General Moly, Inc
Form 10-Q
May 04, 2015
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended March 31, 2015

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

For the transition period from to

Commission File Number: 001-32986

General Moly, Inc.

(Exact name of registrant as specified in its charter)

DELAWARE	**91-0232000**

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

1726 Cole Blvd., Suite 115

Lakewood, CO 80401

Telephone: (303) 928-8599

(Address and telephone number of principal executive offices)

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

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 x NO o

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 o	Accelerated filer x
Non-accelerated filer o (Do not check if smaller reporting company)	Smaller reporting company o

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES o NO x

The number of shares outstanding of issuer s common stock as of April 30, 2015, was 95,368,979.

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PART I - FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

GENERAL MOLY, INC.

CONSOLIDATED BALANCE SHEETS

(In thousands, except par value amounts)

	March 31, 2015 (Unaudited)	December 31, 2014
ASSETS:		
CURRENT ASSETS		
Cash and cash equivalents	$ 16,332	$ 13,269
Deposits, prepaid expenses and other current assets	728	698
Total Current Assets	17,060	13,967
Mining properties, land and water rights	218,030	216,595
Deposits on project property, plant and equipment	85,452	74,151
Restricted cash held at EMLLC	18,160	36,000
Restricted cash held for electricity transmission	12,021	12,021
Restricted cash held for reclamation bonds	5,109	5,358
Non-mining property and equipment, net	482	519
Debt Issuance Costs	374	441
Other assets	2,994	2,994
TOTAL ASSETS	$ 359,682	$ 362,046
LIABILITIES, CRNCI, AND EQUITY:		
CURRENT LIABILITIES		
Accounts payable and accrued liabilities	$ 6,077	$ 4,633
Accrued advance royalties	500	500
Current portion of long term debt	271	290
Total Current Liabilities	6,848	5,423
Provision for post closure reclamation and remediation costs	1,241	1,276
Accrued advance royalties	5,200	5,200
Accrued payments to Agricultural Sustainability Trust	4,000	4,000
Long term debt, net of current portion	481	249
Convertible Senior Notes	7,677	7,763
Return of Contributions Payable to POS-Minerals	34,322	
Other accrued liabilities	1,125	1,125
Total Liabilities	60,894	25,036
COMMITMENTS AND CONTINGENCIES		
CONTINGENTLY REDEEMABLE NONCONTROLLING INTEREST (CRNCI)	175,301	210,317
EQUITY		

Common stock, $0.001 par value; 200,000,000 shares authorized, 93,493,979 and 92,200,657 shares issued and outstanding, respectively		93		92
Additional paid-in capital		277,285		276,718
Accumulated deficit		(153,891)		(150,117)
Total Equity		123,487		126,693
TOTAL LIABILITIES, CRNCI, AND EQUITY	$	359,682	$	362,046

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

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GENERAL MOLY, INC. (GMI)
CONSOLIDATED STATEMENTS OF OPERATIONS AND COMPREHENSIVE LOSS

(Unaudited In thousands, except per share amounts)

	March 31, 2015	March 31, 2014
REVENUES	$	$
OPERATING EXPENSES:		
Exploration and evaluation	117	134
General and administrative expense	2,986	2,225
TOTAL OPERATING EXPENSES	3,103	2,359
LOSS FROM OPERATIONS	(3,103)	(2,359)
OTHER INCOME/(EXPENSE):		
Interest and dividend income		
Loss on Extinguishment of Convertible Senior Notes	(120)	
Interest expense	(561)	
TOTAL OTHER (EXPENSE)/INCOME, NET	(681)	
LOSS BEFORE INCOME TAXES	(3,784)	(2,359)
Income Taxes		
CONSOLIDATED NET LOSS	$ (3,784)	$ (2,359)
Less: Net loss attributable to CRNCI	10	
NET LOSS ATTRIBUTABLE TO GMI	$ (3,774)	$ (2,359)
Basic and diluted net loss attributable to GMI per share of common stock	$ (0.04)	$ (0.03)
Weighted average number of shares outstanding basic and diluted	93,052	91,863
COMPREHENSIVE LOSS	$ (3,774)	$ (2,359)

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

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GENERAL MOLY, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(Unaudited In thousands)

	Three Months Ended	
	March 31, 2015	**March 31, 2014**
CASH FLOWS FROM OPERATING ACTIVITIES:		
Consolidated Net Loss	$ (3,784)	$ (2,359)
Adjustments to reconcile net loss to net cash used by operating activities:		
Depreciation and amortization	60	73
Non-cash Interest expense	351	
Stock-based compensation for employees and directors	338	574
Increase in deposits, prepaid expenses and other	(30)	(16)
(Decrease) increase in accounts payable and accrued liabilities	(959)	274
Extinguishment of Convertible Senior Notes	120	
Decrease in post closure reclamation and remediation costs	(54)	(131)
Net cash used by operating activities	(3,958)	(1,585)
CASH FLOWS FROM INVESTING ACTIVITIES:		
Purchase and development of mining properties, land and water rights	(1,369)	(2,890)
Deposits on property, plant and equipment	(8,898)	(192)
Decrease (Increase) in restricted cash held for reclamation bonds	249	(6)
Decrease in restricted cash EMLLC	17,840	
Net cash provided by (used in) investing activities	7,822	(3,088)
CASH FLOWS FROM FINANCING ACTIVITIES:		
Cash contributions from/returned to POS-Minerals	(684)	23
Repayment of Long-Term Debt	(54)	(65)
Proceeds from issuance of stock, net of issuance costs	(63)	(4)
Net cash used in (provided by) financing activities	(801)	(46)
Net increase (decrease) in cash and cash equivalents	3,063	(4,719)
Cash and cash equivalents, beginning of period	13,269	21,685
Cash and cash equivalents, end of period	$ 16,332	$ 16,966
NON-CASH INVESTING AND FINANCING ACTIVITIES:		
Equity compensation capitalized as development	$ 70	$ 333
Change in accrued portion of deposits on property, plant and equipment	2,403	(190)
Conversion of Convertible Senior Notes	(370)	
Non-Convertible Senior Notes Issued	267	
Return of Contributions	36,000	
Decrease in Return of Contributions	(1,678)	

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

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GENERAL MOLY, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

NOTE 1 DESCRIPTION OF BUSINESS

General Moly, Inc. (we, us, our, Company, or General Moly) is a Delaware corporation originally incorporated as General Mines Corporatio November 23, 1925. We have gone through several name changes and on October 5, 2007, we reincorporated in the State of Delaware (Reincorporation) through a merger involving Idaho General Mines, Inc. and General Moly, Inc., a Delaware corporation that was a wholly owned subsidiary of Idaho General Mines, Inc. The Reincorporation was effected by merging Idaho General Mines, Inc. with and into General Moly, with General Moly being the surviving entity. For purposes of the Company s reporting status with the United States Securities and Exchange Commission (SEC), General Moly is deemed a successor to Idaho General Mines, Inc.

The Company conducted exploration and evaluation activities from January 1, 2002 until October 4, 2007, when our Board of Directors (Board) approved the development of the Mt. Hope molybdenum property (Mt. Hope Project) in Eureka County, Nevada. The Company is currently proceeding with the development of the Mt. Hope Project. We are also conducting exploration and evaluation activities on our Liberty molybdenum and copper property (Liberty Project) in Nye County, Nevada.

The Mt. Hope Project

From October 2005 to January 2008, we owned the rights to 100% of the Mt. Hope Project. Effective as of January 1, 2008, we contributed all of our interest in the assets related to the Mt. Hope Project, including our lease of the Mt. Hope Project, into Eureka Moly, LLC (the LLC), and in February 2008 entered into an agreement (LLC Agreement) for the development and operation of the Mt. Hope Project with POS-Minerals Corporation (POS-Minerals). Under the LLC Agreement, POS-Minerals owns a 20% interest in the LLC and General Moly, through Nevada Moly, LLC (Nevada Moly), a wholly-owned subsidiary, owns an 80% interest. In this report, POS-Minerals and Nevada Moly are also referred to as the members . The ownership interests and/or required capital contributions under the LLC Agreement can change as discussed below.

Pursuant to the terms of the LLC Agreement, POS-Minerals made its first and second capital contributions to the LLC totaling $100.0 million during the year ended December 31, 2008 (Initial Contributions). Additional amounts of $100.7 million were received from POS-Minerals in December 2012, following receipt of major operating permits for the Mt. Hope Project, including the Record of Decision (ROD) from the U.S. Bureau of Land Management (BLM).

In addition, under the terms of the LLC Agreement, since commercial production at the Mt. Hope Project was not achieved by December 31, 2011, the LLC will be required to return to POS-Minerals $36.0 million of its capital contributions (Return of Contributions), with no corresponding reduction in POS-Minerals ownership percentage. Effective January 1, 2015, as part of a comprehensive agreement concerning the release of the reserve account described below, Nevada Moly and POS-Minerals agreed that the $36.0 million will be due to POS-Minerals on December 31, 2020; provided that, at any time on or before November 30, 2020, Nevada Moly and POS-Minerals may agree in writing to

extend the due date to December 31, 2021; and if the due date has been so extended, at any time on or before November 30, 2021, Nevada Moly and POS-Minerals may agree in writing to extend the due date to December 31, 2022. If the repayment date is extended, the unpaid amount will bear interest at a rate per annum of LIBOR plus 5%, which interest shall compound quarterly, commencing on December 31, 2020 through the date of payment in full. Payments of accrued but unpaid interest, if any, shall be made on the repayment date. Nevada Moly may elect, on behalf of the Company to cause the Company to prepay, in whole or in part, the $36.0 million at any time, without premium or penalty, along with accrued and unpaid interest, if any.

The $36.0 million due to POS-Minerals will be reduced, dollar for dollar, by the amount of capital contributions for equipment payments required from POS-Minerals under approved budgets of the LLC, as discussed further below. As of March 31, 2015, this amount has been reduced by $1.7 million, 20% of an $8.4 million dollar principal payment made on milling equipment in March 2015. If Nevada Moly does not fund its additional capital contribution in order for the LLC to make the required Return of Contributions to POS-Minerals set forth above, POS-Minerals has an election to either make a secured loan to the LLC to fund the Return of Contributions, or receive an additional interest in the LLC estimated to be 5%. In the latter case, Nevada Moly s interest in the LLC is subject to dilution by a percentage equal to the ratio of 1.5 times the amount of the unpaid Return of Contributions over the aggregate amount of deemed capital contributions (as determined under the LLC Agreement) of both parties to the LLC (Dilution Formula). At March 31, 2015, the aggregate amount of deemed capital contributions of both parties was $1,084.7 million.

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Furthermore, the LLC Agreement permits POS-Minerals to put its interest in the LLC to Nevada Moly after a change of control of Nevada Moly or the Company, as defined in the LLC Agreement, followed by a failure by us or our successor company to use standard mining industry practice in connection with the development and operation of the Mt. Hope Project as contemplated by the parties for a period of 12 consecutive months. If POS-Minerals puts its interest, Nevada Moly or its transferee or surviving entity would be required to purchase the interest for 120% of POS-Minerals total contributions to the LLC, which, if not paid timely, would be subject to 10% interest per annum.

In November 2012, the Company and POS-Minerals began making monthly pro rata capital contributions to the LLC to fund costs incurred as required by the LLC Agreement. The interest of a party in the LLC that does not make its monthly pro rata capital contributions to fund costs incurred is subject to dilution based on the Dilution Formula. The Company and POS-Minerals consented, effective July 1, 2013, to Nevada Moly accepting financial responsibility for POS-Minerals 20% interest in costs related to Nevada Moly s compensation and reimbursement as Manager of the LLC, and certain owners costs associated with Nevada Moly s ongoing progress to complete project financing for its 80% interest, resulting in $2.9 million paid by Nevada Moly on behalf of POS-Minerals during the term of the consensual agreement, which ended on June 30, 2014. From July 1 to December 31, 2014, POS-Minerals once again contributed its 20% interest in all costs incurred by the LLC. Subject to the terms above, all required monthly contributions have been made by both parties.

Effective January 1, 2015, Nevada Moly and POS-Minerals signed an amendment to the LLC agreement under which $36.0 million held by the LLC in a reserve account established in December 2012 will be released over the next few years for the benefit of the Mt. Hope Project. In January 2015, the reserve account funded a reimbursement of contributions made by the members during the fourth quarter of 2014, inclusive of $0.7 million to POS-Minerals and $2.7 million to Nevada Moly. The funds are now being used to pay ongoing expenses of the LLC until the Company obtains full financing for its portion of the Mt. Hope Project construction cost, or until the reserve account is exhausted. Any remaining funds after financing is obtained will be returned to the Company.

