AMEDISYS INC
Form 10-Q
May 08, 2014
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UNITED STATES

SECURITIES AND EXCHANGE COMMISSION

Washington D.C. 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2014

or

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

For the transition period from _____ to _____

Commission File Number: 0-24260

AMEDISYS, INC.

(Exact Name of Registrant as Specified in its Charter)

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

5959 S. Sherwood Forest Blvd., Baton Rouge, LA 70816

(Address of principal executive offices, including zip code)

(225) 292-2031 or (800) 467-2662

(Registrant s telephone number, including area code)

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

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

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

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

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

The number of shares outstanding of each of the issuer s classes of common stock, as of the latest practicable date, is as follows: Common stock, $0.001 par value, 32,812,605 shares outstanding as of May 2, 2014.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Quarterly Report on Form 10-Q, or in other documents that we file with the Securities and Exchange Commission (SEC) or in statements made by or on behalf of the Company, words like believes, belief, expects, plans, anticipates, intends, projects, estimates, may, might, would, should and similar expressions are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to the following: changes in Medicare and other medical payment levels, our ability to open care centers, acquire additional care centers and integrate and operate these care centers effectively, our ability to divest care centers currently held for sale, changes in or our failure to comply with existing Federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, competition in the home health industry, changes in the case mix of patients and payment methodologies, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new patient referral sources, our ability to attract and retain qualified personnel, changes in payments and covered services due to the economic downturn and deficit spending by Federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing due to the volatility and disruption of the capital and credit markets, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate and manage our information systems, our ability to fund required settlement payments in the manner agreed upon in our settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral matter, our ability to comply with requirements stipulated in our corporate integrity agreement and changes in law or developments with respect to any litigation or investigations relating to the Company, including the SEC investigation, the OIG Self-Disclosure issues and various other matters, many of which are beyond our control.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see our Annual Report on Form 10-K for the year ended December 31, 2013, filed with the SEC on March 12, 2014, particularly Part I, Item 1A. Risk Factors therein, which are incorporated herein by reference and Part II, Item 1A. Risk Factors of this Quarterly Report on Form 10-Q. Additional risk factors may also be described in reports that we file from time to time with the SEC.

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled Investors on our website home page. We also use our website to expedite public access to time-critical information regarding our company in advance of or in lieu of distributing a press release or a filing with the SEC disclosing the same information. Therefore, investors should look to the Investor Relations subpage of our website for important and time-critical information. Visitors to our website can also register to receive automatic e-mail and other notifications alerting them when new information is made available on the Investor Relations subpage of our website. In addition, we make available on the Investor Relations subpage of our website (under the link SEC filings) free of charge our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, ownership reports on Forms 3, 4 and 5 and any amendments to those reports as soon as practicable after we electronically file such reports with the SEC. Further, copies of our Certificate of Incorporation and Bylaws, our Code of Ethical Business Conduct, our Corporate Governance Guidelines and the charters for the Audit, Compensation, Quality of Care, Compliance and Ethics and Nominating and Corporate Governance Committees of our Board are also available on the Investor Relations subpage of our website (under the link Corporate Governance).

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

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PART I. FINANCIAL INFORMATION

ITEM 1. FINANCIAL STATEMENTS

AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED BALANCE SHEETS

(Amounts in thousands, except share data)

(Unaudited)

	March 31, 2014	December 31, 2013
ASSETS		
Current assets:		
Cash and cash equivalents	$ 2,840	$ 17,303
Patient accounts receivable, net of allowance for doubtful accounts of $14,131 and $14,231	115,350	111,133
Prepaid expenses	13,675	10,669
Deferred income taxes	57,325	55,329
Other current assets	14,309	10,785
Assets held for sale	18	60
Total current assets	203,517	205,279
Property and equipment, net of accumulated depreciation of $137,022 and $129,891	157,034	159,025
Goodwill	208,923	208,915
Intangible assets, net of accumulated amortization of $25,279 and $25,133	34,336	36,690
Deferred income taxes	95,991	90,214
Other assets, net	27,589	26,283
Total assets	$ 727,390	$ 726,406
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 24,198	$ 20,139
Accrued charge related to U.S. Department of Justice settlement	150,000	150,000
Payroll and employee benefits	76,066	70,801
Accrued expenses	61,498	57,572
Current portion of long-term obligations	12,952	13,904
Total current liabilities	324,714	312,416
Long-term obligations, less current portion	30,000	33,000
Other long-term obligations	9,761	8,511
Total liabilities	364,475	353,927
Commitments and Contingencies Note 6		
Equity:		
Preferred stock, $0.001 par value, 5,000,000 shares authorized; none issued or outstanding		
Common Stock, $0.001 par value, 60,000,000 shares authorized; 33,484,218, and 33,413,970 shares issued; and 32,608,356 and 32,538,971 shares outstanding	33	33
Additional paid-in capital	470,851	467,890
Treasury Stock at cost 875,862, and 874,999 shares of common stock	(18,191)	(18,176)
Accumulated other comprehensive income	15	15

