-cash compensation	16,401	11,824	5,597
401(k) employer match	6,875	6,089	6,216
Write-off of investment	196	—	—
Loss on disposal of property and equipment	582	775	4,592
Gain on sale of care centers	—	(184)	(2,967)
Deferred income taxes	24,547	(677)	22,561
Write off of deferred debt issuance costs/debt discount	—	2,512	488
Equity in earnings from equity method investments	(5,588)	(9,823)	(2,991)
Amortization of deferred debt issuance costs/debt discount	740	959	797
Return on equity investment	4,323	5,610	2,025
Asset impairment charge	4,432	77,268	3,107
Changes in operating assets and liabilities, net of impact of acquisitions:			
Patient accounts receivable	(55,519)	(36,493)	(5,290)
Other current assets	4,231	6,455	(6,269)
Other assets	(11,415)	(3,523)	1,694
Accounts payable	3,970	7,639	(3,168)
U.S. Department of Justice settlement	—	—	(150,000)
Accrued expenses	(7,618)	8,406	3,495
Other long-term obligations	(726)	(829)	(3,226)
Net cash provided by (used in) operating activities	62,259	107,785	(65,534)
Cash Flows from Investing Activities:			
Proceeds from sale of deferred compensation plan assets	230	1,229	11
Proceeds from the sale of property and equipment	—	20,000	3
Purchases of deferred compensation plan assets	—	(19)	(132)
Purchases of property and equipment	(15,717)	(21,429)	(12,008)
Purchase of investments	(1,040)	(3,485)	(6,407)
Proceeds from sale of investment	—	5,000	—
Acquisitions of businesses, net of cash acquired	(35,522)	(69,130)	—
Proceeds from disposition of care centers	—	413	4,233
Net cash used in investing activities	(52,049)	(67,421)	(14,300)
Cash Flows from Financing Activities:			
Proceeds from issuance of stock upon exercise of stock options and warrants	—	399	564
Proceeds from issuance of stock to employee stock purchase plan	2,483	2,204	2,433
Tax benefit from stock options exercised and restricted stock vesting	7,241	2,073	—
Non-controlling interest distribution	(329)	(436)	—
Proceeds from revolving line of credit	134,500	63,400	241,800
Repayments of revolving line of credit	(134,500)	(78,400)	(226,800)
Proceeds from issuance of long-term obligations	—	100,000	68,250
Principal payments of long-term obligations	(5,000)	(103,000)	(13,904)
Debt issuance costs	—	(2,553)	(1,780)
Purchase of company stock	(12,315)	(4,581)	—
Assets contributed to equity investment	405	—	—
Net cash (used in) provided by financing activities	(7,515)	(20,894)	70,563
Net increase (decrease) in cash and cash equivalents	2,695	19,470	(9,271)
Cash and cash equivalents at beginning of period	27,502	8,032	17,303
Cash and cash equivalents at end of period	$ 30,197	$ 27,502	$ 8,032
Supplemental Disclosures of Cash Flow Information:			
Cash paid for interest	$ 2,897	$ 6,175	$ 7,602
Cash paid for income taxes, net of refunds received	$ 755	$ (12,185)	$ (1,766)
Supplemental Disclosures of Non-Cash Financing and Investing Activities:			
(Sale) acquisition of non-controlling interests	$ —	$ —	$ (1,549)

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

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016

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

Amedisys, Inc., a Delaware corporation, and its consolidated subsidiaries ("Amedisys," "we," "us," or "our") are a multi-state provider of home health, hospice and personal care services with approximately 78%, 80% and 82% of our revenue derived from Medicare for 2016, 2015 and 2014, respectively. As of December 31, 2016, we owned and operated 327 Medicare-certified home health care centers, 79 Medicare-certified hospice care centers and 14 personal-care care centers in 34 states within the United States and the District of Columbia.

Use of Estimates

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

Reclassifications and Comparability

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

Principles of Consolidation

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

Equity Investments

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

We account for investments in entities in which we have the ability to exercise significant influence under the equity method if we hold 50% or less of the voting stock and the entity is not a variable interest entity in which we are the primary beneficiary. The book value of investments that we accounted for under the equity method of accounting was $27.8 million as of December 31, 2016 and $25.7 million as of December 31, 2015. We account for investments in entities in which we have less than a 20% ownership interest under the cost method of accounting if we do not have the ability to exercise significant influence over the investee.

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS—(Continued)
December 31, 2016

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue Recognition

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

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

Home Health Revenue Recognition

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system ("PPS") based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, with larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) adjustments to payments if we are unable to perform periodic therapy assessments; (f) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (g) changes in the base episode payments established by the Medicare Program; (h) adjustments to the base episode payments for case mix and geographic wages; and (i) recoveries of overpayments. In addition, we make adjustments to Medicare revenue if we find that we are unable to produce appropriate documentation of a face to face encounter between the patient and physician.

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

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. We estimate this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end

of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on the number of days elapsed during an episodes of care. As of December 31, 2016 and 2015, the difference between the cash received from Medicare for a request for anticipated payment ("RAP") on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our consolidated balance sheets for such periods.

Non-Medicare Revenue

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

Non-episodic based Revenue. Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates, as applicable. Contractual adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue and are also recorded as a reduction to our outstanding patient accounts receivable. In addition, we receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounts for 99%, 99%, and 98% of our total net Medicare hospice service revenue for 2016, 2015 and 2014, respectively. Beginning January 1, 2016, CMS has provided for two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, beginning January 1, 2016, Medicare is also reimbursing for a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse ("RN") or medical social worker ("MSW") for patients in a routine level of care.

We make adjustments to Medicare revenue for an inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these adjustments based on our historical experience, which primarily includes our historical collection rate on Medicare claims, and record it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable.

Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap for each provider number, we monitor these caps and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in other accrued liabilities. Beginning for the cap year ending October 31, 2014, providers are required to self-report and pay their estimated cap liability by March 31st of the following year. As of December 31, 2016, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012 and we have recorded $0.8 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years

ended October 31, 2013 through October 31, 2016. As of December 31, 2015, we had recorded $1.4 million for estimated amounts due back to Medicare in other accrued liabilities for the Federal cap years ended October 31, 2013 through October 31, 2016.

Hospice Non-Medicare Revenue

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

Personal Care Revenue Recognition

Personal Care Non-Medicare Revenue

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

Cash and Cash Equivalents

Cash and cash equivalents include certificates of deposit and all highly liquid debt instruments with maturities of three months or less when purchased.

Patient Accounts Receivable

Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. As of December 31, 2016, there is one single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables (approximately 10.1%). Thus, we believe there are no other significant concentrations of receivables that would subject us to any significant credit risk in the collection of our patient accounts receivable. We fully reserve for accounts which are aged at 365 days or greater. We write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible.

We believe the credit risk associated with our Medicare accounts, which represent 61% and 64% of our net patient accounts receivable at December 31, 2016 and December 31, 2015, respectively, is limited due to our historical collection rate of over 99% from Medicare and the fact that Medicare is a U.S. government payor. Accordingly, we do not record an allowance for doubtful accounts for our Medicare patient accounts receivable, which are recorded at their net realizable value after recording estimated revenue adjustments as discussed above. During 2016, 2015 and 2014, we recorded $7.9 million, $6.1 million and $5.1 million, respectively, in estimated revenue adjustments to Medicare revenue.

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

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Medicare Home Health

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

Medicare Hospice

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

Non-Medicare Home Health, Hospice, and Personal Care

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

Property and Equipment

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

We consider our reporting units to represent asset groups for purposes of testing long-lived assets for impairment. We assess the impairment of a long-lived asset group whenever events or changes in circumstances indicate that the asset's carrying value may not be recoverable. Factors we consider important that could trigger an impairment review include but are not limited to the following:

- A significant change in the extent or manner in which the long-lived asset group is being used.

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- A significant change in the business climate that could affect the value of the long-lived asset group.
- A significant change in the market value of the assets included in the asset group.

If we determine that the carrying value of long-lived assets may not be recoverable, we compare the carrying value of the asset group to the undiscounted cash flows expected to be generated by the asset group. If the carrying value exceeds the undiscounted cash flows, an impairment charge is indicated. An impairment charge is recognized to the extent that the carrying value of the asset group exceeds its fair value.

We generally provide for depreciation over the following estimated useful service lives.

	Years
Building	39
Leasehold improvements	Lesser of life or lease or expected useful life
Equipment and furniture	3 to 7
Vehicles	5
Computer software	3 to 5

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

During 2015, we began the transition of all our care centers from our proprietary operating system to Homecare Homebase (“HCHB”), a leading home health and hospice platform, with all of our care centers operating on HCHB as of December 31, 2016. As part of our conversion process, we determined that a number of assets (primarily laptops) were not compatible with HCHB and had no other alternative or secondary use. As a result, we recorded a non-cash asset impairment charge of $4.4 million to write-off these assets during the three-month period ended December 31, 2016.

During the three-month period ended September 30, 2015, we commenced an active program to sell our corporate headquarters located in Baton Rouge, Louisiana. In accordance with U.S. GAAP, we classified this asset as held for sale and reduced the carrying value of the asset to its estimated fair value less estimated costs to sell the asset; no further depreciation expense for the asset was recorded. As a result, we recorded a non-cash asset impairment charge of $2.1 million during the three-month period ended September 30, 2015. The asset was sold during the three-month period ended December 31, 2015 and the Company now leases equivalent office space.

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The following table summarizes the balances related to our property and equipment for 2016 and 2015 (amounts in millions):

	As of December 31,	
	2016	2015
Building and leasehold improvements	6.9	2.3
Equipment and furniture	71.9	89.6
Computer software	96.8	92.6
	175.6	184.5
Less: accumulated depreciation	(138.6)	(141.8)
	$ 37.0	$ 42.7

Depreciation expense for 2016, 2015 and 2014 was $17.2 million, $20.0 million and $28.0 million, respectively.

Goodwill and Other Intangible Assets

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include but are not limited to, a significant adverse change in the business environment; regulatory environment or legal factors; or a substantial decline in market capitalization of our stock. To determine whether goodwill is impaired, we perform a two-step impairment test. In the first step of the test, the fair values of the reporting units are compared to their aggregate carrying values, including goodwill. If the fair value of the reporting unit is greater than its carrying amount, goodwill is not considered impaired and no further testing is required. If the fair value of the reporting unit is less than its carrying amount, we would proceed to step two of the test. In step two of the test, the implied fair value of the goodwill of the reporting unit is determined by a hypothetical allocation of the fair value calculated in step one to all of the assets and liabilities of that reporting unit (including any recognized and unrecognized intangible assets) as if the reporting unit had been acquired in a business combination and the fair value was reflective of the price paid to acquire the reporting unit. The implied fair value of goodwill is the excess, if any, of the calculated fair value after hypothetical allocation to the reporting unit's assets and liabilities. If the implied fair value of the goodwill is greater than the carrying amount of the goodwill at the analysis date, goodwill is not impaired and the analysis is complete. If the implied fair value of the goodwill is less than the carrying value of goodwill at the analysis date, goodwill is deemed impaired by the amount of that variance.

We calculate the estimated fair value of our reporting units using discounted cash flows as well as a market approach that compares our reporting units' earnings and revenue multiples to those of comparable public companies. To determine fair value we must make assumptions about a wide variety of internal and external factors. Significant assumptions used in the impairment analysis include financial projections of free cash flow (including significant assumptions about operations, in particular expected organic growth rates, future Medicare reimbursement rates, capital requirements and income taxes), long-term growth rates for determining terminal value, and discount rates. Our estimates of discounted cash flows may differ from actual cash flows due to, among other things, economic conditions, changes to our business model or changes in operating performance. These factors increase the risk of differences between projected and actual performance that could impact future estimates of fair value of all reporting units. Significant differences between these estimates and actual cash flows could result in additional impairment in future periods.

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Each of our operating segments described in Note 15 – Segment Information is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocation and significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice care centers and personal-care care centers and have also deemed them to be a single reporting unit.

During 2016, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units was considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

Intangible assets consist of Certificates of Need, licenses, acquired names and non-compete agreements. We amortize non-compete agreements and acquired names that we do not intend to use in the future on a straight-line basis over their estimated useful lives, which is generally three years for non-compete agreements and up to five years for acquired names.

Debt Issuance Costs

We amortize deferred debt issuance costs related to our long-term obligations over its term through interest expense, unless the debt is extinguished, in which case unamortized balances are immediately expensed. We amortized $0.7 million, $0.8 million and $0.7 million in deferred debt issuance costs in 2016, 2015 and 2014, respectively. As of December 31, 2016 and 2015, we had unamortized debt issuance costs of $2.7 million and $3.4 million, respectively, recorded as long-term obligations, less current portion in our accompanying consolidated balance sheets. The unamortized debt issuance costs of $2.7 million at December 31, 2016, will be amortized over a weighted-average amortization period of 3.7 years.

Fair Value of Financial Instruments

The following details our financial instruments where the carrying value and the fair value differ (amounts in millions):

		Fair Value at Reporting Date Using		
Financial Instrument	As of December 31, 2016	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term obligations	$ 95.7	$ —	$ 97.8	$ —

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

- Level 1 – Quoted prices in active markets for identical assets and liabilities.

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

Our deferred compensation plan assets are recorded at fair value and are considered a level 2 measurement. For our other financial instruments, including our cash and cash equivalents, patient accounts receivable, accounts payable, payroll and employee benefits and accrued expenses, we estimate the carrying amounts' approximate fair value.

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date. As of December 31, 2016 and 2015 our net deferred tax assets were $107.9 million and $125.2 million, respectively.

Management regularly assesses the ability to realize deferred tax assets recorded in the Company's entities based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

Share-Based Compensation

We record all share-based compensation as expense in the financial statements measured at the fair value of the award. We recognize compensation cost on a straight-line basis over the requisite service period for each separately vesting portion of the award. We reflect the excess tax benefits related to stock option exercises as financing cash flows. Share-based compensation expense for 2016, 2015 and 2014 was $16.4 million, $11.8 million and $5.6 million, respectively, and the total income tax benefit recognized for these expenses was $6.4 million, $4.7 million and $2.0 million, respectively.

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Weighted-Average Shares Outstanding

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

	For the Years Ended December 31,		
	2016	2015	2014
Weighted average number of shares outstanding – basic	33,198	33,018	32,301
Effect of dilutive securities:			
Stock options	162	—	1
Non-vested stock and stock units	381	—	521
Weighted average number of shares outstanding – diluted	33,741	33,018	32,823
Anti-dilutive securities	221	922	106

Advertising Costs

We expense advertising costs as incurred. Advertising expense for 2016, 2015 and 2014 was $7.8 million, $6.9 million and $4.7 million, respectively.

Recently Issued Accounting Pronouncements

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

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

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842),* which will require lessees to recognize a lease liability and right-of-use asset for all leases (with the exception of short-term leases) at the commencement date. The ASU is effective for annual and interim periods beginning on or after December 15, 2018. Early adoption is permitted. The standard requires a modified retrospective transition method which requires application of the new guidance for all periods presented. While the Company expects adoption of this standard to lead to a material increase in the assets and liabilities recorded on our balance sheet, we are still evaluating the overall impact on our consolidated financial statements and related disclosures and the effect of the standard on our ongoing financial reporting.

In March 2016, the FASB issued ASU 2016-09, *Compensation – Stock Compensation (Topic 718): Improvement to Employee Share-Based Payment Accounting*, which will simplify the accounting for share-based payment award transactions, including income tax consequences, classification of awards as either equity or liability, and classification on the statement of cash flows. The ASU is effective for annual and interim periods beginning after December 15, 2016. Early adoption is permitted. The element of the new standard that will have the most impact on our consolidated financial statements will be income tax consequences. Excess tax benefits and tax deficiencies on share-based compensation awards will now be included in our tax provision within our consolidated statement of operations as discrete items in the reporting period in which they occur, rather than our current accounting of recording in additional paid-in capital on our consolidated balance sheets.

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

3. ACQUISITIONS

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

2016 Acquisitions

Personal Care Division

On March 1, 2016, we acquired Associated Home Care which owns and operates 9 personal-care care centers servicing the state of Massachusetts for a total purchase price of $27.7 million, net of cash acquired (subject to

certain adjustments), of which $0.5 million was placed in escrow for indemnification purposes and working capital price adjustments. The purchase price was paid with cash on hand on the date of the transaction. Based on our preliminary purchase price allocation, in connection with the acquisition, we recorded goodwill ($23.5 million) and other assets and liabilities, net ($4.2 million) during the three-month period ended March 31, 2016. During the three-month period ended June 30, 2016, we received the final report from our outside appraisal firm. As a result, we reduced our preliminary goodwill by $5.0 million and recorded corresponding increases in the fair value of assets acquired ($0.2 million), other intangibles – acquired names of business ($3.5 million) and other intangibles – non-compete agreements ($1.3 million). We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 years.

On September 1, 2016, we acquired the assets of Professional Profiles, Inc. which owns and operates 4 personal-care care centers servicing the state of Massachusetts for a total purchase price of $4.4 million, (subject to certain adjustments), of which $0.7 million was placed in a promissory note to be paid over 24 months, subject to any offsets or withholds for indemnification purposes. The purchase price was paid with cash on hand on the date of the transaction. During the three-month period ended September 30, 2016, we recorded goodwill ($4.2 million) and other intangibles – non-compete agreements ($0.2 million) in connection with the acquisition. We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 years.

Home Health Division

On October 20, 2016, we acquired the assets of a former nonprofit organization in New York for a purchase price of $4.6 million. During the three-month period ended December 31, 2016, we recorded goodwill ($4.4 million) and other intangibles – certificate of need ($0.2 million) in connection with the acquisition. We expect the entire amount of goodwill recorded for this acquisition to be deductible for income tax purposes over approximately 15 years.

The following table contains unaudited pro forma condensed consolidated statement of operations information assuming that our 2016 acquisitions closed on January 1, 2015, for the years ended December 31, 2016 and 2015 (amounts in millions, except per share data):

	2016	2015
Net service revenue	$1,449.7	$1,322.2
Operating income (loss)	53.9	(7.8)
Net income	35.0	0.4
Basic earnings (loss) per share	$ 1.04	$ (0.01)
Diluted earnings (loss) per share	$ 1.03	$ (0.01)

The pro forma information presented above includes adjustments for (i) amortization of identifiable intangible assets and (ii) income tax provision using the Company’s statutory tax rate. This pro forma information is presented for illustrative purposes only and may not be indicative of the results of operations that would have actually occurred. In addition, future results may vary significantly from the results reflected in the pro forma information.

2015 Acquisitions

Hospice Division

On July 24, 2015, we acquired one hospice care center in Tennessee for a total purchase price of $5.8 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($5.5 million) and other intangibles ($0.3 million).

Home Health Division

On October 2, 2015, we acquired the assets of a home health care center in Georgia for a total purchase price of $0.3 million. The purchase price was paid with cash on hand on the date of the transaction. In connection with the acquisition, we recorded goodwill ($0.3 million).

On December 31, 2015, we acquired Infinity HomeCare ("Infinity") for a total purchase price of $63 million, net of cash acquired (subject to certain adjustments), of which $3.2 million was placed in escrow for indemnification purposes and working capital price adjustments. The purchase price was paid with cash on hand on the date of the transaction. Infinity owned and operated 15 home health care centers servicing the state of Florida. In connection with the acquisition, we recorded goodwill ($50.2 million), other intangibles ($10.9 million) and other assets and liabilities, net ($1.9 million). Approximately $47.6 million of the $50.2 recorded as goodwill is expected to be deductible for income tax purposes over approximately 15 years.

4. DISCONTINUED OPERATIONS AND ASSETS HELD FOR SALE

As of December 31, 2013, we had three care centers classified as held for sale. During 2014, we sold assets associated with two of these care centers and consolidated one of these care centers with a care center servicing the same market. There were no care centers classified as held for sale as of December 31, 2014.