Termination of Agreements with Hanlong (USA) Mining Investment Inc.

In March 2010, we signed a series of agreements with Hanlong (USA) Mining Investment, Inc. (Hanlong), an affiliate of Sichuan Hanlong Group, a privately held Chinese company. The agreements formed the basis of an anticipated $745 million transaction that was intended to provide the Company with adequate capital to contribute its 80% share of costs to develop the Mt. Hope Project. The agreements resulted in the sale to Hanlong of 11.8 million shares of our common stock for a purchase price of $40 million, with additional potential equity issuances conditioned on Hanlong procuring a project financing Term Loan from a Chinese bank. The agreements also provided for Hanlong representation on our Board, limitations on how Hanlong would vote its shares of the Company and on their ability to purchase or dispose of our securities, and included a $10.0 million Bridge Loan to the Company to preserve liquidity until availability of the Term Loan. Their shares were registered effective January 29, 2014, allowing Hanlong to sell their shares to a third party.

Most of the provisions of the agreements with Hanlong were terminated in 2013 because no project financing occurred. However, Hanlong remains the owner of approximately 13% of our outstanding common stock and their representative continues as a member of our Board as of March 31, 2015.

NOTE 2 LIQUIDITY

The cash needs for the development of the Mt. Hope Project are significant and require that we and/or the LLC arrange for financing to be combined with funds anticipated to be received from POS-Minerals in order to retain its 20% membership interest. If we are unsuccessful in obtaining financing, we will not be able to proceed with the development of the Mt. Hope Project.

The Company continues its efforts to obtain full financing of the fully permitted, construction-ready Mt. Hope Project. As discussed more fully in Note 13 Subsequent Events, on April 17, 2015, the Company announced a significant Investment and Securities Purchase Agreement with AMER International Group (AMER). With this new investment, which remains subject to shareholder approval and satisfaction of other conditions, the Company is creating a strategic partnership with AMER and AMER is making an equity investment in the Company to assist with the Company s ability to secure full project financing for the Mt. Hope Project. AMER has agreed to work with the Company to procure and support a senior secured term loan (Bank Loan) of approximately $700 million from a major Chinese bank or banks for development of the Mt. Hope Project, and to provide a guarantee for the Bank Loan.

Discussions on sponsorship requirements, and indicative loan terms associated with a $700 million debt and up to $60 million equity package are continuing to advance, with strong interest from a large Chinese bank in advancing the loan proceeds to the Mt. Hope Project. There is no assurance that the Company will be successful in raising the financing required to complete the Mt. Hope Project, or in raising additional financing in the future on terms acceptable to the Company, or at all. Further, the Company does not have an estimated timeframe for finalizing any financing agreements.

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In order to preserve our cash liquidity, in the third quarter of 2013, we implemented a cost reduction and personnel retention program, which included reductions in base cash compensation for our executive officers, senior management employees and members of the Board of Directors. We approved cash and equity incentives for the executive officers who remained with the Company through the earliest to occur of a financing plan for the Mt. Hope Project approved by the Board of Directors, a Change of Control (as defined in the employment or change of control agreements between the Company and each of our executive officers); involuntary termination (absent cause); or January 15, 2015 (the Vesting Date), and a personnel retention program providing cash and equity incentives for other employees who remained with the Company. On the January 15, 2015 Vesting Date, we paid $1.1 million in cash stay incentives to our eligible employees and executive officers, excluding our CEO, Bruce D. Hansen. Mr. Hansen agreed to defer his $0.4 million cash stay incentive in consideration for an equity grant. The Company also issued 726,493 shares of common stock on the January 15th Vesting Date under this plan.

In December 2014, the Company sold and issued $8.5 million in units consisting of Convertible Senior Notes (the Notes) and warrants to accredited investors, including several directors and each of our named executive officers of the Company, pursuant to Section 4(a)(2) of the Securities Act of 1933, as amended, and Rule 506 thereunder. The Notes are unsecured obligations and are senior to any of the Company s future secured obligations to the extent of the value of the collateral securing such obligations. The warrants are exercisable between June 26, 2015 and December 26, 2019, for an aggregate of 8,535,000 shares of the Company s common stock at $1.00 per share. The Company received net proceeds from the sale of the units of approximately $8.0 million, after deducting offering expenses of approximately $0.5 million. Net proceeds from the sale will be used to fund ongoing operations.

As previously mentioned, effective January 1, 2015, Nevada Moly and POS-Minerals amended their LLC agreement to allow for the use of the $36.0 million held by the LLC in a reserve account for use on the Mt. Hope Project. The funds are now being used to pay ongoing expenses of the LLC until the Company obtains full financing for its portion of the Mt. Hope Project construction cost, or until the reserve account is exhausted.

We continue to work with our long-lead vendors to manage the timing of contractual payments for milling equipment. In March 2015, the LLC remitted $8.9 million to the manufacturer of our crusher, SAG and ball mills, and in early April 2015, made a $2.4 million payment due to the manufacturer of the two 230kV primary transformers. Both payments were funded with cash from the reserve account, described above. The following table sets forth the LLC s remaining cash commitments under these equipment contracts (collectively, Purchase Contracts) at March 31, 2015 (in millions):

Year		As of March 31, 2015 *
2015		2.4
2016		2.6
2017		0.8
Total	$	5.8

* All amounts are commitments of the LLC, and as a result of the agreement between Nevada Moly and POS-Minerals are to be funded by the reserve account until such time that the Company obtains financing for its portion of construction costs at the Mt. Hope Project or until the reserve account balance is exhausted, and thereafter are to be funded 80% by Nevada Moly and 20% by POS-Minerals. POS-Minerals remains obligated to make capital contributions for its 20% portion of equipment payments required by approved budgets of the LLC, and such amounts contributed by the reserve account on behalf of POS-Minerals will reduce, dollar for dollar, the amount of capital contributions that the LLC is required to return to POS-Minerals, as described in Note 1.

If the LLC does not make the payments contractually required under these purchase contracts, it could be subject to claims for breach of contract or to cancellation of the respective purchase contract. In addition, the LLC may proceed to selectively suspend, cancel or attempt to renegotiate additional purchase contracts if necessary to further conserve cash. If the LLC cancels or breaches any contracts, the LLC will take all appropriate action to minimize any losses, but could be subject to liability under the contracts or applicable law. The cancellation of certain key contracts could cause a delay in the commencement of operations, and could add to the cost to develop the Company s interest in the Mt. Hope Project.

Through March 31, 2015, the LLC has made deposits and/or final payments of $85.5 million on equipment orders for which the LLC has additional contractual commitments of $5.8 million noted in the table above. Of these deposits and/or final payments, $75.7 million relate to fully fabricated items, primarily milling equipment, while the remaining $9.8 million reflects both partially fabricated milling equipment, and non-refundable deposits on mining equipment. The underlying value and recoverability of these deposits and our mining properties in our consolidated balance sheets are dependent on the LLC s ability to fund development activities that would lead to profitable production and positive cash flow from operations, or proceeds from the disposition of these assets. There can be no assurance that the LLC will be successful in generating future profitable operations, disposing of these assets

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or the Company securing additional funding in the future on terms acceptable to us or at all. Our consolidated financial statements do not include any adjustments relating to recoverability and classification of recorded assets or liabilities.

Based on our commitments as of March 31, 2015, the LLC expects to make additional payments for reclamation bonding costs of $0.8 million and advance royalties of $0.5 million through the end of 2015. With our cash conservation plan, our non-equipment related cash requirements have declined to approximately $1.3 million per month, a portion of which is payable out of the $36.0 million reserve account. Accordingly, based on our current cash on hand and our ongoing cash conservation plan, the Company expects it will have adequate liquidity to fund our working capital needs through 2015. Potential funding sources include public or private equity offerings, including the equity investment described in Note 13 below, arranging for use of restricted cash, or sale of non-core assets owned by the Company. There is no assurance that the Company will be successful in securing additional funding. This could result in further cost reductions, contract cancellations, and potential delays which ultimately may jeopardize the development of the Mt. Hope Project.

NOTE 3 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The interim consolidated financial statement (interim statements) of the Company are unaudited. In the opinion of management, all adjustments and disclosures necessary for a fair presentation of these interim statements have been included. All such adjustments are, in the opinion of management, of a normal recurring nature. The results reported in these interim statements are not necessarily indicative of the results that may be presented for the entire year. These interim statements should be read in conjunction with the consolidated financial statements included in our Annual Report on Form 10-K for the year ended December 31, 2014, filed with the Securities and Exchange Commission (SEC) on March 11, 2015.

This summary of significant accounting policies is presented to assist in understanding the financial statements. The financial statements and notes are representations of the Company s management, which is responsible for their integrity and objectivity. These accounting policies conform to accounting principles generally accepted in the United States of America (GAAP) and have been consistently applied in the preparation of the financial statements.

Accounting Method

Our financial statements are prepared using the accrual basis of accounting in accordance with GAAP. With the exception of the LLC, all of our subsidiaries are wholly owned. In February 2008, we entered into the LLC Agreement, which established our ownership interest in the LLC at 80%. The consolidated financial statements include all of our wholly owned subsidiaries and the LLC. The POS-Minerals contributions attributable to their 20% interest are shown as Contingently Redeemable Noncontrolling Interest on the Consolidated Balance Sheet. The net loss attributable to contingently redeemable noncontrolling interest is reflected separately on the Consolidated Statement of Operations and reduces the Contingently Redeemable Noncontrolling Interest on the Consolidated Balance Sheet. Net losses of the LLC are attributable to the members of the LLC based on their respective ownership percentages in the LLC. During 2015, the LLC had a $50,000 loss primarily associated with accretion expense related to reclamation liabilities and the amortization of the electricity transmission contract, of which $10,000 was attributed to the Contingently Redeemable Noncontrolling Interest.

Contingently Redeemable Noncontrolling Interest (CRNCI)

Under GAAP, certain noncontrolling interests in consolidated entities meet the definition of mandatorily redeemable financial instruments if the ability to redeem the interest is outside of the control of the consolidating entity. As described in Note 1 Description of Business , the LLC Agreement permits POS-Minerals the option to put its interest in the LLC to Nevada Moly upon a change of control, as defined in the LLC Agreement, followed by a failure by us or our successor company to use standard mining industry practice in connection with development and operation of the Mt. Hope Project as contemplated by the parties for a period of 12 consecutive months. As such, the CRNCI has continued to be shown as a separate caption between liabilities and equity. The carrying value of the CRNCI has historically included the $36.0 million Return of Contributions that will be returned to POS-Minerals in 2020, unless further extended by the members of the LLC as discussed above. The expected Return of Contributions to POS-Minerals was carried at redemption value as we believed redemption of this amount was probable. Effective January 1, 2015, Nevada Moly and POS-Minerals agreed that the $36.0 million Return of Contributions will be due to POS-Minerals on December 31, 2020, unless further extended by the members of the LLC as discussed above. As a result, we have reclassified the $36.0 million payable to POS-Minerals from CRNCI to a non-current liability at redemption value.

The remaining carrying value of the CRNCI has not been adjusted to its redemption value as the contingencies that may allow POS-Minerals to require redemption of its noncontrolling interest are not probable of occurring. Under GAAP, until such time as that contingency has been eliminated and redemption is no longer contingent upon anything other than the passage of time, no adjustment to the CRNCI balance should be made. Future changes in the redemption value will be recognized immediately as they

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occur and the Company will adjust the carrying amount of the CRNCI to equal the redemption value at the end of each reporting period.

Estimates

The process of preparing consolidated financial statements requires the use of estimates and assumptions regarding certain types of assets, liabilities, revenues, and expenses. Such estimates primarily relate to unsettled transactions and events as of the date of the financial statements. Accordingly, upon settlement, actual results may differ from estimated amounts.

Cash and Cash Equivalents and Restricted Cash

We consider all highly liquid investments with original maturities of three months or less to be cash equivalents. The Company s cash equivalent instruments are classified within Level 1 of the fair value hierarchy established by FASB guidance for Fair Value Measurements because they are valued based on quoted market prices in active markets.

We consider all restricted cash to be long-term. As discussed above, in December 2012, the Company established a reserve account at the direction of the LLC management committee in the amount of $36.0 million. Effective January 1, 2015, Nevada Moly and POS-Minerals agreed upon procedures for maintaining the Mt. Hope Project as described above. Under the agreement, the $36.0 million held by the LLC, which funds were to remain restricted until availability of the Company s portion of financing for the Mt. Hope Project is confirmed or until the LLC management committee agreed to release the funds, will be released for the benefit of the Mt. Hope Project. The balance of the reserve account at March 31, 2015 was $18.2 million.