Retained earnings	(89,978)	(77,561)
Total Amedisys, Inc. stockholders equity	362,730	372,201
Noncontrolling interests	185	278
Total equity	362,915	372,479
Total liabilities and equity	$ 727,390	$ 726,406

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

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AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS

(Amounts in thousands, except per share data)

(Unaudited)

	For the Three-Month Periods Ended March 31,	
	2014	2013
Net service revenue	$ 298,739	$ 328,602
Cost of service, excluding depreciation and amortization	177,008	185,667
General and administrative expenses:		
Salaries and benefits	83,171	79,840
Non-cash compensation	431	2,056
Other	42,698	41,848
Provision for doubtful accounts	4,894	3,854
Depreciation and amortization	7,902	9,970
Other intangibles impairment charge	2,208	
Operating expenses	318,312	323,235
Operating (loss) income	(19,573)	5,367
Other (expense) income:		
Interest income	6	11
Interest expense	(1,261)	(1,092)
Equity in earnings from equity investments	787	363
Miscellaneous, net	190	59
Total other expense, net	(278)	(659)
(Loss) income before income taxes	(19,851)	4,708
Income tax benefit (expense)	7,618	(1,851)
(Loss) income from continuing operations	(12,233)	2,857
Discontinued operations, net of tax	(277)	(724)
Net (loss) income	(12,510)	2,133
Net loss attributable to noncontrolling interests	93	546
Net (loss) income attributable to Amedisys, Inc.	$ (12,417)	$ 2,679
Basic earnings per common share:		
(Loss) income from continuing operations attributable to Amedisys, Inc. common stockholders	$ (0.38)	$ 0.11
Discontinued operations, net of tax	(0.01)	(0.02)
Net (loss) income attributable to Amedisys, Inc. common stockholders	$ (0.39)	$ 0.09
Weighted average shares outstanding	31,864	30,640
Diluted earnings per common share:		

(Loss) income from continuing operations attributable to Amedisys, Inc. common stockholders	$ (0.38)	$ 0.11
Discontinued operations, net of tax	(0.01)	(0.02)
Net (loss) income attributable to Amedisys, Inc. common stockholders	$ (0.39)	$ 0.09
Weighted average shares outstanding	31,864	31,104
Amounts attributable to Amedisys, Inc. common stockholders:		
(Loss) income from continuing operations	$ (12,140)	$ 3,403
Discontinued operations, net of tax	(277)	(724)
Net (loss) income	$ (12,417)	$ 2,679

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

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AMEDISYS, INC. AND SUBSIDIARIES

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(Amounts in thousands)

(Unaudited)

	For the Three-Month Periods Ended March 31,	
	2014	**2013**
Cash Flows from Operating Activities:		
Net (loss) income	$ (12,510)	$ 2,133
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	7,936	10,123
Provision for doubtful accounts	4,968	3,967
Non-cash compensation	431	2,056
401(k) employer match	1,392	2,240
Loss on disposal of property and equipment	332	211
Gain on sale of care centers	(645)	
Deferred income taxes	(7,799)	(1,287)
Equity in earnings of equity investments	(787)	(363)
Amortization of deferred debt issuance costs	141	193
Return on equity investment	400	400
Other intangibles impairment charge	2,208	
Changes in operating assets and liabilities, net of impact of acquisitions:		
Patient accounts receivable	(9,185)	20,545
Other current assets	(6,337)	(8,420)
Other assets	(1,219)	(517)
Accounts payable	3,491	(945)
Accrued expenses	9,591	1,990
Other long-term obligations	1,250	90
Net cash (used in) provided by operating activities	(6,342)	32,416
Cash Flows from Investing Activities:		
Proceeds from sale of deferred compensation plan assets		71
Proceeds from the sale of property and equipment		61
Purchases of deferred compensation plan assets	(33)	(29)
Purchases of property and equipment	(5,532)	(10,074)
Purchase of investments		(6,227)
Acquisitions of businesses, net of cash acquired		(627)
Proceeds from dispositions of care centers	645	
Net cash used in investing activities	(4,920)	(16,825)
Cash Flows from Financing Activities:		
Proceeds from issuance of stock upon exercise of stock options and warrants	89	
Proceeds from issuance of stock to employee stock purchase plan	657	837
Tax benefit from stock option exercises	5	
Proceeds from revolving line of credit	54,000	12,500
Repayments of revolving line of credit	(54,000)	(12,500)
Principal payments of long-term obligations	(3,952)	(23,952)

