U S PHYSICAL THERAPY INC /NV
Form 10-K
March 18, 2019
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2018
OR

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 1-11151

U.S. PHYSICAL THERAPY, INC.
(EXACT NAME OF REGISTRANT AS SPECIFIED IN ITS CHARTER)

NEVADA	**76-0364866**
(STATE OR OTHER JURISDICTION OF INCORPORATION OR ORGANIZATION)	***(I.R.S. EMPLOYER IDENTIFICATION NO.)***
1300 WEST SAM HOUSTON PARKWAY SOUTH, SUITE 300, HOUSTON, TEXAS	**77042**
(ADDRESS OF PRINCIPAL EXECUTIVE OFFICES)	***(ZIP CODE)***

REGISTRANT'S TELEPHONE NUMBER, INCLUDING AREA CODE: (713) 297-7000
SECURITIES REGISTERED PURSUANT TO SECTION 12(b) OF THE EXCHANGE ACT:

Title of Each Class	**Name of Each Exchange on Which Registered**
Common Stock, $.01 par value	**New York Stock Exchange**

SECURITIES REGISTERED PURSUANT TO SECTION 12(g) OF THE EXCHANGE ACT: NONE

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

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

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

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes No o

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company or an emerging growth company. See the definitions of large accelerated filer, accelerated filer , smaller reporting company and emerging growth company in Rule 12b-2 of the Exchange Act.

Large accelerated filer	o	Accelerated filer	
Non-accelerated filer	o (Do not check if a smaller reporting company)	Smaller reporting company	o
		Emerging growth company	o

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. 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

The aggregate market value of the shares of the registrant s common stock held by non-affiliates of the registrant at June 30, 2018 was $761.9 million based on the closing sale price reported on the NYSE for the registrant s common stock on June 30, 2018, the last business day of the registrant s most recently completed second fiscal quarter. For purposes of this computation, all executive officers, directors and 5% or greater beneficial owners of the registrant were deemed to be affiliates. Such determination should not be deemed an admission that such executive officers, directors and beneficial owners are, in fact, affiliates of the registrant.

As of March 15, 2019, the number of shares outstanding of the registrant s common stock, par value $.01 per share, was: 12,761,092.

DOCUMENTS INCORPORATED BY REFERENCE

DOCUMENT	PART OF FORM 10-K
Portions of Definitive Proxy Statement for the 2018 Annual Meeting of Shareholders	Part III

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FORWARD-LOOKING STATEMENTS

We make statements in this report that are considered to be forward-looking statements within the meaning given such term under Section 21E of the Securities Exchange Act of 1934, as amended (the Exchange Act). These statements contain forward-looking information relating to the financial condition, results of operations, plans, objectives, future performance and business of our Company. These statements (often using words such as believes , expects , intends , plans , appear , should and similar words) involve risks and uncertainties that could cause actual results to differ materially from those we project. Included among such statements are those relating to opening clinics, availability of personnel and the reimbursement environment. The forward-looking statements are based on our current views and assumptions and actual results could differ materially from those anticipated in such forward-looking statements as a result of certain risks, uncertainties, and factors, which include, but are not limited to:

- changes as the result of government enacted national healthcare reform
- changes in Medicare rules and guidelines and reimbursement or failure of our clinics to maintain their Medicare certification status
- revenue we receive from Medicare and Medicaid being subject to potential retroactive reduction
- business and regulatory conditions including federal and state regulations
- governmental and other third party payor inspections, reviews, investigations and audits
- compliance with federal and state laws and regulations relating to the privacy of individually identifiable patient information, and associated fines and penalties for failure to comply
- changes in reimbursement rates or payment methods from third party payors including government agencies and deductibles and co-pays owed by patients
- revenue and earnings expectations
- legal actions, which could subject us to increased operating costs and uninsured liabilities
- general economic conditions
- availability and cost of qualified physical therapists
- personnel productivity and retaining key personnel
- competitive, economic or reimbursement conditions in our markets which may require us to reorganize or close certain clinics and thereby incur losses and/or closure costs including the possible write-down or write-off of goodwill and other intangible assets
- acquisitions, purchase of non-controlling interests (minority interests) and the successful integration of the operations of the acquired businesses
- maintaining our information technology systems with adequate safeguards to protect against cyber attacks
- maintaining adequate internal controls
- maintaining necessary insurance coverage
- availability, terms, and use of capital and
- weather and other seasonal factors.

Many factors are beyond our control. Given these uncertainties, you should not place undue reliance on our forward-looking statements. Please see the other sections of this report and our other periodic reports filed with the Securities and Exchange Commission (the SEC) for more information on these factors. Our forward-looking statements represent our estimates and assumptions only as of the date of this report. Except as required by law, we are under no obligation to update any forward-looking statement, regardless of the reason the statement may no longer be accurate.

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PART I

ITEM 1. *BUSINESS.*

GENERAL

Our company, U.S. Physical Therapy, Inc. (we , us , our or the Company), through its subsidiaries, operates outpatie physical therapy clinics that provide pre-and post-operative care and treatment for orthopedic-related disorders, sports-related injuries, preventative care, rehabilitation of injured workers and neurological-related injuries. We primarily operate through subsidiary clinic partnerships in which we generally own a 1% general partnership interest and a 49% to 99% limited partnership interest and the managing therapist(s) of the clinics owns the remaining limited partnership interest in the majority of the clinics (hereinafter referred to as Clinic Partnerships). To a lesser extent, we operate some clinics through wholly-owned subsidiaries under profit sharing arrangements with therapists (hereinafter referred to as Wholly-Owned Facilities). Also, we have a majority interest in a company, which is a leading provider of industrial injury prevention. Services provided include onsite injury prevention and rehabilitation, performance optimization and ergonomic assessments. The majority of these services are contracted with and paid for directly by employers including a number of Fortune 500 companies.

Unless the context otherwise requires, references in this Annual Report on Form 10-K to we , our or us includes the Company and all of its subsidiaries.

Our strategy is to develop outpatient physical therapy clinics and to acquire single and multi-clinic outpatient physical therapy practices on a national basis. At December 31, 2018, we operated 591 clinics in 42 states. The average age of the 591 clinics in operation at December 31, 2018 was 10.0 years. Our highest concentration of clinics are in the following states: Texas, Tennessee, Michigan, Virginia, Washington, Oregon, Florida, Maryland, Georgia, Pennsylvania and Arizona. In addition to our 591 clinics, at December 31, 2018, we also managed 28 physical therapy practices for unrelated physician groups and hospitals and operated the industrial injury prevention business, as described above.

During the last three years, we completed the following multi-clinic acquisitions:

Acquisition	Date	% Interest Acquired	Number of Clinics
August 2018 Acquisition	August 31	70 %	4
	2017		
January 2017 Acquisition	January 1	70 %	17
May 2017 Acquisition	May 31	70 %	4
June 2017 Acquisition	June 30	60 %	9
October 2017 Acquisition	October 31	70 %	9
	2016		
February 2016 Acquisition	February 29	55 %	8
November 2016 Acquisition	November 30	60 %	12

In March 2017, we purchased a 55% interest in our initial industrial injury prevention business. On April 30, 2018, we made a second acquisition and subsequently combined the two businesses. After the combination, we own a 59.45% interest in the combined business. Services provided include onsite injury prevention and rehabilitation, performance

optimization and ergonomic assessments. The majority of these services are contracted with and paid for directly by employers, including a number of Fortune 500 companies. Other clients include large insurers and their contractors. We perform these services through Industrial Sports Medicine Professionals, consisting of both physical therapists and highly specialized certified athletic trainers (ATCs).

In addition to the multi-clinic acquisitions above, on February 28, 2018, we, through several of our majority owned Clinic Partnerships, acquired five separate clinic practices. These practices operate as satellites of the respective existing Clinic Partnership.

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Also, during the year of 2017, we purchased the assets and business of two physical therapy clinics in separate transactions. One clinic was consolidated with an existing clinic and the other operates as a satellite clinic of one of the existing partnerships. In addition to the 2016 multi-clinic acquisitions, we acquired two single clinic practices in separate transactions during 2016.

The results of operations of the acquired clinics have been included in our consolidated financial statements since the date of their respective acquisition.

We continue to seek to attract for employment physical therapists who have established relationships with physicians and other referral sources by offering these therapists a competitive salary and incentives based on the profitability of the clinic that they manage. We also look for therapists with whom to establish new, de novo clinics to be owned jointly by us and such therapists. In these situations, the therapist is typically offered the opportunity to co-invest in the new clinic and also receives a competitive salary for managing the clinic. For multi-site clinic practices in which a controlling interest is acquired by us, the prior owners typically continue on as employees to manage the clinic operations, retaining a non-controlling ownership interest in the clinics and receiving a competitive salary for managing the clinic operations. In addition, we have developed satellite clinic facilities as part of existing Clinic Partnerships and Wholly-Owned facilities, with the result that a substantial number of Clinic Partnerships and Wholly-Owned facilities operate more than one clinic location. In 2019, we intend to continue to acquire clinic practices and continue to focus on developing new clinics and on opening satellite clinics where appropriate along with increasing our patient volume through marketing and new programs.

Therapists at our clinics initially perform a comprehensive evaluation of each patient, which is then followed by a treatment plan specific to the injury as prescribed by the patient s physician. The treatment plan may include a number of procedures, including therapeutic exercise, manual therapy techniques, ultrasound, electrical stimulation, hot packs, iontophoresis, education on management of daily life skills and home exercise programs. A clinic s business primarily comes from referrals by local physicians. The principal sources of payment for the clinics services are managed care programs, commercial health insurance, Medicare/Medicaid and workers compensation insurance.

We were re-incorporated in April 1992 under the laws of the State of Nevada and have operating subsidiaries organized in various states in the form of limited partnerships, limited liability companies and wholly-owned corporations. This description of our business should be read in conjunction with our financial statements and the related notes contained in Item 8 in this Annual Report on Form 10-K. Our principal executive offices are located at 1300 West Sam Houston Parkway South, Suite 300, Houston, Texas, 77042. Our telephone number is (713) 297-7000. Our website is www.usph.com.

OUR CLINICS

Most of our clinics are operated as Clinic Partnerships in which we own the general partnership interest and a majority of the limited partnership interests. The managing healthcare practitioner of the clinics usually owns a portion of the limited partnership interests. Generally, the therapist partners have no interest in the net losses of Clinic Partnerships, except to the extent of their capital accounts. Since we also develop satellite clinic facilities of existing clinics, most Clinic Partnerships consist of more than one clinic location. As of December 31, 2018, through wholly-owned subsidiaries, we owned a 1% general partnership interest in all the Clinic Partnerships. Our limited partnership interests range from 49% to 99% in the Clinic Partnerships. For the vast majority of the Clinic Partnerships, the managing healthcare practitioner is a physical therapist who owns the remaining limited partnership interest in the Clinic Partnership.

For our Clinic Partnership agreements related to those that we acquired a majority interest, generally, the prior management continues to own a 10% to 50% interest.

Typically, each therapist partner or director, including those employed by Clinic Partnerships in which we acquired a majority interest, enters into an employment agreement for a term of up to five years with their Clinic Partnership. Each agreement typically provides for a covenant not to compete during the period of his or her employment and for up to two years thereafter. Under each employment agreement, the therapist partner receives a base salary and may receive a bonus based on the net revenues or profits generated by their Clinic Partnership or specific clinic. In the case of Clinic Partnerships, the therapist partner receives earnings distributions based upon their ownership interest. Upon termination of employment, we typically have the right, but not the

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obligation, to purchase the therapist s partnership interest in de novo Clinic Partnerships. In connection with most of our acquired clinics, in the event that a limited minority partner s employment ceases and certain requirements are met as detailed in the respective limited partnership agreements, we have a call right (the Call Right) and the selling entity or individual has a put right (the Put Right) with respect to the partner s limited partnership interests. The Put Right and the Call Right do not expire, even upon an individual partner s death, and contain no mandatory redemption feature. The purchase price of the partner s limited partnership interest upon exercise of the Put Right or the Call Right is calculated at a predetermined multiple of earnings performance as detailed in the respective agreements.

Each Clinic Partnership maintains an independent local identity, while at the same time enjoying the benefits of national purchasing, negotiated third-party payor contracts, centralized support services and management practices. Under a management agreement, one of our subsidiaries provides a variety of support services to each clinic, including supervision of site selection, construction, clinic design and equipment selection, establishment of accounting systems and billing procedures and training of office support personnel, processing of accounts payable, operational direction, auditing of regulatory compliance, payroll, benefits administration, accounting services, legal services, quality assurance and marketing support.

Our typical clinic occupies approximately 1,600 to 3,000 square feet of leased space in an office building or shopping center. We attempt to lease ground level space for patient ease of access to our clinics.

Typical minimum staff at a clinic consists of a licensed physical therapist and an office manager. As patient visits grow, staffing may also include additional physical therapists, occupational therapists, therapy assistants, aides, exercise physiologists, athletic trainers and office personnel. Therapy services are performed under the supervision of a licensed therapist.

We provide services at our clinics on an outpatient basis. Patients are usually treated for approximately one hour per day, two to three times a week, typically for two to six weeks. We generally charge for treatment on a per procedure basis. Medicare patients are charged based on prescribed time increments and Medicare billing standards. In addition, our clinics will develop, when appropriate, individual maintenance and self-management exercise programs to be continued after treatment. We continually assess the potential for developing new services and expanding the methods of providing our existing services in the most efficient manner while providing high quality patient care.

FACTORS INFLUENCING DEMAND FOR THERAPY SERVICES

We believe that the following factors, among others, influence the growth of outpatient physical therapy services:

Economic Benefits of Therapy Services. Purchasers and providers of healthcare services, such as insurance companies, health maintenance organizations, businesses and industries, continuously seek cost savings for traditional healthcare services. We believe that our therapy services provide a cost-effective way to prevent short-term disabilities from becoming chronic conditions, to help avoid invasive procedures, to speed recovery from surgery and musculoskeletal injuries and eliminate or minimize the need for opioids.

Earlier Hospital Discharge. Changes in health insurance reimbursement, both public and private, have encouraged the earlier discharge of patients to reduce costs. We believe that early hospital discharge practices foster greater demand for outpatient physical therapy services.

Aging Population. In general, the elderly population has a greater incidence of disability compared to the population as a whole. As this segment of the population continues to grow, we believe that demand for rehabilitation services will expand.

Increase in Obesity. Two of every three American men are considered to be overweight or obese and the rate continues to grow. The strain on a person s body can be significant. Physical therapy services help the obese become more active and fit by teaching them how to move in ways that are pain free.

MARKETING

We focus our marketing efforts primarily on physicians, including orthopedic surgeons, neurosurgeons, physiatrists, internal medicine physicians, podiatrists, occupational medicine physicians and general practitioners. In marketing to the physician community, we emphasize our commitment to quality patient care and regular

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communication with physicians regarding patient progress. We employ personnel to assist clinic directors in developing and implementing marketing plans for the physician community and to assist in establishing relationships with health maintenance organizations, preferred provider organizations, industry, case managers and insurance companies.

SOURCES OF REVENUE

Payor sources for clinic services are primarily managed care programs, commercial health insurance, Medicare/Medicaid and workers compensation insurance. Commercial health insurance, Medicare and managed care programs generally provide coverage to patients utilizing our clinics after payment by the patients of normal deductibles and co-insurance payments. Workers compensation laws generally require employers to provide, directly or indirectly through insurance, costs of medical rehabilitation for their employees from work-related injuries and disabilities and, in some jurisdictions, mandatory vocational rehabilitation, usually without any deductibles, co-payments or cost sharing. Treatments for patients who are parties to personal injury cases are generally paid from the proceeds of settlements with insurance companies or from favorable judgments. If an unfavorable judgment is received, collection efforts are generally not pursued against the patient and the patient s account is written-off against established reserves. Bad debt reserves relating to all receivable types are regularly reviewed and adjusted as appropriate.