Basic and Diluted Net Loss Per Share

Net loss per share was computed by dividing the net loss attributable to the Company by the weighted average number of shares outstanding during the period. The weighted average number of shares was calculated by taking the number of shares outstanding and weighting them by the amount of time that they were outstanding. Outstanding awards as of March 31, 2015 and December 31, 2014, respectively, were as follows:

	March 31, 2015	December 31, 2014
Warrants	9,535,000	9,535,000
Stock Options	257,779	271,112
Unvested Stock Awards	2,359,776	1,723,328
Stock Appreciation Rights	1,803,146	1,923,144

- changes to case mix or therapy thresholds;
- the reclassification of home health resource groups or long-term care diagnosis-related groups; or
- further limitations on referrals to long-term acute care hospitals from host hospitals.

We receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. Also beginning on April 1, 2013 Medicare reimbursement was cut an additional 2% through sequestration as mandated by the Congressional Budget Act. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related

groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted.

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

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

- licensure and certificates of need and permits of approval;
- coding and billing for services;
- conduct of operations, including financial relationships among health care providers, Medicare fraud and abuse and physician self-referral;
- maintenance and protection of records, including HIPAA;
- environmental protection, health and safety;
- certification of additional agencies or facilities by the Medicare program; and
- payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer and our interactions with patients and other providers. See Part I, Item 1. Government Regulations in this Annual Report on Form 10-K for additional information concerning applicable laws and regulations. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws, regulations, their interpretations or the enactment of new laws or regulations could increase our costs of doing business and cause our net income to decline. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state reimbursement programs.

On December 11, 2014, CMS proposed a star rating methodology for home health agencies to meet the PPACA's call for more transparent, public information on provider quality. All Medicare-certified home health agencies would be eligible to receive a star rating (from one to five stars) based on a number of quality measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring, and bathing, among others. The "Quality of Patient Care Star Ratings" were first published in July, 2015, and are updated quarterly thereafter based upon new data that is published with the ratings on the "Home Health Compare" section of the medicare.gov website. While we are pleased with the initial ratings received by our home health agencies and are striving to improve our results, it is not clear at this time what impact, if any, the new rating system will have on our home health business.

We face 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.

We are subject to various routine and non-routine governmental reviews, audits and investigations. These audits include those conducted through the recovery audit contractor program ("RAC") and the zone program integrity contractor program ("ZPIC"), in which third party firms engaged by CMS conduct extensive reviews of claims data and non-medical and other records to identify potential improper payments under the Medicare Program. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including with respect to referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Although we have invested substantial time and effort in implementing policies and procedures to comply with laws and regulations, we could be subject to liabilities arising from violations. A violation of the laws governing our operations, or changes in the interpretation of

those laws, could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs or the suspension or revocation of our licenses to operate. If we become subject to material fines or if other sanctions or other corrective actions are imposed upon us, we may suffer a substantial reduction in net income.

We are subject to federal and state laws that govern our employment practices. Failure to comply with these laws, or changes to these laws that increase our employment-related expenses, could adversely impact our operations.

We are required to comply with all applicable federal and state laws and regulations relating to employment, including occupational safety and health requirements, wage and hour requirements, employment insurance, and equal employment opportunity laws. These laws can vary significantly among states and can be highly technical. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal or state laws or regulations requiring employers to provide specified benefits to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits, or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any

increased costs and expenses. Furthermore, any failure to comply with these laws, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business. Additionally, a number of states require that direct care workers receive state-mandated minimum wage and/or overtime pay. Opponents say that the new protections will make in-home care more expensive for government programs that pay for such services, and that these new rules and regulations could result in a reduction in covered services. We will continue to evaluate the effect of these various new rules and regulations on our operations.

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

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

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

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

On October 6, 2014, CMS issued a proposed rule that would revise the Medicare and Medicaid conditions of participation for home health agencies. The proposed rule would require home health agencies to develop, implement, and maintain an agency-wide, data-driven quality assessment and improvement program and a system of communication and integration to identify patient needs and coordinate care. The proposed rule also aims to clarify and expand current patient rights requirements and contains several other clarifications and updates largely focused on creating a more patient-centered, data-driven, outcome-oriented process for patient care. If the proposed rule is finalized, we expect to face additional costs associated with compliance with such changes.

Our revenue may be negatively impacted by a failure to appropriately document services, resulting delays in reimbursement.

Reimbursement to us is conditioned upon providing the correct administrative and billing codes and properly documenting the services themselves, including the level of service provided, and the necessity for the services. If incorrect or incomplete documentation is provided or inaccurate reimbursement codes are utilized, this could result in nonpayment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate. In addition, timing delays 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, 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.

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

If our LTACHs fail to meet or maintain the standards for Medicare certification as LTACHs, such as for average minimum patient length-of-stay and restrictions on sources of referral (e.g. 25 Percent rule), they will receive reimbursement under the prospective payment system applicable to general acute care hospitals rather than the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our LTACHs receiving less Medicare reimbursement than they currently receive for their patient services. If any of our LTACHs were subject to payment as general acute care hospitals, our net service revenue and net income would decline.

The implementation of new patient criteria for our LTACHs under the BBA 2013 will reduce the population of patients eligible for LTACH-PPS and change the basis upon which we are paid which could adversely affect our revenues and profitability.

The BBA 2013 creates new Medicare criteria and payment rules for our LTACHs. Under the new criteria, our LTACHs treating patients with at least a three-day prior stay in an acute care hospital intensive care unit and patients on prolonged mechanical ventilation admitted from an acute care hospital will continue to receive payment under LTACH-PPS rate. Other patients will continue to have access to LTACH care, but our LTACH will be paid at a "site-neutral rate" for these patients, based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or LTACH costs.

The effective date of the new patient criteria was October 1, 2015, followed by a two-year phase-in period tied to each LTACH's cost reporting period. During the phase-in period, payment for patients receiving the site-neutral rate will be based 50% on the current LTACH-PPS rate and 50% on the new site-neutral rate. For our two LTACHs that have a cost reporting period starting before July 1 of each year, the phase-in began on June 1, 2016. For our six LTACHs that have a cost reporting period starting on or after July 1 of each year, the phase-in began on September 1, 2016.

We continue to analyze Medicare and internal data to estimate the number of our cases that will continue to be paid under the LTACH-PPS rate. At this time, we estimate that less than one-third of our current LTACH patients will be paid at the site-neutral rate under the new criteria once it is fully phased-in. The site-neutral payment rates will be based on the lesser of per diem Medicare rates paid for patients with the same diagnoses under IPPS or our LTACHs costs. There can be no assurance that these site-neutral payments will not be materially less than the payments currently provided under LTACH-PPS rates.

The additional patient criteria imposed by the BBA 2013 will reduce the population of patients eligible for LTACH-PPS rates and change the basis upon which our LTACHs are paid for other patients. In addition, the BBA 2013 will generate additional governmental regulations, including interpretations and enforcement actions surrounding those regulations. These changes could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

Overall payments made by Medicare to each hospice provider number (generally corresponding to each of our hospice agencies) are subject to an inpatient cap amount and an overall payment cap amount, 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 under any of our hospice provider numbers exceeds either of these caps, we may be required to reimburse Medicare 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.

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

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

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

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

If any of our joint ventures were found to be in violation of federal or state anti-kickback or physician referral laws, we could be required to restructure them or refuse to accept referrals from the physicians or hospitals with which we have entered into a joint venture. We also could be required to repay to Medicare amounts we have received pursuant to any prohibited referrals, and we could suffer civil or

criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs. If any of our joint ventures were subject to any of these penalties, our business could be materially adversely affected. If the structure of any of our joint ventures were found to violate federal or state anti-kickback statutes or physician referral laws, we may be unable to implement our growth strategy, which could have an adverse impact on our future net income and consolidated results of operations.

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

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

As of December 31, 2016, we operated in 12 states that require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

Risk Factors Related to Capital and Liquidity

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

Financial markets may experience significant disruptions, which could impact liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. We have not experienced any individual lender limitations to extend credit under our revolving credit facility. However, the obligations of each of the lending institutions in our revolving credit facility are separate and the availability of future borrowings under our revolving credit facility could be impacted by further volatility and disruptions in the financial credit markets or other events. Our inability to access our revolving credit facility or refinance the revolving credit facility would have a material adverse effect on our business, financial position, results of operations and liquidity.

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

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

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

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

- enter into transactions with affiliates;
- make unapproved acquisitions;
- merge or consolidate;
- transfer or sell assets; and/or
- make fundamental changes in our corporate existence and principal business.

In addition, events beyond our control could affect our ability to comply with and maintain such financial tests and ratios. Any failure by us to comply with or maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to our revolving credit facility or any other future debt agreements. An event of default could lead to the acceleration of the maturity of any outstanding loans and the termination of the commitments to make further extensions of credit. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business at our sole discretion could

harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

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

For the year ended December 31, 2016, our facilities in Louisiana, Mississippi, Tennessee, Alabama, and Arkansas accounted for approximately 58.4% of our net service revenue. Accordingly, any changes in the current demographic, economic, competitive, or regulatory conditions in these states could have an adverse effect on our business, financial condition, results of operations and cash flows. Medicaid changes in these states could also have a material effect on our results of operations and cash flows.

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

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

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our patients.

The majority of our patients are older individuals and others with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or in a public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable patients. For example, if a flu pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Accordingly, certain public health catastrophes could have a material adverse effect on our financial condition and results of operations.

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we request payment for our services to the time we receive reimbursement or payment. A portion of our estimated reimbursement (60% for an initial episode of care and 50% for subsequent episodes of care) for each Medicare episode is billed at the commencement of the episode and we typically receive payment within approximately seven days. The remaining reimbursement is billed upon completion of the episode and is typically paid within 14 to 17 days from the billing date. If we have information system problems or issues arise with Medicare or other payors, we may encounter further delays in our payment cycle. For example, in the past we have experienced delays resulting from problems arising out of the implementation by Medicare of new or modified reimbursement methodologies or as a result of natural disasters, such as hurricanes. We have also experienced delays in reimbursement resulting from our implementation of new information systems related to our accounts receivable and billing functions. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our consolidated results of operations and liquidity. Our working capital management procedures may not successfully negate this risk. Significant delays in payment or reimbursement could have an adverse impact on our liquidity and financial condition.

Risk Factors Related to Operations and our Growth Strategy

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

Goodwill and other intangible assets represent a significant portion of the assets on our balance sheet and are assessed for impairment annually or whenever circumstances indicate potential impairment. The goodwill assessment includes

comparing the fair value of each reporting unit to the carrying value of the assets assigned to the reporting unit. If the carrying value of the reporting unit were to exceed our estimate of fair value of the reporting unit, we would be required to estimate the fair value of the assets and liabilities within the reporting unit to ascertain the fair value of goodwill. If we determine that the fair value is less than our book value, we could be required to record a non-cash impairment charge to our consolidated statements of operations, which could have a material adverse effect on our earnings, debt covenants and ability to access capital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We compete with local and regional home nursing and hospice companies, hospitals and other businesses that provide post-acute health care services, some of which are large, established companies that have significantly greater resources than we do. Our primary competition comes from local operators in each of our markets. We expect our competitors to develop joint ventures with providers, referral sources and payors, which could result in increased competition. The introduction by our competitors of new and enhanced service offerings, in combination with industry consolidation and the development of competitive joint ventures, could cause a decline in net service revenue and loss of market acceptance of our services. Future increases in competition from existing competitors or new entrants may limit our ability to maintain or increase our market share. We may not be able to compete successfully against current or future competitors and competitive pressures may have a material adverse impact on our business, financial condition and results of operations.

We may close additional underperforming agencies in the future.

We regularly review the performance of our various agencies. Our review considers the current financial performance, market penetration, forecasted market growth and current and future reimbursement payment forecasts.

We will continue to monitor the performance of our agencies on an ongoing basis, and closures may from time to time occur in the future. If we take any further action to close agencies, we will incur additional costs and expenses, which may require us to record significant charges in future periods. While any such closures would be made in connection with our constant efforts to improve our profitability, associated charges would have a negative impact on our revenue and possibly our operating results during the short-term.

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

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

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

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

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

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

will result in further growth.