Net cash used in financing activities	(3,201)	(23,115)
Net decrease in cash and cash equivalents	(14,463)	(7,524)
Cash and cash equivalents at beginning of period	17,303	14,545
Cash and cash equivalents at end of period	$ 2,840	$ 7,021
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$ 425	$ 1,629
Cash paid for income taxes, net of refunds received	$	$ 3,135
Supplemental Disclosures of Non-Cash Financing and Investing Activities:		
Acquired non-controlling interests	$	$ 167

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

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AMEDISYS, INC. AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

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

Amedisys, Inc., a Delaware corporation, and its consolidated subsidiaries (Amedisys, we, us, or our) are a multi-state provider of home heal and hospice services with approximately 83% and 84% of our revenue derived from Medicare for the three months ended March 31, 2014 and 2013, respectively. As of March 31, 2014, we owned and operated 358 Medicare-certified home health care centers, including one care center held for sale, 91 Medicare-certified hospice care centers and one hospice inpatient unit in 37 states within the United States, the District of Columbia and Puerto Rico.

Basis of Presentation

In our opinion, the accompanying unaudited condensed consolidated financial statements contain all adjustments (consisting solely of normal recurring adjustments) necessary to present fairly our financial position, our results of operations and our cash flows in accordance with U.S. Generally Accepted Accounting Principles (U.S. GAAP). Our results of operations for the interim periods presented are not necessarily indicative of results of our operations for the entire year and have not been audited by our independent auditors.

Certain information and footnote disclosures normally included in financial statements prepared in accordance with U.S. GAAP have been condensed or omitted from the interim financial information presented. This report should be read in conjunction with our consolidated financial statements and related notes included in our Annual Report on Form 10-K for the year ended December 31, 2013 as filed with the Securities and Exchange Commission (SEC) on March 12, 2014 (the Form 10-K), which includes information and disclosures not included herein.

Use of Estimates

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

Reclassifications and Comparability

Certain reclassifications have been made to prior period s financial statements in order to conform to the current period s presentation.

Principles of Consolidation

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

Investments

We consolidate investments when the entity is a variable interest entity and we are the primary beneficiary or if we have controlling interests in the entity, which is generally ownership in excess of 50%. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our condensed consolidated financial statements.

We account for investments in entities in which we have the ability to exercise significant influence under the equity method if we hold 50% or less of the voting stock and the entity is not a variable interest entity in which we are the primary beneficiary. The book value of investments that we accounted for under the equity method of accounting was $13.7 million as of March 31, 2014 and $11.9 million as of December 31, 2013. We account for investments in entities in which we have less than a 20% ownership interest under the cost method of accounting if we do not have the ability to exercise significant influence over the investee. The aggregate carrying amount of our cost method investment was and $5.0

million as of March 31, 2014 and December 31, 2013.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue Recognition

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

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

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AMEDISYS, INC. AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

Home Health Revenue Recognition

Medicare Revenue

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

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

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. We estimate this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on visits performed. As of March 31, 2014 and 2013, the difference between the cash received from Medicare for a request for anticipated payment (RAP) on episodes in progress and the associated estimated revenue was immaterial and, therefore, the resulting credits were recorded as a reduction to our outstanding patient accounts receivable in our condensed consolidated balance sheets for such periods.

Non-Medicare Revenue

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

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

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounts for 99% of our total net Medicare hospice service revenue for the three month periods ended March 31, 2014 and 2013, respectively. We make adjustments to Medicare revenue for an inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these adjustments based on our historical experience, which primarily includes our historical collection rate on Medicare claims, and record it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable.

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AMEDISYS, INC. AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap for each provider number, we monitor these caps and estimate amounts due back to Medicare if a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in other accrued liabilities. We have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2011. For the Federal cap years ended October 31, 2012 through October 31, 2014, we have $4.0 million recorded for estimated amounts due back to Medicare in other accrued liabilities as of March 31, 2014 and December 31, 2013, respectively.

Hospice Non-Medicare Revenue

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

Patient Accounts Receivable

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

We believe the credit risk associated with our Medicare accounts, which represent 67% of our net patient accounts receivable at March 31, 2014 and December 31, 2013, respectively, is limited due to our historical collection rate of over 99% from Medicare and the fact that Medicare is a U.S. government payor. Accordingly, we do not record an allowance for doubtful accounts for our Medicare patient accounts receivable, which are recorded at their net realizable value after recording estimated revenue adjustments as discussed above. During the three month periods ended March 31, 2014 and 2013, we recorded $1.2 million and $3.8 million, respectively, in estimated revenue adjustments to Medicare revenue.

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

Medicare Home Health

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

Medicare Hospice

For our hospice patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Our Medicare billing begins with a process to ensure that our billings are accurate through the utilization of an electronic

Medicare claim review. Once each patient has been confirmed for eligibility, we will bill Medicare on a monthly basis for the services provided to the patient.