As we exited certain geographical areas and in accordance with applicable accounting guidance, the care centers which were classified as held for sale as of December 31, 2013 and subsequently sold in 2014 are presented as discontinued operations in our consolidated financial statements. The care center consolidated with a care center servicing the same markets is presented in continuing operations as we expect continuing cash flows from these markets. For additional information on the care centers consolidated with care centers servicing the same markets and the care centers sold, see Note 13 – Exit Activities and Restructuring Activities.

Operating results for the twelve-month period ended December 31, 2014 for those care centers classified as discontinued operations are as follows: loss before income taxes of $0.3 million, income tax benefit of $0.1 million and net loss from discontinued operations of $0.2 million.

5. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

During 2016, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units were considered at risk of impairment as of October 31, 2016. Since the date of our last annual goodwill impairment test, there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our reporting units would be less than its carrying amount.

During the fiscal year 2015, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our various reporting units were considered at risk of impairment.

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During the fiscal year 2014, we recognized a non-cash other intangible impairment charge of $0.9 million during step one of our 2014 annual goodwill impairment test. In addition, we recorded non-cash impairment charges of $2.2 million related to those care centers that were closed or consolidated during 2014 as discussed in Note 13 – Exit and Restructuring Activities.

The following table summarizes the activity related to our goodwill for 2016, 2015 and 2014 (amounts in millions):

	Goodwill			
	Home Health	Hospice	Personal Care	Total
Balances at December 31, 2013	$ 16.6	$192.3	$ —	$208.9
Write-off (1)	(0.1)	(3.2)	—	(3.3)
Balances at December 31, 2014	16.5	189.1	—	205.6
Additions	50.6	5.5	—	56.1
Balances at December 31, 2015	67.1	194.6	—	261.7
Additions	4.4	—	22.7	27.1
Adjustments related to acquisitions	0.1	—	—	0.1
Balances at December 31, 2016	$ 71.6	$194.6	$ 22.7	$288.9

(1) Write-off of goodwill related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.

During 2016, we adjusted goodwill by $0.1 million as a result of our completion of the purchase price accounting for our 2015 acquisition of Infinity.

The following table summarizes the activity related to our other intangible assets, net for 2016, 2015 and 2014 (amounts in millions):

	Other Intangible Assets, Net			
	Certificates of Need and Licenses	Acquired Names of Business	Non-Compete Agreements (2)	Total
Balances at December 31, 2013	$ 25.4	$ 11.1	$ 0.2	$36.7
Write-off (1)	(0.2)	—	—	(0.2)
Impairment	(2.1)	(1.0)	—	(3.1)
Amortization	—	—	(0.2)	(0.2)
Balances at December 31, 2014	23.1	10.1	—	33.2
Additions	1.1	4.1	5.9	11.1
Write-off	(0.3)	—	—	(0.3)
Balances at December 31, 2015	23.9	14.2	5.9	44.0
Additions	0.2	3.5	1.5	5.2
Amortization	—	—	(2.5)	(2.5)
Balances at December 31, 2016	$ 24.1	$ 17.7	$ 4.9	$46.7

(1) Write-off of intangible assets related to the sale of care centers as discussed in Note 13 – Exit and Restructuring Activities.
(2) The weighted average amortization period of our non-compete agreements is 1.9 years.

See Note 3 – Acquisitions for further details on additions to goodwill and other intangible assets, net.

The estimated aggregate amortization expense related to intangible assets for each of the five succeeding years is as follows (amounts in millions):

2017	$ 2.7
2018	2.2
2019	—
2020	—
2021	—
	$ 4.9

6. DETAILS OF CERTAIN BALANCE SHEET ACCOUNTS

Additional information regarding certain balance sheet accounts is presented below (amounts in millions):

	As of December 31, 2016	As of December 31, 2015
Other current assets:		
Payroll tax escrow	$ 6.7	$ 6.2
Income tax receivable	1.3	0.5
Due from joint ventures	1.7	1.8
Other	1.6	6.1
	$ 11.3	$ 14.6
Other assets:		
Workers' compensation deposits	$ 0.4	$ 0.3
Health insurance deposits	0.5	1.2
Other miscellaneous deposits	0.9	1.5
Investments	27.8	25.7
Other	8.9	4.1
	$ 38.5	$ 32.8
Accrued expenses:		
Health insurance	$ 10.6	$ 11.7
Workers' compensation	26.8	23.9
Legal and other settlements	5.7	10.5
Lease liability	0.4	0.6
Charity care	1.4	0.7
Estimated Medicare cap liability	0.8	1.4
Hospice cost of revenue	7.2	6.8
OIG self-disclosure accrual	—	4.7
Patient liability	4.3	5.1
Other	6.1	6.6
	$ 63.3	$ 72.0
Other long-term obligations:		
Reserve for uncertain tax positions	$ 0.3	$ 0.7
Deferred compensation plan liability	1.8	2.8
Other	1.6	0.9
	$ 3.7	$ 4.4

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7. LONG-TERM OBLIGATIONS

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

	As of December 31, 2016	2015
$100.0 million Term Loan; principal payments plus accrued interest payable quarterly; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage (2.77% at December 31, 2016); due August 28, 2020	$ 95.0	$ 100.0
$200.0 million Revolving Credit Facility; interest only quarterly payments; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage; due August 28, 2020	—	—
Promissory notes	0.7	—
Deferred debt issuance costs	(2.7)	(3.4)
	93.0	96.6
Current portion of long-term obligations	(5.2)	(5.0)
Total	$ 87.8	$ 91.6

Maturities of debt as of December 31, 2016 are as follows (amounts in millions):

	Long-term obligations
2017	$ 5.2
2018	10.5
2019	10.0
2020	70.0
2021	—
	$ 95.7

Credit Agreement

On August 28, 2015, we entered into a Credit Agreement that provides for senior secured facilities in an initial aggregate principal amount of up to $300 million (the "Credit Facilities").

The Credit Facilities are comprised of (a) a term loan facility in an initial aggregate principal amount of $100 million (the "Term Loan"); and (b) a revolving credit facility in an initial aggregate principal amount of up to $200 million (the "Revolving Credit Facility"). The Revolving Credit Facility provides for and includes within its $200 million limit a $25 million swingline facility and commitments for up to $50 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Credit Facilities by a maximum amount of $150 million.

The net proceeds of the Term Loan and existing cash on hand were used to pay off (i) our existing term loan under our prior Credit Agreement, dated as of October 22, 2012, as amended (the "Prior Credit Agreement") with a principal balance of $27 million and (ii) our existing term loan under our prior Second Lien Credit Agreement dated July 28, 2014 (the "Second Lien Credit Agreement"), with a principal balance of $70 million. The final maturity of the Term Loan is August 28, 2020. The Term Loan began amortizing on March 31, 2016 and will

continue amortizing over 14 quarterly installments (four remaining quarterly installments of $1.25 million followed by eight quarterly installments of $2.5 million, followed by two quarterly installments of $3.1 million, subject to adjustment for prepayments), with the remaining balance due upon maturity.

The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and our subsidiaries, including permitted acquisitions, as defined in the Credit Agreement. The final maturity of the Revolving Credit Facility is August 28, 2020 and will be payable in full at that time.

The interest rate in connection with the Credit Facilities shall be selected from the following by us: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The "Base Rate" means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate for an interest period of one month plus 1% per annum. The "Eurodollar Rate" means the rate at which Eurodollar deposits in the London interbank market for an interest period of one, two, three or six months (as selected by us) are quoted. The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2016, the Applicable Rate is 1.00% per annum for Base Rate Loans and 2.00% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Facilities, as presented in the table below.

Consolidated Leverage Ratio	Margin for ABR Loans	Margin for Eurodollar Loans	Commitment Fee	Letter of Credit Fee
≥ 2.75 to 1.0	2.00%	3.00%	0.40%	3.00%
< 2.75 to 1.0 but ≥ 1.75 to 1.0	1.50%	2.50%	0.35%	2.50%
< 1.75 to 1.0 but ≥ 0.75 to 1.0	1.00%	2.00%	0.30%	2.00%
< 0.75 to 1.0	0.50%	1.50%	0.25%	1.50%

Our weighted average interest rate for our $100.0 million Term Loan, under our Credit Agreement, was 2.5% for 2016 and 2.7% for the period August 28, 2015 to December 31, 2015. Our weighted average interest rate for our $200.0 million Revolving Credit Facility was 3.5% for 2016.

As of December 31, 2016, our availability under our $200.0 million Revolving Credit Facility was $173.3 million as we had $26.7 million outstanding in letters of credit.

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated fixed charge coverage ratio of EBITDA plus rent expense (less cash taxes less capital expenditures) to scheduled debt repayments plus interest expense plus rent expense, all as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. As of December 31, 2016, our consolidated leverage ratio was 1.0 and our consolidated fixed charge coverage ratio was 3.8 and we are in compliance with the Credit Agreement. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens; incurrence of additional debt; sales of assets and other fundamental corporate changes; investments; and declarations of dividends. These covenants contain customary exclusions and baskets.

The Credit Facilities are guaranteed by substantially all of our wholly-owned direct and indirect subsidiaries. The Credit Agreement requires at all times that we (i) provide guarantees from wholly-owned subsidiaries that in the aggregate represent not less than 95% of our consolidated net revenues and adjusted EBITDA from all

wholly-owned subsidiaries and (ii) provide guarantees from subsidiaries that in the aggregate represent not less than 70% of consolidated adjusted EBITDA, subject to certain exceptions.

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated August 28, 2015 and (ii) a Pledge Agreement with the Administrative Agent dated as of August 28, 2015 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions).

In connection with our entry into the Credit Agreement, on August 28, 2015, each of the Prior Credit Agreement and the Second Lien Credit Agreement were terminated. The Company paid a call premium of $700,000 associated with the termination of the Second Lien Credit Agreement and the voluntary prepayment of the amounts owed thereunder as of August 28, 2015, and expensed $2.5 million in deferred debt issuance costs during the three-month period ended September 30, 2015. Also in connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as other assets in our consolidated balance sheet during 2015 which was reclassified to long-term obligations, less current portion during 2016 in accordance with ASU 2015-03.

Promissory Notes

Our promissory note outstanding of $0.7 million, issued in conjunction with an acquisition, bears an interest rate of 2.6%.

8. INCOME TAXES

Income taxes attributable to continuing operations consist of the following (amounts in millions):

	For the Years Ended December 31,		
	2016	2015	2014
Current income tax expense/(benefit):			
Federal	$ (0.5)	$ 2.2	$ (13.9)
State and local	(0.1)	0.5	(1.1)
	(0.6)	2.7	(15.0)
Deferred income tax expense/(benefit):			
Federal	22.1	(0.5)	21.0
State and local	2.4	(0.1)	1.6
Foreign	—	(0.1)	0.1
	24.5	(0.7)	22.7
Income tax expense/(benefit) from continuing operations	$ 23.9	$ 2.0	$ 7.7

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Total income tax expense for the years ended December 31, 2016, 2015 and 2014 was allocated as follows (amounts in millions):

	For the Years Ended December 31,		
	2016	2015	2014
Income from continuing operations	$ 23.9	$ 2.0	$ 7.7
Income from discontinued operations	—	—	(0.1)
Interest expense	(0.1)	0.2	(0.1)
Goodwill	—	(0.1)	—
Stockholders' equity	(7.2)	(2.1)	0.6
	$ 16.6	$ —	$ 8.1

A reconciliation of significant differences between the reported amount of income tax expense and the expected amount of income tax expense that would result from applying the U.S. federal statutory income tax rate of 35 percent to income before taxes from continuing operations is as follows:

	For the Years Ended December 31,		
	2016	2015 (1)	2014
Income tax expense at U.S. federal statutory rate	35.0 %	35.0 %	35.0 %
State and local income taxes, net of federal income tax benefit	4.8	(7.1)	5.8
Valuation allowance	0.1	79.1	1.5
Tax credits	(0.6)	136.0	(8.4)
Uncertain tax positions	(1.0)	(230.3)	0.6
Other items, net (2)	0.6	(663.3)	2.1
Income tax expense/(benefit)	38.9 %	(650.6)%	36.6 %

(1) The information provided for the year ended December 31, 2015 does not provide a meaningful reconciliation of the effective tax rate or comparable to other periods. The effective tax rate for the year is influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to income or loss before taxes. A significant asset impairment was recorded in the first quarter, resulting in a scenario where the company's loss before tax for the year was near zero. Consequently, for 2015, the relationship between the "effective tax rate drivers" and loss before taxes is distorted.

(2) Includes various items such as, non-deductible expenses, non-taxable income, return-to-accrual adjustments, and foreign tax rate differential.

As of December 31, 2016 and 2015, the Company had income taxes receivable of $1.3 million and $0.5 million, respectively, included in other current assets.

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Deferred tax assets (liabilities) consist of the following components (amounts in millions):

	As of December 31,	
	2016	2015
Deferred tax assets:		
Allowance for doubtful accounts	$ 6.9	$ 6.4
Accrued payroll & employee benefits	11.4	5.1
Workers' compensation	10.9	9.8
Amortization of intangible assets	56.3	72.2
Share-based compensation	7.8	5.0
Net operating loss carryforwards (1)	44.2	48.5
Tax credit carryforwards (2)	4.8	4.7
Other	1.1	4.0
Gross deferred tax assets	143.4	155.7
Less: valuation allowance	(0.4)	(0.3)
Net deferred tax assets	143.0	155.4
Deferred tax (liabilities):		
Property and equipment	(7.8)	(9.5)
Deferred revenue	(23.2)	(18.5)
Investment in partnerships	(3.2)	(0.2)
Other liabilities	(0.9)	(2.0)
Gross deferred tax (liabilities)	(35.1)	(30.2)
Net deferred tax assets (liabilities)	$ 107.9	$ 125.2

(1) The net operating loss ("NOL") carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the NOL carry forwards, as of December 31, 2016 and 2015, are presented net of unrecognized tax benefits of $3.1 million.

(2) The tax credit carry forwards in the income tax returns include unrecognized tax benefits resulting from uncertain tax positions. Accordingly, the deferred tax assets recognized for the tax credit carry forwards are presented net of unrecognized tax benefits of $0.7 million for each of the years ended December 31, 2016 and 2015.

As of December 31, 2016, we have U.S. net operating loss ("NOL") carry forwards of $102.1 million that are available to reduce future taxable income and begin to expire in 2034. In addition, we have research and development tax credits, employment tax credits, and alternative minimum tax credits of $1.9 million, $0.2 million and $1.4 million, respectively, available to reduce future U.S. federal income taxes. The research and development tax credits and employment tax credits begin to expire in 2032, and the alternative minimum tax credits are available indefinitely.

As of December 31, 2016, we have state NOL carry forwards of $268.4 million that are available to reduce future taxable income. In addition, we have $3.1 million of various state tax credits available to reduce future taxable income. The state NOL and tax credit carry forwards begin to expire at various times.

The valuation allowance for deferred tax assets as of December 31, 2016 and 2015 was $0.4 million and $0.3 million, respectively. The net change in the total valuation allowance for the year ended December 31, 2016 and December 31, 2015 was an increase of $0.1 million and a decrease of $0.3 million, respectively. The valuation allowance during 2016 and 2015 was primarily related to certain state NOL and state tax credit carry forwards.

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In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income in those jurisdictions during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities (including the impact of available carry back and carry forward periods), projected future taxable income, and tax-planning strategies in making this assessment. In order to fully realize the deferred tax assets, the Company will need to generate future taxable income before the expiration of the carry forwards governed by the tax code. Based on the current level of pretax earnings, the Company will generate the minimum amount of future taxable income to support the realization of the deferred tax assets. As a result, management believes that it is more likely than not that we will realize the benefits of these deferred tax assets, net of the existing valuation allowances at December 31, 2016. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carry forward period are reduced.

Uncertain Tax Positions

We account for uncertain tax positions in accordance with the authoritative guidance for uncertain tax positions. A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows (amounts in millions):

	For the Years Ended December 31,	
	2016	2015
Balance at beginning of period	$ 4.7	$ 4.0
Additions for tax positions related to current year	—	—
Additions for tax positions related to prior year	—	1.0
Reductions for tax positions related to prior years	—	—
Lapse of statute of limitations	(0.6)	(0.3)
Settlements	—	—
Balance at end of period	$ 4.1	$ 4.7

As of December 31, 2016, there are $0.3 million and $3.8 million of unrecognized tax benefits recorded in accrued other long-term obligations and deferred income taxes, respectively, within the consolidated balance sheet.

Included in the balance of unrecognized tax benefits at December 31, 2016 is $4.1 million of tax benefits that, if recognized in future periods, would impact our effective tax rate.

During the years ended December 31, 2016 and 2015, we recognized interest and penalties of $(0.1) million and $0.2 million, respectively, as components of penalties or interest expense in connection with our reserve for uncertain tax positions. Interest and penalties, related to uncertain tax positions, included in the consolidated balance sheet at December 31, 2016 and 2015 were less than $0.1 and $0.2 million, respectively.

We are subject to income taxes in the U.S. and in many of the 50 individual states, with significant operations in Louisiana, Alabama, Georgia, and Tennessee. We are open to examination in the U.S. and in various individual states for tax years ended December 31, 2013 through December 31, 2016. We are also open to examination in various states for the years ended 2001 – 2016 resulting from net operating losses generated and available for carry forward from those years.

We believe that it is reasonably possible that decreases of up to $0.3 million in unrecognized tax benefits, each of which are individually insignificant, may be recognized by the end of December 31, 2017 as a result of an anticipated settlement and lapse of the statute of limitations.

9. CAPITAL STOCK AND SHARE-BASED COMPENSATION

We are authorized by our Certificate of Incorporation to issue 60,000,000 shares of common stock, $0.001 par value and 5,000,000 shares of preferred stock, $0.001 par value. As of December 31, 2016, there were 35,253,577 and 33,597,215 shares of common stock issued and outstanding, respectively, and no shares of preferred stock issued or outstanding. Our Board of Directors is authorized to fix the dividend rights and terms, conversion and voting rights, redemption rights and other privileges and restrictions applicable to our preferred stock.

Share-Based Awards

Our 2008 Omnibus Incentive Compensation Plan (the "Plan") authorizes the grant of various types of equity-based awards, such as stock awards, restricted stock units, stock appreciation rights and stock options to eligible participants, which include all of our employees and all employees of our 50% or more owned subsidiaries, our non-employee directors and certain consultants. The vesting terms of the awards may be tied to continued employment (or, for our non-employee directors, continued service on the Board of Directors) and/or achievement of certain pre-determined performance goals. We refer to stock awards subject to service-based vesting conditions as "non-vested stock" and restricted stock units subject to service-based and performance-based or market-based vesting conditions as "non-vested stock units." The Plan is administered by the Compensation Committee of our Board of Directors, which determines, within the provisions of the Plan, those eligible employees to whom, and the times at which, awards shall be granted. The Compensation Committee, in its discretion, may delegate its authority and duties under the Plan to specified officers; however, only the Compensation Committee may approve the terms of awards to our executive officers.

Equity-based awards may be granted for a number of shares not to exceed, in the aggregate, approximately 5.5 million shares of common stock, and we had approximately 1.2 million shares available at December 31, 2016. The price per share for stock options shall be of no less than the greater of (a) 100% of the fair value of a share of common stock on the date the option is granted or (b) the aggregate par value of the shares of our common stock on the date the option is granted. If a stock option is granted to any owner of 10% or more of our total combined voting power of us and our subsidiaries, the price is to be at least 110% of the fair value of a share of our common stock on the date the award is granted. Each equity-based award vests ratably over a 12 month to six year period, with the exception of those issued under contractual arrangements that specify otherwise, that may be exercised during a period as determined by our Compensation Committee or as otherwise approved by our Compensation Committee. The contractual terms of stock options exercised shall not exceed ten years from the date such option is granted.