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

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

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

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

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

We depend upon reliable and secure information systems to provide valuable tools by which we manage our business, comply with legal requirements and provide services. In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software. We utilize a third-party software information system for billing and maintaining patient claim receivables for our LTACHs. Our systems require constant maintenance and upgrading to preserve and enhance system capabilities and security. Problems with, or the failure of, our information systems or software could negatively impact our clinical performance and our management and reporting capabilities. Any significant problems with or failures of our information systems or software could materially and adversely affect our operations and reputation, result in significant costs to us, cause delays in our ability to bill Medicare or other payors for our services, or impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems with our proprietary and non-proprietary software may be substantial and could adversely affect our net income. Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, payroll, education tracking and operational performance. If we experience a reduction in the performance, reliability, availability or accuracy of our information systems, our operations and financial performance, and ability to report timely and accurate information, could be adversely affected.

Operations that we acquire must be integrated into our various information systems in an efficient and effective manner. For certain aspects, we rely upon third party contractors to assist us with those activities. If we are unable to integrate and transition any acquired business into our information systems, due to our failures or any failure of our third party contractors, we could incur unanticipated expenses, suffer disruptions in service, experience regulatory issues and lose revenue from the operation of such business.

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

Our information systems are also subject to damage or service interruption due to natural disasters, floods, fires, loss of power, loss of telecommunications connectivity, and other events that may be beyond our immediate control. While

we maintain and test various disaster recovery plans and procedures, our failure to successfully implement and execute upon such plans and procedures, and restore the full operational capabilities of our information systems and software in an effective and efficient manner, could have a material adverse effect on the functionality of our information systems and our business, financial condition, results of operations and cash flows, and cause a possible significant disruption of our operations and services.

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 secure favorable contracts with managed care payors. However, we may not be successful in these efforts. Additionally, there is a risk that any favorable managed care contracts that we can secure may be terminated on short notice, since managed care contracts typically permit the payor to terminate without cause, typically on 60 days notice. Such provisions can provide payors with leverage to reduce volume or obtain favorable pricing. Our failure to negotiate, secure and maintain favorable managed care contracts could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risk Factors Related to our Ownership and Management

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

We are a holding company, whereby our material assets and operations are held by our subsidiaries. Accordingly, our ability to service our debt, if any, is dependent upon the earnings from the business conducted by our subsidiaries. The distributions of those earnings or advances or other distributions of funds by these subsidiaries to us are contingent upon the subsidiaries' earnings and are subject to various business considerations. In addition, distributions by subsidiaries could be subject to statutory restrictions, including state laws requiring that the subsidiary be solvent, or contractual restrictions. If our subsidiaries are unable to make sufficient distributions or advances to us, we may not have the cash resources necessary to service our debt.

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

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

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

Our executive officers and directors and individuals or entities affiliated with them, beneficially own an aggregate of approximately 14.9% of our outstanding shares of common stock as of December 31, 2016. The interests of these stockholders may differ from other stockholders' interests. If they were to act together, these affiliated stockholders would be able to significantly influence all matters that our stockholders vote upon, including the election of directors, business combinations, the amendment of our certificate of incorporation and other significant corporate actions.

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

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

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

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

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

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

We have a relatively low volume of daily trades in our common stock on the NASDAQ Global Select Market ("NASDAQ"). For example, the average daily trading volume of our common stock on NASDAQ over the three-month trading period ending March 1, 2017 was approximately 128,094 shares per day. Because our common stock is traded infrequently, the price per share of our common stock can fluctuate more significantly from day-to-day than a widely

held stock that is actively traded on a daily basis. For example, trading of a large volume of our common stock may have a significant impact on the trading price of our common stock. In addition, future issuances of our common stock, including the exercise of any options or the vesting of any restricted stock that we may grant to directors, executive officers and other employees in the future and the issuance of our common stock in connection with acquisitions, could have an adverse effect on the market price of our common stock.

We do not anticipate paying dividends on our common stock in the foreseeable future and, consequently, your ability to achieve a return on your investment will depend solely on appreciation in the price of our common stock.

We do not pay dividends on our shares of common stock and intend to retain all future earnings to finance the continued growth and development of our business and for general corporate purposes. In addition, we do not anticipate paying cash dividends on our common stock in the foreseeable future. Any future payment of cash dividends will depend upon our financial condition, capital requirements, credit facility limitations, earnings and other factors deemed relevant by our board of directors.

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

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

Item 1B. Unresolved Staff Comments.

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

Item 2. Properties.

Our principal executive office is located in Lafayette, Louisiana in a 66,846 square feet building that is leased. The lease agreement commenced on February 1, 2015 and will expire on March 30, 2025.

Of our operating service locations, three are owned by us and the remaining locations are in leased facilities. Most of our operating service locations are located in general commercial office space. Generally, the leases have initial terms of one year, but range from one to five years. Most of the leases either contain multiple options to extend the lease period in one-year increments or convert to a month-to-month lease upon the expiration of the initial term.

Seven of our LTACHs are HWHs, meaning we have a lease or sublease for space with the host hospital. Generally, our leases or subleases for LTACHs have initial terms of five years, but range from three to ten years. Most of our leases and subleases for our LTACHs contain multiple options to extend the term in one-year increments.

The following table shows our locations of our home health services, hospice services, community-based services, and facility-based services facilities as of December 31, 2016:

	Home health services	Hospice services	Community-based services	Facility-based services
Louisiana	40	7	—	12
Mississippi	34	9	—	—
Alabama	27	8	—	—
Tennessee	29	2	1	—
Arkansas	21	8	1	1
Kentucky	28	—	2	—
West Virginia	17	3	—	—
Georgia	8	11	—	—
Washington	10	4	1	—
Missouri	6	5	2	—
Maryland	10	—	1	—
Illinois	9	—	—	—
Texas	8	—	—	—

Idaho	4	2	—	—
North Carolina	2	1	3	—
Arizona	4	1	—	—
California	5	—	—	—

South Carolina	1	4	—	—
Colorado	4	—	—	—
Florida	4	—	—	—
Oregon	4	—	—	—
Virginia	3	—	—	—
Ohio	2	—	—	—
Oklahoma	1	—	—	—
Rhode Island	1	—	—	—
Wisconsin	1	—	—	—
	283	65	11	13

Item 3. Legal Proceedings.

We provide services in a highly regulated industry and are a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from our obligation to self-report suspected violations of law). We cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. The DOJ, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future. These matters could potentially subject us to sanctions, damages, recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on our business and financial condition.

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

On October 7, 2015, the parties entered into a Stipulation of Settlement in the consolidated case styled In re LHC Group, Inc. Derivative Litigation, Case No. 6:13-cv-02899-JTT-CBW. On October 19, 2015, Plaintiffs filed an Unopposed Motion for Preliminary Approval of Proposed Derivative Settlement. On October 26, 2015, the District Court entered an Order Preliminarily Approving Settlement in the amount of $0.6 million. On January 11, 2016, the District Court entered its Order and Final Judgment approving the settlement and dismissing the consolidated action with prejudice. The Company's insurance carrier has funded the entire settlement amount, which was immediately releasable to Plaintiffs' counsel on January 11, 2016. The time for appeal has passed and no appeals were filed. This matter is now concluded. At December 31, 2015, the Company's balance sheet reflected the entire settlement in current assets as a receivable due from insurance carrier and correspondingly reflected the entire settlement in current liabilities as a legal settlement payable.

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

Sales of Unregistered Common Stock

None

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market ("NASDAQ") under the symbol "LHCG." As of March 6, 2017, there were approximately 167 registered holders of record of our common stock.

Dividend Policy

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

Price Range of Common Stock

The following table provides the high and low prices of our common stock during each quarter in 2016 and 2015 as quoted by NASDAQ:

	High	Low
2016		
Fourth Quarter	$45.70	$32.48
Third Quarter	46.51	34.90
Second Quarter	43.67	35.05
First Quarter	44.10	33.55
	High	Low
2015		
Fourth Quarter	$49.16	$42.97
Third Quarter	51.12	36.95
Second Quarter	40.61	30.15
First Quarter	34.40	28.88

The closing price of our common stock as reported by NASDAQ on March 6, 2017 was $48.86.

Performance Graph

This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2016.

Issuer Purchases of Equity Securities

None.

Item 6. Selected Financial Data.

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for each of the years in the five year period ended December 31, 2016. 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 Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations and Item 8. Financial Statements and Supplementary Data included herein (amounts in thousands, except share and per share data).

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Year Ended December 31,	2016	2015	2014	2013	2012
Consolidated Statements of Operations Data:					
Net service revenue	$914,823	$816,366	$733,632	$658,283	$637,569
Gross margin	357,173	335,488	298,857	274,819	271,817
Operating income	70,562	66,343	45,486	46,737	54,305
Income from continuing operations	45,942	41,650	28,752	29,146	35,428
Net income attributable to LHC Group, Inc.'s common stockholders	36,583	32,335	21,837	22,342	27,440
Net income attributable to LHC Group, Inc.'s common stockholders:					
Basic	$2.08	$1.86	$1.27	$1.31	$1.54
Diluted	$2.07	$1.84	$1.26	$1.30	$1.53
Weighted average shares outstanding:					
Basic	17,559,477	17,405,379	17,229,026	17,049,794	17,853,321
Diluted	17,682,820	17,547,531	17,315,333	17,132,751	17,899,195

As of December 31,	2016	2015	2014	2013	2012
Consolidated Balance Sheet Data:					
Cash	$3,264	$6,139	$531	$14,014	$9,720
Total assets	614,071	566,054	491,739	422,226	386,894
Total debt	87,796	98,784	61,008	23,212	19,500
Total LHC Group, Inc. stockholders' equity	395,126	354,582	318,639	293,009	268,181

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

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

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

Overview

We provide post-acute health care services primarily to Medicare beneficiaries throughout the United States, through our home health agencies, hospice agencies, community-based services agencies, and long-term acute care hospitals. Our net service revenue increased $98.4 million to $914.8 million for the year ending December 31, 2016 from $816.4 million for the year ending December 31, 2015. During 2016, we acquired 23 agencies, such that, as of December 31, 2016, we operated 372 locations in 26 states within the continental United States.

Segments

Our services are classified into four segments: (1) home health services; (2) hospice services; (3) community-based services and (4) facility-based services offered primarily through our LTACHs.

Through our home health services segment we offer a wide range of services, including skilled nursing, medically-oriented social services, and physical, occupational and speech therapy. As of December 31, 2016, we operated 283 home health service locations, of which 164 are wholly-owned by us, 114 are majority-owned or controlled by us through equity joint ventures, three are controlled by us through license lease arrangements and the remaining two are only managed by us.

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Through our hospice services segment, we offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2016, we operated 65 hospice locations, of which 49 are wholly-owned by us, 14 are majority-owned by us through equity joint ventures and two are controlled by us through license lease arrangements.

Through our community-based services segment, our services are performed by paraprofessional personnel, and include assistance to the elderly, chronically ill, and disabled patients with activities of daily living. As of December 31, 2016, we operated 11 community-based services locations, of which 10 are wholly-owned and one is majority-owned through an equity joint venture.

We provide facility-based services principally through our LTACHs. As of December 31, 2016, we owned and operated six LTACHs with eight locations, of which all but one are located within host hospitals. We also operate a pharmacy, family health center, family health clinic, and physical therapy clinics. Of these 13 facility-based services locations as of December 31, 2016, seven are wholly-owned by us and six are controlled by us through equity joint ventures.

The percentage of net service revenue contributed from each reporting segment for the each of the periods ended December 31, 2016, 2015 and 2014 was as follows:

Type of Segment	2016	2015	2014
Home health services	72.8 %	75.1 %	77.0 %
Hospice services	14.8	10.5	9.2
Community-based services	4.8	5.1	3.8
Facility-based services	7.6	9.3	10.0
	100.0%	100.0%	100.0%

Development Activities

The following table provides a summary of our acquisitions, divestitures and internal development activities from January 1, 2014 through December 31, 2016. This table does not include the two management services agreements under which we manage the operations of two home nursing agencies, through our home health services segment, nor does it include our pharmacy, family health center, family health clinic, and physical therapy clinics through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Community-based Agencies	Long-Term Acute Care Hospitals
Total at January 1, 2014	256	34	7	9
Developed	3	1	—	—
Acquired	40	6	6	—
Divested/Merged	(22)	(3)	(1)	(1)
Total at January 1, 2015	277	38	12	8
Developed	—	2	—	—
Acquired	9	17	2	—
Divested/Merged	(6)	(1)	(1)	—
Total at December 31, 2015	280	56	13	8
Developed	5	1	—	—
Acquired	12	10	1	—
Divested/Merged	(16)	(2)	(3)	—
Total at December 31, 2016	281	65	11	8

Recent Developments

Home Health Services

On April 14, 2015, legislation was passed which limits any increase in home health payments to 1% for fiscal year 2018 and extended the 3% rural home health safeguard for two years through December 31, 2017.