Non-Medicare Home Health and Hospice

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

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AMEDISYS, INC. AND SUBSIDIARIES

NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Unaudited)

Fair Value of Financial Instruments

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

		Fair Value at Reporting Date Using		
Financial Instrument	**As of March 31, 2014**	**Quoted Prices in Active Markets for Identical Items (Level 1)**	**Significant Other Observable Inputs (Level 2)**	**Significant Unobservable Inputs (Level 3)**
Long-term obligations	$ 43.0	$	$ 42.6	$

The estimates of the fair value of our long-term debt are based upon a discounted present value analysis of future cash flows. Due to the existing uncertainty in the capital and credit markets the actual rates that would be obtained to borrow under similar conditions could materially differ from the estimates we have used.

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

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

Level 2 Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities; quoted prices in markets that are not active; or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.

Level 3 Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities.

For our other financial instruments, including our cash and cash equivalents, patient accounts receivable, accounts payable and accrued expenses, we estimate the carrying amounts approximate fair value. Our deferred compensation plan assets are recorded at fair value.

Weighted-Average Shares Outstanding

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

	For the Three-Month Periods Ended March 31,	
	2014	2013
Weighted average number of shares outstanding basic	31,864	30,640
Effect of dilutive securities:		
Stock options		21
Non-vested stock and stock units		443
Weighted average number of shares outstanding diluted	31,864	31,104
Anti-dilutive securities	772	220

Recently Issued Accounting Pronouncements

In April 2014, the FASB issued Accounting Standards Update (ASU) 2014-08, *Presentation of Financial Statements (Topic205) and Property, Plant, and Equipment (Topic 360):Reporting Discontinued Operations and Disclosures of Disposals of Components of an Entity* changing the criteria for reporting discontinued operations. The ASU states that only those disposed components (or components held-for-sale) representing a strategic shift that have (or will have) a major effect on operations and financial results (or that are businesses or non-profit activities held-for-sale at acquisition) will be reported in discontinued operations. The ASU also required expanded disclosures about discontinued operations in the financial statement notes. The ASU is effective for disposals (or classifications as held-for-sale) that occur within annual periods beginning on or after December 15, 2014 and interim periods within those annual periods. Early application is permitted, but only for those disposals (or classifications as held-for-sale) that have not been reported in financial statements previously issued or available for issuance.

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3. DISCONTINUED OPERATIONS AND ASSETS HELD FOR SALE

As part of our management of our portfolio of care centers, we review each care center s current financial performance, market penetration, forecasted market growth and the impact of proposed CMS payment revisions. As a result of our review, we consolidated 41 home health care centers and five hospice care centers with care centers servicing the same markets, sold 19 home health care centers and one hospice care center and closed 10 home health care centers during 2013. We had previously classified 28 of these care centers as held for sale during 2013 and three care centers remained classified as held for sale at December 31, 2013. During the three month period ended March 31, 2014, we sold assets associated with one of these care centers and consolidated one of these care centers with a care center servicing the same market; one care center remains classified as held for sale as of March 31, 2014. For additional information on the care centers consolidated with care centers servicing the same markets and the care centers sold, see Note 4 Exit and Restructuring Activities.

Net revenues and operating results for the periods presented for the care centers classified as discontinued operations are as follows (dollars in millions):

	For the Three-Month Periods Ended March 31,	
	2014	2013
Net revenues	$ (0.3)	$ 10.6
(Loss) before income taxes	(0.5)	(1.2)
Income tax benefit	0.2	0.5
Discontinued operations, net of tax	$ (0.3)	$ (0.7)

4. EXIT AND RESTRUCTURING ACTIVITIES

Exit Activity

As of December 31, 2013, we reported three home health care centers as held for sale. During the three month period ended March 31, 2014, we sold assets associated with one of these care centers for cash consideration of approximately $0.6 million and recognized a gain of approximately $0.6 million which is included in discontinued operations. In addition, during the three months ended March 31, 2014, one of the care centers classified as held for sale as of December 31, 2013 was consolidated with a care center servicing the same market. One home health care center remains classified as held for sale as of March 31, 2014.

In addition to the sale of care center mentioned above, during the three month period ended March 31, 2014, we committed to a plan to consolidate 21 operating home health care centers and four operating hospice care centers with care centers servicing the same markets and close 23 home health care centers and six hospice care centers. These care centers included in this plan are not concentrated in certain selected geographical areas and do not meet the criteria to be classified as discontinued operations in accordance with applicable accounting guidance. In connection with these care centers, we recorded non-cash charges of $2.2 million in goodwill and other intangibles impairment expense related to the write-off of intangible assets, $2.1 million in other general and administrative expenses related to lease termination costs and $2.1 million in salaries and benefits related to severance costs during the three month period ended March 31, 2014.

Restructuring Activity

During the quarter ended March 31, 2014, we restructured our regional leadership and corporate support functions. As such, we recorded charges of $3.4 million in salaries and benefits related to severance costs during the three month period ended March 31, 2014. In addition, on

February 20, 2014 William F. Borne stepped down from his positions as Chief Executive Officer, Chairman and a member of our Board of Directors and we recorded charges of $2.3 million in salaries and benefits related to severance costs.