Employee Stock Purchase Plan ("ESPP")

We have a plan whereby our eligible employees may purchase our common stock at 85% of the market price at the time of purchase. On June 7, 2012, our stockholders ratified an amendment adopted by our Board of Directors to increase the total number of shares of our common stock authorized for the issuance under our ESPP

from 2,500,000 shares to 4,500,000 shares, and as of December 31, 2016, there were 1,460,800 shares available for future issuance. The following is a detail of the purchases that were made or pending Board of Director approval under the plan:

Employee Stock Purchase Plan Period	Shares Issued	Price
2014 and Prior	2,899,528	$13.78
January 1, 2015 to March 31, 2015	24,368	22.76
April 1, 2015 to June 30, 2015	15,750	33.77
July 1, 2015 to September 30, 2015	18,984	32.27
October 1, 2015 to December 31, 2015	19,082	33.42
January 1, 2016 to March 31, 2016	13,850	41.09
April 1, 2016 to June 30, 2016	14,236	42.91
July 1, 2016 to September 30, 2016	16,520	40.32
October 1, 2016 to December 31, 2016	16,882	36.24
	3,039,200	

ESPP expense included in general and administrative expense in our accompanying consolidated statements of operations was $0.4 million for each of 2016, 2015 and 2014, respectively.

Stock Options

We use the Black-Scholes option pricing model to estimate the fair value of our stock options. There were 268,538, 590,647 and 250,000 options granted during 2016, 2015 and 2014, respectively. Stock option compensation expense included in general and administrative expense in our accompanying consolidated statements of operations was $6.3 million, $3.8 million and $0.1 million for 2016, 2015 and 2014, respectively.

The fair value of the 2016 awards were estimated using the following assumptions:

Risk Free Rate	1.19% – 1.58%
Expected Volatility	53.44% – 54.89%
Expected Term	5.86 – 6.25 years
Weighted Average Fair Value	$25.99

We used the simplified method to estimate the expected term for the stock options granted during 2016.

The following table presents our stock option activity for 2016:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Contractual Life (Years)
Outstanding options at January 1, 2016	838,494	$ 30.18	9.31
Granted	268,538	37.21	
Exercised	—	—	
Canceled, forfeited or expired	(98,875)	35.45	
Outstanding options at December 31, 2016	1,008,157	$ 31.54	8.42
Exercisable options at December 31, 2016	281,458	$ 28.86	8.21

The aggregate intrinsic value of our outstanding options and exercisable options at December 31, 2016 was $11.9 million and $3.9 million, respectively. There were no options exercised during 2016. Total intrinsic value of options exercised was $0.2 million and $0.1 million for 2015 and 2014, respectively.

The following table presents our non-vested stock option award activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock options at January 1, 2016	775,994	$ 30.47
Granted	268,538	37.21
Vested	(219,872)	29.55
Forfeited	(97,961)	35.38
Non-vested stock options at December 31, 2016	726,699	$ 32.58

At December 31, 2016, there was $7.2 million of unrecognized compensation cost related to stock options that we expect to be recognized over a weighted-average period of 2.1 years.

Non-Vested Stock

We issue shares of non-vested stock with vesting terms ranging from one to six years. The compensation expense is determined based on the market price of our common stock at the date of grant applied to the total number of shares that are anticipated to fully vest. Non-vested stock compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $2.3 million, $5.0 million and $4.6 million for 2016, 2015 and 2014, respectively.

The following table presents our non-vested stock award activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock at January 1, 2016	500,888	$ 18.24
Granted	21,202	50.55
Vested	(222,783)	18.00
Canceled, forfeited or expired	(89,929)	17.26
Non-vested stock at December 31, 2016	209,378	$ 22.20

The weighted average grant date fair value of non-vested stock granted was $50.55, $28.48 and $16.38 in 2016, 2015, and 2014, respectively.

At December 31, 2016, there was $1.4 million of unrecognized compensation cost related to non-vested stock award payments that we expect to be recognized over a weighted average period of 0.9 years.

Non-Vested Stock Units

We issue non-vested stock unit awards that are service-based, performance-based or a combination of both with vesting terms ranging from one to six years. Based on the terms and conditions of these awards, we determine if

the awards should be recorded as either equity or liability instruments. The compensation expense is determined based on the market price of our common stock at the date of grant, applied to the total number of units that are anticipated to vest, unless the award specifies differently. We account for such awards similar to our non-vested stock awards; however, no shares of stock are issued to the recipient until the stock unit awards have vested and after the pre-determined delivery date has occurred.

Non-Vested Stock Units – Service-Based

Service-based non-vested stock unit compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $3.6 million and $1.0 million for 2016 and 2015, respectively.

The following table presents our service-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	183,332	$ 37.89
Granted	147,896	45.60
Vested	(32,607)	38.81
Canceled, forfeited or expired	(49,192)	39.38
Non-vested stock units at December 31, 2016	249,429	$ 42.05

The weighted average grant date fair value of service-based non-vested stock units granted was $45.60 and $37.98 in 2016 and 2015, respectively.

At December 31, 2016, there was $6.7 million of unrecognized compensation cost related to our service-based non-vested stock units that we expect to be recognized over a weighted average period of 2.2 years.

Non-Vested Stock Units – Service-Based and Performance-Based Awards

During 2016, we awarded performance-based awards to certain employees. The target level established by the award, which is based on the Company's 2016 adjusted earnings before interest, taxes and depreciation ("EBITDA"), provided for the recipients to receive 182,796 non-vested stock units if the target was achieved. The target number of shares to be potentially awarded has been reduced by forfeitures as indicated in the table below. Performance-based non-vested stock units compensation expense included in general and administrative expenses in our consolidated statements of operations was $3.7 million and $1.3 million for 2016 and 2015, respectively.

The following table presents our performance-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	151,063	$ 39.44
Granted	182,796	46.29
Vested	(44,729)	34.83
Canceled, forfeited or expired	(64,273)	42.41
Non-vested stock units at December 31, 2016	224,857	$ 45.08

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The weighted average grant date fair value of performance-based non-vested stock units granted was $46.29 and $39.54 in 2016 and 2015, respectively.

At December 31, 2016, there were $6.4 million in unrecognized compensation costs related to our performance-based non-vested stock units that we expect to be recognized over a weighted average period of 2.0 years.

Non-Vested Stock Units – Service-Based and Market-Based Awards

During 2013, we awarded market-based awards to certain employees. The target level established by the award, which was based on our average December 2015 stock price, provided for the recipients to receive 417,330 non-vested stock units if the target is achieved. If the target objective was surpassed to the point of achieving the projected maximum payout, the recipients would receive 667,728 non-vested stock units. The target number of shares to be potentially awarded was reduced by forfeitures as indicated in the table below. As of March 3, 2016, it was determined that the market-based objective established by the award was satisfied at maximum payout and as a result, 248,654 stock units were awarded to the recipients on April 1, 2016.

For market-based awards, the effect of the market condition is reflected in the fair value of the awards at the date of grant using a Monte-Carlo simulation model. A Monte-Carlo simulation model estimates the fair value of the market-based award based upon the expected term, risk-free interest rate and expected volatility. Compensation expense for market-based awards is recognized over the vesting period regardless of whether the market conditions are expected to be achieved. Market-based non-vested stock units compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $0.1 million, $0.3 million and $0.5 million for 2016, 2015 and 2014, respectively. The fair value of the 2013 award was estimated using the following assumptions:

Forward Interest Rate	0.327 % – 1.460%
Expected Volatility	54.38%
Requisite Service Period	3 years
Fair Value	$10.51

The following table presents our market-based non-vested stock units activity for 2016:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2016	164,534	$ 10.51
Granted (1)	93,257	10.51
Vested	(248,654)	10.51
Canceled, forfeited or expired	(9,137)	10.51
Non-vested stock units at December 31, 2016	—	$ —

(1) Represents shares awarded upon achievement of maximum payout.

The weighted average grant date fair value of market-based non-vested stock units granted was $10.51 in 2013. All of our outstanding market-based non-vested stock units were fully vested as of April 1, 2016.

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December 31, 2016

10. COMMITMENTS AND CONTINGENCIES

Legal Proceedings – Ongoing

We are involved in the following legal actions:

Securities Class Action Lawsuits

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

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

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

On May 3, 2013, the Co-Lead Plaintiffs appealed the dismissal of the Securities Complaint to the United States Court of Appeals for the Fifth Circuit (the "Fifth Circuit"). On October 2, 2014, a three-judge panel of the Fifth Circuit issued a decision reversing the District Court's dismissal of the Securities Complaint. On October 16, 2014, all defendants filed a petition with the Fifth Circuit to review the three-judge panel's decision *en banc*, or as a whole court. On December 29, 2014, the Fifth Circuit denied the defendants' motion for *en banc* review of the Fifth Circuit panel's decision reversing the District Court's dismissal of the Securities Complaint. The case then returned to the District Court for further proceedings. On March 30, 2015, the defendants filed a Petition for Writ of Certiorari (the "Petition") with the United States Supreme Court asking the Supreme Court to consider whether the Fifth Circuit erred in reversing the District Court's dismissal of the Securities Complaint. The Supreme Court denied the Petition on June 29, 2015, which did not affect the ongoing proceedings before the District Court, including the District Court's consideration of a motion filed on April 3, 2015, by the Co-Lead Plaintiffs for leave to amend the Securities Complaint, which motion was granted by the District Court. On December 15, 2015, the defendants filed a motion to dismiss the Co-Lead Plaintiffs' First Amended Consolidated Complaint. All discovery in the case is currently stayed pursuant to federal law. The parties agreed to explore the possibility of a mediated settlement of this matter, and a mediation was held on June 21, 2016. The parties were unable to resolve this matter during the mediation. On August 19, 2016, the District Court denied the defendants motion to dismiss the Co-Lead Plantiffs' First Amended Consolidated Complaint. The Defendants filed an Answer to the Complaint on October 20, 2016. The case is currently in discovery.

We are unable to assess the probable outcome or reasonably estimate the potential liability, if any, arising from the securities litigation described above. The Company intends to continue to vigorously defend itself in the securities litigation matter but, if decided adverse to the Company, its impact could be material. No assurances

can be given as to the timing or outcome of the securities matter described above or the impact of any of the inquiry or litigation matters on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

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

On May 21, 2015, we received a Subpoena Duces Tecum ("Subpoena") issued by the U.S. Department of Justice. The Subpoena requests the delivery of information regarding 53 identified hospice patients to the United States Attorney's Office for the District of Massachusetts. It also requests the delivery of documents relating to our hospice clinical and business operations and related compliance activities. The Subpoena generally covers the period from January 1, 2011, through the present. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

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

On November 3, 2015, we received a civil investigative demand ("CID") issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Morgantown, West Virginia area. The CID requests the delivery of information to the United States Attorney's Office for the Northern District of West Virginia regarding 66 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Morgantown area. The CID generally covers the period from January 1, 2009 through August 31, 2015. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

On June 27, 2016, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Parkersburg, West Virginia area. The CID requests the delivery of information to the United States Attorney's Office for the Southern District of West Virginia regarding 68 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Parkersburg area. The CID generally covers the period from January 1, 2011 through June 20, 2016. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

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

Legal Proceedings – Settled

Wage and Hour Litigation

On July 25, 2012, a putative collective and class action complaint was filed in the United States District Court for the District of Connecticut against us in which three former employees allege wage and hour law violations. The

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

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

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

On September 13, 2012, a putative collective and class action complaint was filed in the United States District Court for the Northern District of Illinois against us in which a former employee alleges wage and hour law violations. The former employee claims she was paid on both a per-visit and an hourly basis, and that such a pay scheme resulted in her misclassification as an exempt employee, thereby denying her overtime. The plaintiff alleges violations of federal and state law and seeks damages under the FLSA and the Illinois Minimum Wage Law. Plaintiff seeks class certification of similar employees who were or are employed in Illinois and seeks attorneys' fees, back wages and liquidated damages going back three years under the FLSA and three years under the Illinois statute. On May 28, 2013, the Court granted the Company's motion to stay the case pending resolution of class certification issues and dispositive motions in the earlier-filed Connecticut case. On December 23, 2015, the parties agreed to explore the possibility of a mediated settlement of the Illinois case, and a mediation occurred on April 18, 2016. The parties agreed to settle the case for $0.8 million, subject to court approval, which the Company had accrued as of September 30, 2016. On August 4, 2016, the Court approved the final settlement of this case. The final payment of $0.6 million was paid on November 21, 2016.

Frontier Litigation

On April 2, 2015, Frontier Home Health and Hospice, L.L.C. ("Frontier") filed a complaint against the Company in the United States District Court for the District of Connecticut alleging breach of contract, negligent misrepresentation and unfair and deceptive trade practices under Conn. Gen. Stat. §42-110b. Frontier acquired our interest in five home health and four hospice care centers in Wyoming and Idaho in April 2014. The complaint alleges that certain of the hospice patients on service at the time of the acquisition did not meet Medicare eligibility requirements and that we breached certain of the representations and warranties under the purchase agreement and therefore, the businesses were worth less than the purchase price. Under the complaint, Frontier seeks declaratory judgment from the District Court that, under the terms of the purchase agreement with Frontier, we are obligated to determine the amount of the alleged Medicare overpayments and reimburse the government for the same in a timely manner, as well as unspecified compensatory and punitive damages, attorneys' fees and pre- and post-judgment interest. The Company resolved the Frontier litigation for $2.9 million during the three-month period ended December 31, 2016.

Other Investigative Matters – Ongoing

Corporate Integrity Agreement

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

Computer Inventory and Data Security Reporting

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

Frontier Litigation

Separate from the Frontier litigation described above under "Legal Proceedings – Settled", the Company engaged an independent auditing firm to perform a clinical audit of the hospice care centers acquired by Frontier. No assurances can be given as to the timing or outcome of the audit on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

Other Investigative Matters – Settled

Corporate Integrity Agreement

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

Third Party Audits – Ongoing

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

In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a Zone Program Integrity Contractor ("ZPIC") a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the "Review Period") to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC's findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the MAC for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment. We dispute these findings, and our Florence subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturned. An ALJ hearing was held in early January 2015. On January 18, 2016 we received a letter dated January 6, 2016 referencing the ALJ hearing decision for the overpayment issued on June 6, 2011. The decision was partially favorable with a new overpayment amount of $3.7 million with a balance owed of $5.6 million

including interest based on 9 disputed claims (originally 16). We filed an appeal to the Medicare Appeals Council on the remaining 9 disputed claims and also argued that the statistical method used to select the sample was not valid. No assurances can be given as to the timing or outcome of the Medicare Appeals Council decision. As of June 30, 2016, Medicare has withheld payments of $5.7 million (including additional interest) as part of their standard procedures once this level of the appeal process has been reached. In the event we are not able to recoup this alleged overpayment, we are indemnified by the prior owners of the hospice operations for amounts relating to the period prior to August 1, 2009. As of December 31, 2016, we have an indemnity receivable for the amount withheld related to the period prior to August 1, 2009.

In July 2016, the Company received a request for medical records from SafeGuard Services, L.L.C. ("SafeGuard"), a ZPIC, related to services provided by some of the care centers that the Company acquired from Infinity Home Care, L.L.C. The review period covers time periods both before and after our ownership of the care centers, which were acquired on December 31, 2015. Subsequent to the initial ZPIC letter, on September 16, 2016, the Company received a letter from SafeGuard notifying the Company that the Winterhaven, Bradenton, and Tampa care centers were on a prepayment review. On October 28, 2016, the company received a "Notice of Suspension of Medicare Payments" for up to 180 days for these three care centers. On January 10, 2017, the Company received a letter from SafeGuard notifying the Company that the Clearwater care center was on a prepayment review. Subsequently, on February 2, 2017, the Company received a "Notice of Suspension of Medicare Payments" for up to 180 days for the Clearwater care center. Based on the information currently available to the Company, the Company cannot predict the timing or outcome of this audit or reasonably estimate the amount or range of potential losses, which may arise from this matter.

Third Party Audits – Settled

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

Operating Leases

We have leased office space at various locations under non-cancelable agreements that expire between 2017 and 2026, and require various minimum annual rentals. Our typical operating leases are for lease terms of one to seven

years and may include, in addition to base rental amounts, certain landlord pass-through costs for our pro-rata share of the lessor's real estate taxes, utilities and common area maintenance costs. Some of our operating leases contain escalation clauses, in which annual minimum base rentals increase over the term of the lease.

Total minimum rental commitments as of December 31, 2016 are as follows (amounts in millions):

2017	$23.5
2018	17.5
2019	13.0
2020	9.1
2021	4.3
Future years	4.6
Total	$72.0

Rent expense for non-cancelable operating leases was $27.5 million, $23.7 million and $26.5 million for 2016, 2015 and 2014.

Insurance

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

The following table presents details of our insurance programs, including amounts accrued for the periods indicated (amounts in millions) in accrued expenses in our accompanying balance sheets. The amounts accrued below represent our total estimated liability for individual claims that are less than our noted insurance coverage amounts, which can include outstanding claims and claims incurred but not reported.

	As of December 31,	
Type of Insurance	2016	2015
Health insurance	$ 10.6	$ 11.7
Workers' compensation	26.8	23.9
Professional liability	4.7	4.1
	42.1	39.7
Less: long-term portion	(0.8)	(0.9)
	$ 41.3	$ 38.8

The retention limit per claim for our health insurance, worker's compensation and professional liability is $0.9 million, $0.5 million and $0.3 million, respectively.

Employment Contracts

We have commitments related to employment contracts with a number of our senior executives. These contracts generally commit us to pay severance benefits under certain circumstances.

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Other

We are subject to various other types of claims and disputes arising in the ordinary course of our business. While the resolution of such issues is not presently determinable, we believe that the ultimate resolution of such matters will not have a significant effect on our consolidated financial condition, results of operations and cash flows.

11. EMPLOYEE BENEFIT PLANS

401(K) Benefit Plan

We maintain a plan qualified under Section 401(k) of the Internal Revenue Code for all employees who have reached 21 years of age, effective the first month after hire date. Under the plan, eligible employees may elect to defer a portion of their compensation, subject to Internal Revenue Service limits.

During 2016, 2015 and 2014, our match of contributions to be made to each eligible employee contribution was $0.375 for every $1.00 of contribution made up to the first 6% of their salary. Effective January 1, 2017, our match of contributions to be made to each eligible employee contribution is $0.44 for every $1.00 of contribution made up to the first 6% of their salary. The match is discretionary and thus is subject to change at the discretion of management. These contributions are made in the form of our common stock, valued based upon the fair value of the stock as of the end of each calendar quarter end. We expensed approximately $6.9 million, $6.1 million and $6.2 million for 2016, 2015 and 2014, respectively.

Deferred Compensation Plan

We had a Deferred Compensation Plan for additional tax-deferred savings to a select group of management or highly compensated employees. Amounts credited under the Deferred Compensation Plan were funded into a rabbi trust, which is managed by a trustee. The trustee has the discretion to manage the assets of the Deferred Compensation Plan as deemed fit, thus the assets are not necessarily reflective of the same investment choices made by the participants.

Effective January 1, 2015, all prospective salary deferrals ceased. Participants will be allowed to make transactions with any remaining account balances as they wish per plan guidelines.

12. STOCK REPURCHASE PROGRAM

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

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

Pursuant to this program, we repurchased 324,141 shares of our common stock at a weighted average price of $37.96 per share and a total cost of approximately $12.3 million during 2016 and 116,859 shares of our common stock at a weighted average price of $39.20 per share and a total cost of approximately $4.6 million. The repurchased shares are classified as treasury shares. The stock repurchase program expired on September 6, 2016.

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13. EXIT AND RESTRUCTURING ACTIVITIES

As of December 31, 2013, we reported three home health care centers as held for sale. During 2014, we sold assets associated with two of these care centers for cash consideration of approximately $0.8 million and recognized a gain of approximately $0.8 million which is included in discontinued operations. The remaining care center classified as held for sale was consolidated with a care center servicing the same market during 2014.

During 2014, the Company sold its interest in five home health and four hospice care centers in Wyoming and Idaho for approximately $5.0 million and recognized a gain of $2.1 million. We also exited our hospice inpatient unit in New Hampshire and recognized a loss of $0.5 million.