On October 30, 2015, CMS released a Final Rule (effective January 1, 2016) regarding payment rates for home health services provided during calendar year 2016. The national, standardized 60-day episode payment rate increased to $2,965.12 for 2016. The rural rate is

$3,054.07. This is a net 0.01% increase in the national, standardized 60-day episode payment rate due to application of (1) rebasing decrease of $80.95, (2) case-mix adjustment decrease of 0.97%, (3) net market basket increase of 1.9%, (4) case-mix recalibration budget neutrality adjustment increase of 1.87%, and (5) wage index budget neutrality adjustment increase of 0.11%. The home health market basket percentage increase for 2016 is 2.3% and the multifactor productivity adjustment is 0.4%, resulting in a net home health market basket of 1.9%. CMS reduced its estimate of nominal case-mix growth between 2012 and 2014 from 3.41% to 2.88% (0.53%) and spread the adjustment over three years at 0.97% each year to account for nominal case-mix growth. The finalized payment policies results in a 1.4% reduction in Medicare payments for all home health agencies.

In addition, CMS finalized its proposal to implement a Home Health Value-Based Purchasing ("HHVBP") program that is intended to incentivize the delivery of high-quality patient care. The HHVBP program would withhold 3% to 8% of Medicare payments, which would be redistributed to participating home health agencies depending on their performance relative to specified measures. The HHVBP would apply to all home health agencies in Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington.

On October 31, 2016, CMS released a Final Rule (effective January 1, 2017) regarding payment rates for home health services provided during calendar year 2017. The national, standardized 60-day episode payment rate will increase to $2,989.97 for 2017. The rural rate is $3,079.67. The Final Rule implements the final year of the four year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate and the decrease of 0.97% to account for nominal case-mix growth between calendar year 2012 and calendar year 2014, which was not accounted for in the rebasing adjustments finalized in calendar year 2014. The Final Rule also contains minor adjustments to the HHVBP program and to the home health quality reporting program. CMS estimates the overall economic impact of the proposed rule's policy changes and payment rate update is an estimated aggregate decrease of 0.7% in payments to home health agencies, which decrease will vary based on each agency's wage index and patient mix weight.

Hospice

On July 31, 2015, CMS released a Final Rule that updated the Medicare hospice payment rates and wage index for fiscal year 2016, which resulted in an increase in payment rates of 1%. Beginning January, 1, 2016, CMS finalized its proposal for two routine home care rates, in a budget-neutral manner, to provide separate payment rates for the first 60 days of care and care beyond 60 days. In addition to the two routine home care rates, CMS is implementing a service intensity add-on payment that would help to promote and compensate for the provision of skilled visits at end of life. As finalized, fiscal year 2016 will be the seventh and final year of the Budget Neutrality Adjustment Factor for hospice. CMS updated the aggregate hospice cap to $27,820.75 for the 2016 hospice cap year. CMS is also changing the hospice inpatient and aggregate cap year to coincide with the fiscal year (October 1 to September 30) beginning October 1, 2017. The following table shows the hospice Medicare payment rates for fiscal year 2016, which began on October 1, 2015 and ended September 30, 2016:

Description	Rate per patient day
Routine Home Care days 1-60 (effective January 1, 2016)	$186.84
Routine Home Care days 60+ (effective January 1, 2016)	$146.83
Continuous Home Care	$944.79
Full Rate = 24 hours of care	
$39.37 = hourly rate	
Inpatient Respite Care	$167.45
General Inpatient Care	$720.11

On July 29, 2016, CMS issued a final rule updating Medicare payment rates and the wage index for hospices for fiscal year 2017, which will result in 2.1% increase in payment rates. The 2.1% increase is based on 2.7% inpatient hospital market basket update, reduced by a 0.3% productivity adjustment, and a 0.3% adjustment set by the Patient Protection and Affordable Care Act ("PPACA"). The hospice cap amount for the 2017 hospice cap year will be $28,404.99. The following table shows the hospice Medicare payment rates for fiscal year 2017, which began on October 1, 2016 and

will end September 30, 2017:

Description	Rate per patient day
Routine Home Care days 1-60	$190.55
Routine Home Care days 60+	$149.82
Continuous Home Care	$964.63
Full Rate = 24 hours of care	
$40.19 = hourly rate	
Inpatient Respite Care	$170.97
General Inpatient Care	$734.94

Community-Based Services

Community-based services are in-home care services, which are primarily performed by paraprofessional personnel, and include assistance with activities of daily living to elderly, chronically ill, and disabled patients. Revenue is generated on an hourly basis. Our primary payors are TennCare Managed Care Organization and Medicaid. Approximately 80% of our net service revenue in this segment is generated in Tennessee.

Facility-Based Services

On December 26, 2013, President Obama signed into law the Bipartisan Budget Act of 2013 (Public Law 113-67). This law prevents a scheduled payment reduction for physicians and other practitioners who treat Medicare patients from taking effect on January 1, 2014. Included in the legislation are the following changes to LTACH reimbursement:

- Medicare discharges from LTACHs will continue to be paid at full LTACH-PPS rates if
- the patient spent at least three days in a short-term care hospital ("STCH") intensive care unit ("ICU") during a STCH stay that immediately preceded the LTACH stay, or
- the patient was on a ventilator for more than 96 hours in the LTACH (based on the MS-LTACH DRG assigned) and had a STCH stay immediately preceding the LTACH stay.
- Also, the LTACH discharge cannot have a principal diagnosis that is psychiatric or rehabilitation.
- All other Medicare discharges from LTACHs will be paid at a new “site neutral” rate, which is the lesser of the IPPS comparable per diem amount determined using the formula in the short-stay outlier regulation at 42 C.F.R. § 412.529(d)(4) plus applicable outlier payments or 100% of the estimated cost of the services involved.
- The above new payment policy became effective for cost reporting periods that began on or after October 1, 2015, and the site neutral payment rate will be phased-in over two years.
- For cost reporting periods beginning on or after October 1, 2015, discharges paid at the site neutral payment rate or by a Medicare Advantage plan (Part C) will be excluded from the LTACH average length-of-stay (“ALOS”) calculation.
- For cost reporting periods beginning in fiscal year 2016 and later, CMS will notify LTACHs of their “LTACH discharge payment percentage” (i.e., the number of discharges not paid at the site neutral payment rate divided by the total number of discharges).
- For cost reporting periods beginning in fiscal year 2020 and later, LTACHs with less than 50% of their discharges paid at the full LTACH-PPS rates will be switched to payment under the IPPS for all discharges in subsequent cost reporting periods. However, CMS will set up a process for LTACHs to seek reinstatement of LTACH-PPS rates for applicable discharges.
- MedPAC will study the impact of the above changes on quality of care, use of hospice and other post-acute care settings, different types of LTACHs and growth in Medicare spending on LTACHs. MedPAC is to submit a report to Congress with any recommendations by June 30, 2019. The report is to also include MedPAC's assessment of whether the 25 Percent rule should continue to be applied.
- The moratorium on new LTACH facilities and increases in LTACH beds will be renewed for the period from April 1, 2014 to September 30, 2017. Although the introductory language only refers to a moratorium extension for LTACH bed increases, the amendment to the Medicare, Medicaid, and SCHIP Extension Act ("MMSEA") would extend both moratoriums. No exceptions will apply during this extension of the

moratoriums. The original rule renewed the moratorium for the period beginning January 1, 2015; however, a provision with HR4302 accelerated the moratorium period beginning on April 1, 2014.

On July 31, 2015, CMS issued a Final Rule to update fiscal year 2016 payment policies and rates under the IPPS and LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2015. CMS projects that LTACH PPS rates would decrease by 4.6%. This estimated decrease is preliminary attributable to the statutory decrease in payment rates for site neutral LTACH PPS cases that do not meet the clinical criteria to qualify for higher LTACH rates in cost reporting years beginning on or after October 1, 2015. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 1.7% (based on a market basket

update of 2.4% adjusted by a multi-factor productivity adjustment of -0.5 percentage point and an additional adjustment of -0.2 percentage point in accordance with the Affordable Care Act). CMS also finalized its proposal to implement a transitional blended payment rate (50% site neutral rate and 50% LTACH PPS rates) for site neutral discharges occurring in fiscal years 2016 and 2017.

On August 2, 2016, CMS released the final rule to update fiscal year 2017 LTACH reimbursement and policies under the LTACH PPS, which affects discharges occurring in cost reporting periods beginning on or after October 1, 2016. CMS projects that overall LTACH PPS spending would decrease by 7.1%, compared to fiscal year 2016 payments. This estimated decrease is attributable to the statutory decrease in payment rates for site neutral LTACH PPS cases that do not meet the clinical criteria to qualify for higher LTACH rates in cost reporting years beginning on or after October 1, 2016. Cases that do qualify for higher LTACH PPS rates will see a payment rate increase of 0.7% (including a market basket update of 2.8% reduced by a multi-factor productivity adjustment of 0.3%, minus an additional adjustment of 0.75 percentage point in accordance with the PPACA, for a net market basket of 1.75%). The LTACH PPS standard federal payment rate for fiscal year 2017 is $42,476.41 (increased from $41,762.85 in fiscal year 2016). Site-neutral discharges will have a 23% reduction in payments. CMS also proposes to begin enforcement of the 25 Percent rule which will cap the number of patients treated at an LTACH who have been referred from all locations of a hospital. Grandfathered LTACH facilities are exempt from the 25 Percent rule, while rural LTACHs will have a threshold of 50% and MSA-dominant hospitals will have a threshold between 25% and 50%. The 25 Percent rule will apply to discharges occurring after October 1, 2016. CMS will have two separate outlier pools and thresholds for LTACH-appropriate patients and for site-neutral patients. For 2017, CMS finalized an increase of its fixed-loss threshold to $21,943 from 2016’s $16,423, to limit outlier spending at no more than 8% of total LTACH spending (2016 outlier payments may reach 9.0%). CMS is applying the proposed inpatient fixed-loss threshold of $23,570 for site neutral patients. CMS also finalized four new measures for the LTACH Quality Reporting Program to meet the requirements of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act. For the fiscal year 2018 LTACH Quality Reporting Program, CMS added quality measures for Medicare spending per beneficiary, discharge to community and potentially-preventable 30-day post-discharge readmissions. For the fiscal year 2020 LTACH Quality Reporting Program, CMS adopted a new drug regimen review measure.

On December 7, 2016, Congress passed the 21st Century Cures Act ("Cures"), which boosts funding for medical research, eases the development and approval of experimental treatments and reforms federal policy on mental health care. Included in the bill was relief for LTACHs under a one year moratorium on the 25 Percent Rule, which would otherwise penalize LTACHs that admit more than 25% of their patients from a particular acute care hospital. As modified by Cures, implementation of the 25 Percent Rule will be suspended during federal fiscal year 2017 (October 1, 2016 through September 30, 2017).

None of the above described estimated changes to Medicare payments for home health, hospice and LTACHs include the deficit reduction sequester cuts to Medicare that began on April 1, 2013, which reduced Medicare payments by 2% for patients whose service dates ended on or after April 1, 2013.