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5. LONG-TERM OBLIGATIONS

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

	March 31, 2014	December 31, 2013
$60.0 million Term Loan; $3.0 million principal payments plus accrued interest payable quarterly; interest rate at ABR Rate plus applicable percentage or Eurodollar Rate plus the applicable percentage (3.41% at March 31, 2014); due October 26, 2017	42.0	45.0
Promissory notes	1.0	1.9
	43.0	46.9
Current portion of long-term obligations	(13.0)	(13.9)
Total	$ 30.0	$ 33.0

Our weighted average interest rate for our five year $60.0 million Term Loan was 3.4% for the three month periods ended March 31, 2014.

As of March 31, 2014, our total leverage ratio was 3.2 and our fixed charge coverage ratio was 1.4 and we are in compliance with the Credit Agreement. We currently anticipate we will be in compliance with the covenants associated with our long-term obligations over the next 12 months. In the event we are not in compliance with our debt covenants in the future, we would pursue various alternatives in an attempt to successfully resolve the non-compliance, which might include, among other things, seeking debt covenant waivers or amendments.

As of March 31, 2014, our availability under our $165.0 million Revolving Credit Facility was $143.7 million as we had $21.3 million outstanding in letters of credit.

6. COMMITMENTS AND CONTINGENCIES

Legal Proceedings

We are involved in the following legal actions:

United States Senate Committee on Finance Inquiry

On May 12, 2010, we received a letter of inquiry from the Senate Finance Committee requesting documents and information relating to our policies and practices regarding home therapy visits and therapy utilization trends. A similar letter was sent to the other major publicly traded home health care companies. We cooperated with the Committee with respect to this inquiry.

On October 3, 2011, the Committee publicly issued a report titled Staff Report on Home Health and the Medicare Therapy Threshold. The Committee recommended that the CMS must move toward taking therapy out of the payment model. We believe that the issuance of the report concludes the Committee s inquiry, but are not in a position to speculate on the potential for future legislative or oversight action by the Committee.

Securities Class Action Lawsuits

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

On October 22, 2010, the Court issued an order consolidating the putative securities class action lawsuits and the Federal Derivative Actions (described immediately below) for pre-trial purposes. In the same order, the Court appointed the Public Employees Retirement System of Mississippi and the Puerto Rico Teachers Retirement System as co-lead plaintiffs (together, the Co-Lead Plaintiffs) for the putative class. On December 10, 2010, the Court also consolidated the ERISA class action lawsuit (described below) with the putative securities class actions and Federal Derivative Actions for pre-trial purposes.

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

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

On May 3, 2013, the Co-Lead Plaintiffs appealed the dismissal of the Securities Complaint to the United States Court of Appeals for the Fifth Circuit. The parties appellate briefing is complete and oral argument was held on March 31, 2014. While the Company will seek to have the Court s order granting the defendants motion to dismiss affirmed on appeal, no assurances can be given as to the timing or outcome of the appeals process.

Derivative Actions

On July 2, 2010, an alleged shareholder of the Company filed a derivative lawsuit in the United States District Court for the Middle District of Louisiana, purporting to assert claims on behalf of the Company against certain of our current and former officers and directors. Three similar derivative suits were filed in the Court on July 15, July 21, and August 2, 2010 (together, the Federal Derivative Actions). We are named as a nominal defendant in all of those actions. As noted above, on October 22, 2010, the Court issued an order consolidating the Federal Derivative Actions with the putative securities class action lawsuits and for pre-trial purposes.

On January 18, 2011, the plaintiffs in the Federal Derivative Actions filed a consolidated, amended complaint (the Derivative Complaint) which supersedes the earlier-filed derivative complaints. The Derivative Complaint alleges that certain of our current and former officers and directors breached their fiduciary duties to the Company by making allegedly false statements, by allegedly failing to establish sufficient internal controls over certain of our home health and Medicare billing practices, by engaging in alleged insider trading, and by committing unspecified acts of waste of corporate assets and unjust enrichment. All defendants in the Federal Derivative Actions, including the Company as a nominal defendant, moved to dismiss the Derivative Complaint. That motion was still pending before the Court when the parties reached the settlement described below.

On June 24, 2013, all parties to the Federal Derivative Actions entered into a Stipulation of Settlement (the Stipulation) with respect to the Federal Derivative Actions. On September 5, 2013, following notice to shareholders and a final approval hearing, the Court issued an order of dismissal with prejudice finally approving the proposed settlement in accordance with the Stipulation. As part of the Court-approved settlement, the Company has agreed to adopt and/or maintain certain corporate governance reforms as set forth in the Stipulation. The Court s order also awarded co-lead plaintiffs counsel of attorneys fees and expenses in an amount of $445,000, which was paid by the Company s insurer on its behalf. The order dismissed the Federal Derivative Actions with prejudice, and approved the release of all named defendants by all plaintiffs, the Company, and its shareholders from all claims that were or could have been alleged in the Federal Derivative Actions.