In addition to the exit activity related to the care centers mentioned above, we consolidated 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and closed 22 home health care centers and four hospice care centers during 2014. In connection with these care centers, we recorded non-cash charges of $2.2 million in other intangibles impairment expense related to the write-off of intangible assets, $2.1 million in other general and administrative expenses related to lease termination costs and $2.1 million in salaries and benefits related to severance costs. These care centers were not concentrated in certain selected geographical areas and did not meet the criteria to be classified as discontinued operations in accordance with applicable accounting guidance.

Restructuring Activity

During 2014, we restructured our regional leadership and corporate support functions. As such, we recorded charges of $3.4 million in salaries and benefits related to severance costs. In addition, during 2014, William F. Borne stepped down from his positions as Chief Executive Officer, Chairman and a member of our Board of Directors and we recorded charges of $2.3 million in salaries and benefits related to severance costs.

Our reserve activity for our 2014 exit and restructuring activity is as follows (amounts in millions):

	2014 Exit Activity	
	Lease Termination	Severance
Balances at December 31, 2013	$ —	$ —
Charge in 2014	2.1	7.8
Cash expenditures in 2014	(1.6)	(5.5)
Balances at December 31, 2014	**0.5**	**2.3**
Charge in 2015	—	—
Cash expenditures in 2015	(0.4)	(1.9)
Balances at December 31, 2015	**0.1**	**0.4**
Charge in 2016	—	—
Cash expenditures in 2016	(0.1)	(0.4)
Balances at December 31, 2016	$ —	$ —

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016—(Continued)

14. VALUATION AND QUALIFYING ACCOUNTS

The following table summarizes the activity and ending balances in our allowance for doubtful accounts and estimated revenue adjustments (amounts in millions):

Allowance for Doubtful Accounts

Year End	Balance at Beginning of Year	Provision for Doubtful Accounts (1)	Write-Offs	Balance at End of Year
2016	$ 16.5	$ 19.5	$ (18.3)	$ 17.7
2015	14.3	14.1	(11.9)	16.5
2014	14.2	16.4	(16.3)	14.3

(1) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

Estimated Revenue Adjustments

Year End	Balance at Beginning of Year	Provision for Estimated Revenue Adjustments (1)	Write-Offs	Balance at End of Year
2016	$ 4.0	$ 7.9	$ (7.8)	$ 4.1
2015	3.1	6.1	(5.2)	4.0
2014	3.9	5.1	(5.9)	3.1

(1) Includes $0.1 million from discontinued operations for the year ended December 31, 2014.

15. SEGMENT INFORMATION

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from surgery, have a chronic disability or terminal illness or need assistance with the essential activities of daily living. Our hospice segment provides palliative care and comfort to terminally ill patients and their families. Our personal care segment, which was established with the acquisition of Associated Home Care during the three-month period ended March 31, 2016, provides patients with assistance with the essential activities of daily living. The “other” column in the following tables consists of costs relating to executive management and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration.

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016—(Continued)

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

	For the Year Ended December 31, 2016				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$ 1,085.5	$316.0	$ 35.9	$ —	$1,437.4
Cost of service, excluding depreciation and amortization	643.7	163.1	26.3	—	833.1
General and administrative expenses	283.4	70.2	7.9	141.9	503.4
Provision for doubtful accounts	13.8	5.5	0.2	—	19.5
Depreciation and amortization	6.0	1.3	—	12.4	19.7
Asset impairment charge	—	—	—	4.4	4.4
Operating expenses	946.9	240.1	34.4	158.7	1,380.1
Operating income (loss)	$ 138.6	$ 75.9	$ 1.5	$(158.7)	$ 57.3

	For the Year Ended December 31, 2015				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$ 1,005.1	$275.4	$ —	$ —	$1,280.5
Cost of service, excluding depreciation and amortization	584.2	141.7	—	—	725.9
General and administrative expenses	263.2	62.7	—	126.5	452.4
Provision for doubtful accounts	12.2	1.9	—	—	14.1
Depreciation and amortization	5.2	1.4	—	13.4	20.0
Asset impairment charge	—	—	—	77.3	77.3
Operating expenses	864.8	207.7	—	217.2	1,289.7
Operating income (loss)	$ 140.3	$ 67.7	$ —	$(217.2)	$ (9.2)

	For the Year Ended December 31, 2014				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$ 956.9	$247.6	$ —	$ —	$1,204.5
Cost of service, excluding depreciation and amortization	559.4	131.7	—	—	691.1
General and administrative expenses	269.0	58.3	—	114.4	441.7
Provision for doubtful accounts	14.8	1.5	—	—	16.3
Depreciation and amortization	9.0	2.1	—	17.2	28.3
Asset impairment charge	1.6	1.5	—	—	3.1
Operating expenses	853.8	195.1	—	131.6	1,180.5
Operating income (loss)	$ 103.1	$ 52.5	$ —	$(131.6)	$ 24.0

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016—(Continued)

16. UNAUDITED SUMMARIZED QUARTERLY FINANCIAL INFORMATION

	Revenue	Net Income (Loss) Attributable to Amedisys, Inc.	Net Income (Loss) Attributable to Amedisys, Inc. Common Stockholders (1) Basic	Net Income (Loss) Attributable to Amedisys, Inc. Common Stockholders (1) Diluted
2016:				
1st Quarter (2)(3)(4)	$ 348.8	$ 6.2	$ 0.19	$ 0.19
2nd Quarter (2)(3)(4)	360.7	10.7	0.32	0.32
3rd Quarter (2)(3)(4)	361.6	11.4	0.34	0.34
4th Quarter (2)(3)(4)(5)	366.3	8.9	0.27	0.26
	$1,437.4	$ 37.3	$ 1.12	$ 1.10
2015:				
1st Quarter (6)(7)	$ 301.6	$ (35.0)	$(1.07)	$ (1.07)
2nd Quarter (7)	314.1	10.6	0.32	0.32
3rd Quarter (6)(7)(9)	326.4	8.4	0.25	0.25
4th Quarter (7)(8)(9)	338.4	12.9	0.39	0.38
	$1,280.5	$ 3.0	$(0.09)	$ (0.09)

(1) Because of the method used in calculating per share data, the quarterly per share data may not necessarily total to the per share data as computed for the entire year.

(2) During each of the four quarters of 2016, we incurred certain costs associated with the implementation of Homecare Homebase. Net of income taxes, these costs amounted to $1.5 million, $1.6 million, $1.2 million and $0.8 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(3) During each of the four quarters of 2016, we incurred certain costs associated with various legal matters. Net of income taxes, these costs amounted to $0.9 million, $0.3 million, $0.2 million and $1.8 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(4) During each of the four quarters of 2016, we incurred certain costs associated with various acquisition costs. Net of income taxes, these costs amounted to $1.0 million, $0.2 million, $0.3 million and $0.5 million for the three-month periods ended March 31, 2016, June 30, 2016, September 30, 2016 and December 31, 2016, respectively.

(5) During the fourth quarter of 2016, we recorded a non-cash asset impairment charge to write-off assets as a result of our conversion from our proprietary operating system to Homecare Homebase in the amount of $2.7 million, net of income taxes.

(6) During the first quarter of 2015, we recorded a non-cash asset impairment charge to write-off the software costs incurred related to the development of AMS3 Home Health and Hospice in the amount of $45.5 million, net of income taxes. During the third quarter of 2015, we recorded a non-cash asset impairment charge related to our corporate headquarters in the amount of $1.2 million, net of income taxes.

(7) During each of the four quarters of 2015, we incurred certain costs associated with various legal matters. Net of income taxes, these costs amounted to $1.3 million, $4.8 million, $0.2 million and $(1.1) million for the three-month periods ended March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015, respectively.

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
December 31, 2016—(Continued)

(8) During the fourth quarter of 2015, we recorded an accrual related to an OIG Self-Disclosure matter. Net of income taxes, this charge amounted to $3.4 million.

(9) During the third and fourth quarters of 2015, we incurred certain costs associated with the implementation of Homecare Homebase. Net of income taxes, these costs amounted to $1.2 million and $1.4 million for the three-month periods ended September 30, 2015 and December 31, 2015, respectively.

17. RELATED PARTY TRANSACTIONS

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

Effective October 22, 2015, we entered into a contract for telemonitoring services with Care Innovations, LLC ("Care Innovations"). Paul Kusserow, our President and Chief Executive Officer, is a member of the Advisory Board to Care Innovations. Care Innovations will receive an annual fee of approximately $1.8 million in connection with our contract for telemonitoring services for the Company. Care Innovations has confirmed to us that Mr. Kusserow will not receive any direct compensation or direct financial benefit from the engagement of Care Innovations as our telemonitoring partner. During 2016 we incurred costs of approximately $1.5 million related to this related party engagement.

18. SUBSEQUENT EVENTS

On February 1, 2017, we acquired Home Staff, LLC, a personal care provider with three care centers for a purchase price of $4.0 million.

Unaudited – On February 28, 2017, we signed a definitive agreement to acquire Tenet Healthcare's home health and hospice operations in Arizona, Illinois, Massachusetts and Texas. We do not believe that the closing of this acquisition will have a material impact on our 2017 results of operations.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

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

In connection with the preparation of this Annual Report on Form 10-K, as of December 31, 2016, under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15d-15(e) promulgated under the Exchange Act.

Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures were effective at a reasonable assurance level as of December 31, 2016, the end of the period covered by this Annual Report on Form 10-K.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Exchange Act. Under the supervision and with the participation of our management, including our principal executive officer and our principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control – Integrated Framework*, our management concluded our internal control over financial reporting was effective as of December 31, 2016.

Our internal control system is designed to provide reasonable assurance to our management and Board of Directors regarding the preparation and fair presentation of published financial statements. All internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and presentation.

In conducting this evaluation, management did not include an assessment of internal control over financial reporting of Associated Home Care acquired on March 1, 2016 and Professional Profiles, Inc. acquired on September 1, 2016, which are included in the consolidated financial statements of the Company for the year ended December 31, 2016. Associated Home Care and Professional Profiles accounted for approximately 1% of total assets and 2% of revenue as of and for the year ended December 31, 2016. As a result of its evaluation, management has concluded that the Company's internal control over financial reporting was effective as of December 31, 2016 based on those criteria.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Controls

During 2015, we began the implementation of Homecare Homebase ("HCHB") with all care centers operating on HCHB as of December 31, 2016. The Company has included the changes to processes, information technology systems and other components of internal controls over financial reporting as part of its ongoing implementation activities as part of its review of internal controls over financial reporting.

There have been no other changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that have occurred during the quarter ended December 31, 2016 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our principal executive officer and principal financial officer, does not expect that our disclosure controls or our internal controls over financial reporting will prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of controls' effectiveness to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies and procedures. Our disclosure controls and procedures are designed to provide reasonable assurance of achieving their objectives and, based on an evaluation of our controls and procedures, our principal executive officer and our principal financial officer concluded our disclosure controls and procedures were effective at a reasonable assurance level as of December 2016, the end of the period covered by this Annual Report.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Amedisys, Inc.:

We have audited Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)*, issued by the Committee of Sponsoring Organizations of the Treadway Commission. Amedisys, Inc.'s management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying *Management's Annual Report on Internal Control over Financial Reporting* under Item 9A. Our responsibility is to express an opinion on Amedisys, Inc.'s internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of consolidated financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the consolidated financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, Amedisys, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2016, based on criteria established in *Internal Control – Integrated Framework (2013)*, issued by the Committee of Sponsoring Organizations of the Treadway Commission.

Amedisys, Inc. acquired Associated Home Care on March 1, 2016 and the assets of Professional Profiles, Inc. on September 1, 2016, and management excluded from its assessment of the effectiveness of Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, Associated Home Care and Professional Profiles, Inc.'s internal control over financial reporting associated with approximately 1% of total assets and 2% of revenue included in the consolidated financial statements of Amedisys, Inc. as of and for the year ended December 31, 2016. Our audit of internal control over financial reporting of Amedisys, Inc. also excluded an evaluation of the internal control over financial reporting of Associated Home Care and Professional Profiles, Inc.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Amedisys, Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2016, and our report dated March 1, 2017, expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 1, 2017

ITEM 9B. OTHER INFORMATION

None.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees, including our principal executive officer, principal financial officer and principal accounting officer. This code of ethics, which is entitled Code of Ethical Business Conduct, is posted at our internet website, http://www.amedisys.com. Any amendments to, or waivers of, the code of ethics will be disclosed on our website promptly following the date of such amendment or waiver.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

ITEM 14. PRINCIPAL ACCOUNTING FEES AND SERVICES

The information required by this item is incorporated by reference to the 2017 Proxy Statement to be filed with the SEC within 120 days after the end of the year ended December 31, 2016.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a) 1. Financial Statements

All financial statements are set forth under Part II, Item 8 of this report.

2. Financial Statement Schedules

There are no financial statement schedules included in this report as they are either not applicable or included in the financial statements.

3. Exhibits

The Exhibits are listed in the Exhibit Index required by Item 601 of Regulation S-K immediate following the signature pages of this report, which is incorporated by reference.

ITEM 16. FORM 10-K SUMMARY

None.

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SIGNATURES

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

AMEDISYS, INC.

By: /S/ PAUL B. KUSSEROW
Paul B. Kusserow,
President, Chief Executive Officer and
Member of the Board

Date: March 1, 2017

Pursuant to the requirements of the Securities Exchange Act of 1934, as amended, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the date indicated:

Signature	Title	Date
/S/ PAUL B. KUSSEROW **Paul B. Kusserow**	President, Chief Executive Officer and Member of the Board (Principal Executive Officer)	March 1, 2017
/S/ GARY D. WILLIS **Gary D. Willis**	Chief Financial Officer (Principal Financial Officer)	March 1, 2017
/S/ SCOTT G. GINN **Scott G. Ginn**	Chief Accounting Officer (Principal Accounting Officer)	March 1, 2017
/S/ LINDA J. HALL **Linda J. Hall**	Director	March 1, 2017
/S/ JULIE D. KLAPSTEIN **Julie D. Klapstein**	Director	March 1, 2017
/S/ RICHARD A. LECHLEITER **Richard A. Lechleiter**	Director	March 1, 2017
/S/ JAKE L. NETTERVILLE **Jake L. Netterville**	Director	March 1, 2017
/S/ BRUCE D. PERKINS **Bruce D. Perkins**	Director	March 1, 2017
/S/ JEFFREY A. RIDEOUT **Jeffrey A. Rideout**	Director	March 1, 2017
/S/ DONALD A. WASHBURN **Donald A. Washburn**	Non-Executive Chairman of the Board	March 1, 2017
/S/ NATHANIEL M. ZILKHA **Nathaniel M. Zilkha**	Director	March 1, 2017

EXHIBIT INDEX

The exhibits marked with the cross symbol (†) are filed and the exhibits marked with a double cross (††) are furnished with this Form 10-K. Any exhibits marked with the asterisk symbol (*) are management contracts or compensatory plans or arrangements filed pursuant to Item 601(b)(10)(iii) of Regulation S-K. The registrant agrees to furnish to the Commission supplementally upon request a copy of any schedules or exhibits omitted pursuant to Item 601(b)(2) of Regulation S-K of any material plan of acquisition, disposition or reorganization set forth below.

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
2.1	Equity Purchase Agreement dated February 5, 2016, by and between the Company, as Purchaser, and Michael Trigilro, as Seller	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016	0-24260	2.1
3.1	Composite of Certificate of Incorporation of the Company inclusive of all amendments through June 14, 2007	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007	0-24260	3.1
3.2	Composite of By-Laws of the Company inclusive of all amendments through April 20, 2016	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016	0-24260	3.2
4.1	Common Stock Specimen	The Company's Registration Statement on Form S-3 filed August 20, 2007	333-145582	4.8
10.1	Form of Director Indemnification Agreement dated February 12, 2009	The Company's Annual Report on Form 10-K for the year ended December 31, 2008	0-24260	10.1
10.2*	Amended and Restated Amedisys, Inc. Employee Stock Purchase Plan dated June 7, 2012	The Company's Current Report on Form 8-K filed June 8, 2012	0-24260	10.1
†10.3*	Composite Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan (inclusive of Plan amendments dated June 7, 2012 and October 25, 2012, April 23, 2015 and June 4, 2015, January 20, 2017 and February 22, 2017 and the full text of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan)			
10.4*	Form of Nonvested Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.3

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.5*	Form of Restricted Stock Unit Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2008	0-24260	10.4
10.6*	Form of Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.6
10.7*	Form of Performance Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.7
10.8	Form of Restricted Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.8
10.9*	Form of Restricted Performance Stock Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.9
10.10*	Composite Amedisys, Inc. 1998 Stock Option Plan (inclusive of amendments dated June 10, 2004, June 8, 2006 and June 22, 2006 and the full text of the Amedisys, Inc. 1998 Stock Option Plan)	The Company's Registration Statement on Form S-8 filed June 22, 2007	333-143967	4.2
10.11*	Composite Director's Stock Option Plan (inclusive of Plan amendments dated June 10, 2004, and the full text of the Directors Stock Option Plan)	The Company's Annual Report on Form 10-K for the year ended December 31, 2005	0-24260	10.4
10.12*	Employment Agreement dated December 11, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Paul B. Kusserow	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.12
10.13.1*	Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed November 2, 2011	0-24260	10.1
10.13.2*	Amendment No. 1 dated December 29, 2011 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Current Report on Form 8-K filed December 30, 2011	0-24260	10.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.13.3*	Amendment No. 2 dated December 19, 2012 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Annual Report on Form 10-K for the year ended December 31, 2013	0-24260	10.10.3
10.13.4*	Amendment No. 3 dated May 1, 2014 to Employment Agreement dated November 1, 2011 by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Ronald A. LaBorde	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.4
10.14*	Employment Agreement dated as of May 2, 2016 between Amedisys, Inc. and Jeffrey D. Jeter	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2016	0-24260	10.1
†10.15*	Amedisys Holding, L.L.C. Severance Plan for Key Executives dated as of April 30, 2015 (inclusive of all amendments thereto adopted on or before December 13, 2016)			
10.16.1	Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Current Report on Form 8-K filed on October 30, 2012	0-24260	10.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.16.2	First Amendment and Limited Waiver dated as of September 4, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.1
10.16.3	Second Amendment dated as of November 11, 2013 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.1.2
10.16.4	Third Amendment dated as of April 17, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2014	0-24260	10.3

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.16.5	Fourth Amendment dated as of July 28, 2014 to the Credit Agreement dated October 26, 2012 among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the several banks and other financial institutions party thereto from time to time, BOKF, NA DBA Bank of Texas, Compass Bank, Fifth Third Bank and RBS Citizens, N.A., as Documentation Agents, Bank of America, N.A., as Syndication Agent, JPMorgan Chase Bank, N.A., as Administrative Agent, and J.P. Morgan Securities LLC and Merrill Lynch, Pierce, Fenner & Smith Incorporated, as Co-Lead Arrangers and Joint Bookrunners	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.1.2
10.17	Security and Pledge Agreement dated as of November 11, 2013, among Amedisys, Inc., Amedisys Holding, L.L.C., the Guarantors party thereto and JPMorgan Chase Bank, N.A., not in its individual capacity but solely as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2013	0-24260	10.2
10.18	Second Lien Credit Agreement dated as of July 28, 2014 by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as co-borrowers, the banks and other financial institutions or entities from time to time parties thereto as lenders, and Cortland Capital Market Services LLC, as Administrative Agent	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.8
10.19	Second Lien Security and Pledge Agreement dated as of July 28, 2014 by and among Amedisys, Inc., Amedisys Holding, L.L.C, the guarantors party thereto and Cortland Capital Market Services LLC, not in its individual capacity, but solely as collateral agent for the secured parties	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.9
10.20	Intercreditor Agreement dated as of July 28, 2014 by and among JPMorgan Chase Bank, N.A., as Administrative Agent for the first priority secured parties, Cortland Capital Market Services LLC, as Administrative Agent for the second priority secured parties, and the direct and indirect subsidiaries of Amedisys, Inc. and Amedisys Holding, L.L.C. from time to time party thereto	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2014	0-24260	10.10

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.21.1	Credit Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain subsidiaries of Amedisys, Inc. party thereto as guarantors, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, JPMorgan Chase Bank, N.A., as Syndication Agent, Citizens Bank, N.A., Compass Bank, Fifth Third Bank, and Regions Bank, as Co-Documentation Agents, the lenders party thereto, Merrill Lynch, Pierce Fenner & Smith Incorporated, Citizens Bank N.A., Fifth Third Bank and J.P. Morgan Securities LLC, as Joint Lead Arrangers, and Merrill Lynch, Pierce, Fenner & Smith Incorporated and J.P. Morgan Securities LLC, as Joint Bookrunners	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.1
10.212	Security Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "grantors" on the signature pages thereto and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.2
10.21.3	Pledge Agreement dated as of August 28, 2015, among Amedisys, Inc. and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "pledgers" on the signature pages thereto, and Bank of America, N.A., in its capacity as Administrative Agent	The Company's Current Report on Form 8-K filed September 2, 2015	0-24260	10.3
10.22	Settlement Agreement effective April 23, 2014 by and among (a) the United States of America, acting through the United States Department of Justice and on Behalf of the Office of Inspector General of the Department of Health and Human Services, (b) Amedisys, Inc. and Amedisys Holding, L.L.C. and (c) the various Relators named therein	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.1
10.23	Corporate Integrity Agreement effective April 22, 2014 between the Office of Inspector General of the Department of Health and Human Services and Amedisys, Inc. and Amedisys Holding, L.L.C.	The Company's Current Report on Form 8-K filed on April 24, 2014	0-24260	10.2

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.24	Agreement and Plan of Merger dated October 31, 2015 by and among Amedisys Health Care West, L.L.C., IHC Acquisitions, L.L.C., Infinity Home Care, L.L.C., Axiom HealthEquity Holdings Management, LLC, Infinity Healthcare Holdings, LLC, and Amedisys, Inc.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.27
10.25	Agreement of Purchase and Sale dated as of November 25, 2015, between Amedisys, Inc., through its wholly-owned subsidiary, Amedisys Property, L.L.C., as seller and Franciscan Missionaries of Our Lady of the Lake Heath System, Inc., as purchaser.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.28
†21.1	Subsidiaries of the Registrant			
†23.1	Consent of KPMG LLP			
†31.1	Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002			
†31.2	Certification of Gary D. Willis, Chief Financial Officer (principal financial officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002			
††32.1	Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002			
††32.2	Certification of Gary D. Willis, Chief Financial Officer (principal financial officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002			
†101.INS	XBRL Instance			
†101.SCH	XBRL Taxonomy Extension Schema Document			
†101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document			

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
†101.DEF	XBRL Taxonomy Extension Definition Linkbase			
†101.LAB	XBRL Taxonomy Extension Labels Linkbase Document			
†101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document			

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Section 2: EX-10.3 (EX-10.3)

Exhibit 10.3

COMPOSITE AMEDISYS, INC. 2008 OMNIBUS INCENTIVE COMPENSATION PLAN

(Inclusive of Plan amendments dated June 7, 2012, October 25, 2012, April 23, 2015, January 20, 2017, February 22, 2017, the full text of the Plan and the proposed Plan amendment to increase the number of shares authorized for issuance under the Plan)

1. ***PURPOSE.***

The purpose of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan (the "Plan") is to promote the interests of Amedisys, Inc., a Delaware corporation (the "Company") and its stockholders by (i) attracting and retaining key officers, employees, and directors of, and consultants to, the Company and its Subsidiaries and Affiliates; (ii) motivating such individuals by means of performance-related incentives to achieve long-range performance goals; (iii) enabling such individuals to participate in the long-term growth and financial success of the Company; (iv) encouraging ownership of stock in the Company by such individuals; and (v) linking their compensation to the long-term interests of the Company and its stockholders. Toward this objective, the Committee may grant stock options, SAR, Stock Awards, cash bonuses and other incentive awards to Employees of the Company and its Subsidiaries and Affiliates on the terms and subject to the conditions set forth in the Plan. In addition, this Plan is intended to enable the Company to effectively attract, retain and reward Outside Directors by providing for grants of Outside Director Awards to Outside Directors. No Award under this Plan (or modification thereof) shall provide for deferral of compensation that does not comply with Section 409A of the Code unless the Committee, at the time of grant, specifically provides that the Award is not intended to comply with Section 409A of the Code. Notwithstanding any provision of this Plan to the contrary, if one or more of the payments or benefits received or to be received by a Participant pursuant to an Award would cause the Participant to incur any additional tax or interest under Section 409A of the Code, the Committee may reform such provision to maintain to the maximum extent practicable the original intent of the applicable provision without violating the provisions of Section 409A of the Code.

2. ***DEFINITIONS.***

2.1 "Affiliate" means any entity (other than the Company and any Subsidiary) that is designated by the Board as a participating employer under the Plan, provided that the Company directly or indirectly owns at least 20% of the combined voting power of all classes of stock of that entity or at least 20% of the ownership interests in that entity.

2.2 "Alternative Award" has the meaning assigned to such term in Section 22, herein.

2.3 "Award" means any form of Option, SAR, Stock Award, Restricted Share Unit, cash bonus or other incentive award granted under the Plan, whether singly, in combination, or in tandem, to a Participant by the Committee pursuant to terms, conditions, restrictions and limitations, if any, as the Committee may establish by the Award Notice or otherwise.

2.4 "Award Notice" means a written notice from the Company to a Participant that establishes the terms, conditions, restrictions, and limitations applicable to an Award in addition to those established by the Plan and by the Committee's exercise of its administrative powers. In the event of a conflict between the terms of the Plan and any Award Notice, the terms of the Plan shall prevail. The Committee shall, subject to applicable law, determine the date an Award is deemed to be granted. The Committee or, except to the extent prohibited under applicable law, its delegate(s) may establish the terms of agreements or other documents evidencing Awards under this Plan and may, but need not, require as a condition to any such agreement's or document's effectiveness that such agreement or document be executed by the Participant, including by electronic signature or other electronic indication of acceptance, and that such Participant agree to such further terms and conditions as specified in such agreement or document.

2.5 "Board" means the Board of Directors of the Company.

2.6 "Cause" means, when used in connection with the termination of a Participant's Employment, (i) if the Participant has an effective employment agreement with the Company or any Subsidiary or Affiliate as of the date an Award is granted, the definition used in such employment agreement as of such date, or (ii) if the Participant does not have an effective employment agreement with the Company or any Subsidiary or Affiliate as of the date an Award is granted, unless otherwise provided in the Participant's Award Notice, matters which, in the judgment of the Committee, constitute any one or more of the following: (i) default or breach of any of the provisions of any agreement that the Participant may have with the Company or any Affiliate or Subsidiary; (ii) actions constituting fraud, abuse, dishonesty, embezzlement, destruction or theft of Company property, or breach of the duty of loyalty owned by the Participant to the Company; (iii) violation of any applicable laws, rules or regulations (including, without limitation, all Medicare and other health care laws, rules and regulations pertaining to the provision of home health care, hospice or any other services provided by the Company); (iv) furnishing materially false, inaccurate, misleading or incomplete information to the Company; (v) actions constituting a material breach of the Company's Code of Ethical Business Conduct, the Company's employee handbook or any other Company policy; (vi) willful failure to follow reasonable and lawful directives of the Participant's supervisor, or any of the Company's senior executive officers, which are consistent with the Participant's job responsibilities and performance; or (vii) failure to satisfy the requirements of the Participant's job, regardless whether or not such failure is willful, including the failure to satisfy the objectives of any action plan or performance improvement plan that the Participant may be under. Any determination of Cause for purposes of the Plan or any Award shall be made by the Committee in its sole discretion. Any such determination shall be final and binding on a Participant.

2.7 "Change In Control" means the happening of any of the following:

a. any person or entity, including a "group" as defined in Section 13(d)(3) of the Exchange Act, other than the Company or a wholly-owned Subsidiary, or any employee benefit plan of the Company or any Subsidiary, becomes the beneficial owner of the Company's securities having 50% or more of the combined voting power of the then outstanding securities of the Company that may be cast for the election of directors of the Company (other than as a result of an issuance of securities initiated by the Company in the ordinary course of business); or

b. as the result of, or in connection with, any cash tender or exchange offer, merger or other business combination, sales of assets or contested election, or any combination of the foregoing transactions, after the transaction less than a majority of the combined voting power of the then outstanding securities of the Company, or any successor corporation or cooperative or entity, entitled to vote generally in the election of the directors of the Company, or other successor corporation or other entity, are held in the aggregate by the holders of the Company's securities who immediately prior to the transaction had been entitled to vote generally in the election of directors of the Company; or

c. during any period of 2 consecutive years, individuals who at the beginning of the period constitute the Board cease for any reason to constitute at least a majority of the Board, unless the election, or the nomination for election by the Company's stockholders, of each director of the Company first elected during the relevant 2-year period was approved by a vote of at least 2/3 of the directors of the Company then still in office who were directors of the Company at the beginning of that period.

2.8 "Change In Control Price" means the closing price (or, if the shares are not traded on an exchange, the last sale price or closing "asked" price) per share paid for the purchase of Common Stock in a national securities market on the date the Change In Control occurs.

2.9 "Code" means the Internal Revenue Code of 1986, as amended from time to time.

2.10 "Committee" means the Compensation Committee of the Board, or any other committee designated by the Board, authorized to administer the Plan under Section 3 of this Plan. The Committee shall consist of not less than 2 members who shall be appointed by, and shall serve at the pleasure of, the Board. The directors appointed to serve on the Committee shall be: (i) "independent" within the meaning of the listing standards of any securities exchange or automated quotation system upon which the Common Stock is listed or quoted; (ii) "non-employee directors" (within the meaning of Rule 16b-3 under the Exchange Act); and (iii) "outside directors" (within the meaning of Code Section 162(m) and its related regulations). However, the mere fact that a Committee member fails to qualify under any of the foregoing requirements shall not invalidate any Award made by the Committee if the Award is otherwise validly made under the Plan.

2.11 "Common Stock" means the $0.001 par value common stock of the Company.

2.12 "Company" means Amedisys, Inc. or any successor.

2.13 "Consultant" shall mean any consultant to the Company or its Subsidiaries or Affiliates.

2.14 "Covered Employee" means an individual who is, with respect to the Company, an individual defined in Code Section 162(m)(3).

2.15 "Director" means an individual who is a member of the Board.

2.16 "Disability" has the same meaning as provided in the long-term disability plan or policy maintained by the Company or if applicable, most recently maintained, by the Company or if applicable, a Subsidiary or Affiliate, for the Participant, whether or not that Participant actually receives disability benefits under the plan or policy. If no long-term disability plan or policy was ever maintained on behalf of Participant or if the determination of Disability relates to an Incentive Stock Option, Disability means Permanent and Total Disability as defined in Section 22(e)(3) of the Code. In a dispute, the determination whether a Participant has suffered a Disability will be made by the Committee and may be supported by the advice of a physician competent in the area to which that Disability relates.

2.17 "Effective Date" is defined in Section 6.

2.18 "Employee" means an employee or prospective employee of the Company, a Subsidiary or an Affiliate.

2.19 "Employment" means, except as otherwise required by Section 409A of the Code, employment with the Company or any Affiliate or Subsidiary, and shall include the provision of services as an Outside Director or Consultant for the Company or any Affiliate or Subsidiary. A Participant's Employment shall terminate on the date the Participant is no longer employed by an entity that is at least one of (i) the Company, (ii) an Affiliate or (iii) a Subsidiary as of such date. **"Employed"** shall have a correlative meaning.

2.20 "Exchange Act" means the Securities and Exchange Act of 1934, as amended from time to time.

2.21 "Exercise Price" means the purchase price payable to purchase one Share upon the exercise of an Option or the price by which the value of a SAR shall be determined upon exercise, pursuant to Section 2.34.

2.22 "Fair Market Value" with respect to the Common Stock, as of any given date, unless otherwise determined by the Committee in good faith, means the reported closing sale price of a share of Common Stock on the automated quotation system or other market or exchange that is the principal trading market for the Common Stock, or if no sale of a share of Common Stock is so reported on that date, the fair market value of a share of Common Stock as determined by the Committee in good faith.

2.23 "Immediate Family" means any child, stepchild, grandchild, parent, stepparent, grandparent, spouse, sibling, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law, and includes adoptive relationships.

2.24 "Incentive Stock Option" means an option to purchase Common Stock from the Company that is granted under Section 8 of the Plan and that is intended to meet the requirements of Section 422 of the Code or any successor provision thereto. To the extent the aggregate Fair Market Value (determined at the time the Incentive Stock Option is granted) of the Common Stock with respect to which all Incentive Stock Options are exercisable for the first time by an Employee during any calendar year (under all plans described in subsection (d) of Section 422 of the Code of the Employee's employer corporation and its parent and Subsidiaries) exceeds $100,000, such Options shall be treated as Non-Qualified Stock Options.

2.25 "Non-Qualified Stock Option" shall mean an option to purchase Common Stock from the Company that is granted under Section 8 or 23 of the Plan and is not intended to be an Incentive Stock Option.

2.26 "Option" means an Incentive Stock Option or a Non-Qualified Stock Option.

2.27 "Outside Director" means a member of the Board who is not an officer or employee of the Company or any Subsidiary or Affiliate of the Company.

2.28 "Outside Director Award" means either a Director Option or a Director Stock Award or combination thereof awarded to an Outside Director under Section 23.

2.29 "Participant" means any individual to whom an Award has been granted by the Committee under this Plan.

2.30 "Qualified Performance-Based Award" means (i) any Option or SAR granted under the Plan, or (ii) any other Award that is intended to qualify for the Section 162(m) Exemption and is made subject to performance goals based on Qualified Performance Measures as set forth in Section 12.

2.31 "Qualified Performance Measures" means one or more of the performance measures listed in Section 12.2 upon which performance goals for certain Qualified Performance-Based Awards may be established by the Committee.

2.32 "Qualifying Termination" means, with respect to a Participant, a termination of such Participant's Employment by the Company (and all then-Affiliates or Subsidiaries) without Cause following a Change in Control of the Company. It is understood that a Participant shall not have a Qualifying Termination by virtue of ceasing to be Employed by an entity or its subsidiaries undergoing a Change in Control where, following such Change in Control, the Participant remains employed by an entity that is at least one of (i) the Company or (ii) any entity that was an Affiliate or Subsidiary undergoing a Change in Control immediately prior to such Change in Control. Notwithstanding the foregoing, payments on account of a Participant's Qualifying Termination that constitute "deferred compensation" within the meaning of Section 409A of the Code shall not commence unless and until the Participant has also incurred a "separation from service" within the meaning of Code Section 409A.

2.33 "Restricted Share Unit" means a bookkeeping entry used by the Company to record and account for the grant of an Award of restricted Common Stocks under Section 10 of the Plan until the Award is paid, canceled, forfeited or terminated, as the case may be.

2.34 "SAR" is an Award that shall entitle the recipient to receive, with respect to each share of Common Stock encompassed by the exercise of the SAR, a payment equal to the excess of the Fair Market Value on the date of exercise over the Fair Market Value on the date of grant.

2.35 "Section 162(m)" means Section 162(m) of the Code and the regulations promulgated thereunder and any successor provision thereto as in effect from time to time.

2.36 "Section 162(m) Cash Maximum" means $5 million.

2.37 "Section 162(m) Exemption" means the exemption from the limitation on deductibility imposed by Section 162(m) that is set forth in Section 162(m)(4)(C) of the Code or any successor provision thereto.

2.38 "Section 16" means Section 16 of the Exchange Act and the rules promulgated thereunder and any successor provision thereto as in effect from time to time.

2.39 "Section 16 Insider" means a Participant who is subject to the reporting requirements of Section 16 as a result of the Participant's position with the Company.

2.40 "Stock Award" means an Award granted pursuant to Section 10 in the form of shares of Common Stock or restricted shares of Common Stock.

2.41 "Subsidiary" means a corporation or other business entity in which the Company directly or indirectly has an ownership interest of 50% or more.

3. *ADMINISTRATION.*

The Plan shall be administered by the Committee. The Committee shall have the discretionary authority to: (a) interpret the Plan; (b) establish any rules and regulations it deems necessary for the proper operation and administration of the Plan; (c) select persons to become Participants and receive Awards under the Plan; (d) determine the form of an Award, whether an Option, SAR, Stock Award, cash bonus, or other incentive award established by the Committee, the number of shares subject to the Award, all the terms, conditions, restrictions and limitations, if any, of an Award, including the time and conditions of exercise or vesting, and the terms of any Award Notice; (e) determine whether Awards should be granted singly, in combination or in tandem; (f) grant waivers of Plan terms, conditions, restrictions and limitations; (g) accelerate the vesting, exercise or payment of an Award or the performance period of an Award in the event of a Participant's termination of employment or when that action or actions would be in the best interests of the Company; (h) establish such other types of Awards, besides those specifically enumerated in Section 2.3, which the Committee determines are consistent with the Plan's purpose; and (i) take all other action it deems necessary or advisable for the proper operation or administration of the Plan. Subject to Section 20, the Committee also shall have the authority to grant Awards in replacement of Awards previously granted under the Plan or any other executive compensation plan of the Company or a Subsidiary. All determinations of the Committee shall be made by a majority of its members, and its determinations shall be final, binding and conclusive on all persons, including the Company and Participants. The Committee, in its discretion, may delegate its authority and duties under the Plan to the Chief Executive Officer or to other senior officers of the Company under conditions and limitations the Committee may establish; however, only the Committee may select, grant, and establish the terms of Awards to Section 16 Insiders or Covered Employees, and only the Board shall have the authority to grant and establish the terms of awards under Section 23.

4. *ELIGIBILITY.*

Any Employee, Director or Consultant shall be eligible to be designated a Participant; provided, however, that Non-Employee Directors shall only be eligible to receive Awards granted consistent with Section 23.

5. *NUMBER OF SHARES AVAILABLE*.

Subject to adjustment as provided in Section 16 of the Plan, the maximum number of shares of Common Stock that shall be available for grant of Awards under the Plan (including incentive stock options) during its term shall not exceed 5,462,459 shares. Any shares of Common Stock related to Awards that are settled in cash in lieu of Common Stock shall be available again for grant under the Plan. Similarly, any shares of Common Stock related to Awards that terminate by expiration, forfeiture, cancellation or otherwise without the issuance of the related

shares or are exchanged with the Committee's permission for Awards not involving Common Stock, shall be available again for grant under the Plan. Any shares of Common Stock related to Awards that are cancelled on settlement of options or SARs in payment of the exercise price thereof and shares of Common Stock withheld to pay taxes shall not be available again for grant under the Plan. Finally, and notwithstanding the foregoing and subject to adjustment as provided in Section 16 of the Plan, the maximum number of shares of Common Stock with respect to which Awards may be granted under the Plan shall be increased by the number of shares of Common Stock with respect to which options or other awards were granted under either the Company's 1998 Stock Option Plan (the "1998 Plan") or the Directors Stock Option Plan (the "Directors Plan") as of the record date for the meeting of stockholders to approve this Plan, but which thereafter terminate, expire unexercised or are settled for cash, forfeited or cancelled without the delivery of Common Stock under the terms of the 1998 Plan or the Directors Plan (but excluding shares of Common Stock cancelled on settlement of options or SARs in payment of the exercise price thereof or shares of Common Stock withheld to pay taxes); and any such shares shall again be available for grant as Awards under this Plan. Notwithstanding any provision in the Plan to the contrary, and subject to adjustment as provided in Section 16 hereof, no Participant may receive Options, SARs, Stock Awards or Restricted Share Units under the Plan during any one calendar year under the Plan that, taken together, relate to more than 500,000 shares of Common Stock. For purposes of this limitation, forfeited, canceled or repriced shares granted to a Participant in any given calendar year shall continue to be counted against the maximum number of shares that may be granted to that Participant in that calendar year. The shares of Common Stock available for issuance under the Plan may be authorized and unissued shares. With the exception of Qualified Performance-Based Awards, which are subject to a minimum one-year vesting period, effective for Awards issued on or after the Effective Date, no more than 5% of the total number of shares authorized for delivery under the Plan may be granted as SARs, Stock Awards or Restricted Share Units which vest within one year after the date of grant. With respect to such Awards in excess of 5% of the Shares authorized for delivery under the Plan, the vesting period must exceed one year, with no more than one-third of the shares becoming vested at the end of each of the twelve-month periods following the date of grant.