2016 and 2015 Operational Data

The following table sets forth, for the period indicated, each of our segment's data regarding census, admissions, billable hours and patient days:

	Three Months Ended March 31, 2016	Three Months Ended June 30, 2016	Three Months Ended September 30, 2016	Three Months Ended December 31, 2016
Home Health Services:				
Average census	38,218	38,357	38,511	39,407
Average Medicare census	28,246	28,046	27,983	28,381
Admissions	39,124	38,949	40,657	41,184

Medicare admissions	26,136	25,817	26,810	26,812
Hospice Services:				
Average census	2,425	2,615	2,736	2,713
Average Medicare census	2,248	2,431	2,547	2,520
Admissions	2,463	2,523	2,554	2,607
Medicare admissions	2,152	2,246	2,266	2,218
Patient days	220,694	237,968	251,753	249,608
Community-based Services:				
Billable hours	304,487	330,350	354,998	349,053
LTACHs:				
Patient days	15,537	13,929	13,499	13,257

	Three Months Ended March 31, 2015	Three Months Ended June 30, 2015	Three Months Ended September 30, 2015	Three Months Ended December 31, 2015
Home Health Services:				
Average census	36,450	36,834	36,858	37,060
Average Medicare census	27,235	27,336	27,278	27,432
Admissions	35,965	35,211	35,772	36,249
Medicare admissions	24,875	23,862	24,114	24,060
Hospice Services:				
Average census	1,357	1,446	1,528	2,360
Average Medicare census	1,256	1,328	1,411	2,205
Admissions	1,481	1,497	1,584	2,225
Medicare admissions	1,285	1,316	1,379	1,935
Patient days	122,179	131,565	140,592	217,157
Community-based Services:				
Billable hours	294,016	316,598	318,995	307,781
LTACHs:				
Patient days	16,162	15,393	15,422	14,450

Consolidated Results of Operations

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

	Year Ended December 31,		
	2016	2015	2014
Consolidated Services Data:			
Net service revenue	$914,823	$816,366	$733,632
Cost of service revenue	557,650	480,878	434,775
Gross margin	357,173	335,488	298,857
Provision for bad debts	14,790	19,243	15,780
General and administrative expenses	270,622	247,919	233,898
Impairment of intangibles and other	—	1,273	3,646
Loss on disposal of assets	1,199	710	47
Operating income	70,562	66,343	45,486
Interest expense	(2,936)	(2,302)	(2,486)
Non-operating income	492	457	265
Income tax expense	22,176	22,848	14,513
Income attributable to noncontrolling interests	9,359	9,315	6,915
Net income available to LHC Group, Inc.'s common stockholders.	$36,583	$32,335	$21,837

The following table sets forth our consolidated results as a percentage of net service revenue, except income tax expense, which is presented as a percentage of income attributable to LHC Group, Inc.'s common stockholders:

	Year Ended December 31,		
	2016	2015	2014
Consolidated Services Data:			
Cost of service revenue	61.0 %	58.9 %	59.3 %
Gross margin	39.0	41.1	40.7
Provision for bad debts	1.6	2.4	2.2
General and administrative expenses	29.6	30.4	31.9
Impairment of intangibles and other	—	0.2	0.5
Loss on disposal of assets	0.1	0.1	—

Operating income	7.7	8.1	6.2
Interest expense	(0.3)	(0.3)	(0.3)
Non-operating income	0.1	0.1	—

Income tax expense	37.7	41.4	39.9
Income attributable to noncontrolling interests	1.0	1.1	0.9
Net income attributable to LHC Group, Inc.'s common stockholders	4.0	4.0	3.0

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

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2016 was $914.8 million compared to $816.4 million for the same period in 2015, an increase of $98.4 million, or 12.1%. Consolidated net service revenue growth in 2016 was primarily due to both our acquisitions of 28 agencies during 2015 and an increase in same store growth.

Consolidated net service revenue was comprised of the following for the periods ending December 31:

Type of Segment	2016	2015
Home health services	72.8 %	75.1 %
Hospice services	14.8	10.5
Community-based services	4.8	5.1
Facility-based services	7.6	9.3
	100.0%	100.0%

Revenue derived from Medicare represented 74.5% of our consolidated net service revenue for both years ended December 31, 2016 and 2015.

The following table sets forth each of our segment's revenue growth or loss, admissions, census, episodes and patient days for the twelve months ended December 31, 2016 and the related change from the same period in 2015 (amounts in thousands, except admissions, census, episode data and patient days):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home Health Services							
Revenue	$651,015	$1,158	$652,173	6.4 %	$13,723	$665,896	8.6 %
Revenue Medicare	$494,378	$921	$495,299	4.7	$10,775	$506,074	6.9
New admissions	156,359	159	156,518	9.3	3,396	159,914	11.7
New Medicare admissions	103,175	106	103,281	6.6	2,294	105,575	8.9
Average census	37,344	265	37,609	2.3	978	38,587	5.0
Average Medicare census	27,226	188	27,414	0.4	732	28,146	3.1
Home health episodes	195,057	303	195,360	2.2	3,875	199,235	4.2
Hospice Services							
Revenue	$95,095	$2,028	$97,123	13.1	$37,825	$134,948	57.2
Revenue Medicare	$88,852	$1,985	$90,837	13.8	$35,047	$125,884	57.7
New admissions	7,392	55	7,447	9.7	2,700	10,147	49.5
New Medicare admissions	6,493	48	6,541	10.6	2,342	8,883	50.2
Average census	1,668	68	1,736	3.6	887	2,623	56.6
Average Medicare census	1,547	66	1,613	3.9	824	2,437	57.0
Patient days	687,853	14,564	702,417	14.9	257,606	960,023	57.0
Community-based Services							
Revenue	$43,734	$—	$43,734	6.1 %	$157	$43,891	6.5 %
Billable hours	1,331,448	—	1,331,448	9.7 %	7,734	1,339,182	10.3 %
Facility-Based Services							

LTACHs						
Revenue	$64,607	$—	$64,607	(11.1)	$—	$64,607 (10.3)%
Patient days	56,224	—	56,224	(8.5)	—	56,224 (8.5)

(1) Same store - location that has been in service with us for greater than 12 months.
(2) De Novo - internally developed location that has been in service for 12 months or less.
(3) Organic - combination of same store and de novo.
(4) Acquired - purchased location that has been in service with us 12 months or less.

Total organic revenue and patient days decreased in our facility-based services segment due to the negative impact from the reduction of 18 beds in one LTACH location. In addition, patient criteria changes went into effect for two of our LTACH locations on June 1, 2016 and six of our LTACH locations on September 1, 2016. The criteria changes are reflective in our decrease of revenue per patient day.

Organic growth is primarily generated by population growth in areas covered by mature agencies and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first 24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage of growth, in the second full year of operation after the acquisition.

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2016 was $557.7 million compared to $480.9 million for the same period in 2015, an increase of approximately $76.8 million, or 16.0%.

The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2016		2015	
Home health services				
Salaries, wages and benefits	$360,378	54.1%	$320,548	52.3%
Transportation	22,252	3.3	21,056	3.4
Supplies and services	15,820	2.4	13,146	2.1
Total	$398,450	59.8%	$354,750	57.9%
Hospice services				
Salaries, wages and benefits	$58,094	43.0%	$35,022	40.8%
Transportation	5,384	4.0	3,638	4.2
Supplies and services	19,881	14.7	12,246	14.3
Total	$83,359	61.8%	$50,906	59.3%
Community-based services				
Salaries, wages and benefits	$32,086	73.1%	$28,525	69.2%
Transportation	263	0.6	263	0.6
Supplies and services	254	0.6	288	0.7
Total	$32,603	74.3%	$29,076	70.5%
Facility-based services				
Salaries, wages and benefits	$28,802	41.1%	$29,898	39.3%
Transportation	233	0.3	240	0.3
Supplies and services	14,203	20.3	16,008	21.0
Total	$43,238	61.7%	$46,146	60.6%

Consolidated cost of service revenue variances were as follows:

- Home Health Segment -- Cost of service increased as a percentage of net service revenue due in part to 1.5% Medicare reimbursement cuts recognized in 2016. Additionally, acquisitions accounted for $7.0 million of the $76.8 million increase, with the remaining difference caused by the growth in our same store agencies.
- Hospice Segment -- Acquisitions accounted for $26.3 million of the $76.8 million increase.

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- Community-Based Services Segment -- Cost of service revenue increased as a percentage of net service revenue due to an increase in labor costs related to providing a higher level of care for our current patient mix.
- Facility-Based Services Segment -- Cost of service revenue increased as a percentage of net service revenue due to the reduction of LTACH licensed beds and lower revenue per patient day for the period caused by patient criteria changes that went into effect in June and September of 2016.

Provision for Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2016 was $14.8 million, or 1.6% of net service revenue, compared to $19.2 million, or 2.4% of net service revenue, for the same period in 2015, a decrease of approximately $4.5 million, or 23.1%. The decrease in provision for bad debts was primarily due to continued process improvements in our revenue cycle department that were implemented during 2015 and improved cash collections. In addition, provisions for bad debts in 2015 was higher due to claims associated with two payors in our home health services segment and delayed payment issues related to our transition to a new billing system for our community-based services segment. These issues were resolved.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2016 were $270.6 million compared to $247.9 million for the same period in 2015, an increase of approximately $22.7 million, or 9.2%; however, as a percentage of net service revenue, it is a decrease of 0.8%. Of the $22.7 million increase: acquisitions accounted for $14.0 million; a severance package of $1.1 million was recorded due to the resignation of our prior Chief Financial Officer; the remainder of the increase was due to growth in our same store agencies.

The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2016		2015	
Home health services				
General and administrative	$195,591	29.4%	$182,107	29.7%
Depreciation and amortization	7,827	1.1	8,484	1.4
Total	$203,418	30.5%	$190,591	31.1%
Hospice services				
General and administrative	$35,046	26.0%	$24,893	29.0%
Depreciation and amortization	2,161	1.6	1,544	1.8
Total	$37,207	27.6%	$26,437	30.8%
Community-based services				
General and administrative	$8,380	19.1%	$8,309	20.2%
Depreciation	405	0.9	156	0.4
Total	$8,785	20.0%	$8,465	20.6%
Facility-based services				
General and administrative	$19,445	27.7%	$20,657	27.1%
Depreciation and amortization	1,767	2.5	1,769	2.3
Total	$21,212	30.2%	$22,426	29.5%

Loss on disposal of assets

The loss on disposal of assets increased during the twelve months ended December 31, 2016 due to the sale of an aircraft. The aircraft incurred damage and was subsequently sold at a price below the aircraft's net book value. The sale generated a loss of $0.9 million, which was realized during the twelve months ended December 31, 2016.

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

Net Service Revenue

Consolidated net service revenue for the year ended December 31, 2015 was $816.4 million compared to $733.6 million for the same period in 2014, an increase of $82.7 million, or 11.3%. Consolidated net service revenue growth in 2015 was primarily due to both our

acquisitions of 28 agencies during 2015 and an increase in same store growth. Consolidated net service revenue was comprised of the following for the periods ending December 31:

Type of Segment	2015	2014
Home health services	75.1 %	77.0 %
Hospice services	10.5	9.2
Community-based services	5.1	3.8
Facility-based services	9.3	10.0
	100.0%	100.0%

Revenue derived from Medicare represented 74.5% and 75.9% of our consolidated net service revenue for the years ended December 31, 2015 and 2014, respectively.

The following table sets forth the growth or loss of each of our segment's revenue and patient statistical data for the twelve months ended December 31, 2015 and the related change for the same period in 2014 (revenue amounts are in thousands):

	Same Store (1)	De Novo (2)	Organic (3)	Organic Growth (Loss)%	Acquired (4)	Total	Total Growth (Loss) %
Home health services							
Revenue	$588,003	$2,105	$590,108	4.5 %	$23,080	$613,188	8.5 %
Revenue Medicare	$452,136	$1,542	$453,678	3.5	$19,515	$473,193	7.9
New admissions	137,041	507	137,548	3.4	5,649	143,197	7.6
New Medicare admissions	92,290	339	92,629	2.4	4,282	96,911	7.1
Average census	35,216	132	35,348	0.1	1,404	36,752	4.1
Average Medicare census	26,114	92	26,206	(0.5)	1,091	27,297	3.6
Episodes	184,774	610	185,384	1.4	5,824	191,208	4.5
Hospice services							
Revenue	$71,620	$1,809	$73,429	8.6	$12,425	$85,854	27.1
Revenue Medicare	$66,378	$1,783	$68,161	9.0	$11,685	$79,846	27.8
New admissions	5,952	46	5,998	8.2	789	6,787	22.4
New Medicare admissions	5,191	45	5,236	7.8	679	5,915	21.8
Average census	1,284	34	1,318	(1.9)	357	1,675	24.7
Average Medicare census	1,184	33	1,217	(1.5)	336	1,553	25.8
Patient days	514,496	12,440	526,936	7.5	84,557	611,493	24.7
Community-based services							
Revenue	$31,797	$180	$31,977	15.4	$9,225	$41,202	48.8
Billable hours	947,395	5,844	953,239	4.6	260,630	1,213,869	33.2
Facility-based services							
LTACHs							
Revenue	$72,668	$—	$72,668	—	$—	$72,668	3.2
Patient days	61,427	—	61,427	—	—	61,427	(1.5)

(1) Same store - location that has been in service with us for greater than 12 months.
(2) De Novo - internally developed location that has been in service for 12 months or less.
(3) Organic - combination of same store and de novo.
(4) Acquired - purchased location that has been in service with us 12 months or less.

Organic growth is primarily generated by population growth in areas covered by mature agencies and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first

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24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage of growth, in the second full year of operation after the acquisition.