On July 23, 2010, a derivative suit (the State Derivative Action) was filed in the Nineteenth Judicial District Court, Parish of East Baton Rouge, State of Louisiana (the State Court) which also purported to assert claims on behalf of the Company against certain of our current and former officers and directors. By order dated December 8, 2010, the State Derivative Action was stayed pending resolution of the Federal Derivative Actions. On October 17, 2013, the State Court issued an order granting the parties joint motion for dismissal of the State Derivative Action based on the federal Court s final approval of the settlement of the Federal Derivative Actions, and dismissing the State Derivative Action with prejudice.

ERISA Class Action Lawsuit

On September 27, 2010 and October 22, 2010, separate putative class action complaints were filed in the United States District Court for the Middle District of Louisiana against the Company, certain of our current and former senior executives and members of our 401(k) Plan Administrative Committee. The suits allege violations of the Employee Retirement Income Security Act (ERISA) since January 1, 2006 and July 1, 2007, respectively. The plaintiffs brought the complaints on behalf of themselves and a class of similarly situated participants in our 401(k) Plan. The plaintiffs assert that the defendants breached their fiduciary duties to the 401(k) Plan s participants by causing the 401(k) Plan to offer and hold Amedisys common stock during the respective class periods when it was an allegedly unduly risky and imprudent retirement investment because of our alleged improper business practices. The complaints seek a determination that the actions may be maintained as a

class action, an award of unspecified monetary damages and other unspecified relief. As noted above, on December 10, 2010, the Court consolidated the putative ERISA class actions with the putative securities class actions and derivative actions for pre-trial purposes. In addition, on December 10, 2010, the Court appointed interim lead counsel and interim liaison counsel in the ERISA class action.

On March 10, 2011, Wanda Corbin, Pia Galimba and Linda Trammell (the Co-ERISA Plaintiffs), filed an amended, consolidated class action complaint (the ERISA Complaint), which supersedes the earlier-filed ERISA class action complaints. The ERISA Complaint seeks a determination that the action may be maintained as a class action on behalf of themselves and a class of similarly situated participants in our 401(k) plan from January 1, 2008 through present. All of the defendants have moved to dismiss the ERISA Complaint. That motion is fully briefed and remains pending before the Court.

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On November 5, 2013, we reached an agreement in principle to settle the ERISA class action lawsuits on a class-wide basis under which we would make a payment of $1.2 million (which we correctly anticipated would be paid by our insurance carrier) and provide additional non-monetary benefits to 401(k) Plan participants. We then negotiated a formal settlement agreement with the Co-ERISA Plaintiffs and on December 13, 2013, submitted it to the Court for preliminary and final approval. The formal settlement agreement describes how the $1.2 million settlement payment would be allocated among the putative class of 401(k) Plan participants after certain expenses and fees are deducted. On April 14, 2014, the Court granted the motion for preliminary approval and scheduled a final fairness hearing for July 22, 2014. Our insurance carrier funded the $1.2 million settlement pool shortly after the entry of the April 14, 2014 order. The settlement remains subject to a number of contingencies, including final approval by the court, and we can provide no assurances as to whether we will be able to successfully consummate the settlement.

SEC Investigation

On June 30, 2010, we received notice of a formal investigation from the SEC and received a subpoena for documents relating to the matters under review by the United States Senate Committee on Finance and other matters involving our operations. We have cooperated with the SEC with respect to this investigation.

U.S. Department of Justice Civil Investigative Demand (CID) Pursuant to False Claims Act and Stark Law Matters

On September 27, 2010, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act. The CID requires the delivery of a wide range of documents and information relating to the Company s clinical and business operations, including reimbursement and billing claims submitted to Medicare for home health services, and related compliance activities. The CID generally covers the period from January 1, 2003. On April 26, 2011, we received a second CID related to the CID issued in September 2010, which generally covers the same time period as the previous CID and requires the production of additional documents. Such CIDs are often associated with previously filed qui tam actions, or lawsuits filed under seal under the False Claims Act (FCA), 31 U.S.C. § 3729 et seq. Qui tam actions are brought by private plaintiffs suing on behalf of the federal government for alleged FCA violations. Subsequently, the Company and certain current and former employees received additional CIDs for additional documents and/or testimony.

In May 2012, we made a disclosure to CMS under the agency s Stark Law Self-Referral Disclosure Protocol relating to certain services agreements between a subsidiary of ours and a large physician group. During some period of time since December 2007, the arrangements appear not to have complied in certain respects with an applicable exemption to the Stark Law referral prohibition. Medicare revenue earned as a result of referrals from the physician group from May 2008 to May 2012, the relevant four year lookback period under the Stark Law Self-Referral Disclosure Protocol, was approximately $4 million. On January 11, 2013, one of our subsidiaries received a CID from the United States Attorney s Office for the Northern District of Georgia seeking certain information relating to that subsidiary s relationship with this physician group.