6. ***EFFECTIVE DATE; TERM.***

The Plan originally became effective January 2008, and was most recently amended by the Committee and the Board effective April 23, 2015 (the "Effective Date"). This Plan shall remain in effect until terminated by action of the Board.

7. ***PARTICIPATION.***

The Committee shall select, from time to time, Participants from those Employees and Consultants who, in the opinion of the Committee, can further the Plan's purposes. Once a Participant is selected, the Committee shall determine the type or types of Awards to be made to the Participant and shall establish in the related Award Notices the terms, conditions, restrictions and limitations, if any, applicable to the Awards in addition to those set forth in the Plan and the administrative rules and regulations issued by the Committee.

8. ***STOCK OPTIONS.***

8.1 Grants. Awards may be granted in the form of Options. Options may be Incentive Stock Options, other tax-qualified stock options, or Non-Qualified Stock Options, or a combination of any of those.

8.2 Terms and Conditions of Options. An Option shall be exercisable in whole or in such installments and at the times determined by the Committee. The Committee also shall determine the performance or other conditions, if any, which must be satisfied before all or part of an Option may be exercised. The price at which Common Stock may be purchased upon exercise of a stock option shall be established by the Committee, but such price shall not be less than 110% of the Fair Market Value of the Common Stock on the date the Option is granted in the case of Incentive Stock Options when the Employee to whom the option is to be granted owns stock possessing more than 10% of the total combined voting power of all classes of stock of the Company or of

any of its Subsidiaries (a "Ten Percent Owner"), and in the case of all Options other than Incentive Stock Options, not less than 100% of the Fair Market Value of the Common Stock on the date the Option is granted. Each Option shall expire not later than 10 years (or, in the case of an Incentive Stock Option granted to a Ten Percent Owner, not later than 5 years) from its date of grant.

8.3 Restrictions Relating to Incentive Stock Options. Incentive Stock Options shall, in addition to being subject to all applicable terms, conditions, restrictions and limitations established by the Committee, comply with Section 422 of the Code. Accordingly, Incentive Stock Options may only be granted to Employees who are employees of the Company or a Subsidiary, and the aggregate market value (determined at the time the option was granted) of the Common Stock with respect to which Incentive Stock Options are exercisable for the first time by a Participant during any calendar year (under the Plan or any other plan of the Company or any of its Subsidiaries) shall not exceed $100,000 (or other limit required by the Code). Except with respect to Ten Percent Owners, each Incentive Stock Option shall expire not later than 10 years from its date of grant.

8.4 Additional Terms and Conditions. The Committee may, by way of the Award Notice or otherwise, establish other terms, conditions, restrictions and limitations, if any, on any Option, provided they are not inconsistent with the Plan.

8.5 Exercise. The Committee shall determine the methods by which the Exercise Price of an Option may be paid, the form of payment, including, without limitation, cash, shares of Common Stock, or other property (including "cashless exercise" arrangements, so long as they do not in any way conflict with the requirements of applicable law), and the methods by which shares of Common Stock shall be delivered or deemed to be delivered by Participants. If, however, shares of Common Stock are used to pay the Exercise Price of an Option, those shares must have been held by the Participant for at least 6 months (or any shorter or longer period necessary to avoid a charge to the Company's earnings for financial reporting purposes).

9. *STOCK APPRECIATION RIGHTS.*

9.1 Grants. Awards may be granted in the form of SARs. The SAR may be granted in tandem with all or a portion of a related Option under the Plan ("Tandem SARs"), or may be granted separately ("Freestanding SARs"). A Tandem SAR may be granted either at the time of the grant of the related Option or at any time thereafter during the term of the Option. In the case of SARs granted in tandem with Options granted prior to the grant of the SARs, the appreciation in value is the difference between the option price of the related stock option and the Fair Market Value of the Common Stock on the date of exercise.

9.2 Terms and Conditions of Tandem SARs. A Tandem SAR shall be exercisable to the extent, and only to the extent, that the related Option is exercisable, and the "exercise price" of that SAR (the base from which the value of the SAR is measured at its exercise) shall be the Exercise Price under the related Option. If a related Option is exercised as to some or all of the shares of Common Stock covered by the Award, the related Tandem SAR, if any, shall be canceled automatically to the extent of the number of shares of Common Stock covered by the Option exercise. Upon exercise of a Tandem SAR as to some or all of the shares of Common Stock covered by the Award, the related Option shall be canceled automatically to the extent of the number of shares of Common Stock covered by the exercise.

9.3 Terms and Conditions of Freestanding SARs. Freestanding SARs shall be exercisable in whole or in the installments and at the times determined by the Committee. Freestanding SARs shall have a term specified by the Committee, in no event to exceed 10 years. The Exercise Price of a Freestanding SAR shall also be determined by the Committee; however, that price shall not be less than 100% of the Fair Market Value on the date of grant of the Freestanding SAR of the number of shares of Common Stock to which the Freestanding SAR relates. The Committee also shall determine the Qualified Performance Measures or other conditions, if any, that must be satisfied before all or part of a Freestanding SAR may be exercised.

9.4 Deemed Exercise. The Committee may provide that an SAR shall be deemed to be exercised at the close of business on the scheduled expiration date of the affected SAR if at that time the SAR by its terms remains exercisable and, if so exercised, would result in a payment to the holder of the SAR.

9.5 Additional Terms and Conditions. The Committee may, by way of the Award Notice or otherwise, determine such other terms, conditions, restrictions and limitations, if any, of any SAR Award, provided they are not inconsistent with the Plan.

10. ***STOCK AWARDS AND RESTRICTED SHARE UNITS.***

10.1 Grants. Awards may be granted in the form of Stock Awards and Restricted Share Units. Stock Awards and Restricted Share Units shall be awarded in such numbers and at such times during the term of the Plan as the Committee shall determine. Stock Awards shall be made in actual shares of Common Stock.

10.2 Award Restrictions. Stock Awards and Restricted Share Units shall be subject to terms, conditions, restrictions, and limitations, if any, the Committee deems appropriate including, without limitation, restrictions on transferability and continued Employment of the Participant. The Committee also shall determine the Qualified Performance Measures or other conditions, if any, that must be satisfied before all or part of the applicable restrictions lapse. The Committee may, at its discretion, waive all or any part of the restrictions applicable to any or all outstanding Stock Awards and Restricted Share Unit Awards.

10.3 Rights as Stockholder. During the period in which any restricted shares of Common Stock are subject to restrictions imposed pursuant to Section 10.2, the Participant to whom restricted shares have been awarded shall generally have the rights and privileges of a stockholder as to such Common Stock, including the right to receive dividends and the right to vote such shares, subject to the following restrictions: (i) the Participant shall not be entitled to delivery of the stock certificate until the expiration of the restricted period and the fulfillment of any other restrictive conditions set forth in the Award Notice with respect to such Common Stock; (ii) none of the Common Stock represented by the Award may be sold, assigned, transferred, pledged, hypothecated or otherwise encumbered or disposed of during such restricted period or until after the fulfillment of any such other restrictive conditions; and (iii) except as otherwise determined by the Committee at or after grant, all of the shares of Common Stock subject to the Award shall be forfeited and all rights of the Participant to such Common Stock shall terminate, without further obligation on the part of the Company, unless the Participant remains in the continuous Employment of the Company for the entire restricted period in relation to which such shares of Common Stock were granted and unless any other restrictive conditions relating to the restricted Share Award are met. Unless otherwise provided in the applicable Award Notice, any shares of Common Stock, any other securities of the Company and any other property (except for cash dividends) distributed with respect to the Common Stock subject to restricted Share Awards shall be subject to the same restrictions, terms and conditions as such restricted Share Award including the right vote such Common Stock. Cash dividends with respect to the Common Stock subject to a restricted Share Award shall be currently paid to the Participant.

10.4 Evidence of Award. Subject to Section 10.5, any Stock Award granted under the Plan shall be evidenced by issuance of a stock certificate or certificates or, in the discretion of the Committee, through issuance of instructions to the Company's transfer agent to issue the shares of Common Stock subject to the Award in book-entry (uncertificated) form on the books and records of the transfer agent through the Direct Registration System ("DRS") or any successor system. Any Restricted Share Unit shall be evidenced by an Award Notice that sets forth any other terms, conditions, restrictions and limitations, if any, established by the Committee with respect to any Restricted Share Unit Award that are consistent with the terms of the Plan.

10.5 Delivery of Shares and Transfer Restrictions. Upon issuance of a certificate evidencing a restricted Share Award, such certificate shall be held by the Company or any custodian appointed by the Company for the account of the Participant subject to the terms and conditions of the Plan, and shall bear such a legend setting forth the restrictions imposed thereon as the Committee, in its discretion, may determine. Unless otherwise

provided in the applicable Award Notice, the grantee shall have all rights of a stockholder with respect to the Restricted Shares Upon the issuance of a restricted Share Award in book entry form, the Company's transfer agent shall be apprised of and shall duly note any restrictions such as those set forth above that are applicable to the restricted Share Award.

10.6 Termination of Restrictions. At the end of the restricted period and provided that any other restrictive conditions of the restricted Share Award are met, or at such earlier time as otherwise determined by the Committee, all restrictions set forth in the Award Notice relating to the restricted Share Award or in the Plan shall lapse as to the restricted shares of Common Stock subject thereto, and either: (i) a stock certificate for the appropriate number of shares of Common Stock, free of the restrictions and restricted stock legend, shall be delivered to the Participant or the Participant's beneficiary or estate, as the case may be; or (ii) in the event the Share Award was evidenced in book entry form, the Company's transfer agent shall be notified of the lapse and or termination of the restrictions and to remove all references thereto in its books and records.

10.7 Payment of Restricted Share Units. Each Restricted Share Unit shall have a value equal to the Fair Market Value of a share of Common Stock. Restricted Share Units shall be paid in cash, Shares, other securities or other property, as determined in the sole discretion of the Committee, upon the lapse of the restrictions applicable thereto, or otherwise in accordance with the applicable Award Notice. Unless otherwise provided in the applicable Award Notice, a Participant shall receive dividend rights in respect of any vested Restricted Share Units at the time of any payment of dividends to stockholders on the Common Stock. The amount of any such dividend right shall equal the amount that would be payable to the Participant as a stockholder in respect of a number of shares of Common Stock equal to the number of vested Restricted Share Units then credited to the Participant. Other than pursuant to Section 15 (but no transfers for consideration shall be permitted), Restricted Share Units may not be sold, assigned, transferred, pledged, hypothecated or otherwise encumbered or disposed of, and all Restricted Share Units and all rights of the grantee to such Restricted Share Units shall terminate, without further obligation on the part of the Company, unless the Participant remains in continuous Employment of the Company for the entire restricted period in relation to which such Restricted Share Units were granted and unless any other restrictive conditions relating to the Restricted Share Unit Award are met.

11. *PLAN CASH BONUSES.*

While cash bonuses may be granted at any time outside this Plan, cash awards may also be granted in addition to other Awards granted under the Plan and in addition to cash awards made outside of the Plan. Subject to the provisions of the Plan, the Committee shall have authority to determine the persons to whom cash bonuses under the Plan shall be granted and the amount, terms and conditions of those cash bonuses. Notwithstanding anything to the contrary in this Plan, no Covered Employee shall be eligible to receive a cash bonus granted under the Plan in excess of the Section 162(m) Cash Maximum in any fiscal year; no cash bonus shall be granted pursuant to this Plan to any Covered Employee unless the cash bonus constitutes a Qualified Performance-Based Award, and no cash bonus awarded pursuant to the Plan shall be paid later than 2 $^1/_2$ months after the end of the calendar year in which such bonus was earned.

12. *PERFORMANCE GOALS FOR CERTAIN SECTION 162(m) AWARDS.*

12.1 162(m) Exemption. This Plan shall be operated to ensure that all stock options and SARs granted hereunder to any Covered Employee qualify for the Section 162(m) Exemption.

12.2 Qualified Performance-Based Awards. When granting any Award other than stock options or SARs, the Committee may designate the Award as a Qualified Performance-Based Award, based upon a determination that the recipient is or may be a Covered Employee with respect to that Award, and the Committee wishes the Award to qualify for the Section 162(m) Exemption. If an Award is so designated, the Committee shall establish performance goals for the Award within the time period prescribed by Section 162(m) of the Code based on one

or more of the following Qualified Performance Measures, which may be expressed in terms of Company-wide objectives or in terms of objectives that relate to the performance of a Subsidiary or a division, region, department or function within the Company or a Subsidiary:

(1) return on capital, equity, or assets (including economic value created),

(2) productivity or operating efficiencies,

(3) cost improvements,

(4) cash flow,

(5) sales revenue growth,

(6) net income, earnings per share, or earnings from operations,

(7) quality,

(8) customer satisfaction,

(9) comparable store sales,

(10) stock price or total stockholder return,

(11) EBITDA or EBITDAR,

(12) after tax operating income,

(13) book value per Share,

(14) debt reduction,

(15) strategic business objectives, consisting of one or more objectives based on meeting specified cost targets, business expansion goals and goals relating to acquisitions or divestitures, or

(16) any combination of the foregoing.

Each goal may be expressed on an absolute and/or relative basis, may be based on or otherwise employ comparisons based on internal targets, the past performance of the Company or any Subsidiary, operating unit, business segment or division of the Company and/or the past or current performance of other companies, and in the case of earnings-based measures, may use or employ comparisons relating to capital, stockholders' equity and/or Common Stock outstanding, or to assets or net assets. The Committee may appropriately adjust any evaluation of performance under criteria set forth in this Section 12.2 to exclude any of the following events that occurs during a performance period: (i) asset write-downs, (ii) litigation or claim judgments or settlements, (iii) the effect of changes in tax law, accounting principles or other such laws or provisions affecting reported results, (iv) accruals for reorganization and restructuring programs and (v) with respect to fiscal years beginning prior to December 16, 2015, "extraordinary items" described in Accounting Principles Board Opinion No. 30, and/or with respect to fiscal years beginning after December 15, 2015, events of an "unusual nature" and/or of a type that indicate "infrequency of occurrence," as defined in FASB Accounting Standards Update 2015 - 01, and appearing in the Company's financial statements or notes thereto appearing in the Company's Annual Report on Form 10-K, and/or in management's discussion and analysis of financial performance appearing in such Annual Report. Measurement of the Company's performance against the goals established by the Committee shall be objectively determinable, and to the extent goals are expressed in standard accounting terms, performance shall be measured according to generally accepted accounting principles as in existence on the date on which the performance goals are established and without regard to any changes in those principles after that date.

12.3 Performance Goal Conditions. Each Qualified Performance-Based Award (other than an Option or SAR) shall be earned, vested and payable (as applicable) only upon the achievement of performance goals established by the Committee based upon one or more of the Qualified Performance Measures, together with the satisfaction of any other conditions, such as continued Employment, the Committee may determine to be

appropriate; however, (i) the Committee may provide, either in connection with the grant of an Award or by later amendment, that achievement of the performance goals will be waived upon the death or Disability of the Participant, and (ii) the provisions of Section 22 shall apply notwithstanding this sentence.

12.4 Certification of Goal Achievement. Any payment of a Qualified Performance-Based Award granted with performance goals shall be conditioned on the written certification of the Committee in each case that the performance goals and any other material conditions were satisfied. Except as specifically provided in Section 12.3, no Qualified Performance-Based Award may be amended, nor may the Committee exercise any discretionary authority it may otherwise have under the Plan with respect to a Qualified Performance-Based Award, in any manner to waive the achievement of the applicable performance goal based on Qualified Performance Measures or to increase the amount payable under, or the value of, the Award, or otherwise in a manner that would cause the Qualified Performance-Based Award to cease to qualify for the Section 162(m) Exemption.

13. *PAYMENT OF AWARDS.*

At the discretion of the Committee, payment of Awards may be made in cash, Common Stock, a combination of cash and Common Stock, or any other form of property the Committee shall determine. In addition, payment of Awards may include terms, conditions, restrictions and limitations, if any, the Committee deems appropriate, including, in the case of Awards paid in the form of Common Stock, restrictions on transfer and forfeiture provisions.

14. *TERMINATION OF EMPLOYMENT.*

The terms in this Section 14 describe a Participant's rights upon termination of Employment with respect to Awards granted under the Plan, provided, however, that the terms provided in a Participant's Award Notice may supplement or modify the results of termination of Employment under this Section 14 and, provided further, in the event of a Change in Control, the Participant's rights under an Award will be determined in accordance with Section 22.

14.1 Options. The portion of an Option that has become vested under the terms of an Award Notice or this Plan following termination of Employment, based on the conditions for such termination, shall be exercisable for the period described in this Section 14.1. Upon the expiration of such right to exercise the Option, the unexercised portion of the Option will be forfeited.

a. Death and Disability. If the Participant's Employment is terminated due to death or Disability, the Option shall become fully vested. The right to exercise the Option will expire one year after death or Disability or, if sooner ten years after the Option was granted.

b. Termination for Cause. If the Participant's employment is terminated for Cause, the Participant shall immediately forfeit the unexercised portion of the Option, whether vested or unvested.

c. Other Termination of Employment. If the Participant's Employment is terminated for any reason not described above in this Section 14.1, the Participant shall immediately forfeit any portion of the Option that is unvested as of the date of termination of Employment. The right to exercise the vested portion of the Option will expire three months following such termination of Employment or, if sooner ten years after the Grant Date.

14.2 Other Awards. Awards of Qualified Performance-Based Awards, Restricted Share Units, SARs, and Stock Awards that have not become vested under the terms of an Award Notice or this Plan will be forfeited upon the termination of the Participant's Employment, except as described in this Section 14.2.

a. Time Vested Awards. With respect to Awards that condition vesting solely with respect to continued employment, upon termination of Employment that is due to death or Disability, the Participant's rights under an Award that shall become fully vested.

b. Performance Vested Awards. With respect to Awards that condition vesting upon achievement of performance measures, which may be stated in the Award Notice, upon termination of Employment that is due to death or Disability, the Participant's rights under an Award that shall become fully vested with respect to the portion of the Award that is earned by achievement of such performance measures on or prior to the date of death or Disability.

15. ***NO ASSIGNMENT.***

No Awards (other than unrestricted Stock Awards) or any other payment under the Plan shall be subject in any manner to alienation, anticipation, sale, transfer (except by will or the laws of descent and distribution), assignment, pledge, or encumbrance; however, the Committee may (but need not) permit other transfers where the Committee concludes that transferability (i) does not result in accelerated taxation, (ii) does not cause any option intended to be an incentive stock option to fail to be described in Code Section 422(b), and (iii) is otherwise appropriate and desirable, taking into account any state or federal securities laws applicable to transferable Awards. During the lifetime of the Participant no Award shall be payable to or exercisable by anyone other than the Participant to whom it was granted, other than (a) the duly appointed conservator or other lawfully designated representative of the Participant in the case of a permanent Disability involving a mental incapacity or (b) the transferee in the case of an Award transferred in accordance with the preceding sentence.

16. ***CAPITAL ADJUSTMENTS.***

The number and price of shares of Common Stock covered by each Award and Outside Director Award and the total number of shares of Common Stock that may be awarded under the Plan shall be proportionately adjusted to reflect any stock dividend, stock split or share combination of the Common Stock or any recapitalization of the Company. In the event of any merger, consolidation, reorganization, liquidation or dissolution of the Company, or any exchange of shares involving the Common Stock, any Award or Outside Director Award granted under the Plan shall automatically be deemed to pertain to the securities and other property to which a holder of the number of shares of Common Stock covered by the Award or Outside Director Award would have been entitled to receive in connection with any such event. The Committee shall have the sole discretion to make all interpretations and determinations required under this section to the extent it deems equitable and appropriate. It is the intent of any such adjustment that the value of the Awards or Outside Director Awards held by the Participants or Outside Directors, as the case may be, immediately following the change is the same as that value immediately prior to the change.

17. ***WITHHOLDING TAXES.***

The Company shall have the power and the right to deduct or withhold, or require a Participant to remit to the Company, an amount sufficient to satisfy Federal, state, and local taxes (including the Participant's FICA obligation) required by law to be withheld with respect to any taxable event arising as a result of this Plan. With respect to withholding required upon any taxable event, the Company may elect in its discretion, and Participants may elect, subject to the approval of the Committee, to satisfy the withholding requirement, in whole or in part, by withholding or having the Company withhold shares of Common Stock having a Fair Market Value on the date the tax is to be determined equal to (and shall not exceed) the maximum statutory total tax which could be imposed on the transaction. All elections by Participants shall be irrevocable, made in writing, and signed by the Participant.

18. ***REGULATORY APPROVALS AND LISTINGS.***

Notwithstanding anything contained in the Plan to the contrary, the Company shall have no obligation to issue or deliver certificates of Common Stock evidencing Stock Awards or any other Award resulting in the payment of shares of Common Stock prior to (a) the obtaining of any approval from any governmental agency which the Company shall, in its sole discretion, determine to be necessary or advisable, (b) the admission of the shares to quotation or listing on the automated quotation system or stock exchange on which the Common Stock may be listed, and (c) the completion of any registration or other qualification of the shares under any State or Federal law or ruling of any governmental body that the Company shall, in its sole discretion, determine to be necessary or advisable.

19. *PLAN AMENDMENT.*

Except as provided in Section 22, the Board or the Committee may, at any time and from time to time, suspend, amend, modify, or terminate the Plan without stockholder approval; however, if an amendment to the Plan would, in the reasonable opinion of the Board or the Committee, either (i) result in repricing stock options or otherwise increase the benefits accruing to Participants or Outside Directors, (ii) increase the number of shares of Common Stock issuable under the Plan, or (iii) modify the requirements for eligibility, then that amendment shall be subject to stockholder approval; and, the Board or Committee may condition any amendment or modification on the approval of stockholders of the Company if that approval is necessary or deemed advisable to (i) permit Awards to be exempt from liability under Section 16(b), (ii) to comply with the listing or other requirements of an automated quotation system or stock exchange, or (iii) to satisfy any other tax, securities or other applicable laws, policies or regulations.

20. *AWARD AMENDMENTS.*

Except as provided in Section 22, the Committee may amend, modify or terminate any outstanding Award or Outside Director Award without approval of the Participant or Outside Director, as applicable; however:

a. subject to the terms of the applicable Award Notice, an amendment, modification or termination shall not, without the Participant's or Outside Director's consent, as applicable, reduce or diminish the value of the Award or Outside Director Award determined as if the Award or Outside Director Award had been exercised, vested, cashed in (at the spread value in the case of stock options or SARs) or otherwise settled on the date of that amendment or termination;

b. the original term of any stock option or SAR may not be extended without the prior approval of the stockholders of the Company;

c. except as otherwise provided in Section 16 of the Plan, the exercise price of any outstanding stock option or SAR may not be reduced, directly or indirectly, and outstanding stock options or SARs may not be cancelled in exchange for cash or replaced by other awards or stock options or SARs with an exercise price that is less than the exercise price of the cancelled stock options or SARs, without the prior approval of the stockholders of the Company; and

d. no termination, amendment, or modification of the Plan shall adversely affect any Award or Outside Director Awards previously granted under the Plan, without the written consent of the affected Participant or Outside Director.

21. *GOVERNING LAW.*

This Plan shall be governed by and construed in accordance with the laws of the State of Delaware, except as superseded by applicable Federal law.

22. *CHANGE IN CONTROL.*

Subject to the limitations set forth in this Section 22, (i) with respect to Awards granted on or after the Effective Date, in the event (A) a Participant has a Qualifying Termination within one year following a Change in Control of the Company, or (B) a Change in Control occurs in which outstanding Awards are not assumed or honored by the successor entity or corporation or replaced with an Alternative Award (as defined below), and (ii) with respect to Awards granted prior to the Effective Date, in connection with a Change in Control, if and to the extent determined by the Committee or the Board at or after the affected award or grant and subject to any right of approval expressly reserved by the Committee or the Board at the time of the determination, the following provisions shall apply to any Award which has not previously terminated or expired:

a. any SAR and any stock option or Outside Director Award awarded under this Plan that is not previously vested and exercisable shall become fully vested and exercisable;

b. the restrictions applicable to any Award which are not already vested under the Plan shall lapse, and those existing shares and awards shall be deemed fully vested;

c. unless otherwise determined by the Board or by the Committee in its sole discretion prior to any Change in Control, the value of all vested outstanding stock options, SARs, Outside Director Awards and other Awards, shall be cashed out on the basis of the Change in Control Price as of the date the Change in Control is determined to have occurred (or other date determined by the Board or Committee prior to the Change in Control); and

d. the Board or the Committee may impose additional conditions on the acceleration or valuation of any Award in any applicable Award Notice.

To qualify as an "Alternative Award," the Committee must determine that the existing Awards are to be assumed, honored or new rights substituted by the successor corporation or entity and further must:

a. be based on shares of common stock that are traded on an established U.S. securities market or another public market;

b. provide the Participant (or each Participant in a class of Participants) with rights and entitlements substantially equivalent to or better than the rights, terms and conditions applicable under such Award, including, but not limited to, an identical or better exercise or vesting schedule and identical or better timing and methods of payment;

c. have substantially equivalent economic value to such Award;

d. contain terms and conditions which provide that in the event that the Participant's employment is terminated for death or Disability or is terminated without Cause within 90 days following a Change of Control, any conditions on the Participant's rights under, or any restrictions on transfer, vesting or exercisability applicable to, each such Award shall lapse; and

e. be on terms and conditions that do not result in adverse tax consequences to the Participant under Section 409A of the Code.

23. ***AWARDS TO OUTSIDE DIRECTORS.***

23.1 The independent members of the Board may provide that all or a portion of an Outside Director's annual retainer, meeting fees and/or other awards or compensation as determined by such independent members of the Board, be payable (either automatically or at the election of an Outside Director) in the form of Non-Qualified Stock Options, Restricted Shares, Restricted Share Units and/or Other Stock-Based Awards, including unrestricted Shares. The Board shall determine the terms and conditions of any such Awards, including the terms and conditions which shall apply upon a termination of the Non-Employee Director's service as a member of the Board, and shall have full power and authority in its discretion to administer such Awards, subject to the terms of the Plan and applicable law.

23.2 The Board may also grant Awards to Outside Directors pursuant to the terms of the Plan, including any Award described in Sections 8, 9 and 10 above. With respect to such Awards, all references in the Plan to the Committee shall be deemed to be references to the independent members of the Board.

24. ***NO RIGHT TO EMPLOYMENT OR PARTICIPATION.***

The grant of an Award under this Plan shall not confer any rights upon the Participant holding such Award other than such terms, and subject to such conditions, as are specified in this Plan as being applicable to such type of Award (or to all Awards) or as are expressly set forth in the Award Notice or other document evidencing such Award. Participation in the Plan shall not give any Participant any right to remain in the employ, or to serve as a director, of the Company or any Subsidiary or Affiliate of the Company or, in the case of employment with a Subsidiary or Affiliate, the Subsidiary or Affiliate reserves the right to terminate the employment of any Participant at any time. Further, the adoption of this Plan shall not be deemed to give any Employee or any other individual any right to be selected as a Participant or to be granted an Award.

25. ***NO RIGHT, TITLE OR INTEREST IN COMPANY ASSETS.***

The Plan is intended to constitute an "unfunded" plan for incentive compensation. No Participant shall have any rights as a stockholder as a result of participation in the Plan until the date of issuance of a stock certificate in the Participant's name, and, in the case of restricted shares of Common Stock, such rights are granted to the Participant under Section 10.3 hereof. To the extent any person acquires a right to receive payments from the Company under the Plan, those rights shall be no greater than the rights of an unsecured creditor of the Company. In its sole discretion, the Committee may authorize the creation of trusts or other arrangements to meet the obligations created under the Plan to deliver Common Stock or to make payments in lieu of, or with respect to, Plan awards. However, unless the Committee determines otherwise with the express consent of the affected Participant, the existence of any such trusts or other arrangements is consistent with this "unfunded" status of the Plan.

26. ***SECURITIES LAWS.***

With respect to Section 16 Insiders, transactions under this Plan are intended to comply with all applicable conditions of Rule 16b-3 or its successors under the Exchange Act. To the extent any provision of the Plan or action by the Committee fails so to comply, it shall be deemed null and void, to the extent permitted by law and deemed advisable by the Committee.

27. ***REQUIRED WRITTEN REPRESENTATIONS.***

The Committee may require each person purchasing shares pursuant to a stock option or other award under the Plan to represent to and agree with the Company in writing that the optionee or Participant is acquiring any shares of Common Stock without a view to their distribution. The certificates for shares may include any legend which the Committee deems appropriate to reflect any restrictions on transfer. All certificates for shares of Common Stock or other securities delivered under the Plan shall be subject to stop transfer orders and other restrictions the Committee deems advisable under the rules, regulations and other requirements of the Securities and Exchange Commission, any stock exchange upon which the Common Stock is then listed, and any applicable Federal or state securities laws, and the Committee may cause a legend or legends to be put on any certificates to make appropriate reference to the applicable restrictions. Each Participant is responsible for fully complying with all applicable state and federal securities laws and rules and the Company assumes no responsibility for compliance with any such laws or rules pertaining to a Participant's resale of any shares of Common Stock acquired pursuant to this Plan.

28. ***NON-EXCLUSIVE ARRANGEMENT.***

Nothing contained in this Plan shall prevent the Board from adopting other or additional compensation arrangements, subject to stockholder approval if required; and those arrangements may be either generally applicable or applicable only in specific cases.

29. LIMITS ON LIABILITY AND INDEMNIFICATION.

The members of the Committee and the Board shall not be liable to any employee or other person with respect to any determination made under the Plan in a manner that is not inconsistent with their legal obligations as members of the Board. In addition to all other rights of indemnification they may have as directors or as members of the Committee, the members of the Committee shall be indemnified by the Company against reasonable expenses, including attorneys' fees actually and necessarily incurred in connection with the defense of any action, suit or proceeding, or in connection with any appeal therein, to which they or any of them may be a party because of any action taken or failure to act under or in connection with the Plan or any Award granted under it, and against all amounts paid by them in settlement (provided the settlement is approved by independent legal counsel selected by the Company) or paid to them in satisfaction of a judgment in that action, suit or proceeding, except in relation to matters as to which it shall be adjudged in the action, suit or proceeding that the Committee member is liable for negligence or misconduct in the performance of his or her duties. Within 60 days after institution of any action, suit or proceeding covered by this Section 29, the Committee member must inform the Company in writing of the claim and offer the Company the opportunity, at its own expense, to handle and defend the matter.

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Section 3: EX-10.15 (EX-10.15)

Exhibit 10.15

AMEDISYS HOLDING, L.L.C.

SEVERANCE PLAN FOR KEY EXECUTIVES

APRIL 30, 2015

Inclusive of all Amendments to Sections 2 and 4 dated on or before December 31, 2016

1. Purpose. The purpose of this Amedisys Holding, L.L.C. Severance Plan for Key Employees (this "Plan") is to provide a fair framework in the event of the termination of employment in certain circumstances of certain key executive employees of the Company. This document supersedes any prior plan, program or arrangement that provides severance benefits to a Covered Executive (as defined below) eligible for benefits under this Plan. This document is intended to serve both as the official plan document and the summary plan description for this Plan. The Plan is sponsored by Amedisys Holding, L.L.C. ("Company"). The Company is the Plan Administrator.

2. Covered Executives. To be eligible for benefits under this Plan an executive must (1) be employed by the Company with any of the following job titles: Chief Operating Officer, Chief Financial Officer, Vice Chairman, Chief Human Resources Officer, General Counsel, Chief Information Officer, Chief Strategy Officer, Chief Clinical Operations Officer, or the Chief Compliance Officer; (2) have been designated in writing by the Board of Directors (the "Board") of Amedisys, Inc. or the Compensation Committee of the Board (the "Committee"), as appropriate, as being covered by this Plan; and (3) have executed and delivered to the Company (and not have revoked or attempted to revoke) the Company's Executive Protective Covenants Agreement ("EPCA" or other similarly named agreement) (a "Covered Executive").

This Plan shall not be applicable to any employee who is a party to a separate employment agreement, change of control agreement, or similar agreement with the Company.

If a Covered Executive under this Plan is or becomes eligible to participate in the April 2013 Severance Plan for Senior Management Leaders or the Severance Plan for Senior Vice Presidents, then such employee will only be eligible for severance benefits under the terms of the April 2013 Severance Plan for Senior Management Leaders or the Severance Plan for Senior Vice Presidents, except in the event of a "Change in Control" (as such term is defined in Section 3, below), in which case the terms of this Plan (including, without limitation, the provisions of Section 5, herein) shall control, regardless of whether such employee still qualifies as a Covered Executive. In no event will a Covered Executive be entitled to simultaneously receive benefits under the April 2013 Severance Plan for Senior Management Leaders, the Severance Plan for Senior Vice Presidents and this Plan.

3. Definitions.

(a) **Cause**. "Cause," as it applies to the determination by the Company to terminate the employment of a Covered Executive, shall mean any one or more of the following: (i) Covered Executive's willful, material, and irreparable breach of Covered Executive's duties to the Company; (ii) Covered Executive's gross negligence in the performance or intentional

nonperformance of any of Covered Executive's material duties and responsibilities to the Company; (iii) Covered Executive's willful dishonesty, fraud, or misconduct with respect to the business or affairs of the Company, which materially and adversely affects the operations or reputation of the Company; (iv) Covered Executive's conviction or plea of nolo contendere to a felony crime; and (v) Covered Executive engages in an act or series of acts constituting misconduct resulting in a misstatement of a Company's financial statements due to material non-compliance with any financial reporting requirement within the meaning of Section 304 of The Sarbanes Oxley Act of 2002. In the event of a termination by the Company for Cause, Covered Executive shall have no right to any severance benefits under this Plan.

(b) **Code.** "Code" shall mean the United States Internal Revenue Code of 1986, as amended, or any successor provision of law, and the regulations promulgated thereunder.

(c) **Good Reason**. "Good Reason," as it applies to the determination by a Covered Executive to terminate Covered Executive's employment with the Company at his or her initiative shall mean the occurrence of any of the following events without Covered Executive's written consent: (i) Covered Executive suffers a material diminution in authority, responsibilities, or duties; or (ii) Covered Executive suffers a material reduction in base salary other than in connection with a proportionate reduction in the base salaries of all similarly situated senior officer-level employees. Good Reason shall not be deemed to have occurred unless (i) Covered Executive provides the Company with notice of one of the conditions described above within 90 days of the existence of the condition, (ii) the Company is provided at least 30 days to cure the condition and fails to cure same within such 30 day period and (iii) Covered Executive terminates employment within at least 150 days of the existence of the condition.

(d) **Employment Termination**. "Employment Termination" shall mean a Covered Executive no longer being an employee of the Company as a result of a termination by the Company without Cause or by Covered Executive with Good Reason.

(e) **Change in Control.** A "Change in Control" shall be deemed to have occurred if:

a. any person or entity, including a "group" as defined in Section 13(d)(3) of the Exchange Act, other than the Company or a wholly-owned Subsidiary, or any employee benefit plan of the Company or any Subsidiary, becomes the beneficial owner of the Company's securities having 50% or more of the combined voting power of the then outstanding securities of the Company that may be cast for the election of directors of the Company (other than as a result of an issuance of securities initiated by the Company in the ordinary course of business); or

b. as the result of, or in connection with, any cash tender or exchange offer, merger or other business combination, sales of assets or contested election, or any combination of the foregoing transactions, after the transaction less than a majority of the combined voting power of the then outstanding securities of the Company, or any

successor corporation or cooperative or entity, entitled to vote generally in the election of the directors of the Company, or other successor corporation or other entity, are held in the aggregate by the holders of the Company's securities who immediately prior to the transaction had been entitled to vote generally in the election of directors of the Company; or

c. during any period of 2 consecutive years, individuals who at the beginning of the period constitute the Board cease for any reason to constitute at least a majority of the Board, unless the election, or the nomination for election by the Company's stockholders, of each director of the Company first elected during the relevant 2-year period was approved by a vote of at least 2/3 of the directors of the Company then still in office who were directors of the Company at the beginning of that period.

4. Result of Termination by the Company without Cause or by Covered Executive with Good Reason Prior to a Change in Control. The following provisions shall apply should the Company terminate a Covered Executive's employment without Cause or should a Covered Executive terminate Covered Executive's employment with Good Reason:

(a) **Salary and Bonus**. The Company shall pay to Covered Executive an amount equal to one (1) times the sum of (A) the Covered Executive's base salary, as in effect on the date of Employment Termination (or in the event a reduction in base salary is a basis for a termination with Good Reason, then the base salary in effect immediately prior to such reduction) and (B) the greater of (x) an amount equal to the cash bonus earned by the Covered Executive for the previous fiscal year or (y) an amount equal to twenty-five (25) percent of the Covered Executive's base salary, as in effect on the date of Employment Termination (or, in the event a reduction in base salary is a basis for termination for Good Reason, then the base salary in effect immediately prior to such reduction), which amount shall be payable in substantially equal monthly installments in accordance with the Company's normal payroll practices for a period of 12 months and which payments shall commence in accordance with the provisions of Section 6, herein (unless otherwise required to be paid in accordance with Section 7 below).

(b) **Stock Vesting.** Any unvested equity awards issued in the name of Covered Employee as of the date of termination, will vest in accordance with the terms contained in the applicable Award Agreement for such awards.

5. Termination by the Company without Cause or Termination by Covered Executive with Good Reason Following a Change in Control. The following provisions shall apply should the Company terminate a Covered Executive's employment without Cause or should a Covered Executive terminate Covered Executive's employment with Good Reason, in either case within one year following a Change in Control (as defined above):

(a) **Salary and Bonus.** The Company shall pay to Covered Executive (i) an amount equal to two (2) times the sum of (A) the Covered Executive's base salary, as in effect on the date of Employment Termination (or in the event a reduction in base salary is a basis for a termination with Good Reason, then the base salary in effect immediately prior to such reduction) and (B) the greater of (x) an amount equal to the cash bonus earned by the Covered

Executive for the previous fiscal year or (y) an amount equal to twenty-five (25) percent of the Covered Executive's base salary, as in effect on the date of Employment Termination (or, in the event a reduction in base salary is a basis for termination for Good Reason, then the base salary in effect immediately prior to such reduction), which amount shall be payable in a lump sum on the date or dates specified in Section 6, herein (unless otherwise required to be paid in accordance with Section 7 below).

(b) **Stock Vesting.** Any unvested equity awards issued in the name of Covered Employee as of the occurrence of a Change in Control will vest in accordance with the provisions of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan, as the same may be amended from time to time, or any successor plan thereto.

6. Release of Claims. The Company's obligations under this Plan are contingent upon Covered Executive's executing (and not revoking during any applicable revocation period) a valid, enforceable, full and unconditional release of all claims Covered Executive may have against the Company, Amedisys, Inc. and their respective directors, officers, employees, subsidiaries, stockholders, successors, assigns, agents, representatives subsidiaries and affiliates (whether known or unknown) as of the date of Employment Termination in such form as provided by the Company no later than 60 days after the date of Employment Termination. If the foregoing release is executed and delivered and no longer subject to revocation within 60 days after the date of Employment Termination, then the following shall apply:

(a) To the extent any payments due to Covered Executive under this Plan are not "deferred compensation" for purposes of Section 409A of the Code then such payments shall commence upon the first regularly-scheduled payment date immediately following the date the release is executed and no longer subject to revocation (the "Release Effective Date"). The first such cash payment shall include payment of all amounts that otherwise would have been due prior to the Release Effective Date under the terms of this Plan had such payments commenced after the date of Employment Termination, and any payments to be made thereafter shall continue as provided herein. The delayed payments shall in any event expire at the time such payments would have expired had such payments commenced after the date of Employment Termination.

(b) To the extent any payments due to Covered Executive under this Plan above are "deferred compensation" for purposes of Section 409A, then such payments shall commence upon the 60th day following the date of Employment Termination. The first such cash payment shall include payment of all amounts that otherwise would have been due prior thereto under the terms of this Plan had such payments commenced after the date of Employment Termination, and any payments to be made thereafter shall continue as provided herein. The delayed payments shall in any event expire at the time such payments would have expired had such payments commenced immediately following the date of Employment Termination.

7. Section 409A. Notwithstanding any provisions in this Plan to the contrary, if at the time of the Employment Termination the Covered Executive is a "specified employee" as defined in Section 409A and the deferral of the commencement of any payments or benefits

otherwise payable as a result of such Employment Termination is necessary to avoid the additional tax under Section 409A, the Company will defer the payment or commencement of the payment of any such payments or benefits (without any reduction in such payments or benefits ultimately paid or provided to Covered Executive) until one day after the day which is six months from the date of Employment Termination. Any monthly payment amounts deferred will be accumulated and paid to Covered Executive (without interest) six months after the date of Employment Termination in a lump sum, and the balance of payments due to Covered Executive will be paid as otherwise provided in this Plan. Each monthly payment described in this Plan is designated as a "separate payment" for purposes of Section 409A and, subject to the six month delay, if applicable, and the first monthly payment shall commence on the payroll date as in effect on termination following the termination. For purposes of this Plan, a termination of employment means a separation from service as defined in Section 409A. No reimbursement payable to Covered Executive pursuant to any provisions of this Plan or pursuant to any plan or arrangement of the Company shall be paid later than the last day of the calendar year following the calendar year in which the related expense was incurred, and no such reimbursement during any calendar year shall affect the amounts eligible for reimbursement in any other calendar year, except, in each case, to the extent that the right to reimbursement does not provide for a "deferral of compensation" within the meaning of Section 409A. This Plan will be interpreted, administered and operated in accordance with Section 409A, although nothing herein will be construed as an entitlement to or guarantee of any particular tax treatment to Covered Executive.

8. Claims Procedure. If a Covered Executive does not receive a benefit to which the Covered Executive believes he or she is entitled under the Plan, or if the Covered Executive believes that the Covered Executive is entitled to a greater benefit than was approved, the Covered Executive must, within 60 days following the date of Employment Termination, file a written claim with the Plan Administrator. The Plan Administrator will investigate the claim and will send the Covered Executive a written decision within 60 days from the date upon which it receives the claim. If the claim is denied, the written decision will specify the reasons for the denial (including the pertinent Plan provisions upon which the denial is based), as well as an explanation of how the Covered Executive may obtain a further review by the Plan Administrator. If the Covered Executive does not receive a notice regarding his or her claim within these time periods, the claim will be considered denied.

If the Covered Executive disagrees with the Plan Administrator's decision, in whole or in part, the Covered Executive has 60 days following receipt of written notice from the Plan Administrator to request a review in writing. The request must describe the reasons why the Covered Executive believes the denial was wrong and whatever evidence the Covered Executive believes supports his or her position. If the Covered Executive wishes to examine any Company documents, he or she must request an examination and specify the documents requested.

Within 60 days following a request for review, the Plan Administrator will send the Covered Executive its written decision specifying the reasons for the decision, including the pertinent Plan provisions upon which it is based. This decision shall be final and binding.

If special circumstances require an extension of time for the Plan Administrator to render a decision, the Plan Administrator will send the Covered Executive a written notice of the extension prior to the commencement of the extension and will explain the reasons for the delay.

The Company, as Plan Administrator, has the exclusive discretionary authority to construe and interpret the Plan, to decide all questions of eligibility for severance benefits under the Plan and to determine the amount of any such severance benefits, and its decisions on such matters are final and conclusive. Any interpretations or determinations made pursuant to such discretionary authority will be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious).

9. Your Rights Under ERISA. As a participant in the Plan, a Covered Executive is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Executive and other Plan participants and beneficiaries. No one, including the employer, or any other person, may fire the Covered Executive or otherwise discriminate against the Covered Executive in any way to prevent the Covered Executive from obtaining a welfare benefit or exercising his or her rights under ERISA. If the Covered Executive's claim for a welfare benefit is denied, in whole or in part, he or she must receive a written explanation of the reason for the denial. The Covered Executive has the right to have the Plan review and reconsider his or her claim.

Under ERISA, there are steps a Covered Executive can take to enforce the above rights. For instance, if the Covered Executive requests materials from the Plan and does not receive them within 30 days, he or she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Executive up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If the Covered Executive has a claim tor benefits which is denied or ignored, in whole or in part, the Covered Executive may file suit in a state or Federal court. In addition, if the Covered Executive disagrees with the Plan's decision or lack thereof concerning the qualified status of a

medical child support order, he or she may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Covered Executive is discriminated against for asserting his or her rights, the Covered Executive may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the Covered Executive is successful, the court may order the person the Covered Executive has sued to pay these costs and fees. If the Covered Executive loses, the court may order him or her to pay these costs and fees — for example, if the court finds the Covered Executive's claim is frivolous.

If the Covered Executive has any questions about the Plan, he or she should contact the Plan Administrator. If the Covered Executive has any questions about this statement or about his or her rights under ERISA, the Covered Executive should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

10. Additional Important Information. The name of the Plan is the Amedisys Holding, L.L.C. Severance Plan for Key Executives.

The sponsor of the Plan is Amedisys Holding, L.L.C. and its employer identification number is 36-4576454. The sponsor's address and telephone number is 209 10th Avenue South, Suite 512, Nashville, TN 37203, (615) 928-5458.

Amedisys Holding, L.L.C. also serves as the Plan Administrator under ERISA for the Plan, and can be contacted at 209 10th Avenue South, Suite 512, Nashville, TN 37203, (615) 928-5458.

The agent for service of process for the Plan is Secretary, Amedisys Holding, L.L.C., 209 10th Avenue South, Suite 512, Nashville, TN 37203, (615) 928-5458.

The Plan is an employee welfare benefit plan providing severance pay and benefits as described in this Plan document. All Severance Benefits under the Plan shall be paid directly by the Company from its general assets, and the rights of an eligible employee to any benefits hereunder shall not be superior to those of an unsecured general creditor of the Company.

The Plan year shall be the calendar year. The Plan number is 1.

Severance benefits under the Plan may not be assigned, transferred or pledged to a third party.

11. At-Will Employment. No provision of the Plan is intended to provide any Covered Executive with any right to continue as an employee or in any other capacity with the Company, for any specific period of time, or otherwise affect the right of the Company to terminate the employment or service of any individual at any time for any reason with or without cause.

12. Amendment and Termination. The Company reserves the right in its discretion to terminate the Plan and to amend the Plan in any manner at any time, subject to the prior approval of the Board and/or the Committee, as applicable. Any such action will be in writing and signed by the Chief Executive Officer or the Chief Human Resources Officer of the Company or such other persons as he or she shall designate. Oral or other informal communications made by the Company or its representatives shall not give rise to any rights or benefits other than those contained in the Plan described herein, and such communications will not diminish the Company's rights to amend or terminate the Plan in any manner.

This document is executed as of this 10th day of January 2017.

AMEDISYS HOLDING, L.L.C.

By: AMEDISYS, INC.
Its Sole Member and Manager

By: /s/ Larry Pernosky
Larry Pernosky
Chief Human Resources Officer

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Section 4: EX-21.1 (EX-21.1)

Exhibit 21.1

LIST OF SUBSIDIARIES

CORPORATIONS

AMEDISYS HOME HEALTH, INC. OF SOUTH CAROLINA, a South Carolina corporation
HI-TECH CARE, INC., a Florida Corporation
HMR ACQUISITION, INC., a Delaware corporation
INFINITY HOME CARE ACQUISITION CORP., a Florida corporation

LIMITED LIABILITY COMPANIES

ACCUMED HEALTH SERVICES, L.L.C., a Texas limited liability company
ACCUMED HOLDING, L.L.C., a Delaware limited liability company
ACCUMED HOME HEALTH OF GEORGIA, L.L.C.., a Georgia limited liability company
ADVENTA HOSPICE, L.L.C., a Florida limited liability company
ALBERT GALLATIN HOME CARE AND HOSPICE SERVICES, LLC, a Delaware limited liability company
AMEDISYS AIR, L.L.C., a Louisiana limited liability company
AMEDISYS ALABAMA, L.L.C., an Alabama limited liability company
AMEDISYS ALASKA, LLC, an Alaska limited liability company
AMEDISYS ARIZONA, L.L.C., an Arizona limited liability company
AMEDISYS ARKANSAS, LLC, an Arkansas limited liability company
AMEDISYS BA, LLC, a Delaware limited liability company
AMEDISYS DELAWARE, L.L.C., a Delaware limited liability company
AMEDISYS FLORIDA, L.L.C., a Florida limited liability company
AMEDISYS GEORGIA, L.L.C., a Georgia limited liability company
AMEDISYS HEALTH CARE WEST, L.L.C., a Delaware limited liability company
AMEDISYS HOLDING, L.L.C., a Louisiana limited liability company
AMEDISYS HOME HEALTH OF ALABAMA, L.L.C. an Alabama limited liability company
AMEDISYS HOME HEALTH OF VIRGINIA, L.L.C. a Virginia limited liability company
AMEDISYS HOSPICE, L.L.C., a Louisiana limited liability company
AMEDISYS IDAHO, L.L.C., an Idaho limited liability company
AMEDISYS ILLINOIS, L.L.C., an Illinois limited liability company
AMEDISYS INDIANA, L.L.C., an Indiana limited liability company
AMEDISYS IOWA, L.L.C., an Iowa limited liability company
AMEDISYS KANSAS, L.L.C., a Kansas limited liability company
AMEDISYS LA ACQUISITIONS, L.L.C., a Louisiana limited liability company
AMEDISYS LOUISIANA, L.L.C., a Louisiana limited liability company
AMEDISYS MAINE, P.L.L.C., a Maine professional limited liability company
AMEDISYS MARYLAND, L.L.C., a Maryland limited liability company
AMEDISYS MICHIGAN, L.L.C., a Michigan limited liability company
AMEDISYS MISSISSIPPI, L.L.C., a Mississippi limited liability company
AMEDISYS MISSOURI, L.L.C., a Missouri limited liability company

AMEDISYS NEW HAMPSHIRE, L.L.C., a New Hampshire limited liability company
AMEDISYS NEW JERSEY, L.L.C., a New Jersey limited liability company
AMEDISYS NEW MEXICO, L.L.C., a New Mexico limited liability company
AMEDISYS NORTH CAROLINA, L.L.C., a North Carolina limited liability company
AMEDISYS NORTHWEST, L.L.C., a Georgia limited liability company
AMEDISYS OHIO, L.L.C., an Ohio limited liability company
AMEDISYS OKLAHOMA, L.L.C., an Oklahoma limited liability company
AMEDISYS OREGON, L.L.C., an Oregon limited liability company
AMEDISYS PENNSYLVANIA, L.L.C., a Pennsylvania limited liability company
AMEDISYS PERSONAL CARE, LLC, a Delaware limited liability company
AMEDISYS PROPERTY, L.L.C., a Louisiana limited liability company
AMEDISYS RHODE ISLAND, L.L.C., a Rhode Island limited liability company
AMEDISYS SC, L.L.C., a South Carolina limited liability company
AMEDISYS SOUTH FLORIDA, L.L.C., a Florida limited liability company
AMEDISYS SPECIALIZED MEDICAL SERVICES, L.L.C., a Louisiana limited liability company

AMEDISYS SP-IN, L.L.C., an Indiana limited liability company
AMEDISYS SP-KY, L.L.C., a Kentucky limited liability company
AMEDISYS SP-OH, L.L.C., an Ohio limited liability company
AMEDISYS SP-TN, L.L.C., a Tennessee limited liability company
AMEDISYS TENNESSEE, L.L.C., a Tennessee limited liability company
AMEDISYS TEXAS, L.L.C., a Texas limited liability company
AMEDISYS TLC ACQUISITION, L.L.C., a Louisiana limited liability company
AMEDISYS WASHINGTON, L.L.C., a Washington limited liability company
AMEDISYS WEST VIRGINIA, L.L.C., a West Virginia limited liability company
AMEDISYS WISCONSIN, L.L.C., a Wisconsin limited liability company
ANGEL WATCH HOME CARE, L.L.C., a Florida limited liability company
ANMC VENTURES, L.L.C., a Louisiana liability company
ASSOCIATED HOME CARE, L.C.C., a Massachusetts limited liability company
AVENIR VENTURES, L.L.C., a Louisiana limited liability company
BEACON HOSPICE, L.L.C., a Delaware limited liability company
BROOKSIDE HOME HEALTH, LLC, a Virginia limited liability company
CH HOLDINGS, LLC, a Louisiana limited liability company
COMPREHENSIVE HOME HEALTHCARE SERVICES, L.L.C., a Tennessee limited liability company
ELDER HOME OPTIONS, L.C.C., a Massachusetts limited liability company
EMERALD CARE, L.L.C., a North Carolina limited liability company
FAMILY HOME HEALTH CARE, L.L.C., a Kentucky limited liability company
HHC, L.L.C., a Tennessee limited liability company
HOME HEALTH OF ALEXANDRIA, L.L.C., a Louisiana limited liability company
HOME HOSPITALISTS OF AMERICA, LLC, a Delaware limited liability company
HORIZONS HOSPICE CARE, L.L.C., an Alabama limited liability company
HOUSECALL, L.L.C., a Tennessee limited liability company
HOUSECALL HOME HEALTH, L.L.C., a Tennessee limited liability company
HOUSECALL MEDICAL RESOURCES, L.L.C., a Delaware limited liability company
HOUSECALL MEDICAL SERVICES, L.L.C., a Tennessee limited liability company
INFINITY HOME CARE, L.L.C., a Florida limited liability company
INFINITY HOME CARE OF BROWARD, LLC, a Florida limited liability company
INFINITY HOME CARE OF LAKELAND, LLC, a Florida limited liability company
INFINITY HOME CARE OF OCALA, LLC, a Florida limited liability company
INFINITY HOME CARE OF PINELLAS, LLC, a Florida limited liability company
INFINITY HOME CARE OF PORT CHARLOTTE, LLC, a Florida limited liability company
INFINITY HOME CARE OF JACKSONVILLE, LLC, a Florida limited liability company
INFINITY HOMECARE OF DISTRICT 9, LLC, a Florida limited liability company
MC VENTURES, LLC, a Mississippi limited liability company
NINE PALMS 1, L.L.C., a Virginia limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES INTERNATIONAL, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF BROWARD, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF ERIE NIAGARA, LLC, a New York limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF GEORGIA, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF NASSAU SUFFOLK, LLC, a New York limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF NEW ENGLAND, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF WEST VIRGINIA, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES SOUTHEAST, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES WESTERN, LLC, a Delaware limited liability company
TLC HOLDINGS I, L.L.C., a Delaware limited liability company
TLC HEALTH CARE SERVICES, L.L.C., a Delaware limited liability company

LIMITED PARTNERSHIPS/LIMITED LIABILITY PARTNERSHIPS

NINE PALMS 2, LLP, a Mississippi limited liability partnership

JOINT VENTURES

AMEDISYS HOME HEALTH, A LAWRENCE MEDICAL CENTER PARTNER, L.L.C, a Delaware limited liability company **(66.67% ownership)**

AMEDISYS PRIVATE DUTY, LLC, a Delaware limited liability company **(50% ownership)**
GEORGETOWN HOSPITAL HOME HEALTH, LLC, a Delaware limited liability company **(70% ownership)**
MARIETTA HOME HEALTH AND HOSPICE, L.L.C., an Ohio limited liability company **(50% ownership)**
MORGANTOWN HOSPICE, LLC, a Delaware limited liability company **(80% ownership)**
TRI-CITIES HOME HEALTH, LLC, a Delaware limited liability company **(50% ownership)**
TUCSON HOME HEALTH, LLC, a Delaware limited liability company **(70% ownership)**
WENTWORTH HOME CARE AND HOSPICE, LLC, a New Hampshire limited liability company **(50% ownership)**
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Section 5: EX-23.1 (EX-23.1)

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

The Board of Directors
Amedisys, Inc.:

We consent to the incorporation by reference in the registration statements (Nos. 333-138255 and 333-145582) on Form S-3 and (Nos. 333-60525, 333-51704, 333-53786, 333-143967, 333-152359, 333-182347 and 333-205267) on Form S-8 of Amedisys, Inc. and subsidiaries of our reports dated March 1, 2017, with respect to the consolidated balance sheets of Amedisys, Inc. and subsidiaries as of December 31, 2016 and 2015, and the related consolidated statements of operations, comprehensive income (loss), stockholders' equity and cash flows for each of the years in the three-year period ended December 31, 2016, and the effectiveness of internal control over financial reporting as of December 31, 2016, which reports appear in the December 31, 2016 Annual Report on Form 10-K of Amedisys, Inc. and subsidiaries.

Our report dated March 1, 2017, on the effectiveness of internal control over financial reporting as of December 31, 2016, contains an explanatory paragraph that states Amedisys, Inc. acquired Associated Home Care on March 1, 2016 and the assets of Professional Profiles, Inc. on September 1, 2016, and management excluded from its assessment of the effectiveness of Amedisys, Inc.'s internal control over financial reporting as of December 31, 2016, Associated Home Care's and Professional Profiles, Inc.'s internal control over financial reporting associated with approximately 1% of total assets and 2% of revenue included in the consolidated financial statements of Amedisys, Inc. as of and for the year ended December 31, 2016. Our audit of internal control over financial reporting of Amedisys, Inc. also excluded an evaluation of the internal control over financial reporting of Associated Home Care and Professional Profiles, Inc.

/s/ KPMG LLP

Baton Rouge, Louisiana
March 1, 2017
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Section 6: EX-31.1 (EX-31.1)

Exhibit 31.1

CERTIFICATION

I, Paul B. Kusserow, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2016, of Amedisys, Inc.;

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

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

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

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

b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under

our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

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

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

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

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

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

Date: March 1, 2017

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

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Section 7: EX-31.2 (EX-31.2)

Exhibit 31.2

CERTIFICATION

I, Gary D. Willis, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2016, of Amedisys, Inc.;

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

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

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

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

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

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

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

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

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

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

Date: March 1, 2017

/S/ Gary D. Willis
Gary D. Willis
Chief Financial Officer
(Principal Financial Officer)

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Section 8: EX-32.1 (EX-32.1)

Exhibit 32.1

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

In connection with the Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2016 (the "Report"), I, Paul B. Kusserow, President and Chief Executive Officer of the Company, hereby certify to my knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Date: March 1, 2017

/S/ Paul B. Kusserow
Paul B. Kusserow
President and Chief Executive Officer
(Principal Executive Officer)
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Section 9: EX-32.2 (EX-32.2)

Exhibit 32.2

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

In connection with the Annual Report of Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2016 (the "Report"), I, Gary D. Willis, Chief Financial Officer of the Company, hereby certify to my knowledge, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

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

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

Date: March 1, 2017

/S/ Gary D. Willis
Gary D. Willis
Chief Financial Officer
(Principal Financial Officer)
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