Cost of Service Revenue

Consolidated cost of service revenue for the year ended December 31, 2015 was $480.9 million compared to $434.8 million for the same period in 2014, an increase of $46.1 million, or 10.6%; however, as a percentage of net service revenue, it was a decrease of 0.4%. Of the $46.1 million increase, acquisitions purchased during 2015 accounted for $8.7 million. The remainder of the increase was due to the accretion of same store agencies. The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2015		2014	
Home health services				
Salaries, wages and benefits	$320,548	52.3%	$295,340	52.3%
Transportation	21,056	3.4	21,463	3.8
Supplies and services	13,146	2.1	13,053	2.3
Total	$354,750	57.9%	$329,856	58.4%
Hospice services				
Salaries, wages and benefits	$35,022	40.8%	$27,263	40.3%
Transportation	3,638	4.2	3,027	4.5
Supplies and services	12,246	14.3	9,514	14.1
Total	$50,906	59.3%	$39,804	58.9%
Community-based services				
Salaries, wages and benefits	$28,525	69.2%	19,287	69.6%
Transportation	263	0.6	170	0.6
Supplies and services	288	0.7	154	0.6
Total	$29,076	70.5%	$19,611	70.8%
Facility-based services				
Salaries, wages and benefits	$29,898	39.3%	$30,047	41.0%
Transportation	240	0.3	281	0.4
Supplies and services	16,008	21.0	15,176	20.7
Total	$46,146	60.6%	$45,504	62.0%

Provision For Bad Debts

Consolidated provision for bad debts for the year ended December 31, 2015 was $19.2 million compared to $15.8 million for the same period in 2014, an increase of $3.4 million, or 21.5%. Provision for bad debts increased in the home health services segment due to additional reserves being recorded for patient claims related to prior period patient care associated with commercial payors. Accounts receivable that are aged over 365 days increased during the period by $4.5 million. For home health services and facility-based services, an increase of $2.1 million was due to the continued backlog of Medicare Administrative Contractor audit claims awaiting appeal hearing. Appeals have historically experienced a substantial success rate in claim recovery. In addition, aged account receivable in our home health services increased by $0.8 million due to a legacy system transition for prior year acquisitions.

General and Administrative Expenses

Consolidated general and administrative expenses for the year ended December 31, 2015 was $247.9 million compared to $233.9 million for the same period in 2014, an increase of $14.0 million, or 6.0%; however, as a percentage of net service revenue, it is a decrease of 1.5%. The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2015		2014	
Home health services				
General and administrative	$182,107	29.7%	$180,363	31.9%
Depreciation and amortization	8,484	1.4	6,917	1.2

Total	$190,591	31.1%	$187,280	33.1%
Hospice services				

General and administrative	$24,893	29.0%	$17,789	26.3%
Depreciation and amortization	1,544	1.8	1,086	1.6
Total	$26,437	30.8%	$18,875	27.9%
Community-based services				
General and administrative	$8,309	20.2%	$6,445	23.3%
Depreciation and amortization	156	0.4	106	0.4
Total	$8,465	20.6%	$6,551	23.7%
Facility-based services				
General and administrative	$20,657	27.1%	$19,730	26.9%
Depreciation and amortization	1,769	2.3	1,462	2.0
Total	$22,426	29.5%	$21,192	28.9%

For home health services, hospice services, and community-based services, $6.9 million of the increase was from agencies acquired during 2015. The remainder of the increase was due to growth in our same store agencies. This increase was partially offset with savings associated with prior year closures of underperforming providers. For the facility-based services segment, general and administrative expenses increased due to the implementation of management roles in sales and administrative support staff.

Depreciation and amortization expense increased in the home health services segment and hospice services segment due to the capitalization of point of care licenses. In 2014, we successfully completed the roll out of our point of care technology. These licenses are amortized over their estimated useful life of 36 months. Depreciation in the facility-based services segment increased due to the purchase of patient care equipment, which occurred during the latter part of 2014.

Prior to 2015, the Company's principal executive offices were located in three properties. During 2015, the Company consolidated its corporate headquarters into one property. Depreciation expense associated with leasehold improvements and office furniture in the original three properties was accelerated during 2015 as the Company terminated these leases and disposed of the assets; the depreciation expense related to this was $1.3 million.

Impairment of intangibles and other

Consolidated impairment of intangibles and other for the year ended December 31, 2015 was $1.3 million compared to $3.6 million for the same period in 2014. During 2015, goodwill and other intangible asset disposal costs for underperforming providers that were closed was $0.7 million and as other intangible asset impairment of $0.6 million in the home health segment was recorded. In 2014, goodwill and other intangible asset disposal costs for closures were $1.6 million. In addition, there was $2.0 million related to the impairment of intangible trade names in the home-health segment.

Net Income Attributable to Noncontrolling Interest

Consolidated net income attributable to noncontrolling interest represents the minority owners' allocable share of income in the equity joint venture partners. For the year ended December 31, 2015, noncontrolling interest was $9.3 million compared to $6.9 million for the same period in 2014, an increase of approximately $2.4 million, or 34.8%. Noncontrolling interest increased due to the overall growth in same store agencies, and overall operational efficiencies gained through the joint ventures' use of our point of care platform.

Liquidity and Capital Resources

Cash at December 31, 2016 was $3.3 million, compared to $6.1 million at December 31, 2015. Based on our current plan of operations, including acquisitions, we believe this amount, when combined with expected cash flows from operations and amounts available under our revolving credit facility will be sufficient to fund our growth strategy and to meet our anticipated operating expenses, capital expenditures and debt service obligations for at least the next 12

months.

Liquidity

Our principal source of liquidity needed to fund our operating activities is the collection of patient accounts receivable, most of which are collected from governmental and third-party commercial payors. We also have the ability to obtain additional liquidity, if necessary, through our revolving credit facility, which provides for aggregate borrowings, including outstanding letters of credit, up to $225 million.

Our reported cash flows are affected by various external and internal factors, including the following:

- Operating Results – Our net income has a significant effect on our operating cash flows. Any significant increase or decrease in our net income could have a material effect on our operating cash flows.

- Timing of Acquisitions – We use a portion of our operating and/or financing cash flows for acquisitions. When the acquisitions occur at or near the end of a period, our cash outflows significantly increase.

- Timing of Payroll – Our employees are paid bi-weekly on Fridays. Operating cash outflows increase in reporting periods that end on a Friday.

- Self Insurance Plan Funding – We are self-funded for health insurance and workers compensation insurance. Any significant changes in the amount of insurance claims submitted could have a direct effect on our operating cash flows.

Cash used in investing activities primarily relates to acquisitions of home nursing and hospice agencies, while cash used by financing activities primarily relates to payments on outstanding debt agreements and payments to our noncontrolling interest partners.

The following table summarizes changes in cash flows (amounts in thousands):

	Year Ended December 31,	
	2016	2015
Net cash provided by (used in):		
Operating activities	$ 67,472	$ 59,934
Investing activities	(50,380)	(83,855)
Financing activities	(19,967)	29,529

Cash provided by operating activities changed due to acquisitions purchased in 2016 and the accretion of agencies purchased in 2015.

Cash used in investing activities and financing activities changed due to the difference in volume of acquisition activity occurring between 2016 and 2015. We paid $34.6 million for acquisitions in 2016 compared to $70.6 million for acquisitions in 2015. The acquisition activity in 2015 caused us to draw more on our line of credit compared to 2016.

Credit Facility

Our revolving credit facility with Capital One, National Association is unsecured and provides for a maximum aggregate principal borrowing of $225 million (with a letter of credit sub-limit equal to $15 million), and is scheduled to expire on June 18, 2019. We are required to pay a commitment fee for the unused commitments at rates ranging from 0.225% to 0.375% per annum depending upon the Company's consolidated Leverage Ratio, as defined in the Credit Agreement.

A letter of credit fee equal to the applicable Eurodollar rate multiplied by the face amount of the letter of credit is charged upon issuance and on each anniversary date while the letter of credit is outstanding. The agent’s standard up-front fee and other customary administrative charges are also due upon issuance of the letter of credit, along with a renewal fee on each anniversary date while the letter of credit is outstanding. At December 31, 2016 and 2015, outstanding letters of credit were $11.0 million and $9.8 million, respectively, which are issued as collateral on our workers’ compensation insurance.

Borrowings accrue interest under the Credit Agreement at either the Base Rate or Eurodollar rate are subject to the applicable margins as set forth below:

Leverage Ratio	Eurodollar Margin	Base Rate Margin	Commitment Fee Rate
≤ 1.00:1.00	1.75 %	0.75 %	0.225 %
>1.00:1.00 ≤ 1.50:100	2.00 %	1.00 %	0.250 %
>1.50:1.00 ≤ 2.00:1.00	2.25 %	1.25 %	0.300 %

>2.00:1.00	2.50 %	1.50 %	0.375 %

Our Credit Agreement contains customary affirmative, negative and financial covenants. For example, without prior approval of our bank group, we are restricted in incurring additional debt, disposing of assets, making investments, allowing fundamental changes to our business or organization and making certain payments in respect of stock or other ownership interests, such as dividends and stock repurchases, up to $50.0 million. Under our Credit Agreement, we are also required to meet certain financial covenants with respect to minimum fixed charge coverage and leverage ratios.

Our Credit Agreement contains customary events of default, including bankruptcy and other insolvency events, cross-defaults to other debt agreements, a change in control involving us or any subsidiary guarantor and the failure to comply with certain covenants.

At December 31, 2016, we were in compliance with all covenants contained in the Credit Agreement governing our credit facility.

Contractual Obligations

The following table discloses aggregate information about our contractual obligations and the periods in which payments are due as of December 31, 2016 (amounts in thousands):

	Payment Due by Period				
Contractual Cash Obligation	Total	Less than 1 Year	1-3 Years	3-5 Years	More than 5 Years
Long-term debt	$87,796	$ 252	$87,544	$ —	$ —
Operating leases	51,276	17,785	19,056	8,808	5,627
Total contractual cash obligations	$139,072	$ 18,037	$106,600	$ 8,808	$ 5,627

Off-Balance Sheet Arrangements

We currently do not have any off-balance sheet arrangements with unconsolidated entities, financial partnerships or entities often referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. In addition, we do not engage in trading activities involving non-exchange traded contracts. As such, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in these relationships.

Recently Issued Accounting Pronouncements

For a discussion of recently issued accounting pronouncements, see Note 2 of the Notes to Condensed Consolidated Financial Statements, which is incorporated herein by reference.

Critical Accounting Policies

The following discussions describe our critical accounting policies, which we believe require the most significant judgments and estimates used in the preparation of our consolidated financial statements.

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported revenue and expenses during the reporting period. Changes in the accounting estimates are reasonably likely to occur from period to period. Accordingly, actual results could differ materially from our estimates. To the extent that there are material differences between these estimates and actual results, our financial condition or results of operations will be affected. We base our estimates on past experience and other assumptions that we believe are reasonable under the circumstances and we evaluate these estimates on an ongoing basis.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities controlled by us through our direct ownership of a majority interest or controlling member ownership of such entities. The consolidated financial statements include entities in which we have the obligation to absorb losses of the entities or the right to receive benefits from the entities and have voting control over the entities or both, as a result of ownership, contractual or other financial interests in the entities.

The following table summarizes the percentage of net service revenue earned by type of ownership or relationship we had with the operating entity:

Ownership type	2016	2015	2014
Wholly owned subsidiaries	57.2 %	55.2 %	53.5 %
Equity joint ventures	41.2	42.9	43.9

Other	1.6	1.9	2.6
	100.0%	100.0%	100.0%

All significant inter-company accounts and transactions have been eliminated in consolidation. Business combinations accounted for as purchases have been included in the consolidated financial statements from the respective dates of acquisition.

Equity Joint Ventures

Our equity joint ventures are structured as limited liability companies in which we typically own a majority equity interest ranging from 51% to 91%. Each member of all but one of our equity joint ventures participates in profits and losses in proportion to their equity interests. We have one equity joint venture partner whose participation in losses is limited; otherwise, earnings and losses are based on ownership interest. We consolidate these entities as we have voting control over the entities.

Other (License Leasing Arrangements and Management Services)

Through our wholly owned subsidiaries, we lease home health licenses necessary to operate certain of our home nursing agencies. We own 100% of the equity of these entities and consolidate them based on such ownership, as well as our obligation to absorb losses of the entities and the right to receive benefits from the entities.

We have various management services agreements under which we manage certain operations of agencies and facilities. We do not consolidate these agencies or facilities, as we do not have an ownership interest and do not have an obligation to absorb losses of the entities or the right to receive the benefits from the entities other than our management fee.

Revenue Recognition

For a detailed discussion of revenue recognition, see Item 1, which is incorporated here by reference.

We report net service revenue at the estimated net realizable amount due from Medicare, Medicaid, commercial insurance, managed care payors, patients and others for services rendered. All payors contribute to the home health services, hospice services, community-based services and facility-based services.

The following table sets forth the percentage of net service revenue earned by category of payor for the respective years ending December 31:

Payor	2016	2015	2014
Medicare	74.5 %	74.5 %	75.9 %
Medicaid	1.8	1.5	1.4
Other	23.7	24.0	22.7
	100.0%	100.0%	100.0%

Medicare

Home Health Services

The Company’s home nursing Medicare patients are classified into one of 153 home health resource groups prior to receiving services. Based on this home health resource group, we are entitled to receive a standard prospective Medicare payment for delivering care over a 60-day period referred to as an episode. We recognize revenue based on the number of days elapsed during an episode of care within the reporting period.

Final payments from Medicare may reflect adjustments to ensure the adequacy and effectiveness of the total reimbursement: (a) an outlier payment if the patient’s care was unusually costly; (b) a low utilization adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or transferred from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) base payment adjustments for case-mix and geographic wage differences; and (f) 2% sequestration reduction for episodes beginning after March 31, 2013. Management estimates the adjustments outlined above based on historical experience and as changes become known, and records these adjustments during the period in which the services are provided to the patient. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

We are paid by Medicare under a per diem payment system. We receive one of four predetermined daily or hourly rates based upon the level of care the Company furnished. We record net service revenue from hospice services based on the daily or hourly rate and recognizes revenue as hospice services are provided.

Hospice payments are subject to an inpatient cap and an overall Medicare payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services and the

overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a “cap amount,” calculated by multiplying the number of beneficiaries during the period by a statutory amount that is indexed for inflation. The determination for each cap is made annually based on the 12 -month period ending on October 31 of each year. We monitor its limits on a provider-by-provider basis and record an estimate of its

liability for reimbursements received in excess of the cap amount. Annually, we receive notification of whether any of our hospice providers have exceeded either cap. Beginning with cap year October 1, 2014, CMS implemented a new process requiring hospice providers to self-report their cap liabilities and remit applicable payment by March 31 of the following year.

Facility-Based Services

Long-Term Acute Care Services. We are reimbursed by Medicare for services provided under the LTACH-PPS, which was implemented on October 1, 2002. Each patient is assigned a long-term care diagnosis-related group. We are paid a predetermined fixed amount intended to reflect the average cost of treating a Medicare patient classified in that particular long-term care diagnosis-related group. For selected patients, the amount may be further adjusted based on length-of-stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently re-admitted, among other factors. We calculate the adjustment based on a historical average of these types of adjustments for claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Revenue is recognized for our LTACHs as services are provided.

Medicaid, managed care and other payors

Our Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as services are provided based on this fee schedule. Our managed care payors and other payors reimburse us, and we recognize revenue, in a manner similar to our Medicare and Medicaid reimbursements.

Management Services

We record management services revenue as services are provided in accordance with the various management services agreements to which we are a party. As described in the agreements, we provide billing, management and other consulting services suited to and designed for the efficient operation of the applicable home nursing agency. We are responsible for the costs associated with the locations and personnel required for the provision of services. We are compensated based on a percentage of cash collections for one management services agreement and reimbursed for operating expenses plus a percentage of operating net income for the remaining management services agreement.

Income Tax

We operate in numerous tax jurisdictions and recognize income tax expense based on the revenue and expenses earned in those jurisdictions, which requires us to apportion and allocate revenue and expenses in all taxable jurisdictions. During 2011, we entered into a settlement with the United States of America which we believe is fully deductible for income tax purposes. As of December 31, 2016, $1.3 million was recorded in income tax payable as an unrecognized tax benefit which, if recognized, would decrease the our effective tax rate. All of the unrecognized tax benefit is due to the settlement with the United States of America, which was announced September 30, 2011. On July 31, 2014, the Internal Revenue Service ("IRS") issued a notice of proposed adjustment asserting that a portion of the original tax deduction claimed by us associated with the settlement of the United States of America should be disallowed. In December 2016, we signed a final settlement offer from the IRS that reduced the unrecognized tax benefit from $3.4 million to $1.3 million. We received approval from Joint Committee Review in February 2017 to finalize the settlement. Due to the approval being received subsequent to year-end, we continue to show the amount as an uncertain tax position as of December 31, 2016.

Accounts Receivable and Allowances for Uncollectible Accounts

We report accounts receivable net of estimated allowances for uncollectible accounts and adjustments. Accounts receivable are uncollateralized and primarily consist of amounts due from Medicare, other third-party payors and patients. To provide for accounts receivable that could become uncollectible in the future, we establish an allowance for uncollectible accounts to reduce the carrying amount of such receivables to their estimated net realizable value. The amount of the provision for uncollectible accounts is based upon our assessment of historical and expected net collections, business and economic conditions and trends in government reimbursement. Uncollectible accounts are written off after exhausting collection efforts and we have concluded that the account will not be collected. Because Medicare is our primary payor, the credit risk associated with receivables from other payors is limited. We believe the credit risk associated with our Medicare accounts, which represent over 60% of our patient accounts receivable at December 31, 2016 and 2015, respectively, is limited due to (a) our historical collections experience with Medicare

and (b) the fact that Medicare is a U.S. government payor. We do not believe that there are any other significant concentrations of receivables from any particular payor that would subject it to any significant credit risk in the collection of accounts receivable.

A portion of the estimated Medicare prospective payment system reimbursement from each submitted home nursing episode is received in the form of a request for anticipated payment ("RAP"). We submit a RAP for 60% of the estimated reimbursement for the initial episode at the start of care. The full amount of the episode is billed after the episode has been completed. The RAP received for that particular episode is deducted from the 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 Medicare claims in process for that particular provider. The RAP and final claim must then be resubmitted. For subsequent episodes of care contiguous with the first episode for a particular patient, we submit a RAP for 50% instead of 60% of the estimated reimbursement.

Our Medicare population is paid at a prospectively set amount that can be determined at the time services are rendered. Our Medicaid reimbursement is based on a predetermined fee schedule applied to each individual service we provide. Our managed care contracts are structured similar to the Medicare and Medicaid payment methodologies. Because of our payor mix, we are able to more accurately calculate our actual amount due at the patient level and adjust the gross charges to the actual amount at the time of billing. This negates the need to record an estimated allowance for uncollectible accounts, similar to a contractual adjustment, when reporting the majority of our net service revenue for each reporting period.

At December 31, 2016, our allowance for uncollectible accounts, as a percentage of patient accounts receivable, was approximately 18.9%, or $29.0 million, compared to 19.5%, or $26.7 million, at December 31, 2015. Accounts Receivable days sales outstanding ("DSO") for the year ended December 31, 2016 was 49 days compared to 46 days for the same period in 2015. Increased accounts receivable from acquisitions, an increase in managed care accounts receivable, and collection delays resulting from reviews, audits and investigations from ZPICs, RACs, and additional development requests have each contributed to the increase in days sales outstanding.

The following table sets forth, as of December 31, 2016, the aging of accounts receivable (based on the end of episode date) (amounts in thousands):

Payor	0-90	91-180	181-365	Over 365	Total
Medicare	$71,386	$9,590	$5,547	$5,720	$92,243
Medicaid	4,600	1,470	1,380	268	7,718
Other	33,084	5,943	7,179	7,672	53,878
Total	$109,070	$17,003	$14,106	$13,660	$153,839

For home health services, hospice services, and community-based services, we calculate the allowance for uncollectible accounts as a percentage of total patient receivables. The percentage changes depending on the payor and increases as the patient receivables age. For facility-based services, we calculate the allowance for uncollectible accounts based on a claim by claim review.

The following table sets forth, as of December 31, 2015, the aging of accounts receivable (based on the end of episode date) (amounts in thousands):

Payor	0-90	91-180	181-365	Over 365	Total
Medicare	$65,910	$8,244	$4,971	$4,960	$84,085
Medicaid	2,994	1,033	903	561	5,491
Other	26,794	7,248	7,699	5,745	47,486
Total	$95,698	$16,525	$13,573	$11,266	$137,062

The following table summarizes the activity and ending balances in the allowance for uncollectible accounts (amounts in thousands):

	Beginning of Year Balance	Additions	Deductions	End of Year Balance
Year ended December 31:				
2016	$ 26,712	$ 14,790	$ 12,466	$ 29,036
2015	18,582	19,243	11,113	26,712
2014	14,334	15,780	11,532	18,582

Goodwill and Intangible Assets

We have a significant amount of goodwill on our balance sheet that resulted from the numerous business acquisitions we have made in prior years. We review goodwill and other intangible assets with indefinite lives annually for impairment or more frequently if circumstances indicate impairment may have occurred. We evaluate goodwill for impairment by comparing the current fair value of each of our reporting units to their carrying value, including goodwill. Our business is comprised of four reporting units: home health, hospice, community-based, and LTACH. To

the extent the carrying value of a reporting unit exceeds the fair value of the reporting unit, the Company would be required to perform the second step of the impairment test. Our impairment analysis is performed on November 30th of each year.

We performed a qualitative assessment to determine if it is more likely than not that the fair value of the reporting units are less than its carrying value. We evaluated relevant events and circumstances, such as market conditions, financial performance, and share price to determine if any goodwill impairment is indicated. Based on our analysis, an impairment of goodwill was not indicated.

We have not recognized any goodwill impairment charges in 2016, 2015 or 2014 related to the annual impairment testing.

Included in intangible assets are definite-lived assets subject to amortization such as software licenses, non-compete agreements and defensive assets, which are defined as trade names that are not actively used. Amortization of the definite-lived intangible assets is calculated on a straight-line basis over the estimated useful lives of the related assets. Non-compete agreements are amortized over the life of the agreement, usually ranging from one to three years.

We also have indefinite-lived assets that are not subject to amortization expense such as actively used trade names, certificates of need and licenses to conduct specific operations within geographic markets. Such trade names, certificates of need and licenses have indefinite lives because there are no legal, regulatory, contractual, economic or other factors that would limit the useful life of these intangible assets and we intend to renew and operate the certificates of need and licenses and use these trade names indefinitely. These indefinite-lived intangibles are reviewed annually for impairment or more frequently if circumstances indicate impairment may have occurred. To determine whether an indefinite-lived intangible asset is impaired, we perform a qualitative assessment to support the conclusion that the indefinite-lived intangible asset is not impaired. Based on the results of that qualitative assessment, we may perform a quantitative test. The quantitative impairment test on trade names uses the relief-from-royalty method. Under this method, the fair value of the trade name is determined by calculating the present value of the after-tax cost savings associated with owning the trade names and, therefore, not having to pay royalties for use over its estimated useful life. The quantitative impairment test for certificates of need and licenses applies the cost approach. Under this method, assumptions are made about the cost to replace the certificates of need and licenses. Based on our analysis, there were no indicators that any other intangible assets were impaired and no impairment charge was recorded for the year ended December 31, 2016. We did record impairment charges of $0.6 million and $2.0 million for the twelve months ended December 31, 2015 and 2014, respectively.

Self Insurance Reserves

We maintain insurance programs, which include employee health insurance and workers' compensation. Our employee health insurance program is self-funded, with stop-loss coverage on claims that exceed $0.2 million for any individually covered employee or employee family member. We are responsible for workers' compensation claims up to $0.5 million per individual incident. The self insurance reserve payable reflects the current estimate of incurred but not reported losses, historical claims experience, and expected costs to settle unpaid claims. We record amounts due from insurance policies in other current assets while recording the estimated liability in self insurance reserves.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Our exposure to market risk relates to fluctuations in interest rates from borrowings under the credit facility. Our letter of credit fees and interest accrued on our debt borrowings are subject to the applicable Eurodollar rate or Base Rate. A hypothetical 100 basis point increase in interest rates on the average daily amounts outstanding under the credit facility would have increased interest expense by $1.6 million and $0.6 million for the years ended December 31, 2016 and 2015, respectively.

Item 8. Financial Statements and Supplementary Data.

The consolidated financial statements and financial statement schedules in Part IV, Item 15 of this Annual Report on Form 10-K are incorporated by reference into this Item 8.

Item 9. Changes In and Disagreements with Accountants on Accounting and Financial Disclosure.

None.

Item 9A. Disclosure Controls and Procedures.