On October 4, 2013, we reached an agreement in principle to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral matter. We agreed to this tentative settlement without any admission of wrongdoing to resolve these matters and to avoid the uncertainty and expense of protracted litigation. On April 23, 2014, we entered into a settlement agreement to resolve both the U.S. Department of Justice investigation and the Stark Law Self-Referral matter. The settlement agreement contains no admissions of liability on our part.

Pursuant to the settlement agreement, we paid the United States an initial payment in the amount of $116.5 million on May 2, 2014, representing the first installment of $115 million plus interest thereon due under the settlement agreement. A second installment of $35 million plus interest thereon will be payable on or prior to October 23, 2014.

In consideration of our obligations under the settlement agreement and conditioned upon our full payment of the settlement amount, the United States agreed to release us from any civil or administrative monetary claim under the False Claims Act and various other statutes and legal theories for (a) claims involving home health services rendered by certain of our care centers from January 1, 2008 through December 31, 2010 that the United States contended were (i) provided to patients who were not homebound, (ii) provided to patients lacking a need for skilled

nursing and/or skilled therapy services, (iii) provided to patients without regard to medical necessity, or (iv) overbilled by upcoding patients diagnoses, and (b) claims arising from our billings to the Medicare program during the period from April 1, 2008 through April 30, 2012 for home health services referred by a particular physician practice group while we were providing such practice group remuneration that was not consistent with fair market value in the form of patient care coordination services performed by our employees.

The settlement agreement also resolves allegations made against us by various *qui tam* relators, who are required to dismiss their claims with prejudice. We are required to pay various relators attorneys fees and expenses in the aggregate sum of approximately $3.9 million. In addition, we may incur additional expenses in connection with compliance measures mandated by the corporate integrity agreement discussed below.

We have previously recorded an accrual for the settlement amount and will add the amount of the relators attorneys fees to this accrual in the quarter ended March 31, 2014.

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In connection with the settlement agreement, on April 23, 2014, we entered into a corporate integrity agreement with the Office of Inspector General-HHS. The corporate integrity agreement formalizes various aspects of our already existing ethics and compliance programs and contains other requirements designed to help ensure our ongoing compliance with federal health care program requirements. Among other things, the corporate integrity agreement requires us to maintain our existing compliance program and compliance committee; provide certain compliance training; continue screening new and current employees against certain lists to ensure they are not ineligible to participate in federal health care programs; engage an independent review organization to perform certain auditing and reviews and prepare certain reports regarding our compliance with federal health care programs, our billing submissions to federal health care programs and our compliance and risk mitigation programs; and provide certain reports and management certifications to Office of Inspector General-HHS. Upon breach of the corporate integrity agreement, we could become liable for payment of certain stipulated penalties, or could be excluded from participation in federal health care programs. The corporate integrity agreement has a term of five years.

OIG Self-Disclosure

In October 2012, we made a disclosure to the Office of Counsel to the Inspector General of the United States Department of Health and Human Services (the OIG) pursuant to the OIG Provider Self-Disclosure Protocol regarding certain clinical documentation issues and eligibility regulatory requirements at two of our hospice care centers. These hospice care centers did not comply in some respects with certain state and Medicare hospice regulations, including those requiring physicians to certify patient eligibility and requiring patient face-to-face encounters. We recorded an additional accrual of approximately $1 million during the three-month period ended September 30, 2013 increasing the total accrual to approximately $2 million as of September 30, 2013 where it remained at December 31, 2013. A final settlement agreement with OIG, pursuant to which we agreed to pay approximately $2 million to settle the matter, was executed on March 12, 2014.

In September and October 2013, we made preliminary disclosures to OIG under the OIG s Provider Self-Disclosure Protocol regarding certain clinical documentation issues at one of our home health care centers. This care center appears to have not complied with certain Medicare home health regulations, including those relating to physician signature requirements and face-to-face documentation. We made a disclosure in March 2014 to OIG providing additional information relating to the information disclosed in the preliminary disclosures sent in September and October 2013. As of December 31, 2013, we recorded an accrual of approximately $0.5 million for this matter. Our review is ongoing, and we intend to cooperate with the OIG in its review of this matter.