The following table shows our payor mix for the years ended:

	December 31, 2018		December 31, 2017		December 31, 2016	
Payor	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage	Net Patient Revenue	Percentage
	(Net Patient Revenues in Thousands)					
Managed Care Programs	$ 134,748	32.3 %	$ 120,773	31.0 %	$ 94,861	27.2 %
Commercial Health Insurance	72,786	17.4 %	79,968	20.5 %	84,784	24.3 %
Medicare/Medicaid	117,554	28.1 %	103,713	26.7 %	89,743	25.7 %
Workers' Compensation Insurance	59,942	14.4 %	55,364	14.2 %	56,478	16.2 %
Other	32,673	7.8 %	29,408	7.6 %	22,973	6.6 %
Total	$ 417,703	100.0 %	$ 389,226	100.0 %	$ 348,839	100.0 %

Our business depends to a significant extent on our relationships with commercial health insurers, health maintenance organizations, preferred provider organizations and workers compensation insurers. In some geographical areas, our clinics must be approved as providers by key health maintenance organizations and preferred provider plans to obtain payments. Failure to obtain or maintain these approvals would adversely affect financial results.

During the year ended December 31, 2018, approximately 29.7% of our visits and 28.1% of our net patient revenues were from patients with Medicare or Medicaid program coverage. To receive Medicare reimbursement, a facility (Medicare Certified Rehabilitation Agency) or the individual therapist (Physical/Occupational Therapist in Private Practice) must meet applicable participation conditions set by the Department of Health and Human Services (HHS) relating to the type of facility, equipment, recordkeeping, personnel and standards of medical care, and also must comply with all state and local laws. HHS, through Centers for Medicare & Medicaid Services (CMS) and designated agencies, periodically inspects or surveys clinics/providers for approval and/or compliance. We anticipate that our newly developed and acquired clinics will become certified as Medicare providers or will be enrolled as a group of physical/occupation therapists in a private practice. Failure to obtain or maintain this certification would adversely affect financial results.

The Medicare program reimburses outpatient rehabilitation providers based on the Medicare Physician Fee Schedule (MPFS). For services provided in 2018, a 0.5% increase has been applied to the fee schedule payment rates; for services provided in 2019, a 0.25% increase will be applied to the fee schedule payment rates before applying the mandatory budget neutrality adjustment. For services provided in 2020 through 2025, a 0.0% percent update will be applied each year to the fee schedule payment rates, before applying the mandatory budget neutrality adjustment. Beginning in 2021, payments to individual therapists (Physical/Occupational Therapist in Private Practice) paid under the fee schedule may be subject to adjustment based on performance in the Merit Based Incentive Payment System (MIPS), which measures performance based on certain quality metrics, resource use, and meaningful use of electronic health records. Under the MIPS requirements, a

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provider s performance is assessed according to established performance standards each year and then is used to determine an adjustment factor that is applied to the professional s payment for the corresponding payment year. The provider s MIPS performance in 2019 will determine the payment adjustment in 2021. Each year from 2019 through 2024, professionals who receive a significant share of their revenues through an alternate payment model (APM), (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus in the corresponding payment year. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors. The specifics of the MIPS and APM adjustments will be subject to future notice and comment rule-making.

The Budget Control Act of 2011 increased the federal debt ceiling in connection with deficit reductions over the next ten years, and requires automatic reductions in federal spending by approximately $1.2 trillion. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. On April 1, 2013, a 2% reduction to Medicare payments was implemented. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, extended the 2% reductions to Medicare payments through fiscal year 2025. The Bipartisan Budget Act of 2018, enacted on February 9, 2018, extends the 2% reductions to Medicare payments through fiscal year 2027.

Historically, the total amount paid by Medicare in any one year for outpatient physical therapy, occupational therapy, and/or speech-language pathology services provided to any Medicare beneficiary was subject to an annual dollar limit (i.e., the Therapy Cap or Limit). For 2017, the annual Limit on outpatient therapy services was $1,980 for combined Physical Therapy and Speech Language Pathology services and $1,980 for Occupational Therapy services. As a result of Bipartisan Budget Act of 2018, the Therapy Caps have been eliminated, effective as of January 1, 2018.

Under the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRA), since October 1, 2012, patients who met or exceeded $3,700 in therapy expenditures during a calendar year have been subject to a manual medical review to determine whether applicable payment criteria are satisfied. The $3,700 threshold is applied to Physical Therapy and Speech Language Pathology Services; a separate $3,700 threshold is applied to the Occupational Therapy. The MACRA directed CMS to modify the manual medical review process such that those reviews will no longer apply to all claims exceeding the $3,700 threshold and instead will be determined on a targeted basis based on a variety of factors that CMS considers appropriate The Bipartisan Budget Act of 2018 extends the targeted medical review indefinitely, but reduces the threshold to $3,000 through December 31, 2027. For 2028, the threshold amount will be increased by the percentage increase in the Medicare Economic Index (MEI) for 2028 and in subsequent years the threshold amount will increase based on the corresponding percentage increase in the MEI for such subsequent year.

CMS adopted a multiple procedure payment reduction (MPPR) for therapy services in the final update to the MPFS for calendar year 2011. The MPPR applied to all outpatient therapy services paid under Medicare Part B — occupational therapy, physical therapy and speech-language pathology. Under the policy, the Medicare program pays 100% of the practice expense component of the Relative Value Unit (RVU) for the therapy procedure with the highest practice expense RVU, then reduces the payment for the practice expense component for the second and subsequent therapy procedures or units of service furnished during the same day for the same patient, regardless of whether those therapy services are furnished in separate sessions. Since 2013, the practice expense component for the second and subsequent therapy service furnished during the same day for the same patient was reduced by 50%. In addition, the MCTRA directed CMS to implement a claims-based data collection program to gather additional data on patient function during the course of therapy in order to better understand patient conditions and outcomes. All practice settings that provide outpatient therapy services are required to include this data on the claim form. Since 2013, therapists have been required to report new codes and modifiers on the claim form that reflect a patient s functional limitations and goals at initial evaluation, periodically throughout care, and at discharge. Reporting of these functional limitation codes and modifiers are required on the claim for payment.

Medicare claims for outpatient therapy services furnished by therapy assistants on or after January 1, 2022 must include a modifier indicating the service was furnished by a therapy assistant. CMS is required to develop a

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modifier to mark services provided by a therapy assistant by January 1, 2019, and then submitted claims have to report the modifier mark starting January 1, 2020. Outpatient therapy services furnished on or after January 1, 2022 in whole or part by a therapy assistant will be paid at an amount equal to 85% of the payment amount otherwise applicable for the service.

Statutes, regulations, and payment rules governing the delivery of therapy services to Medicare beneficiaries are complex and subject to interpretation. We believe that we are in compliance in all material respects with all applicable laws and regulations and are not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on our financial statements as of December 31, 2018. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare program. For 2018, net patient revenue from Medicare accounted for approximately $103.6 million.

REGULATION AND HEALTHCARE REFORM

Numerous federal, state and local regulations regulate healthcare services and those who provide them. Some states into which we may expand have laws requiring facilities employing health professionals and providing health-related services to be licensed and, in some cases, to obtain a certificate of need (that is, demonstrating to a state regulatory authority the need for, and financial feasibility of, new facilities or the commencement of new healthcare services). Only one of the states in which we currently operate requires a certificate of need for the operation of our physical therapy business functions. Our therapists and/or clinics, however, are required to be licensed, as determined by the state in which they provide services. Failure to obtain or maintain any required certificates, approvals or licenses could have a material adverse effect on our business, financial condition and results of operations.

Regulations Controlling Fraud and Abuse. Various federal and state laws regulate financial relationships involving providers of healthcare services. These laws include Section 1128B(b) of the Social Security Act (42 U.S. C. § 1320a-7b[b]) (the Fraud and Abuse Law), under which civil and criminal penalties can be imposed upon persons who, among other things, offer, solicit, pay or receive remuneration in return for (i) the referral of patients for the rendering of any item or service for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid); or (ii) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, ordering any good, facility, service, or item for which payment may be made, in whole or in part, by a Federal health care program (including Medicare and Medicaid). We believe that our business procedures and business arrangements are in compliance with these provisions. However, the provisions are broadly written and the full extent of their specific application to specific facts and arrangements to which we are a party is uncertain and difficult to predict. In addition, several states have enacted state laws similar to the Fraud and Abuse Law, which may be more restrictive than the federal Fraud and Abuse Law.

The Office of the Inspector General (OIG) of HHS has issued regulations describing compensation financial arrangements that fall within a Safe Harbor and, therefore, are not viewed as illegal remuneration under the Fraud and Abuse Law. Failure to fall within a Safe Harbor does not mean that the Fraud and Abuse Law has been violated; however, the OIG has indicated that failure to fall within a Safe Harbor may subject an arrangement to increased scrutiny under a facts and circumstances test.

The OIG also has issued special fraud alerts and special advisory bulletins to remind the provider community of the importance and application of certain aspects of the Fraud and Abuse Law. One of the OIG special fraud alerts related to the rental of space in physician offices by persons or entities to which the physicians refer patients. The OIG s stated concern in these arrangements is that rental payments may be disguised kickbacks to the physician-landlords to induce referrals. We rent clinic space for some of our clinics from referring physicians and have taken the steps that we believe are necessary to ensure that all leases comply to the extent possible and applicable, with the space rental Safe

Harbor to the Fraud and Abuse Law.

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One of the OIG s special advisory bulletins addressed certain complex contractual arrangements for the provision of items and services. This special advisory bulletin identified several characteristics commonly exhibited by suspect arrangements, the existence of one or more of which could indicate a prohibited arrangement to the OIG. Generally, the indicia of a suspect contractual joint venture as identified by the special advisory bulletin and an associated OIG advisory opinion include the following:

New Line of Business. A provider in one line of business (Owner) expands into a new line of business that can be provided to the Owner s existing patients, with another party who currently provides the same or similar item or service as the new business (Manager/Supplier).

Captive Referral Base. The arrangement predominantly or exclusively serves the Owner s existing patient base (or patients under the control or influence of the Owner).

Little or No Bona Fide Business Risk. The Owner s primary contribution to the venture is referrals; it makes little or no financial or other investment in the business, delegating the entire operation to the Manager/Supplier, while retaining profits generated from its captive referral base.

Status of the Manager/Supplier. The Manager/Supplier is a would-be competitor of the Owner s new line of business and would normally compete for the captive referrals. It has the capacity to provide virtually identical services in its own right and bill insurers and patients for them in its own name.

Scope of Services Provided by the Manager/Supplier. The Manager/Supplier provides all, or many, of the new business key services.

Remuneration. The practical effect of the arrangement, viewed in its entirety, is to provide the Owner the opportunity to bill insurers and patients for business otherwise provided by the Manager/Supplier. The remuneration from the venture to the Owner (i.e., the profits of the venture) takes into account the value and volume of business the Owner generates.

Exclusivity. The arrangement bars the Owner from providing items or services to any patients other than those coming from Owner and/or bars the Manager/Supplier from providing services in its own right to the Owner s patients.

Due to the nature of our business operations, many of our management service arrangements exhibit one or more of these characteristics. However, we believe we have taken steps regarding the structure of such arrangements as necessary to sufficiently distinguish them from these suspect ventures, and to comply with the requirements of the Fraud and Abuse Law. However, if the OIG believes we have entered into a prohibited contractual joint venture, it could have an adverse effect on our business, financial condition and results of operations.

Although the business of managing physician-owned physical therapy facilities is regulated by the Fraud and Abuse Law, the manner in which we contract with such facilities often falls outside the complete scope of available Safe Harbors. We believe our arrangements comply with the Fraud and Abuse Law, even though federal courts provide limited guidance as to the application of the Fraud and Abuse Law to these arrangements. If our management contracts are held to violate the Fraud and Abuse Law, it could have an adverse effect on our business, financial condition and results of operations.

Stark Law. Provisions of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. § 1395nn) (the Stark Law) prohibit referrals by a physician of designated health services which are payable, in whole or in part, by Medicare or Medicaid, to an entity in which the physician or the physician s immediate family member has an investment interest or other financial relationship, subject to several exceptions. Unlike the Fraud and Abuse Law, the Stark Law is a

strict liability statute. Proof of intent to violate the Stark Law is not required. Physical therapy services are among the designated health services . Further, the Stark Law has application to our management contracts with individual physicians and physician groups, as well as, any other financial relationship between us and referring physicians, including medical advisor arrangements and any financial transaction resulting from a clinic acquisition. The Stark Law also prohibits billing for services rendered pursuant to a prohibited referral. Several states have enacted laws similar to the Stark Law. These state laws may cover all (not just Medicare and Medicaid) patients. As with the Fraud and Abuse Law, we consider the Stark Law in planning our clinics, establishing contractual and other arrangements with physicians, marketing and other

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activities, and believe that our operations are in compliance with the Stark Law. If we violate the Stark Law or any similar state laws, our financial results and operations could be adversely affected. Penalties for violations include denial of payment for the services, significant civil monetary penalties, and exclusion from the Medicare and Medicaid programs.

HIPAA. In an effort to further combat healthcare fraud and protect patient confidentially, Congress included several anti-fraud measures in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA created a source of funding for fraud control to coordinate federal, state and local healthcare law enforcement programs, conduct investigations, provide guidance to the healthcare industry concerning fraudulent healthcare practices, and establish a national data bank to receive and report final adverse actions. HIPAA also criminalized certain forms of health fraud against all public and private payors. Additionally, HIPAA mandates the adoption of standards regarding the exchange of healthcare information in an effort to ensure the privacy and electronic security of patient information and standards relating to the privacy of health information. Sanctions for failing to comply with HIPAA include criminal penalties and civil sanctions. In February of 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law. Title XIII of ARRA, the Health Information Technology for Economic and Clinical Health Act (HITECH), provided for substantial Medicare and Medicaid incentives for providers to adopt electronic health records (EHRs) and grants for the development of health information exchange (HIE). Recognizing that HIE and EHR systems will not be implemented unless the public can be assured that the privacy and security of patient information in such systems is protected, HITECH also significantly expanded the scope of the privacy and security requirements under HIPAA. Most notable are the mandatory breach notification requirements and a heightened enforcement scheme that includes increased penalties, and which now apply to business associates as well as to covered entities. In addition to HIPAA, a number of states have adopted laws and/or regulations applicable in the use and disclosure of individually identifiable health information that can be more stringent than comparable provisions under HIPAA.

We believe that our operations comply with applicable standards for privacy and security of protected healthcare information. We cannot predict what negative effect, if any, HIPAA/HITECH or any applicable state law or regulation will have on our business.

Other Regulatory Factors. Political, economic and regulatory influences are fundamentally changing the healthcare industry in the United States. Congress, state legislatures and the private sector continue to review and assess alternative healthcare delivery and payment systems. Potential alternative approaches could include mandated basic healthcare benefits, controls on healthcare spending through limitations on the growth of private health insurance premiums and Medicare and Medicaid spending, the creation of large insurance purchasing groups, and price controls. Legislative debate is expected to continue in the future and market forces are expected to demand only modest increases or reduced costs. For instance, managed care entities are demanding lower reimbursement rates from healthcare providers and, in some cases, are requiring or encouraging providers to accept capitated payments that may not allow providers to cover their full costs or realize traditional levels of profitability. We cannot reasonably predict what impact the adoption of federal or state healthcare reform measures or future private sector reform may have on our business.

COMPETITION

The healthcare industry, including the physical therapy business, is highly competitive. The physical therapy business is highly fragmented with no company having a significant market share nationally. We believe that we are currently the third largest national outpatient rehabilitation provider.

Competitive factors affecting our business include quality of care, cost, treatment outcomes, convenience of location, and relationships with, and ability to meet the needs of, referral and payor sources. Our clinics compete, directly or

indirectly, with many types of healthcare providers including the physical therapy departments of hospitals, private therapy clinics, physician-owned therapy clinics, and chiropractors. We may face more intense competition if consolidation of the therapy industry continues.

We believe that our strategy of providing key therapists in a community with an opportunity to participate in ownership or clinic profitability provides us with a competitive advantage by helping to ensure the commitment of local management to the success of the clinic.

We also believe that our competitive position is enhanced by our strategy of locating our clinics, when possible, on the ground floor of buildings and shopping centers with nearby parking, thereby making the clinics

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more easily accessible to patients. We offer convenient hours. We also attempt to make the decor in our clinics less institutional and more aesthetically pleasing than traditional hospital clinics.

ENFORCEMENT ENVIRONMENT

In recent years, federal and state governments have launched several initiatives aimed at uncovering behavior that violates the federal civil and criminal laws regarding false claims and fraudulent billing and coding practices. Such laws require providers to adhere to complex reimbursement requirements regarding proper billing and coding in order to be compensated for their services by government payors. Our compliance program requires adherence to applicable law and promotes reimbursement education and training; however, a determination that our clinics billing and coding practices are false or fraudulent could have a material adverse effect on us.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental inspections, reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. In addition, our Corporate Integrity Agreement requires annual audits to be performed by an independent review organization on a small sample of our clinics, the results of which are reported to the federal government. See -Compliance Program – Corporate Integrity Agreement . Managed care payors may also reserve the right to conduct audits. An adverse inspection, review, audit or investigation could result in: refunding amounts we have been paid; fines penalties and/or revocation of billing privileges for the affected clinics; expansion of the scope of our Corporate Integrity Agreement; exclusion from participation in the Medicare or Medicaid programs or one or more managed care payor network; or damage to our reputation.

We and our clinics are subject to federal and state laws prohibiting entities and individuals from knowingly and willfully making claims to Medicare, Medicaid and other governmental programs and third party payors that contain false or fraudulent information. The federal False Claims Act encourages private individuals to file suits on behalf of the government against healthcare providers such as us. As such suits are generally filed under seal with a court to allow the government adequate time to investigate and determine whether it will intervene in the action, the implicated healthcare providers often are unaware of the suit until the government has made its determination and the seal is lifted. Violations or alleged violations of such laws, and any related lawsuits, could result in (i) exclusion from participation in Medicare, Medicaid and other federal healthcare programs, or (ii) significant financial or criminal sanctions, resulting in the possibility of substantial financial penalties for small billing errors that are replicated in a large number of claims, as each individual claim could be deemed a separate violation. In addition, many states also have enacted similar statutes, which may include criminal penalties, substantial fines, and treble damages.

COMPLIANCE PROGRAM

Our Compliance Program. Our ongoing success depends upon our reputation for quality service and ethical business practices. We operate in a highly regulated environment with many federal, state and local laws and regulations. We take a proactive interest in understanding and complying with the laws and regulations that apply to our business.

Our Board of Directors (the Board) has adopted a Code of Business Conduct and Ethics and a set of Corporate Governance Guidelines to clarify the ethical standards under which the Board and management carry out their duties. In addition, the Board has created a Compliance Committee of the Board (Compliance Committee) whose purpose is to assist the Board in discharging their oversight responsibilities with respect to compliance with federal and state laws and regulations relating to healthcare.

We have issued an Ethics and Compliance Manual and created compliance training materials, hand-outs and an on-line testing program. These tools were prepared to ensure that every employee of our Company and subsidiaries has a clear understanding of our mutual commitment to high standards of professionalism, honesty, fairness and

compliance with the law in conducting business. These standards are administered by our Chief Compliance Officer (CO), who has the responsibility for the day-to-day oversight, administration and development of our compliance program. The CO, internal and external counsel, management and the Compliance Committee review our policies and procedures for our compliance program from time to time in an effort to improve operations and to ensure compliance with requirements of standards, laws and regulations and to reflect the on-going compliance focus areas which have been identified by management, counsel or the Compliance Committee. We also have established systems for reporting potential violations, educating our employees, monitoring and auditing compliance and handling enforcement and discipline.

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Committees. Our Compliance Committee, appointed by the Board, consists of four independent directors. The Compliance Committee has general oversight of our Company s compliance with the legal and regulatory requirements regarding healthcare operations. The Compliance Committee relies on the expertise and knowledge of management, the CO and other compliance and legal personnel. The CO regularly communicates with the Chairman of the Compliance Committee. The Compliance Committee meets at least four times a year or more frequently as necessary to carry out its responsibilities and reports regularly to the Board regarding its actions and recommendations.

We also have an Internal Compliance Committee, which is comprised of Company leaders in the areas of operations, clinical services, finance, human resources, legal, information technology and credentialing. The Internal Compliance Committee has the responsibility for evaluating and assessing Company areas of risk relating to compliance with federal and state healthcare laws, and generally to assist the CO. The Internal Compliance Committee meets at least four times a year or more frequently as necessary to carry out its responsibilities. In addition, management has appointed a team to address our Company s compliance with HIPAA. The HIPAA team consists of a security officer and employees from our legal, information systems, finance, operations, compliance, business services and human resources departments. The team prepares assessments and makes recommendations regarding operational changes and/or new systems, if needed, to comply with HIPAA.

Each clinic certified as a Medicare Rehabilitation Agency has a formally appointed governing body composed of a member of our management and the director/administrator of the clinic. The governing body retains legal responsibility for the overall conduct of the clinic. The members confer regularly and discuss, among other issues, clinic compliance with applicable laws and regulations. In addition, there are Professional Advisory Committees which serve as Infection Control Committees. These committees meet in the facilities and function as advisors.

We have in place a Risk Management Committee consisting of, among others, the CO, the Corporate Vice President of Administration, and other legal, compliance and operations personnel. This committee reviews and monitors all employee and patient incident reports and provides clinic personnel with actions to be taken in response to the reports.

Reporting Violations. In order to facilitate our employees ability to report in confidence, anonymously and without retaliation any perceived improper work-related activities, accounting irregularities and other violations of our compliance program, we have set up an independent national compliance hotline. The compliance hotline is available to receive confidential reports of wrongdoing Monday through Friday (excluding holidays), 24 hours a day. The compliance hotline is staffed by experienced third party professionals trained to utilize utmost care and discretion in handling sensitive issues and confidential information. The information received is documented and forwarded timely to the CO, who, together with the Compliance Committee, has the power and resources to investigate and resolve matters of improper conduct.

Educating Our Employees. We utilize numerous methods to train our employees in compliance related issues. All employees complete an initial training program comprised of numerous modules relating to our business and proper practices. The directors/administrators also provide periodic refresher training for existing employees and one-on-one comprehensive training with new hires. The corporate compliance group responds to questions from clinic personnel and conducts frequent teleconference meetings, webinars and training sessions on a variety of compliance related topics.

When a clinic opens, we provide a package of compliance materials containing manuals and detailed instructions for meeting Medicare Conditions of Participation Standards and other compliance requirements. During follow up training with the director/administrator of the clinic, compliance department staff explain various details regarding requirements and compliance standards. Compliance staff will remain in contact with the director/administrator while the clinic is implementing compliance standards and will provide any assistance required. All new office managers

receive training (including Medicare, regulatory and corporate compliance, insurance billing, charge entry and transaction posting and coding, daily, weekly and monthly accounting reports) from the training staff at the corporate office. The corporate compliance group will assist in continued compliance, including guidance to the clinic staff with regard to Medicare certifications, state survey requirements and responses to any inquiries from regulatory agencies.

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Monitoring and Auditing Clinic Operational Compliance. We have in place audit programs and other procedures to monitor and audit clinic operational compliance with applicable policies and procedures. We employ internal auditors who, as part of their job responsibilities, conduct periodic audits of each clinic. Most clinics are audited at least once every 24 months and additional focused audits are performed as deemed necessary. During these audits, particular attention is given to compliance with Medicare and internal policies, Federal and state laws and regulations, third party payor requirements, and patient chart documentation, billing, reporting, record keeping, collections and contract procedures. The audits typically are conducted on site and include interviews with the employees involved in management, operations, billing and accounts receivable.

Formal audit reports are prepared and reviewed with corporate management and the Compliance Committee. Each clinic director/administrator receives a letter instructing them of any corrective measures required. Each clinic director/administrator then works with the compliance team and operations to ensure such corrective measures are achieved.

Handling Enforcement and Discipline. It is our policy that any employee who fails to comply with compliance program requirements or who negligently or deliberately fails to comply with known laws or regulations specifically addressed in our compliance program should be subject to disciplinary action up to and including discharge from employment. The Compliance Committee, compliance staff, human resources staff and management investigate violations of our compliance program and impose disciplinary action as considered appropriate.

Corporate Integrity Agreement. We also perform certain additional compliance related functions pursuant to the Corporate Integrity Agreement (Corporate Integrity Agreement or CIA) that we entered into with the OIG. The CIA, which became effective as of December 21, 2015, outlines certain specific requirements relating to compliance oversight and program implementation, as well as periodic reporting. In addition, pursuant to the CIA, an independent review organization annually will perform a Medicare billing and coding audit on a small group of randomly selected Company clinics. Our Company Compliance Program has been modified so as to comply with the requirements of the CIA. The term of the CIA is five years.

The CIA was entered into as part of the settlement by one of our Subsidiaries with the U. S. Department of Justice related to certain Medicare billings that occurred between 2007 and 2009 at a single outpatient physical therapy clinic. The settlement resolved claims relating to whether certain physical therapy services provided to a limited number of Medicare patients at the clinic satisfied all of the criteria for payment by the Medicare program, including proper supervision of physical therapist assistants. The Subsidiary paid $718,000 in 2015 to resolve the matter, and we and the Subsidiary entered into the CIA. The Subsidiary no longer conducts any business.

EMPLOYEES

At December 31, 2018, we employed approximately 4,600 people, of which approximately 3,100 were full-time employees. At that date, no Company employees were governed by collective bargaining agreements or were members of a union. We consider our relations with our employees to be good.

In the states in which our current clinics are located, persons performing designated physical therapy services are required to be licensed by the state. Based on standard employee screening systems in place, all persons currently employed by us who are required to be licensed are licensed. We are not aware of any federal licensing requirements applicable to our employees.

AVAILABLE INFORMATION

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act are made available free of charge on our internet website at www.usph.com as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC.

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ITEM 1A. *RISK FACTORS.*

Our business, operations and financial condition are subject to various risks. Some of these risks are described below, and readers of this Annual Report on Form 10-K should take such risks into account in evaluating our Company or making any decision to invest in us. This section does not describe all risks applicable to our Company, our industry or our business, and it is intended only as a summary of material factors affecting our business.

Risks related to our business and operations

Healthcare reform legislation may affect our business.

In recent years, many legislative proposals have been introduced or proposed in Congress and in some state legislatures that would affect major changes in the healthcare system, either nationally or at the state level. At the federal level, Congress has continued to propose or consider healthcare budgets that substantially reduce payments under the Medicare programs. See Business- Sources of Revenue in Item 1 for more information. The ultimate content, timing or effect of any healthcare reform legislation and the impact of potential legislation on us is uncertain and difficult, if not impossible, to predict. That impact may be material to our business, financial condition or results of operations.

Our operations are subject to extensive regulation.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to:

- facility and professional licensure/permits, including certificates of need;
- conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse, and physician self-referral;
- addition of facilities and services; and
- billing and payment for services.

In recent years, there have been heightened coordinated civil and criminal enforcement efforts by both federal and state government agencies relating to the healthcare industry. We believe we are in substantial compliance with all laws, but differing interpretations or enforcement of these laws and regulations could subject our current practices to allegations of impropriety or illegality or could require us to make changes in our methods of operations, facilities, equipment, personnel, services and capital expenditure programs and increase our operating expenses. If we fail to comply with these extensive laws and government regulations, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to an investigation or other enforcement action under these laws or regulations. For a more complete description of certain of these laws and regulations, see Business—Regulation and Healthcare Reform and Business – Compliance Program in Item 1.

The healthcare industry is subject to extensive federal, state and local laws and regulations relating to (1) facility and professional licensure, including certificates of need, (2) conduct of operations, including financial relationships among healthcare providers, Medicare fraud and abuse and physician self-referral, (3) addition of facilities and services and enrollment of newly developed facilities in the Medicare program, (4) payment for services and (5) safeguarding protected health information.

Both federal and state regulatory agencies inspect, survey and audit our facilities to review our compliance with these laws and regulations. While our facilities intend to comply with the existing licensing, Medicare certification requirements and accreditation standards, there can be no assurance that these regulatory authorities will determine that all applicable requirements are fully met at any given time. A determination by any of these regulatory authorities that a facility is not in compliance with these requirements could lead to the imposition of requirements that the

facility takes corrective action, assessment of fines and penalties, or loss of licensure or Medicare certification of accreditation. These consequences could have an adverse effect on our Company.

The Company s CIA imposes certain compliance related functions and reporting obligations on us. In addition, the CIA requires us to engage an independent review organization to conduct annual audits of randomly selected Company clinics in order to review compliance with federal requirements relating to the proper billing

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and coding for claims. While our facilities intend to comply with the federal requirements for properly coding and billing claims for reimbursement, there can be no assurance that these audits will determine that all applicable requirements are fully met at the clinics that are reviewed. In addition, a failure to fully comply with the requirements of the CIA may subject us to the assessment of fines and penalties, or exclusion from participation in the Medicare program. These consequences could have a materially adverse effect on our Company.

Decreases in Medicare reimbursement rates and payment reductions applied to the second and subsequent therapy services may adversely affect our financial results.

The Medicare program reimburses outpatient rehabilitation providers based on the Medicare Physician Fee Schedule (MPFS). For services provided in 2018, a 0.5% increase has been applied to the fee schedule payment rates; for services provided in 2019, a 0.25% increase will be applied to the fee schedule payment rates before applying the mandatory budget neutrality adjustment. For services provided in 2020 through 2025, a 0.0% percent update will be applied each year to the fee schedule payment rates, before applying the mandatory budget neutrality adjustment. Beginning in 2021, payments to individual therapists (Physical/Occupational Therapist in Private Practice) paid under the fee schedule may be subject to adjustment based on performance in the Merit Based Incentive Payment System (MIPS), which measures performance based on certain quality metrics, resource use, and meaningful use of electronic health records. Under the MIPS requirements, a provider s performance is assessed according to established performance standards each year and then is used to determine an adjustment factor that is applied to the professional s payment for the corresponding payment year. The provider s MIPS performance in 2019 will determine the payment adjustment in 2021. Each year from 2019 through 2024, professionals who receive a significant share of their revenues through an alternate payment model (APM), (such as accountable care organizations or bundled payment arrangements) that involves risk of financial losses and a quality measurement component will receive a 5% bonus in the corresponding payment year. The bonus payment for APM participation is intended to encourage participation and testing of new APMs and to promote the alignment of incentives across payors. The specifics of the MIPS and APM adjustments will be subject to future notice and comment rule-making.

The Budget Control Act of 2011 increased the federal debt ceiling in connection with deficit reductions over the next ten years, and requires automatic reductions in federal spending by approximately $1.2 trillion. Payments to Medicare providers are subject to these automatic spending reductions, subject to a 2% cap. On April 1, 2013, a 2% reduction to Medicare payments was implemented. The Bipartisan Budget Act of 2015, enacted on November 2, 2015, extended the 2% reductions to Medicare payments through fiscal year 2025. The Bipartisan Budget Act of 2018, enacted on February 9, 2018, extends the 2% reductions to Medicare payments through fiscal year 2027.

Historically, the total amount paid by Medicare in any one year for outpatient physical therapy, occupational therapy, and/or speech-language pathology services provided to any Medicare beneficiary was subject to an annual dollar limit (i.e., the Therapy Cap or Limit). For 2017, the annual Limit on outpatient therapy services was $1,980 for combined Physical Therapy and Speech Language Pathology services and $1,980 for Occupational Therapy services. As a result of Bipartisan Budget Act of 2018, the Therapy Caps have been eliminated, effective as of January 1, 2018.

Under the Middle Class Tax Relief and Job Creation Act of 2012 (MCTRA), since October 1, 2012, patients who met or exceeded $3,700 in therapy expenditures during a calendar year have been subject to a manual medical review to determine whether applicable payment criteria are satisfied. The $3,700 threshold is applied to Physical Therapy and Speech Language Pathology Services; a separate $3,700 threshold is applied to the Occupational Therapy. The MACRA directed CMS to modify the manual medical review process such that those reviews will no longer apply to all claims exceeding the $3,700 threshold and instead will be determined on a targeted basis based on a variety of factors that CMS considers appropriate The Bipartisan Budget Act of 2018 extends the targeted medical review indefinitely, but reduces the threshold to $3,000 through December 31, 2027. For 2028, the threshold amount will be increased by the percentage increase in the Medicare Economic Index (MEI) for 2028 and in subsequent years the

threshold amount will increase based on the corresponding percentage increase in the MEI for such subsequent year.

CMS adopted a multiple procedure payment reduction (MPPR) for therapy services in the final update to the MPFS for calendar year 2011. The MPPR applied to all outpatient therapy services paid under Medicare Part B — occupational therapy, physical therapy and speech-language pathology. Under the policy, the Medicare

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program pays 100% of the practice expense component of the Relative Value Unit (RVU) for the therapy procedure with the highest practice expense RVU, then reduces the payment for the practice expense component for the second and subsequent therapy procedures or units of service furnished during the same day for the same patient, regardless of whether those therapy services are furnished in separate sessions. Since 2013, the practice expense component for the second and subsequent therapy service furnished during the same day for the same patient was reduced by 50%. In addition, the MCTRA directed CMS to implement a claims-based data collection program to gather additional data on patient function during the course of therapy in order to better understand patient conditions and outcomes. All practice settings that provide outpatient therapy services are required to include this data on the claim form. Since 2013, therapists have been required to report new codes and modifiers on the claim form that reflect a patient s functional limitations and goals at initial evaluation, periodically throughout care, and at discharge. Reporting of these functional limitation codes and modifiers are required on the claim for payment.

Medicare claims for outpatient therapy services furnished by therapy assistants on or after January 1, 2022 must include a modifier indicating the service was furnished by a therapy assistant. CMS is was required to develop a modifier to mark services provided by a therapy assistant by January 1, 2019, and then submitted claims have to report the modifier mark starting January 1, 2020. Outpatient therapy services furnished on or after January 1, 2022 in whole or part by a therapy assistant will be paid at an amount equal to 85% of the payment amount otherwise applicable for the service.

Statutes, regulations, and payment rules governing the delivery of therapy services to Medicare beneficiaries are complex and subject to interpretation. We believe that we are in compliance, in all material respects, with all applicable laws and regulations and are not aware of any pending or threatened investigations involving allegations of potential wrongdoing that would have a material effect on the our financial statements as of December 31, 2018. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from the Medicare program. For year ended December 31, 2018, net patient revenue from Medicare were approximately $103.6 million.

Given the history of frequent revisions to the Medicare program and its reimbursement rates and rules, we may not continue to receive reimbursement rates from Medicare that sufficiently compensate us for our services or, in some instances, cover our operating costs. Limits on reimbursement rates or the scope of services being reimbursed could have a material adverse effect on our revenue, financial condition and results of operations. Additionally, any delay or default by the federal or state governments in making Medicare and/or Medicaid reimbursement payments could materially and, adversely, affect our business, financial condition and results of operations.

We expect the federal and state governments to continue their efforts to contain growth in Medicaid expenditures, which could adversely affect our revenue and profitability.

Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets. This, combined with slower state revenue growth, has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending. We expect these state and federal efforts to continue for the foreseeable future. Furthermore, not all of the states in which we operate, most notably Texas, have elected to expand Medicaid as part of federal healthcare reform legislation. There can be no assurance that the program, on the current terms or otherwise, will continue for any particular period of time beyond the foreseeable future. If Medicaid reimbursement rates are reduced or fail to increase as quickly as our costs, or if there are changes in the rules governing the Medicaid program that are disadvantageous to our businesses, our business and results of operations could be materially and adversely affected.

Revenue we receive from Medicare and Medicaid is subject to potential retroactive reduction.

Payments we receive from Medicare and Medicaid can be retroactively adjusted after examination during the claims settlement process or as a result of post-payment audits. Payors may disallow our requests for reimbursement, or recoup amounts previously reimbursed, based on determinations by the payors or their third-party audit contractors that certain costs are not reimbursable because either adequate or additional documentation was not provided or because certain services were not covered or deemed to not be medically

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necessary. Significant adjustments, recoupments or repayments of our Medicare or Medicaid revenue, and the costs associated with complying with investigative audits by regulatory and governmental authorities, could adversely affect our financial condition and results of operations.

Additionally, from time to time we become aware, either based on information provided by third parties and/or the results of internal audits, of payments from payor sources that were either wholly or partially in excess of the amount that we should have been paid for the service provided. Overpayments may result from a variety of factors, including insufficient documentation supporting the services rendered or medical necessity of the services or other failures to document the satisfaction of the necessary conditions of payment. We are required by law in most instances to refund the full amount of the overpayment after becoming aware of it, and failure to do so within requisite time limits imposed by the law could lead to significant fines and penalties being imposed on us. Furthermore, our initial billing of and payments for services that are unsupported by the requisite documentation and satisfaction of any other conditions of payment, regardless of our awareness of the failure at the time of the billing or payment, could expose us to significant fines and penalties. We, and/or certain of our operating companies, could also be subject to exclusion from participation in the Medicare or Medicaid programs in some circumstances as well, in addition to any monetary or other fines, penalties or sanctions that we may incur under applicable federal and/or state law. Our repayment of any such amounts, as well as any fines, penalties or other sanctions that we may incur, could be significant and could have a material and adverse effect on our results of operations and financial condition.

From time to time we are also involved in various external governmental investigations, audits and reviews. Reviews, audits and investigations of this sort can lead to government actions, which can result in the assessment of damages, civil or criminal fines or penalties, or other sanctions, including restrictions or changes in the way we conduct business, loss of licensure or exclusion from participation in government programs. Failure to comply with applicable laws, regulations and rules could have a material and adverse effect on our results of operations and financial condition. Furthermore, becoming subject to these governmental investigations, audits and reviews can also require us to incur significant legal and document production expenses as we cooperate with the government authorities, regardless of whether the particular investigation, audit or review leads to the identification of underlying issues.

As a result of increased post-payment reviews of claims we submit to Medicare for our services, we may incur additional costs and may be required to repay amounts already paid to us.

We are subject to regular post-payment inquiries, investigations and audits of the claims we submit to Medicare for payment for our services. These post-payment reviews have increased as a result of government cost-containment initiatives. These additional post-payment reviews may require us to incur additional costs to respond to requests for records and to pursue the reversal of payment denials, and ultimately may require us to refund amounts paid to us by Medicare that are determined to have been overpaid.

For a further description of this and other laws and regulations involving governmental reimbursements, see Business—Sources of Revenue and —Regulation and Healthcare Reform in Item 1.

An economic downturn, state budget pressures, sustained unemployment and continued deficit spending by the federal government may result in a reduction in reimbursement and covered services.

An economic downturn could have a detrimental effect on our revenues. Historically, state budget pressures have translated into reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services in the states in which we operate. In addition, an economic downturn, coupled with sustained unemployment, may also impact the number of enrollees in managed care programs as well as the profitability of managed care companies, which could result in reduced reimbursement rates.

The existing federal deficit, as well as deficit spending by federal and state governments as the result of adverse developments in the economy or other reasons, can lead to continuing pressure to reduce governmental expenditures for other purposes, including government-funded programs in which we participate, such as Medicare and Medicaid. Such actions in turn may adversely affect our results of operations.

We depend upon reimbursement by third-party payors.

Substantially all of our revenues are derived from private and governmental third-party payors. In 2018, approximately 71.9% of our revenues were derived collectively from managed care plans, commercial health

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insurers, workers compensation payors, and other private pay revenue sources while approximately 28.1% of our revenues were derived from Medicare and Medicaid. Initiatives undertaken by industry and government to contain healthcare costs affect the profitability of our clinics. These payors attempt to control healthcare costs by contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursement for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services, our profit margins may decline, or we may lose patients if we choose not to renew our contracts with these insurers at lower rates. In addition, in certain geographical areas, our clinics must be approved as providers by key health maintenance organizations and preferred provider plans. Failure to obtain or maintain these approvals would adversely affect our financial results.

In recent years, through legislative and regulatory actions, the federal government has made substantial changes to various payment systems under the Medicare program. See Business—Sources of Revenue in Item 1 for more information. President Obama signed into law comprehensive reforms to the healthcare system, including changes to Medicare reimbursement. Additional reforms or other changes to these payment systems may be proposed or adopted, either by the U.S. Congress or by CMS, including bundled payments, outcomes-based payment methodologies and a shift away from traditional fee-for-service reimbursement. If revised regulations are adopted, the availability, methods and rates of Medicare reimbursements for services of the type furnished at our facilities could change. Some of these changes and proposed changes could adversely affect our business strategy, operations and financial results.

We face inspections, reviews, audits and investigations under federal and state government programs and contracts. These audits could have adverse findings that may negatively affect our business.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental inspections, reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Managed care payors may also reserve the right to conduct audits. An adverse inspection, review, audit or investigation could result in:

- refunding amounts we have been paid pursuant to the Medicare or Medicaid programs or from managed care payors;
- state or federal agencies imposing fines, penalties and other sanctions on us;
- temporary suspension of payment for new patients to the facility or agency;
- decertification or exclusion from participation in the Medicare or Medicaid programs or one or more managed care payor networks;
- expansion of the scope of our Corporate Integrity Agreement;
- damage to our reputation;
- the revocation of a facility's or agency's license; and
- loss of certain rights under, or termination of, our contracts with managed care payors.

If adverse inspections, reviews, audits or investigations occur and any of the results noted above occur, it could have a material adverse effect on our business and operating results.

Our facilities are subject to extensive federal and state laws and regulations relating to the privacy of individually identifiable information.

HIPAA required the HHS to adopt standards to protect the privacy and security of individually identifiable health-related information. The department released final regulations containing privacy standards in 2000 and published revisions to the final regulations in 2002. The privacy regulations extensively regulate the use and disclosure of individually identifiable health-related information. The regulations also provide patients with significant rights related to understanding and controlling how their health information is used or disclosed. The security regulations require healthcare providers to implement administrative, physical and technical practices to protect the

security of individually identifiable health information that is maintained or transmitted electronically.

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HITECH, which was signed into law in 2009, enhanced the privacy, security and enforcement provisions of HIPAA by, among other things establishing security breach notification requirements, allowing enforcement of HIPAA by state attorneys general, and increasing penalties for HIPAA violations. Violations of HIPAA or HITECH could result in civil or criminal penalties.

In addition to HIPAA, there are numerous federal and state laws and regulations addressing patient and consumer privacy concerns, including unauthorized access or theft of personal information. State statutes and regulations vary from state to state. Lawsuits, including class actions and action by state attorneys general, directed at companies that have experienced a privacy or security breach also can occur.

We have established policies and procedures in an effort to ensure compliance with these privacy related requirements. However, if there is a breach, we may be subject to various penalties and damages and may be required to incur costs to mitigate the impact of the breach on affected individuals.

In conducting our business, we are required to comply with applicable laws regarding fee-splitting and the corporate practice of medicine.

Some states prohibit the corporate practice of therapy that restricts business corporations from providing physical therapy services through the direct employment of therapist physicians or from exercising control over medical decisions by therapists. The laws relating to corporate practice vary from state to state and are not fully developed in each state in which we have facilities. Typically, however, professional corporations owned and controlled by licensed professionals are exempt from corporate practice restrictions and may employ therapists to furnish professional services. Those professional corporations may be managed by business corporations, such as the Company.

Some states also prohibit entities from engaging in certain financial arrangements, such as fee-splitting, with physicians or therapists. The laws relating to fee-splitting also vary from state to state and are not fully developed. Generally, these laws restrict business arrangements that involve a physician or therapist sharing medical fees with a referral source, but in some states, these laws have been interpreted to extend to management agreements between physicians or therapists and business entities under some circumstances.

We believe that our current and planned activities do not constitute fee-splitting or the unlawful corporate practice of medicine as contemplated by these state laws. However, there can be no assurance that future interpretations of such laws will not require structural and organizational modification of our existing relationships with the practices. If a court or regulatory body determines that we have violated these laws or if new laws are introduced that would render our arrangements illegal, we could be subject to civil or criminal penalties, our contracts could be found legally invalid and unenforceable (in whole or in part), or we could be required to restructure our contractual arrangements with our affiliated physicians and other licensed providers.

Failure to maintain effective internal control over our financial reporting could have an adverse effect on our ability to report our financial results on a timely and accurate basis.

We are required to produce our consolidated financial statements in accordance with the requirements of accounting principles generally accepted in the United States of America. Effective internal control over financial reporting is necessary for us to provide reliable financial reports, to help mitigate the risk of fraud and to operate successfully. We are required by federal securities laws to document and test our internal control procedures in order to satisfy the requirements of the Sarbanes-Oxley Act of 2002, which requires annual management assessments of the effectiveness of our internal control over financial reporting.

Testing and maintaining our internal control over financial reporting can be expensive and divert our management s attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal control over financial reporting in accordance with applicable law, or our independent registered public accounting firm may not be able to issue an unqualified attestation report if we conclude that our internal control over financial reporting is not effective. If we fail to maintain effective internal control over financial reporting, or our independent registered public accounting firm is unable to provide us with an unqualified attestation report on our internal control, we could be required to take costly and time-consuming corrective measures, be required to restate the affected historical financial statements, be subjected to investigations and/or sanctions by federal and state securities regulators, and be subjected to civil lawsuits by security holders. Any of the foregoing could also cause investors to lose confidence in our reported

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financial information and in our company and would likely result in a decline in the market price of our stock and in our ability to raise additional financing if needed in the future.

We may be adversely affected by a security breach, such as a cyber-attack, which may cause a violation of HIPAA or HITECH and subject us to potential legal and reputational harm.

In the normal course of business, our information technology systems hold sensitive patient information including patient demographic data and other protected health information, which is subject to HIPAA and HITECH. We also contract with third-party vendors to maintain and store our patient s individually identifiable health information. Numerous state and federal laws and regulations address privacy and information security concerns resulting from our access to our patient s and employee s personal information.

Our information technology systems and those of our vendors that process, maintain, and transmit such data are subject to computer viruses, cyber-attacks, or breaches. We adhere to policies and procedures designed to ensure compliance with HIPAA and other privacy and information security laws and require our third-party vendors to do so as well. If, however, we or our third-party vendors experience a breach, loss, or other compromise of unsecured protected health information or other personal information, such an event could result in significant civil and criminal penalties, lawsuits, reputational harm, and increased costs to us, any of which could have a material adverse effect on our financial condition and results of operations.

Furthermore, while our information technology systems, and those of our third-party vendors, are maintained with safeguards protecting against cyber-attacks. A cyber-attack that bypasses our information technology security systems, or those of our third-party vendors, could result in a material adverse effect on our business, financial condition, results of operations, or cash flows. In addition, our future results could be adversely affected due to the theft, destruction, loss, misappropriation, or release of protected health information, other confidential data or proprietary business information, operational or business delays resulting from the disruption of information technology systems and subsequent mitigation activities, or regulatory action taken as a result of such incident. We provide our employees training and regular reminders on important measures they can take to prevent breaches. We routinely identify attempts to gain unauthorized access to our systems. However, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. Accordingly, we may be vulnerable to losses associated with the improper functioning, security breach, or unavailability of our information systems as well as any systems used in acquired operations.

We depend upon the cultivation and maintenance of relationships with the physicians in our markets.

Our success is dependent upon referrals from physicians in the communities our clinics serve and our ability to maintain good relations with these physicians and other referral sources. Physicians referring patients to our clinics are free to refer their patients to other therapy providers or to their own physician owned therapy practice. If we are unable to successfully cultivate and maintain strong relationships with physicians and other referral sources, our business may decrease and our net operating revenues may decline.

We depend upon our ability to recruit and retain experienced physical therapists.

Our revenue generation is dependent upon referrals from physicians in the communities our clinics serve, and our ability to maintain good relations with these physicians. Our therapists are the front line for generating these referrals and we are dependent on their talents and skills to successfully cultivate and maintain strong relationships with these physicians. If we cannot recruit and retain our base of experienced and clinically skilled therapists, our business may

decrease and our net operating revenues may decline. Periodically, we have clinics in isolated communities that are temporarily unable to operate due to the unavailability of a therapist who satisfies our standards.

We may also experience increases in our labor costs, primarily due to higher wages and greater benefits required to attract and retain qualified healthcare personnel, and such increases may adversely affect our profitability. Furthermore, while we attempt to manage overall labor costs in the most efficient way, our efforts to manage them may have limited effectiveness and may lead to increased turnover and other challenges.

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Our revenues may fluctuate due to weather.

We have a significant number of clinics in states that normally experience snow and ice during the winter months. Also, a significant number of our clinics are located in states along the Gulf Coast and Atlantic Coast which are subject to periodic winter storms, hurricanes and other severe storm systems. Periods of severe weather may cause physical damage to our facilities or prevent our staff or patients from traveling to our clinics, which may cause a decrease in our net operating revenues.

We operate in a highly competitive industry.

We encounter competition from local, regional or national entities, some of which have superior resources or other competitive advantages. Intense competition may adversely affect our business, financial condition or results of operations. For a more complete description of this competitive environment, see Business—Competition in Item 1. An adverse effect on our business, financial condition or results of operations may require us to write-down goodwill.

We may incur closure costs and losses.

The competitive, economic or reimbursement conditions in our markets in which we operate may require us to reorganize or to close certain clinics. In the event a clinic is reorganized or closed, we may incur losses and closure costs. The closure costs and losses may include, but are not limited to, lease obligations, severance, and write-down or write-off of goodwill and other intangible assets.

Future acquisitions may use significant resources, may be unsuccessful and could expose us to unforeseen liabilities.

As part of our growth strategy, we intend to continue pursuing acquisitions of outpatient physical therapy clinics. Acquisitions may involve significant cash expenditures, potential debt incurrence and operational losses, dilutive issuances of equity securities and expenses that could have an adverse effect on our financial condition and results of operations. Acquisitions involve numerous risks, including:

- the difficulty and expense of integrating acquired personnel into our business;
- the diversion of management’s time from existing operations;
- the potential loss of key employees of acquired companies;
- the difficulty of assignment and/or procurement of managed care contractual arrangements; and
- the assumption of the liabilities and exposure to unforeseen liabilities of acquired companies, including liabilities for failure to comply with healthcare regulations.

Issuance of shares in connection with financing transactions or under stock incentive plans will dilute current stockholders.

Pursuant to our stock incentive plans, our Compensation Committee of the Board, consisting solely of independent directors, is authorized to grant stock awards to our employees, directors and consultants. Shareholders will incur dilution upon the exercise of any outstanding stock awards or the grant of any restricted stock. In addition, if we raise additional funds by issuing additional common stock, or securities convertible into or exchangeable or exercisable for common stock, further dilution to our existing stockholders will result, and new investors could have rights superior to existing stockholders.

The number of shares of our common stock eligible for future sale could adversely affect the market price of our stock.

At December 31, 2018, we had reserved approximately 400,000 shares for future equity grants. We may issue additional restricted securities or register additional shares of common stock under the Securities Act of 1933, as amended (the Securities Act), in the future. The issuance of a significant number of shares of common stock upon the exercise of stock options or the availability for sale, or sale, of a substantial number of the shares of common stock eligible for future sale under effective registration statements, under Rule 144 or otherwise, could adversely affect the market price of the common stock.

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Provisions in our articles of incorporation and bylaws could delay or prevent a change in control of our company, even if that change would be beneficial to our stockholders.

Certain provisions of our articles of incorporation and bylaws may delay, discourage, prevent or render more difficult an attempt to obtain control of our company, whether through a tender offer, business combination, proxy contest or otherwise. These provisions include the charter authorization of blank check preferred stock and a restriction on the ability of stockholders to call a special meeting.

ITEM 1B. *UNRESOLVED STAFF COMMENTS.*

None

ITEM 2. *PROPERTIES.*

We lease the properties used for our clinics under non-cancelable operating leases with terms ranging from one to five years, with the exception of the property for one clinic which we own. We intend to lease the premises for any new clinic locations except in rare instances where leasing is not a cost-effective alternative. Our typical clinic occupies 1,600 to 3,000 square feet.

We also lease our executive offices located in Houston, Texas, under a non-cancelable operating lease expiring in April 2023. We currently lease approximately 40,777 square feet of space (including allocations for common areas) at our executive offices.

ITEM 3. *LEGAL PROCEEDINGS.*

We are involved in litigation and other proceedings arising in the ordinary course of business. While the ultimate outcome of lawsuits or other proceedings cannot be predicted with certainty, we do not believe the impact of existing lawsuits or other proceedings will have a material impact on our business, financial condition or results of operations.

ITEM 4. *MINE SAFETY DISCLOSURES.*

Not Applicable.

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PART II

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

Our common stock has traded on the New York Stock Exchange (NYSE) since August 14, 2012 under the symbol USPH. Prior to that, our common stock was traded on the Nasdaq Global Select Market under the symbol USPH . As of March 15, 2019, there were 69 holders of record of our outstanding common stock.

DIVIDENDS

On March 5, 2019, the Board of Directors declared a dividend of $0.27 per share on all shares of common stock issued and outstanding to those shareholders of record on March 20, 2019 payable on April 19, 2019. During 2018, we paid a regular quarterly dividend of $0.23 per share totaling $0.92 per share, which amounted to a total of aggregate cash payments of dividend to holders of our common stock in 2018 of approximately $11.7 million. During 2017, we paid a regular quarterly dividend of $0.20 per share totaling $0.80 per share, which amounted to a total of aggregate cash payments of dividends to holders of our common stock in 2017 of approximately $10.1 million. During 2016, we paid a quarterly dividend of $0.17 per share totaling $0.68 per share for 2016, which amounted to a total of aggregate cash payments of dividends to holders of our common stock in 2016 of approximately $8.5 million. We are currently restricted from paying dividends in excess of $20,000,000 in any fiscal year on our common stock under the Credit Agreement (as defined in Item 7. Management s Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources).

FIVE YEAR PERFORMANCE GRAPH

The performance graph and related description shall not be deemed incorporated by reference into any filing under the Securities Act or under the Exchange Act, except to the extent that we specifically incorporate this information by reference. In addition, the performance graph and the related description shall not be deemed soliciting material or filed with the SEC or subject to Regulation 14A or 14C.

On August 14, 2012, our common stock began trading on NYSE. The following performance graph compares the cumulative total stockholder return of our common stock to The NYSE Composite Index and the NYSE Health Care Index for the period from December 31, 2013 through December 31, 2018. The graph assumes that $100 was invested in our common stock and the common stock of each of the companies listed on The NYSE Composite Index and The NYSE Health Care Index on December 31, 2013 and that any dividends were reinvested.

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Comparison of Five Years Cumulative Total Return for the Year Ended December 31, 2018

	12/13	12/14	12/15	12/16	12/17	12/18
U.S. Physical Therapy, Inc.	100	119	152	199	205	290
NYSE Composite	100	104	98	106	123	109
NYSE Healthcare Index	100	117	121	116	139	148

ITEM 6. ***SELECTED FINANCIAL DATA.***

The following selected financial data should be read in conjunction with the description of our critical accounting policies set forth in Management s Discussion and Analysis of Results of Operations and Financial Condition and the Consolidated Financial Statements and Notes included herein.

	For the Years Ended December 31,				
	2018	2017	2016	2015	2014
	($ in thousands, except per share data)				
Net revenues	$ 453,911	$ 414,051	$ 356,546	$ 331,302	$ 305,074
Operating income	$ 60,314	$ 54,728	$ 49,533	$ 47,294	$ 45,768
Gain on derecognition of debt	$ 1,846	$ —	$ —	$ —	$ —
Interest expense					
Mandatorily redeemable non-controlling interests - change in redemption value	$ —	$ 12,894	$ 6,169	$ 2,670	$ 2,978
Mandatorily redeemable non-controlling interests - earnings allocable	$ —	$ 6,055	$ 4,057	$ 3,538	$ 3,388
Debt and other	$ 2,042	$ 2,111	$ 1,252	$ 1,031	$ 1,088
Total interest expense	$ 2,042	$ 21,060	$ 11,478	$ 7,239	$ 7,454
Net income	$ 48,842	$ 27,724	$ 26,268	$ 26,489	$ 25,314
Net income attributable to non-controlling interests	$ 13,969	$ 5,468	$ 5,717	$ 5,874	$ 6,183
Net income attributable to USPH shareholders	$ 34,873	$ 22,256	$ 20,551	$ 20,615	$ 19,131

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	For the Years Ended December 31,				
	2018	2017	2016	2015	2014
	($ in thousands, except per share data)				
Per share net income attributable to USPH shareholders:					
Basic and diluted	$ 1.31	$ 1.76	$ 1.64	$ 1.66	$ 1.57
Dividends declared and paid per common share	$ 0.92	$ 0.80	$ 0.68	$ 0.60	$ 0.48

	On December 31,				
	2018	2017	2016	2015	2014
	($ in thousands)				
Total assets	$ 443,166	$ 418,982	$ 351,231	$ 303,757	$ 268,377
Mandatorily redeemable non-controlling interests	$ —	$ 327	$ 69,190	$ 45,974	$ 40,371
Long-term debt, less current portion	$ 38,402	$ 56,728	$ 50,596	$ 48,335	$ 34,734
Working capital	$ 37,268	$ 37,530	$ 41,347	$ 41,193	$ 29,347
Current ratio	1.89	1.95	2.68	3.17	2.15

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

EXECUTIVE SUMMARY

Our Business. We operate outpatient physical therapy clinics that provide pre- and post-operative care and treatment for a variety of orthopedic-related disorders and sports-related injuries, neurologically-related injuries and rehabilitation of injured workers. At December 31, 2018, we operated 591 clinics in 42 states. The average age of our clinics at December 31, 2018 was 10.0 years. In addition to our ownership and operation of outpatient physical therapy clinics, we also manage physical therapy facilities for third parties, such as physicians and hospitals, with 28 such third-party facilities under management as of December 31, 2018.

In March 2017, we purchased a 55% interest in our initial industrial injury prevention business. On April 30, 2018, we made a second acquisition and subsequently combined the two businesses. After the combination, we own a 59.45% interest in the combined business. Services provided include onsite injury prevention and rehabilitation, performance optimization and ergonomic assessments. The majority of these services are contracted with and paid for directly by employers, including a number of Fortune 500 companies. Other clients include large insurers and their contractors. We perform these services through Industrial Sports Medicine Professionals, consisting of both physical therapists and highly specialized certified athletic trainers (ATCs).

In addition to the above acquired interests in the industrial injury prevention businesses, during 2018, 2017 and 2016, we completed the following multi-clinic acquisitions:

Acquisition	Date	% Interest Acquired	Number of Clinics
	2018		
August 2018 Acquisition	August 31	70 %	4

	2017			
January 2017 Acquisition	January 1	70	%	17
May 2017 Acquisition	May 31	70	%	4
June 2017 Acquisition	June 30	60	%	9
October 2017 Acquisition	October 31	70	%	9
	2016			
February 2016 Acquisition	February 29	55	%	8
November 2016 Acquisition	November 30	60	%	12

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Besides the multi-clinic acquisitions above, on February 28, 2018, we, through several of our majority owned Clinic Partnerships, acquired five separate clinic practices. These practices will operate as satellites of the respective existing Clinic Partnership.

Also, during the year of 2017, we purchased the assets and business of two physical therapy clinics in separate transactions. One clinic was consolidated with an existing clinic and the other operates as a satellite clinic of one of the existing partnerships. In addition to the multi-clinic acquisitions, we acquired two single clinic practices in separate transactions during 2016.

The results of operations of the acquired clinics have been included in our consolidated financial statements since the date of their respective acquisition. We intend to continue to pursue additional acquisition opportunities, develop new clinics and open satellite clinics.

CRITICAL ACCOUNTING POLICIES

Critical accounting policies are those that have a significant impact on our results of operations and financial position involving significant estimates requiring our judgment. Our critical accounting policies are:

Revenue Recognition.

Revenues are recognized in the period in which services are rendered. Net patient revenues consists of revenues for physical therapy and occupational therapy clinics that provide pre-and post-operative care and treatment for orthopedic related disorders, sports-related injuries, preventative care, rehabilitation of injured workers and neurological-related injuries. Net patient revenues (patient revenues less estimated contractual adjustments) are recognized at the estimated net realizable amounts from third-party payors, patients and others in exchange for services rendered when obligations under the terms of the contract are satisfied. There is an implied contract between us and the patient upon each patient visit. Generally, this occurs as we provide physical and occupational therapy services, as each service provided is distinct and future services rendered are not dependent on previously rendered services. We have agreements with third-party payors that provide for payments to us at amounts different from its established rates. The allowance for estimated contractual adjustments is based on terms of payor contracts and historical collection and write-off experience.

Management contract revenues, which are included in other revenues in the consolidated statements of net income, are derived from contractual arrangements whereby we manage a clinic owned by a third party. We do not have any ownership interest in these clinics. Typically, revenues are determined based on the number of visits conducted at the clinic and recognized at the point in time when services are performed. Costs, typically salaries for our employees, are recorded when incurred.

Revenues from the industrial injury prevention business, which are also included in other revenues in the consolidated statements of net income, are derived from onsite services we provide to clients employees including injury prevention, rehabilitation, ergonomic assessments and performance optimization. Revenue from the industrial injury prevention business is recognized when obligations under the terms of the contract are satisfied. Revenues are recognized at an amount equal to the consideration we expect to receive in exchange for providing injury prevention services to its clients. The revenue is determined and recognized based on the number of hours and respective rate for services provided in a given period.

Additionally, other revenues include services we provide on-site, such as schools and industrial worksites, for physical or occupational therapy services, and athletic trainers and gym membership fees. Contract terms and rates are agreed to in advance between us and the third parties. Services are typically performed over the contract period and revenue

is recorded at the point of service. If the services are paid in advance, revenue is recorded as a contract liability over the period of the agreement and recognized at the point in time, when the services are performed.

In May 2014, March 2016, April 2016, and December 2016, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, Revenue from Contracts with Customers, ASU 2016-08, Revenue from Contracts with Customers, Principal versus Agent Considerations, ASU 2016-10, Revenue from Contracts with Customers, Identifying Performance Obligations and Licensing, ASU 2016-12, Revenue from Contracts with Customers, Narrow Scope Improvements and Practical Expedients, and ASU 2016-20, Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customer (collectively the standards), respectively, which supersede most of the current revenue recognition

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requirements (ASC 606). The core principle of the new guidance is that an entity should recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services.

We implemented the new standards beginning January 1, 2018 using a modified retrospective transition method. The principal change relates to how the new standard requires healthcare providers to estimate the amount of variable consideration to be included in the transaction price up to an amount which is probable that a significant reversal will not occur. The most common forms of variable consideration we experience are amounts for services provided that are ultimately not realizable from a customer. There were no changes to revenues or other revenues upon implementation. Under the new standards, our estimate for unrealizable amounts will continue to be recognized as a reduction to revenue. The bad debt expense historically reported will not materially change.

For ASC 606, there is an implied contract between us and the patient upon each patient visit. Separate contractual arrangements exist between us and third party payors (e.g. insurers, managed care programs, government programs, workers compensation) which establish the amounts the third parties pay on behalf of the patients for covered services rendered. While these agreements are not considered contracts with the customer, they are used for determining the transaction price for services provided to the patients covered by the third party payors. The payor contracts do not indicate performance obligations for us, but indicate reimbursement rates for patients who are covered by those payors when the services are provided. At that time, we are obligated to provide services for the reimbursement rates stipulated in the payor contracts. The execution of the contract alone does not indicate a performance obligation. For self-paying customers, the performance obligation exists when we provide the services at established rates. The difference between our established rate and the anticipated reimbursement rate is accounted for as an offset to revenue – contractual allowance.

We determine allowances for doubtful accounts based on the specific agings and payor classifications at each clinic. The provision for doubtful accounts is included in clinic operating costs in the statements of net income. Patient accounts receivable, which are stated at the historical carrying amount net of contractual allowances, write-offs and allowance for doubtful accounts, includes only those amounts we estimate to be collectible.

The following table details the revenue related to the various categories.

	Year Ended December 31,		
	2018	**2017**	**2016**
Patient revenues	$ 417,703	$ 389,226	$ 348,839
Management contract revenues	8,339	6,275	5,535
Industrial injury prevention services revenues	25,466	14,908	—
Other revenues	2,403	3,642	2,172
	$ 453,911	$ 414,051	$ 356,546

Contractual Allowances. Contractual allowances result from the differences between the rates charged for services performed and expected reimbursements by both insurance companies and government sponsored healthcare programs for such services. Medicare regulations and the various third party payors and managed care contracts are often complex and may include multiple reimbursement mechanisms payable for the services provided in our clinics. We estimate contractual allowances based on our interpretation of the applicable regulations, payor contracts and historical calculations. Each month we estimate our contractual allowance for each clinic based on payor contracts and the historical collection experience of the clinic and applies an appropriate contractual allowance reserve percentage to the gross accounts receivable balances for each payor of the clinic. Based on our historical experience, calculating the contractual allowance reserve percentage at the payor level is sufficient to allow us to provide the necessary detail and

accuracy with our collectability estimates. However, the services authorized and provided and related reimbursement are subject to interpretation that could result in payments that differ from our estimates. Payor terms are periodically revised necessitating continual review and assessment of the estimates made by management. Our billing systems may not capture the exact change in our contractual allowance reserve estimate from period to period. Therefore, in order to assess the accuracy of our revenues and hence our contractual allowance reserves, our management regularly compares its cash collections to corresponding net revenues measured both in the aggregate and on a clinic-by-clinic basis. In

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the aggregate, the historical difference between net revenues and corresponding cash collections has generally reflected a difference within approximately 1% of net revenues. Additionally, analysis of subsequent period s contractual write-offs on a payor basis reflects a difference within approximately 1% between the actual aggregate contractual reserve percentage as compared to the estimated contractual allowance reserve percentage associated with the same period end balance. As a result, we believe that a reasonable likely change in the contractual allowance reserve estimate would not be more than 1% at December 31, 2018. For purposes of demonstrating the sensitivity of this estimate on our Company s financial condition, a one percent increase or decrease in our aggregate contractual allowance reserve percentage would decrease or increase, respectively, net patient revenue by approximately $1,081,410 for the year ended December 31, 2018. Management believes the changes in the estimate of the contractual allowance reserve for the periods ended December 31, 2018, 2017 and 2016 have not been material to the statement of income.

The following table sets forth information regarding our patient accounts receivable as of the dates indicated (in thousands):

	December 31,	
	2018	**2017**
Gross patient accounts receivable	$ 108,141	$ 108,667
Less contractual allowances	60,718	61,687
Subtotal - accounts receivable	47,423	46,980
Less allowance for doubtful accounts	2,672	2,273
Net patient accounts receivable	$ 44,751	$ 44,707

The following table presents our patient accounts receivable aging by payor class as of the dates indicated (in thousands):

	December 31, 2018			December 31, 2017		
Payor	**Current to 120 Days**	**120+ Days**	**Total**	**Current to 120 Days**	**120+ Days**	**Total**
Managed Care/ Commercial Plans.	$ 14,852	$ 2,263	$ 17,115	$ 15,150	$ 2,120	$ 17,270
Medicare/Medicaid..	10,026	1,736	11,762	10,021	1,511	11,532
Workers Compensation*	7,056	1,339	8,395	7,767	1,243	9,010
Self-pay	4,497	3,748	8,245	3,837	3,185	7,022
Other**	945	961	1,906	1,586	560	2,146
Totals	$ 37,376	$ 10,047	$ 47,423	$ 38,361	$ 8,619	$ 46,980

* *Workers compensation is paid by state administrators or their designated agents.*

** *Other includes primarily litigation claims and, to a lesser extent, vehicular insurance claims.*

Reimbursement for Medicare beneficiaries is based upon a fee schedule published by HHS. For a more complete description of our third party revenue sources, see Business—Sources of Revenue in Item 1.

Provision for Doubtful Accounts. We determine our provision for doubtful accounts based on the specific agings and payor classifications at each clinic. We review the accounts receivable aging and rely on prior experience with particular payors to determine an appropriate reserve for doubtful accounts. Historically, clinics that have a large number of aged accounts generally have less favorable collection experience, and thus, require a higher provision. Accounts that are ultimately determined to be uncollectible are written off against our bad debt provision. The amount

of our aggregate provision for doubtful accounts is regularly reviewed for adequacy in light of current and historical experience.

Accounting for Income Taxes. We account for income taxes under the asset and liability method. Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases and operating loss and tax credit carryforwards. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in

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income in the period that includes the enactment date. We recognize the financial statement benefit of a tax position only after determining that the relevant tax authority would more likely than not sustain the position following an audit. For tax positions meeting the more-likely-than-not threshold, the amount to be recognized in the financial statements is the largest benefit that has a greater than 50 percent likelihood of being realized upon ultimate settlement with the relevant tax authority.

The Tax Cuts and Jobs Act of 2017 (the TCJA) was passed by Congress on December 20, 2017 and signed into law by President Trump on December 22, 2017. The TCJA made significant changes to U.S. corporate income tax laws including a decrease in the corporate income tax rate to 21% effective January 1, 2018. As a result, we revalued our deferred tax assets and liabilities. Based on a review and analysis as of December 31, 2017, we estimated a reduction in our net deferred tax liabilities of $4.3 million thereby reducing our provision for income taxes by such amount for the 2017 year.

We do not believe that we have any significant uncertain tax positions at December 31, 2018, nor is this expected to change within the next twelve months due to the settlement and expiration of statutes of limitation.

We did not have any accrued interest or penalties associated with any unrecognized tax benefits nor was any interest expense recognized during the twelve months ended December 31, 2018 and 2017.

Carrying Value of Long-Lived Assets. Our property and equipment, intangible assets and goodwill (collectively, our long-lived assets) comprise a significant portion of our total assets. The accounting standards require that we periodically, and upon the occurrence of certain events, assess the recoverability of our long-lived assets. If the carrying value of our property and equipment exceeds their undiscounted cash flows, we are required to write the carrying value down to estimated fair value.

Goodwill. The fair value of goodwill and other intangible assets with indefinite lives are tested for impairment annually and upon the occurrence of certain events, and are written down to fair value if considered impaired. We evaluate goodwill for impairment on at least an annual basis (in the third quarter) by comparing the fair value of its reporting units to the carrying value of each reporting unit including related goodwill. We evaluate indefinite lived tradenames using the relief from royalty method in conjunction with its annual goodwill impairment test. We operate a one segment business which is made up of various clinics within partnerships. The partnerships are components of regions and are aggregated to that operating segment level for the purpose of determining reporting units when performing the annual goodwill impairment test. In 2018, 2017 and 2016, we had six regions. In addition to the six regions, in 2017 and 2018, the impairment test included a separate analysis for the industrial injury prevention business.

An impairment loss generally would be recognized when the carrying amount of the net assets of a reporting unit, inclusive of goodwill and other intangible assets, exceeds the estimated fair value of the reporting unit. The estimated fair value of a reporting unit is determined using two factors: (i) earnings prior to taxes, depreciation and amortization for the reporting unit multiplied by a price/earnings ratio used in the industry and (ii) a discounted cash flow analysis. A weight is assigned to each factor and the sum of each weight times the factor is considered the estimated fair value. For 2018, the factors (i.e., price/earnings ratio, discount rate and residual capitalization rate) were updated to reflect current market conditions. The evaluation of goodwill in 2018, 2017 and 2016 did not result in any goodwill amounts that were deemed impaired. In 2017, we wrote off the goodwill of $0.5 million related to the closure of a single clinic acquired partnership due to the loss of a significant management contract.

Redeemable Non-Controlling Interests – The non-controlling interests that are reflected as redeemable non-controlling interests in our consolidated financial statements consist of those owners, including us, who have certain redemption rights, whether currently exercisable or not, and which currently, or in the future, require that we purchase or the

owner sell the non-controlling interest held by the owner, if certain conditions are met and the owners request the purchase (Put Right). We also have a call right (Call Right). The Put Right or Call Right may be triggered by the owner or us, respectively, at such time as both of the following events have occurred: 1) termination of the owner s employment, regardless of the reason for such termination, and 2) the passage of specified number of years after the closing of the transaction, typically three to five years, as defined in the limited partnership agreement. The Put Rights and Call Rights are not automatic (even upon death) and require either the owner or us to exercise our rights when the conditions triggering the Put or Call Rights have been satisfied. The purchase price is derived at a predetermined formula based on a multiple of trailing twelve months earnings performance as defined in the respective limited partnership agreements.

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On the date we acquire a controlling interest in a partnership and the limited partnership agreement for such partnerships contains redemption rights not under our control, the fair value of the non-controlling interest is recorded in the consolidated balance sheet under the caption – *Redeemable non-controlling interests*. Then, in each reporting period thereafter until it is purchased by us, the redeemable non-controlling interest is adjusted to the greater of its then current redemption value or initial value, based on the predetermined formula defined in the respective limited partnership agreement. As a result, the value of the non-controlling interest is not adjusted below its initial value. We record any adjustment in the redemption value, net of tax, directly to retained earnings and not in the consolidated statements of income. Although the adjustments are not reflected in the consolidated statements of income, current accounting rules require that we reflect the adjustments, net of tax, in the earnings per share calculation. The amount of net income attributable to redeemable non-controlling interest owners is included in consolidated net income on the face of the consolidated income statement. We believe the redemption value (i.e. the carrying amount) and fair value are the same.

Mandatorily Redeemable Non-Controlling Interests – The non-controlling interests that were reflected as mandatorily redeemable non-controlling interests in the consolidated financial statements are subject to Required Redemption (as defined in Footnote 6 – Mandatorily Redeemable Non-Controlling Interest), whether currently exercisable or not, and which currently, or in the future, require that we purchase the non-controlling interest of those owners at a predetermined formula based on a multiple of trailing twelve months earnings performance as defined in the respective limited partnership agreements. The Required Redemption is triggered at such time as both of the following events have occurred: 1) termination of the holder s employment with NewCo (as defined in Footnote 6– Mandatorily Redeemable Non-Controlling Interest), regardless of the reason for such termination, and 2) the passage of specified number of years after the closing of the transaction, typically three to five years, as defined in the applicable limited partnership agreement.

Effective December 31, 2017, we entered into amendments to our limited partnership agreements for our acquired partnerships replacing the mandatory redemption feature. No monetary consideration was paid to the partners to amend the agreements. The amended limited partnership agreements provide that, upon the triggering events, we have a Call Right and the selling entity or individual has a Put Right for the purchase and sale of the limited partnership interest held by the partner. Once triggered, the Put Right and the Call Right do not expire, even upon an individual partner s death, and contain no mandatory redemption feature. The purchase price of the partner s limited partnership interest upon the exercise of either the Put Right or the Call Right is calculated per the terms of the respective agreements. We accounted for the amendment of the limited partnership agreements as an extinguishment of the outstanding mandatorily redeemable non-controlling interests, which were classified as liabilities, through the issuance of new redeemable non-controlling interests classified in temporary equity. Pursuant to Accounting Standards Codification (ASC) 470-50-40-2, we removed the outstanding liabilities at their carrying amounts, recognized the new temporary equities at their fair value, and recorded no gain or loss on extinguishment as management believes the redemption value (i.e. the carrying amount) and fair value are the same. In summary, the redemption values of the mandatorily redeemable non-controlling interest (previously classified as liabilities) were reclassified as redeemable non-controlling interest (temporary equity) at fair value on the December 31, 2017 consolidated balance sheet. On December 31, 2017, the remaining balance of $327,000 in the line item – *Mandatorily redeemable non-controlling interests* – relates to one limited partnership agreement that was not amended as the non-controlling interest was purchased by us in January 2018.

Non-Controlling Interests – We recognize non-controlling interests, in which we have no obligation but the right to purchase the non-controlling interests, as equity in the consolidated financial statements separate from the parent entity s equity. The amount of net income attributable to non-controlling interests is included in consolidated net income on the face of the consolidated statements of income. Operating losses are allocated to non-controlling interests even when such allocation creates a deficit balance for the non-controlling interest partner. When we purchase a non-controlling interest and the purchase price exceeds the book value at the time of purchase, any excess

or shortfall is recognized as an adjustment to additional paid-in capital.

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SELECTED OPERATING AND FINANCIAL DATA

The following table and discussion relates to continuing operations unless otherwise noted. The defined terms with their respective description used in the following discussion are listed below:

2018	Year ended December 31, 2018
2017	Year ended December 31, 2017
2016	Year ended December 31, 2016
New Clinics	Clinics opened or acquired during the year ended December 31, 2018
Mature Clinics	Clinics opened or acquired prior to January 1, 2018
2017 New Clinics	Clinics opened or acquired during the year ended December 31, 2017
2017 Mature Clinics	Clinics opened or acquired prior to January 1, 2017
2016 New Clinics	Clinics opened or acquired during the year ended December 31, 2016
2016 Mature Clinics	Clinics opened or acquired prior to January 1, 2016
2015 New Clinics	Clinics opened or acquired during the year ended December 31, 2015

The following table presents selected operating and financial data, used by management as key indicators of our operating performance:

	For the Years Ended December 31,		
	2018	**2017**	**2016**
Number of clinics, at the end of period	591	578	540
Working Days	255	254	255
Average visits per day per clinic	26.6	25.9	25.0
Total patient visits	3,957,534	3,705,226	3,316,729
Net patient revenue per visit	$ 105.55	$ 105.05	$ 105.18

RESULTS OF OPERATIONS

FISCAL YEAR 2018 COMPARED TO FISCAL 2017

- Net revenues increased $39.8 million, or 9.6%, from $414.1 million in 2017 to $453.9 million in 2018, primarily due to an increase in net patient revenues from physical therapy operations from both internal growth and acquisitions, an increase in the revenue from the industrial injury prevention business from a combination of internal growth plus an acquisition and an increase in revenue from management contracts due to acquired contracts. Our first company in the industrial injury prevention business was acquired in March 2017 and, on April 30, 2018, the Company made a second acquisition.
- For the year ended December 31, 2018, our Operating Results increased 28.1% to $33.5 million, or $2.65 per diluted share, as compared to $26.2 million, or $2.08 per diluted share, for the 2017 year. Operating Results (as defined below), a non-generally accepted accounting principles (non-GAAP) measure, for the 2018 fourth quarter and for the 2018 year, equals net income attributable to our shareholders excluding gain on derecognition of debt, net of taxes. For the 2017 fourth quarter and 2017 year, Operating Results is defined as net income attributable to our shareholders prior to the benefit due to the revaluation of deferred tax assets

and liabilities due to the 2017 Tax Cuts and Jobs Act (TCJA), and prior to charges for interest expense – mandatorily redeemable non-controlling interests – change in redemption value and charges for costs related to restatement of financials – legal and accounting, both charges net of tax. See table below.

- For the year ended December 31, 2018, our net income attributable to its shareholders, in accordance with GAAP, was $34.9 million, $1.31 per share, as compared to $22.3 million, or $1.76 per share, for the 2017 year. For both periods of 2018, in accordance with current accounting guidance, the revaluation of redeemable non-controlling interest, net of tax, is not included in net income but rather charged directly to retained earnings, but is included in the earnings per basic and diluted share calculation. See table below.

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- For 2018, our Adjusted EBITDA increased by 7.1% to $62.1 million from $57.9 million in 2017. See definition and reconciliation of Adjusted EBITDA in the following table.

	Year Ended December 31,	
	2018	**2017**
Computation of earnings per share - USPH shareholders		
Net income attributable to USPH shareholders	$ 34,873	$ 22,256
Charges to retained earnings:		
Revaluation of redeemable non-controlling interest	(24,770)	(201)
Tax effect at statutory rate (federal and state) of 26.25%	6,502	75
	$ 16,605	$ 22,130
Basic and diluted per share	1.31	$ 1.76
Adjustments:		
Tax benefit - revaluation of deferred tax assets and liabilities	—	(4,325)
Gain on derecognition of debt	(1,846)	—
Interest expense MRNCI* - change in redemption value	—	12,894
Cost related to restatement of financials - legal and accounting	—	670
Revaluation of redeemable non-controlling interest	24,770	201
Tax effect at statutory rate (federal and state) of 26.25% and 39.25%, respectively	(6,018)	(5,405)
Operating results	$ 33,511	$ 26,165
Basic and diluted operating results per share	$ 2.65	$ 2.08
Shares used in computation:		
Basic and diluted	12,666	12,570

	Year Ended December 31,	
	2018	**2017**
Net income attributable to USPH shareholders	$ 34,873	$ 22,256
Adjustments:		
Depreciation and amortization	9,755	9,710
Gain on derecognition of debt	(1,846)	—
Interest income	(93)	(88)
Interest expense MRNCI* - change in redemption value	—	12,894
Interest expense - debt and other	2,042	2,111
Provision for income taxes	11,369	6,032
Equity-based awards compensation expense	5,939	5,032

Adjusted EBITDA	$ 62,039	$ 57,947

* Mandatorily redeemable non-controlling interests

The above table details the calculation of basic and diluted earnings per share attributable to our shareholders and reconciles net income attributable to our shareholders calculated in accordance with GAAP to Adjusted EBITDA and Operating Results, non-GAAP measures defined below. We believe providing Operating Results and Adjusted EBITDA are useful information to our investors for the purposes of comparing our period-to-period results. In addition, we believe that providing Operating Results allows our investors to compare

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our results with other similar businesses since most do not have redeemable instruments and therefore have different liability and equity structures. We use Operating Results, which eliminates the MRNCI – change in redemption which is a current non-cash item that can be subject to volatility and unusual costs, as one of the principal measures to evaluate and monitor financial performance period over period. Adjusted EBITDA is defined as earnings before gain on derecognition of debt, interest income, interest expense – mandatorily redeemable non-controlling interests – change in redemption value, interest expense – debt and other, taxes, depreciation, amortization and equity-based awards compensation expense.

Operating Results and Adjusted EBITDA are not measures of financial performance under GAAP. Operating Results and Adjusted EBITDA should not be considered in isolation or as an alternative to, or substitute for, net income attributable to USPH shareholders presented in the consolidated financial statements.

Net Patient Revenues

- Net patient revenues increased to $417.7 million for 2018 from $389.2 million for 2017, an increase of $28.5 million, or 7.3%. The increase in net patient revenues of $28.5 million consisted of an increase of $4.7 million from New Clinics and $23.8 million from Mature Clinics. During 2018, we acquired one multi-clinic group consisting of four clinics and five other single clinic practices for a total of 9 clinics. The net patient revenues from acquired clinics are included in our results of operations since the respective date of their acquisition. See above table and discussion under —Executive Summary detailing our multi-clinic acquisitions.
- Total patient visits increased to 3,958,000 for 2018 from 3,705,000 for 2017. The growth in patient visits was attributable to 43,000 visits in New Clinics and an increase of 210,000 visits for Mature Clinics primarily due to 2017 New Clinics.
- The average net patient revenue per visit slightly increased to $105.55 in 2018 from $105.05 in 2017.
- Net patient revenues are based on established billing rates less allowances and discounts for patients covered by contractual programs and workers' compensation. Net patient revenues reflect contractual and other adjustments, which we evaluate monthly, relating to patient discounts from certain payors. Payments received under these contractual programs and workers' compensation are based on predetermined rates and are generally less than the established billing rates of the clinics.

Other Revenues

Other revenues, consisting primarily of industrial injury prevention business and management fees revenue, increased by $11.4 million, from $24.8 million in 2017 to $36.2 million in 2018. The revenues from the recently acquired industrial injury prevention business were $25.5 million in 2018 and $14.9 million in 2017. Revenues from management contracts were $8.3 million for 2018 as compared to $7.4 million for 2017. Other miscellaneous revenue was $2.4 million for 2018 and $2.5 million for 2017.

Operating Costs

Operating costs were $352.2 million, or 77.6% of net revenues, for 2018 and $323.4 million, or 78.1% of net revenues, for 2017. The dollar increase was attributable to $5.3 million in operating costs for New Clinics, an additional $15.1 million related to a Mature Clinics, $7.4 million related to the addition of the industrial injury prevention business, and an increase of $1.0 million related to management contracts. The 2017 closure costs of $0.6 million, included in operating costs, are primarily due to the closure of a single clinic acquired partnership due to the loss of a significant management contract. (See table detailing acquisition dates above under – Executive Summary). Each component of clinic operating costs is discussed below:

Operating Costs—Salaries and Related Costs

Salaries and related costs increased to $259.2 million for 2018 from $237.1 million for 2017, an increase of $22.1 million, or 9.3%. Approximately $3.3 million of the increase was attributable to New Clinics, $12.6 million of the increase was due to higher costs at various Mature Clinics primarily due to an increase in salaries and related costs in 2017 New Clinics which had a full year of activity in 2018, $5.4 million was due to higher salary costs at the industrial injury prevention businesses primarily due to the acquisition in April of 2018 and $0.8 million related to management contracts. Salaries and related costs as a percentage of net revenues was 57.1% for 2018 and 57.3% for 2017.

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Operating Costs—Rent, Supplies, Contract Labor and Other

Rent, supplies, contract labor and other costs increased to $88.4 million for 2018 from $82.1 million for 2017, an increase of $6.3 million, or 7.7%. Approximately $1.9 million of the increase was attributable to New Clinics, $1.7 million of the increase was due to higher costs at various Mature Clinics, $1.7 million was due to the industrial injury prevention businesses primarily due to the acquisition in April of 2018 and $1.0 million related to management contracts. For 2018, New Clinics accounted for approximately $1.9 million of the increase, the industrial injury prevention business accounted for approximately $0.7 million and 2017 New Clinics accounted for approximately $3.7 million of the increase due to a full year of activity. Rent, supplies, contract labor and other costs as a percent of net revenues was 19.5% for 2018 and 19.8% for 2017.

Operating Costs—Provision for Doubtful Accounts

The provision for doubtful accounts for net patient receivables was $4.6 million for 2018 and $3.7 million for 2017. As a percentage of net patient revenues, the provision for doubtful accounts was 1.0% for 2018 and 0.9% for 2017.

Our provision for doubtful accounts as a percentage of total patient accounts receivable was 5.6% at December 31, 2018 and 4.9% at December 31, 2017. The provision for doubtful accounts at the end of each period is based on a detailed, clinic-by-clinic review of overdue accounts and is regularly reviewed in the aggregate in light of historical experience.

The average accounts receivable days outstanding were 37 days at December 31, 2018 and 36 days at December 31, 2017. Net patient receivables in the amount of $3.9 million and $3.3 million were written-off in 2018 and 2017, respectively.

Closure Costs

For 2018 and 2017, closure costs amounted to a credit of $9,000 and a charge of $599,000, respectively. As previously mentioned, the 2017 closure costs are primarily due to the closure of a single clinic acquired partnership due to the loss of a significant management contract.

Gross Profit

The gross profit in 2018 grew by 12.2% or $11.1 million to $101.7 million, as compared to $90.6 million in 2017. The gross profit percentage grew to 22.4% of net revenue in the recent year as compared to 21.9% for 2017. The gross profit percentage for our physical therapy clinics was 22.7% for 2018 as compared to 22.5% for 2017. The gross profit percentage on management contracts was 12.1% for 2018 as compared to 14.9% for 2017. The gross profit percentage for the industrial injury prevention business was 20.4% for 2018 as compared to 13.3% for 2017.

Corporate Office Costs

Corporate office costs, consisting primarily of salaries, benefits and equity based compensation of corporate office personnel and directors, rent, insurance costs, depreciation and amortization, travel, legal, compliance, professional, marketing and recruiting fees, were $41.3 million for 2018 and $35.9 million for 2017. The dollar increase is primarily due to increases in salaries, benefits and equity based compensation. Corporate office costs as a percentage of net revenues were 9.1% for 2018 and 8.7% in 2017.

Interest Expense—mandatorily redeemable non-controlling interest – change in redemption value.

We no longer have mandatorily redeemable non-controlling interests. As previously mentioned, due to amended partnerships agreements, the redemption values of the mandatorily redeemable non-controlling interests (previously classified as liabilities) were reclassified as redeemable non-controlling interest (temporary equity) at fair value on the December 31, 2017 consolidated balance sheet. For 2017, the earnings and liabilities attributable to mandatorily redeemable non-controlling interests were recorded within the consolidated statements of income line item: Interest expense—mandatorily redeemable non-controlling interests—earnings allocable and in the consolidated balance sheet line item: Mandatorily redeemable non-controlling interests. For 2018, any

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adjustments in the redemption value, net of tax, are recorded directly to retained earnings and are not reflected in the consolidated statements of income. Although the redemption adjustments are not reflected in the consolidated statements of income, current accounting rules require that we reflect these adjustments, net of tax, in the earnings per share calculation.

Interest Expense mandatorily redeemable non-controlling interest – change in redemption value for the 2017 year was $12.9 million. The change in redemption value for acquired partnerships was based on the redemption amount (which is derived from a formula based on a specified multiple times the underlying business trailing twelve months of earnings before interest, taxes, depreciation, amortization and our internal management fee) at the end of the reporting period compared to the end of the previous period. This change is directly related to an increase or decrease in the profitability and underlying value of our partnerships as compared to the prior year.

Interest Expense—mandatorily redeemable non-controlling interest – earnings allocable.

For 2018, the amount of net income attributable to redeemable non-controlling interest owners is included in consolidated net income on the face of the consolidated statement of income in the line item – Net income attributable to non-controlling interests. For 2017, interest expense – mandatorily redeemable non-controlling interest – earnings allocable, which represent the portion of earnings allocable to the holders of mandatorily redeemable non-controlling interests, was $6.1 million.

Interest Expense—debt and other

Interest expense – debt and other was $2.0 million for 2018 and $2.1 million for 2017. At December 31, 2018, $38.0 million was outstanding under our Amended Credit Agreement (as defined below under —Liquidity and Capital Resources). See —Liquidity and Capital Resources below for a discussion of the terms of our Amended Credit Agreement.

Gain on Derecognition of Debt

Gain on derecognition of debt was $1.8 million for the year 2018 as a liability relating to some former physical therapy partners is no longer deemed payable.

Provision for Income Taxes

The provision for income tax in 2018 was $11.4 million, inclusive of a $0.5 million benefit related to the reconciliation of the 2017 federal and state returns to our book provision. Without this benefit, the provision for income taxes as a percentage of income before taxes less net income attributable to non-controlling interest was 25.7%. The income tax expense in 2017 was $6.0 million. Included in 2017 is a tax benefit of $4.3 million due to the revaluation of deferred tax assets and liabilities due to the TCJA. Also, included in 2017 was a charge of $0.3 million related to a detailed reconciliation of the federal and state taxes payable and receivable accounts along with federal and state deferred tax assets and liability accounts at December 31, 2016. Without this reconciliation charge and prior to the $4.3 million tax benefit, the provision for income taxes as a percentage of income before taxes less net income attributable to non-controlling interest was 35.6%. As reported, the provision for income tax as a percentage of income before taxes less net income attributable to non-controlling interest was 24.6% in 2018 and 21.3% in 2017.

Net Income Attributable to Non-controlling Interests

Net income attributable to non-controlling interests was $13.9 million in 2018 and $5.5 million in 2017. Net income attributable to non-controlling interests (permanent equity) was $5.5 million in 2018 as compared to $5.2 million in

2017. Net income attributable to redeemable non-controlling interests (temporary equity) was $8.4 million in 2018 and $0.2 million in 2017.

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FISCAL YEAR 2017 COMPARED TO FISCAL 2016

- Net revenues increased 16.1% from $356.5 million in 2016 to $414.1 million in 2017, primarily due to an increase in total patient visits of 11.7% from 3,317,000 to 3,705,000, higher revenues from management contracts and revenues from the industrial injury prevention business acquired in March 2017.
- For the year ended December 31, 2017, Operating Results increased 7.7% to $26.2 million as compared to $24.3 million in 2016. Diluted earnings per share from Operating Results was $2.08 in 2017 as compared to $1.94 in 2016. Operating Results, a non-generally accepted accounting principles (non-GAAP) measure, are defined as net income attributable to common shareholders prior to interest expense – mandatorily redeemable non-controlling interests – change in redemption value and costs related to restatement of financials, both net of tax, and the tax benefit of revaluation of deferred tax assets and liabilities due to the TCJA. See table below.
- For the year ended December 31, 2017, our net income attributable to our shareholders, in accordance with generally accepted accounting principles (GAAP), was $22.3 million, or $1.76 per diluted share, as compared to $20.6 million, or $1.64 per diluted share, for the 2016 year. Included in the quarter and year ended December 31, 2017 is a tax benefit of $4.3 million related to the revaluation of deferred tax assets and liabilities due to the TCJA. See table on next page.
- For 2017, the Company's Adjusted EBITDA increased by 8.2% to $57.9 million from $53.5 million in 2016. See definition and reconciliation of Adjusted EBITDA below.

	Year Ended December 31,	
	2017	**2016**
Computation of earnings per share - USPH shareholders		
Net income attributable to USPH shareholders	$ 22,256	$ 20,551
Charges to retained earnings:		
Revaluation of redeemable non-controlling interest	(201)	—
Tax effect at statutory rate (federal and state) of 26.25%	75	—
	$ 22,130	$ 20,551
Basic and diluted per share	$ 1.76	$ 1.64
Adjustments:		
Tax benefit - revaluation of deferred tax assets and liabilities	(4,325)	—
Gain on derecognition of debt	—	—
Interest expense MRNCI* - change in redemption value	12,894	6,169
Cost related to restatement of financials - legal and accounting	670	—
Revaluation of redeemable non-controlling interest	201	—
Tax effect at statutory rate (federal and state) of 26.25% and 39.25%, respectively	(5,405)	(2,421)
Operating results	$ 26,165	$ 24,299
Basic and diluted operating results per share	$ 2.08	$ 1.94

Shares used in computation:		
Basic and diluted	12,570	12,500

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	2017	2016
Net income attributable to USPH shareholders	$ 22,256	$ 20,551
Adjustments:		
Depreciation and amortization	9,710	8,779
Gain on derecognition of debt	—	—
Interest income	(88)	(93)
Interest expense MRNCI* - change in redemption value	12,894	6,169
Interest expense - debt and other	2,111	1,252
Provision for income taxes	6,032	11,880
Equity-based awards compensation expense	5,032	4,962
Adjusted EBITDA	$ 57,947	$ 53,500

* Mandatorily redeemable non-controlling interests

The above table details the calculation of basic and diluted earnings per share attributable to our shareholders and reconciles net income attributable to our shareholders calculated in accordance with GAAP to Adjusted EBITDA and Operating Results, a non-GAAP measure defined below. We believe providing Operating Results and Adjusted EBITDA is useful information to our investors for the purposes of comparing our period-to-period results. In addition, we believe that providing Operating Results allows our investors to compare our results with other similar businesses since most do not have mandatorily redeemable instruments and therefore have different liability and equity structures. We use Operating Results, which eliminates the MRNCI – change in redemption which is a current non-cash item that can be subject to volatility and unusual costs, as one of the principal measures to evaluate and monitor financial performance period over period. Adjusted EBITDA is defined as earnings before gain on derecognition of debt, interest income, interest expense – mandatorily redeemable non-controlling interests – change in redemption value, interest expense – debt and other, taxes, depreciation, amortization and equity-based awards compensation expense.

Operating Results and Adjusted EBITDA are not measures of financial performance under GAAP. Operating Results and Adjusted EBITDA should not be considered in isolation or as an alternative to, or substitute for, net income attributable to USPH shareholders presented in our consolidated financial statements.

Net Patient Revenues

- Net patient revenues increased to $389.2 million for 2017 from $348.8 million for 2016, an increase of $40.4 million, or 11.6%. The increase in net patient revenues of $40.4 million consisted of an increase of $19.3 million from 2017 New Clinics and $21.1 million from 2017 Mature Clinics. During 2017, we acquired four multi-clinic groups for a total of 39 clinics. The net patient revenues from these multi-clinic groups are included in our results of operations since the respective date of their acquisition. See above table under —Executive Summary detailing our multi-clinic acquisitions.
- Total patient visits increased to 3,705,000 for 2017 from 3,317,000 for 2016. The growth in patient visits was attributable to 229,000 visits in 2017 New Clinics primarily due to the acquisitions in 2016 and an increase of 159,000 visits for 2017 Mature Clinics primarily due to 2016 New Clinics.
- The average net patient revenue per visit slightly decreased to $105.05 in 2017 from $105.18 in 2016.

Net patient revenues are based on established billing rates less allowances and discounts for patients covered by contractual programs and workers compensation. Net patient revenues reflect contractual and other adjustments, which we evaluate monthly, relating to patient discounts from certain payors. Payments received under these programs are based on predetermined rates and are generally less than the established billing rates of the clinics.

Other Revenues

Other revenues, consisting primarily of management fees, increased by $1.9 million, from $5.5 million in 2016 to $7.4 million in 2017.

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Operating Costs

Operating costs were $323.4 million, or 78.1% of net revenues, for 2017 and $274.5 million, or 77.0% of net revenues, for 2016. The increase was attributable to $17.3 million in operating costs for 2017 New Clinics, an additional $15.6 million related to a full year of activity in 2017 for 2016 New Clinics, $12.9 million related to the addition of the industrial injury prevention business, $2.6 million related to 2016 Mature Clinics and an additional $0.5 million in closure costs. The 2017 closure costs are primarily due to the closure of a single clinic acquired partnership due to the loss of a significant management contract. Each component of clinic operating costs is discussed below:

Operating Costs—Salaries and Related Costs

Salaries and related costs increased to $237.1 million for 2017 from $198.5 million for 2016, an increase of $38.6 million, or 19.4%. Approximately $14.2 million of the increase was attributable to 2017 New Clinics, $11.6 million of the increase was due to higher costs at various 2016 New Clinics due to a full year of activity, $10.6 million was due to the ten months of activity for the industrial injury prevention business and higher costs of $2.2 million at 2016 Mature Clinics. Salaries and related costs as a percentage of net revenues was 57.3% for 2017 and 55.7% for 2016.

Operating Costs—Rent, Supplies, Contract Labor and Other

Rent, supplies, contract labor and other costs increased to $82.1 million for 2017 from $71.9 million for 2016, an increase of $10.2 million, or 14.2%. For 2017, 2017 New Clinics accounted for approximately $5.9 million of the increase, the industrial injury prevention business accounted for approximately $2.3 million and 2016 New Clinics accounted for approximately $4.2 million of the increase due to a full year of activity. Rent, supplies, contract labor and other costs for 2016 Mature Clinics decreased $2.2 million in 2017 as compared to 2016. Rent, supplies, contract labor and other costs as a percent of net revenues was 19.8% for 2017 and 20.2% for 2016.

Operating Costs—Provision for Doubtful Accounts

The provision for doubtful accounts for net patient receivables was $3.7 million for 2017 and $4.0 million for 2016. As a percentage of net patient revenues, the provision for doubtful accounts was 0.9% for 2017 and 1.1% for 2016.

Our provision for doubtful accounts as a percentage of total patient accounts receivable was 4.9% at December 31, 2017 and 4.4% at December 31, 2016. The provision for doubtful accounts at the end of each period is based on a detailed, clinic-by-clinic review of overdue accounts and is regularly reviewed in the aggregate in light of historical experience.

The average accounts receivable days outstanding were 36 days for December 31, 2017 and for December 31, 2016. Net patient receivables in the amount of $3.3 million and $3.6 million were written-off in 2017 and 2016, respectively.

Closure Costs

For 2017 and 2016, closure costs amounted to $0.5 million and $0.1 million, respectively. As previously mentioned, the 2017 closure costs are primarily due to the closure of a single clinic acquired partnership due to the loss of a significant management contract.

Gross Profit

In 2017, the gross profit (net revenues less total clinic operating costs) increased by 4.7% to $90.6 million from $82.0 million in 2016. The gross profit percentage for 2017 was 22.0% as compared to 23% for 2016.

Corporate Office Costs

Corporate office costs, consisting primarily of salaries, benefits and equity based compensation of corporate office personnel and directors, rent, insurance costs, depreciation and amortization, travel, legal, compliance, professional, marketing and recruiting fees, were $35.9 million for 2017 and $32.5 million for 2016. The dollar increase is primarily due to increases in salaries, benefits and equity based compensation. Corporate office costs as a percentage of net revenues were 8.7% for 2017 and 9.1% in 2016.

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Interest Expense—mandatorily redeemable non-controlling interest – change in redemption value.

Interest Expense – mandatorily redeemable non-controlling interest – change in redemption value increased to $12.9 million for the year 2017 from $6.2 million in 2016. This increase is primarily due to the increased earnings performance of the underlying businesses. The change in redemption value is based on the redemption amount (which is derived from a formula based on a specified multiple times the underlying business trailing twelve months of earnings before interest, taxes, depreciation, amortization and our internal management fee) at the end of the reporting period compared to the end of the previous period.

Interest Expense—mandatorily redeemable non-controlling interest – earnings allocable.

Interest Expense – mandatorily redeemable non-controlling interest – earnings allocable represent the portion of earnings allocable to the holders of the mandatorily redeemable non-controlling interest. This expense increased to $6.1 million in 2017 as compared to $4.1 million in 2016. The increase is the result of new business acquisitions and increased performance of existing businesses.

Interest Expense—debt and other

Interest expense – debt and other was $2.1 million for 2017 and $1.3 million for 2016. At December 31, 2017, $54.0 million was outstanding under our Amended Credit Agreement (as defined below under —Liquidity and Capital Resources). See —Liquidity and Capital Resources below for a discussion of the terms of our Amended Credit Agreement.

Provision for Income Taxes

The provision for income taxes was $6.0 million for 2017 and $11.9 million for 2016. Included in 2017 is an estimated tax benefit of $4.3 million due to the revaluation of deferred tax assets and liabilities, as previously discussed. The provision for income taxes, prior to the $4.3 million tax benefit, as a percentage of income before taxes less net income attributable to non-controlling interest was 35.6% and 36.6% in 2017 and in 2016, respectively. The reconciliation of the 2016 federal and state returns to our book provision was $312,000 which is included in the 2017 provision. The reconciliation of the 2015 federal and state returns to our book provision was $34,000 which is included in the 2016 provision.

Net Income Attributable to Non-controlling Interests

Net income attributable to non-controlling interests was $5.5 million in 2017 and $5.7 million in 2016. Net income attributable to non-controlling interests (permanent equity) was $5.2 million in 2017 as compared to $5.7 million in 2016. Net income attributable to redeemable non-controlling interests (temporary equity) was $0.2 million in 2017.

LIQUIDITY AND CAPITAL RESOURCES

We believe that our business is generating sufficient cash flow from operating activities to allow us to meet our short-term and long-term cash requirements, other than those with respect to future significant acquisitions. At December 31, 2018, we had $23.4 million in cash and cash equivalents compared to $21.9 million at December 31, 2017. Although the start-up costs associated with opening new clinics and our planned capital expenditures are significant, we believe that our cash and cash equivalents and availability under our Amended Credit Agreement are sufficient to fund the working capital needs of our operating subsidiaries, future clinic development and acquisitions and investments through at least December 2019. Significant acquisitions would likely require financing under our Amended Credit Agreement.

Effective December 5, 2013, we entered into an Amended and Restated Credit Agreement with a commitment for a $125.0 million revolving credit facility. This agreement was amended in August 2015, January 2016, March 2017 and November 2017 (hereafter referred to as Amended Credit Agreement). The Amended Credit Agreement is unsecured and has loan covenants, including requirements that we comply with a consolidated fixed charge coverage ratio and consolidated leverage ratio. Proceeds from the Amended Credit Agreement may be used for working capital, acquisitions, purchases of our common stock, dividend payments to our common stockholders, capital expenditures and other corporate purposes. The pricing grid is based on our consolidated leverage ratio with the applicable spread over LIBOR ranging from 1.25% to 2.0% or the applicable

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spread over the Base Rate ranging from 0.1% to 1%. Fees under the Amended Credit Agreement include an unused commitment fee ranging from 0.25% to 0.3% depending on our consolidated leverage ratio and the amount of funds outstanding under the Amended Credit Agreement.

The January 2016 amendment to the Amended Credit Agreement increased the cash and noncash consideration that we could pay with respect to acquisitions permitted under the Amended Credit Agreement to $50,000,000 for any fiscal year, and increased the amount we may pay in cash dividends to our shareholders in an aggregate amount not to exceed $10,000,000 in any fiscal year. The March 2017 amendment, among other items, increased the amount we may pay in cash dividends to our shareholders in an aggregate amount not to exceed $15,000,000 in any fiscal year. The November 2017 amendment, among other items, adjusted the pricing grid as described above, increased the aggregate amount we may pay in cash dividends to $20,000,000 to our shareholders and extended the maturity date to November 30, 2021.

On December 31, 2018, $38.0 million was outstanding on the Amended Credit Agreement resulting in $87.0 million of availability. As of the date of this report, we were in compliance with all of the covenants thereunder.

The increase in cash and cash equivalents of $1.4 million from December 31, 2018 to December 31, 2017 was due primarily to $73.0 million provided by operations and $16.0 million net proceeds from our Amended Credit Agreement. The major uses of cash for investing and financing activities included: purchase of businesses ($16.4 million), payments of cash dividends to our shareholders ($11.7 million), purchases of fixed assets ($7.2 million), distributions to non-controlling interests ($15.6 million), acquisitions of non-controlling interests through settlements of liabilities related to mandatorily redeemable non-controlling interests ($0.2 million) and payments on notes payable ($4.0 million)

On February 28, 2018, through one of our majority owned partnerships, we acquired the assets and business of two physical therapy clinics, for an aggregate purchase price of $760,000 in cash and $150,000 in seller note that is payable, plus accrued interest, on August 31, 2019.

On April 30, 2018, we purchased a 65% interest in the assets and business of industrial injury prevention services, for an aggregate purchase price of $8.6 million in cash and $400,000 in seller note that is payable, plus accrued interest, on April 30, 2019. The initial industrial injury prevention business was acquired in March 2017 and, on April 30, 2018, we made a second acquisition with the two businesses then combined. After the combination, we own a 59.45% interest in the combined business.

On August 31, 2018 we acquired a 70% interest in a four-clinic physical therapy practice. The purchase price for the 70% interest was $7.3 million in cash and $400,000 in a seller note that is payable in two principal installments totaling $200,000 each, plus accrued interest, in August 2019 and August 2020.

In addition to the multi-clinic acquisitions above in 2018, we through several of our majority owned Clinic Partnerships, acquired five separate clinic practices. These practices will operate as satellites of the respective existing clinic partnership.

On January 1, 2017, we acquired a 70% interest in a seventeen-clinic physical therapy practice. The purchase price for the 70% interest was $10.7 million in cash and $0.5 million in a seller note that is payable in two principal installments totaling $250,000 each, plus accrued interest. The first installment was paid in January 2018 and the second installment was paid in January 2019.

In March 2017, we acquired a 55% interest in a company which is a leading provider of industrial injury prevention solutions. Services provided include onsite injury prevention and rehabilitation, performance optimization and

ergonomic assessments. The majority of these services are contracted with and paid for directly by employers including a number of Fortune 500 companies. Other clients include large insurers and their contractors. The purchase price for the 55% interest was $6.2 million in cash and $0.4 million in a seller note that was paid, principal plus accrued interest, in September 2018.

On May 31, 2017, we acquired a 70% interest in a four-clinic physical therapy practice. The purchase price for the 70% interest was $2.3 million in cash and $250,000 in a seller note that is payable in two principal installments totaling $125,000 each plus accrued interest. The first installment was paid in May 2018 and the second installment is due in May 2019.

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On June 30, 2017, we acquired a 60% interest in a nine-clinic physical therapy practice. The purchase price for the 60% interest was $15.8 million in cash and $0.5 million in a seller note payable in two equal installments. The first installment of $250,000 was paid in June 2018 and the second installment is due in June 2019.

On October 31, 2017, we acquired a 70% interest in a nine-clinic physical therapy practice and two management contracts with third party providers. The purchase price for the 70% interest was $4.0 million in cash and $0.5 million in a seller note payable in two equal installments. The first installment of $250,000 was paid in October 2018 and the second installment is due in October 2019.

On November 30, 2016, we acquired a 60% interest in a 12 clinic physical therapy practice. The purchase price for the 60% interest was $11.0 million in cash and $0.5 million in a seller note that is payable in two principal installments of $250,000 each, plus accrued interest, one of which was paid in November 2017 and one of which was paid in November 2018. On February 29, 2016, we acquired a 55% interest in an eight-clinic physical therapy practice. The purchase price for the 55% interest was $13.2 million in cash and $0.5 million in a seller note that was payable in two principal installments totaling $250,000 each, plus accrued interest. The first installment was paid in February 2017 and the next installment was paid in February 2018.

Historically, we have generated sufficient cash from operations to fund our development activities and to cover operational needs. We plan to continue developing new clinics and making additional acquisitions. We have from time to time purchased the non-controlling interests of limited partners in our Clinic Partnerships. We may purchase additional non-controlling interests in the future. Generally, any acquisition or purchase of non-controlling interests is expected to be accomplished using a combination of cash and financing. Any large acquisition would likely require financing.

We make reasonable and appropriate efforts to collect accounts receivable, including applicable deductible and co-payment amounts. Claims are submitted to payors daily, weekly or monthly in accordance with our policy or payor s requirements. When possible, we submit our claims electronically. The collection process is time consuming and typically involves the submission of claims to multiple payors whose payment of claims may be dependent upon the payment of another payor. Claims under litigation and vehicular incidents can take a year or longer to collect. Medicare and other payor claims relating to new clinics awaiting CMS approval initially may not be submitted for six months or more. When all reasonable internal collection efforts have been exhausted, accounts are written off prior to sending them to outside collection firms. With managed care, commercial health plans and self-pay payor type receivables, the write-off generally occurs after the account receivable has been outstanding for 120 days or longer.

We have future obligations for debt repayments, employment agreements and future minimum rentals under operating leases. The obligations as of December 31, 2018 are summarized as follows (in thousands):

	Total	2019	2020	2021	2022	2023	Thereafter
Credit Agreement	$ 38,000	$ —	$ —	$ 38,000	$ —	$ —	$ —
Notes Payable	1,836	1,434	402	—	—	—	—
Interest Payable	69	59	10	—	—	—	—
Employee Agreements	43,259	33,760	7,143	1,178	1,178	—	—
Operating Leases	102,554	34,139					