Wage and Hour Litigation

On July 25, 2012, a putative collective and class action complaint was filed in the United States District Court for the District of Connecticut against us in which three former employees allege wage and hour law violations. The former employees claim that they were not paid overtime for all hours worked over forty hours in violation of the Federal Fair Labor Standards Act (FLSA), as well as the Pennsylvania Minimum Wage Act. More specifically, they allege they were paid on both a per-visit and an hourly basis, and that such a pay scheme resulted in their misclassification as exempt employees, thereby denying them overtime pay. Moreover, in response to a Company motion arguing that plaintiffs complaint was deficient in that it was ambiguous and failed to provide fair notice of the claims asserted and plaintiffs opposition thereto, the Court, on April 8, 2013, held that the complaint adequately raises general allegations that the plaintiffs were not paid overtime for all hours worked in a week over forty, which may include claims for unpaid overtime under other theories of liability, such as alleged off-the-clock work, in addition to plaintiffs more clearly stated allegations based on misclassification. On behalf of themselves and a class of current and former employees they allege are similarly situated, plaintiffs seek attorneys fees, back wages and liquidated damages going back three years under the FLSA and three years under the Pennsylvania statute. On October 8, 2013, the Court granted plaintiffs motion for equitable tolling requesting that the statute of limitations for claims under the FLSA for plaintiffs who opt-in to the lawsuit be tolled from September 24, 2012, the date upon which plaintiffs filed their original motion for conditional certification, until 90 days after any notice of this lawsuit is issued following conditional certification. Following a motion for reconsideration filed by the Company, on December 3, 2013, the Court modified this order, holding that putative class members FLSA claims are tolled from October 29, 2012 through the date of the Court s order on plaintiffs motion for conditional certification. On January 13, 2014, the Court granted plaintiffs July 10, 2013 motion for conditional certification of their FLSA claims and authorized issuance of notice to putative class members to provide them an opportunity to opt in to the action. On April 17, 2014, that notice was mailed to putative class members. Putative class members who wish to opt in to the action and join in plaintiffs FLSA claims have 90 days from the mailing of the notice to return the written consent form included with the notice packet.

On September 13, 2012, a putative collective and class action complaint was filed in the United States District Court for the Northern District of Illinois against us in which a former employee alleges wage and hour law violations. The former employee claims she was paid on both a per-visit and an hourly basis, thereby misclassifying her as an exempt employee and entitling her to overtime pay. The plaintiff alleges violations of Federal and state law and seeks damages under the FLSA and the Illinois Minimum Wage Law. Plaintiff

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seeks class certification of similar employees who were or are employed in Illinois and seeks attorneys fees, back wages and liquidated damages going back three years under the FLSA and three years under the Illinois statute. On May 28, 2013, the Court granted the Company s motion to stay the case pending resolution of class certification issues and dispositive motions in the earlier-filed Connecticut case referenced above.

We are unable to assess the probable outcome or reasonably estimate the potential liability, if any, arising from the SEC investigation and the securities and wage and hour litigation described above. The Company intends to continue to vigorously defend itself in the securities and wage and hour litigation matters. No assurances can be given as to the timing or outcome of the SEC investigation, the OIG Self-Disclosure issues or the securities and wage and hour litigation matters described above or the impact of any of the inquiry, investigation or litigation matters on the Company, its consolidated financial condition, results of operations or cash flows, which could be material, individually or in the aggregate.

We recognize that additional putative securities class action complaints and other litigation could be filed, and that other investigations and actions could be commenced, relating to matters involving our home therapy visits and therapy utilization trends or other matters.

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

Third Party Audits

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

In January 2010, our subsidiary that provides home health services in Dayton, Ohio received from a Medicare Program Safeguard Contractor (PSC) a request for records regarding 137 claims submitted by the subsidiary paid from January 2, 2008 through November 10, 2009 (the Claim Period) to determine whether the underlying services met pertinent Medicare payment requirements. Based on the PSC s findings for 114 of the claims, which were extrapolated to all claims for home health services provided by the Dayton subsidiary paid during the Claim Period, on March 9, 2011, the Medicare Administrative Contractor (MAC) for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment of approximately $5.6 million. We dispute these findings, and our Dayton subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturned. Most recently, a consolidated administrative law judge (ALJ) hearing was held in late March 2013. In January 2014, the ALJ found fully in favor of our Dayton subsidiary on 74 appeals and partially in favor of our Dayton subsidiary on eight appeals. Taking into account the ALJ s decision, certain determinations that our Dayton subsidiary decided not to appeal as well as certain determinations made by the MAC, of the 114 claims that were originally extrapolated by the MAC, 76 claims have now been decided in favor of our Dayton subsidiary in full, 10 claims have been decided in favor of our Dayton subsidiary in part, and 28 claims have been decided against or not appealed by our Dayton subsidiary. The ALJ has ordered the MAC to recalculate the extrapolation amount based on the ALJ s decision. The Medicare Appeals Council can decide on its own motion to review the ALJ s decisions. As of March 31, 2014, we have recorded no liability with respect to the pending appeals as we do not believe that an estimate of a reasonably possible loss or range of loss can be made at this time.

In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a Zone Program Integrity Contractor (ZPIC) a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the Review Period) to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC s findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the MAC for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment. We dispute these findings, and our Florence subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturne