AMEDISYS INC
Form 10-Q
October 30, 2018

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

FORM 10-Q

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

For the quarterly period ended September 30, 2018
or
¨ TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934
For the transition period from to
Commission File Number: 0-24260

AMEDISYS, INC.
(Exact Name of Registrant as Specified in its Charter)

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

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

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 ý No ¨
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 (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ý No ¨
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. (Check one):

Large accelerated filer ý Accelerated filer ¨

Non-accelerated filer ¨ Smaller reporting company ¨

Emerging growth company ¨

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. ¨

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

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, 31,888,599 shares outstanding as of October 26, 2018.

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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, changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government regulations on a timely basis, competition in the healthcare industry, our ability to integrate our personal care segment into our business efficiently, changes in the case mix of patients and payment methodologies, changes in estimates and judgments associated with critical accounting policies, our ability to maintain or establish new patient referral sources, our ability to attract and retain qualified personnel, changes in payments and covered services due to an economic downturn and deficit spending by federal and state governments, future cost containment initiatives undertaken by third-party payors, our access to financing, our ability to meet debt service requirements and comply with covenants in debt agreements, business disruptions due to natural disasters or acts of terrorism, our ability to integrate, manage and keep our information systems secure, our ability to comply with requirements stipulated in our corporate integrity agreement and changes in law or developments with respect to any litigation relating to the Company, including various other matters, many of which are beyond our control.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as required by law. For a discussion of some of the factors discussed above as well as additional factors, see our Annual Report on Form 10-K for the year ended December 31, 2017, filed with the SEC on February 28, 2018, 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. 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 "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.

PART I. FINANCIAL INFORMATION
ITEM 1. FINANCIAL STATEMENTS
AMEDISYS, INC. AND SUBSIDIARIES
CONDENSED CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except share data)

	September 30, 2018 (unaudited)	December 31, 2017
ASSETS		
Current assets:		
Cash and cash equivalents	$ 14,010	$86,363
Patient accounts receivable	195,030	201,196
Prepaid expenses	11,679	7,329
Other current assets	11,949	16,268
Total current assets	232,668	311,156
Property and equipment, net of accumulated depreciation of $93,432 and $146,814	30,215	31,122
Goodwill	324,145	319,949
Intangible assets, net of accumulated amortization of $32,443 and $30,610	44,309	46,061
Deferred income taxes	41,149	56,064
Other assets	53,406	49,130
Total assets	$ 725,892	$813,482
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 24,519	$25,384
Payroll and employee benefits	92,385	89,936
Accrued expenses	101,177	89,104
Current portion of long-term obligations	1,209	10,638
Total current liabilities	219,290	215,062
Long-term obligations, less current portion	54,853	78,203
Other long-term obligations	6,253	3,791
Total liabilities	280,396	297,056
Commitments and Contingencies—Note 5		
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; 36,146,649 and 35,747,134 shares issued; and 31,877,278 and 33,964,767 shares outstanding	36	35
Additional paid-in capital	592,539	568,780
Treasury stock, at cost 4,269,371 and 1,782,367 shares of common stock	(240,536)	(53,713)
Accumulated other comprehensive income	15	15
Retained earnings	92,089	204
Total Amedisys, Inc. stockholders’ equity	444,143	515,321
Noncontrolling interests	1,353	1,105
Total equity	445,496	516,426
Total liabilities and equity	$ 725,892	$813,482

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

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

	For the Three-Month Periods Ended September 30		For the Nine-Month Periods Ended September 30	
	2018	2017	2018	2017
Net service revenue	$ 417,335	$ 373,704	$ 1,228,200	$ 1,113,311
Cost of service, excluding depreciation and amortization	249,739	227,269	730,612	664,139
General and administrative expenses:				
Salaries and benefits	79,367	77,130	232,213	226,532
Non-cash compensation	4,842	3,558	12,653	11,788
Other	40,335	38,189	124,119	120,223
Depreciation and amortization	3,164	4,185	9,882	13,139
Securities Class Action Lawsuit settlement, net	—	—	—	28,712
Operating expenses	377,447	350,331	1,109,479	1,064,533
Operating income	39,888	23,373	118,721	48,778
Other income (expense):				
Interest income	29	44	263	104
Interest expense	(1,991)	(1,335)	(5,834)	(3,600)
Equity in earnings from equity method investments	1,625	900	6,461	3,149
Miscellaneous, net	1,822	1,043	2,782	3,282
Total other income, net	1,485	652	3,672	2,935
Income before income taxes	41,373	24,025	122,393	51,713
Income tax expense	(9,825)	(9,364)	(29,984)	(17,324)
Net income	31,548	14,661	92,409	34,389
Net income attributable to noncontrolling interests	(171)	(103)	(524)	(240)
Net income attributable to Amedisys, Inc.	$ 31,377	$ 14,558	$ 91,885	$ 34,149
Basic earnings per common share:				
Net income attributable to Amedisys, Inc. common stockholders	$ 0.99	$ 0.43	$ 2.78	$ 1.02
Weighted average shares outstanding	31,815	33,838	33,075	33,640
Diluted earnings per common share:				
Net income attributable to Amedisys, Inc. common stockholders	$ 0.96	$ 0.42	$ 2.71	$ 1.00
Weighted average shares outstanding	32,691	34,363	33,852	34,255

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

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

	For the Nine-Month Periods Ended September 30	
	2018	2017
Cash Flows from Operating Activities:		
Net income	$92,409	$34,389
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	9,882	13,139
Non-cash compensation	12,653	11,788
401(k) employer match	6,934	6,547
Loss (gain) on disposal of property and equipment	738	(22)
Deferred income taxes	14,916	17,228
Equity in earnings from equity method investments	(6,461)	(3,149)
Amortization of deferred debt issuance costs/debt discount	596	555
Return on equity investment	4,373	4,656
Changes in operating assets and liabilities, net of impact of acquisitions:		
Patient accounts receivable	6,166	(10,846)
Other current assets	(32)	(5,896)
Other assets	726	(12,202)
Accounts payable	(670)	(5,430)
Accrued expenses	14,758	22,584
Other long-term obligations	2,462	201
Net cash provided by operating activities	159,450	73,542
Cash Flows from Investing Activities:		
Proceeds from sale of deferred compensation plan assets	563	622
Proceeds from the sale of property and equipment	51	118
Investments in equity method investees	(3,477)	(436)
Purchases of property and equipment	(5,684)	(9,074)
Acquisitions of businesses, net of cash acquired	(4,074)	(24,128)
Net cash used in investing activities	(12,621)	(32,898)
Cash Flows from Financing Activities:		
Proceeds from issuance of stock upon exercise of stock options and warrants	2,749	4,214
Proceeds from issuance of stock to employee stock purchase plan	1,787	1,798
Shares withheld upon stock vesting	(5,421)	(6,454)
Noncontrolling interest distribution	(530)	(216)
Proceeds from borrowings under revolving line of credit	127,500	—
Repayments of borrowings under revolving line of credit	(70,000)	—
Principal payments of long-term obligations	(91,071)	(4,069)
Debt issuance costs	(2,433)	—
Purchase of company stock	(181,402)	—
Repurchase of noncontrolling interest	(361)	—
Net cash used in financing activities	(219,182)	(4,727)
Net (decrease) increase in cash and cash equivalents	(72,353)	35,917
Cash and cash equivalents at beginning of period	86,363	30,197

Cash and cash equivalents at end of period	$14,010	$66,114
Supplemental Disclosures of Cash Flow Information:		
Cash paid for interest	$2,989	$2,188
Cash paid for income taxes, net of refunds received	$11,017	$315

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

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, (together with its consolidated subsidiaries, referred to herein as “Amedisys,” “we,” “us,” or “our”) is a multi-state provider of home health, hospice and personal care services with approximately 73% and 74% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2018, respectively, and approximately 76% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2017. As of September 30, 2018, we owned and operated 323 Medicare-certified home health care centers, 83 Medicare-certified hospice care centers and 15 personal-care care centers in 34 states within the United States and the District of Columbia.

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”) for interim financial reporting. 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.

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, 2017, as filed with the Securities and Exchange Commission (“SEC”) on February 28, 2018 (the “Form 10-K”), which includes information and disclosures not included herein. Certain information and footnote disclosures normally included in annual financial statements prepared in accordance with U.S. GAAP have been condensed or omitted from the interim financial information presented, as allowed by such SEC rules and regulations.

Recently Adopted Accounting Pronouncements

On January 1, 2018, the Company adopted Accounting Standards Update (“ASU”) 2014-09, Revenue from Contracts with Customers (Topic 606) and ASU 2015-14, Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date (collectively, “ASC 606”), the new accounting standards issued by the Financial Accounting Standards Board (“FASB”) on revenue recognition, using the full retrospective method. ASC 606 outlines a single comprehensive model to use in accounting for revenue arising from contracts with customers. The standards supersede existing revenue recognition requirements and eliminate most industry-specific guidance from U.S. GAAP. The core principle of the revenue recognition standard is to require an entity to recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which it expects to be entitled in exchange for those goods or services. As a result of the Company's adoption of ASC 606, the revenue and related estimated uncollectible amounts owed to us by non-Medicare payors that were historically classified as a provision for doubtful accounts are now considered a price concession in determining net service revenue. Accordingly, the Company reports uncollectible balances due from third-party payors and uncollectible balances associated with patient responsibility as a reduction of the transaction price and therefore, as a reduction in net service revenue (or as it relates to Hospice room and board, an increase in cost of service, excluding depreciation and amortization) when historically these amounts were classified as a provision for doubtful accounts within operating expenses within our condensed consolidated statements of operations. In addition, the adoption of ASC 606 resulted in increased disclosure, including qualitative and quantitative disclosures about the nature, amount, timing and uncertainty of revenue and cash flows arising from contracts with customers.

In August 2016, the FASB issued ASU 2016-15, Statement of Cash Flows (Topic 230): Classification of Certain Cash Receipts and Cash Payments, which provides specific guidance on eight cash flow classification issues not specifically addressed by U.S. GAAP. The ASU is effective for annual and interim periods beginning after

December 15, 2017. The standard should be applied using a retrospective transition method unless it is impractical to do so for some of the issues. In such case, the amendments for those issues would be applied prospectively as of the earliest date practicable. Our adoption of this standard on January 1, 2018, using a retrospective transition method for each period presented, did not have an effect on our condensed consolidated financial statements.

In January 2017, the FASB issued ASU 2017-01, Business Combinations (Topic 805): Clarifying the Definition of a Business, which provides guidance to assist entities with evaluating whether transactions should be accounted for as an acquisition (or disposal) of assets or a business. The ASU is effective for annual and interim periods beginning after December 15, 2017. We

AMEDISYS, INC. AND SUBSIDIARIES
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(Unaudited)

adopted this ASU effective January 1, 2018, on a prospective basis. The impact on our consolidated financial statements and related disclosures will depend on the facts and circumstances of any specific future transactions as evaluated under the new framework.

In January 2017, the FASB issued ASU 2017-04, Intangibles—Goodwill and Other (Topic 350)—Simplifying the Test for Goodwill Impairment, which eliminates the requirement to calculate the implied fair value of goodwill to measure a goodwill impairment charge (Step 2 of the goodwill impairment test). Instead, impairment will be measured using the difference between the carrying amount and the fair value of the reporting unit. The ASU is effective for annual and interim periods beginning after December 15, 2019. Early adoption is permitted. We adopted this ASU effective January 1, 2018, on a prospective basis and will apply this guidance to our future tests of goodwill impairment.

Recently Issued Accounting Pronouncements

In February 2016, the FASB issued ASU 2016-02, Leases (Topic 842), which will require lessees to recognize a lease liability and right-of-use asset for all leases (with the exception of short-term leases) at the commencement date. The ASU is effective for annual and interim periods beginning on or after December 15, 2018. Early adoption is permitted. In July 2018, the FASB issued ASU 2018-11, Leases (Topic 842): Targeted Improvements, which provides for a prospective transition method for the recognition and disclosure requirements under the new guidance. While the Company expects adoption of this standard to lead to a material increase in the assets and liabilities recorded on our balance sheet, we are still evaluating the overall impact on our consolidated financial statements and related disclosures and the effect of the standard on our ongoing financial reporting.

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 differ from those estimates.

Reclassifications and Comparability

Certain reclassifications have been made to prior periods' financial statements in order to conform to the current period's presentation. Effective January 1, 2018, we adopted ASC 606 on a full retrospective basis which required the reclassification of certain previously reported results. See Note 2 - Summary of Significant Accounting Policies for further details on the impact of the adoption of ASC 606.

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 equity investments that are accounted for as set forth below.

Equity Investments

We consolidate investments when the entity is a variable interest entity and we are the primary beneficiary or if we have controlling interests in the entity, which is generally ownership in excess of 50%. Third party equity interests in our consolidated joint ventures are reflected as noncontrolling interests in our 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. During the three-month period ended September 30, 2018, we made a $3.3 million investment in a healthcare analytics company; this investment will be accounted for under the equity method. The book value of investments that we account for under the equity method of accounting was $31.9 million and $26.4 million as of September 30, 2018 and December 31, 2017, respectively and is reflected in other assets within our condensed consolidated balance sheets. We account for investments in entities in which we have less than a 20% ownership interest under the cost method of accounting if we do not have the ability to exercise significant influence over the investee.

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES
Revenue Recognition
Our adoption of ASC 606 on January 1, 2018, on a full retrospective basis, impacted the Company's previously reported results as follows (amounts in thousands, unaudited):

	As Previously Reported	Adjustment for the Adoption of ASC 606	As Adjusted
	As of December 31, 2017		
Condensed Consolidated Balance Sheets			
Patient accounts receivable	$201,196	$—	$201,196
Allowance for doubtful accounts	$20,866	$20,866	$—
	For the three-month period ended September 30, 2017		
Condensed Consolidated Statements of Operations			
Net service revenue	$380,163	$(6,459)	$373,704
Cost of service, excluding depreciation and amortization	$226,642	$627	$227,269
Provision for doubtful accounts	$7,086	$(7,086)	$—
Net income attributable to Amedisys, Inc.	$14,558	$—	$14,558
	For the nine-month period ended September 30, 2017		
Condensed Consolidated Statements of Operations			
Net service revenue	$1,129,442	$(16,131)	$1,113,311
Cost of service, excluding depreciation and amortization	$662,192	$1,947	$664,139
Provision for doubtful accounts	$18,078	$(18,078)	$—
Net income attributable to Amedisys, Inc.	$34,149	$—	$34,149
Condensed Consolidated Statements of Cash Flows			
Provision for doubtful accounts	$18,078	$(18,078)	$—
Changes in operating assets and liabilities, net of impact of acquisitions:			
Patient accounts receivable	$(28,924)	$18,078	$(10,846)

We earn net service revenue through our home health, hospice and personal care segments through the delivery of a variety of services that best suit our patients' needs, whether that is home-based recovery and rehabilitation after an operation or injury, care that empowers patients to manage a chronic disease, hospice care at the end of life, or providing assistance with daily activities through our personal care segment. We account for revenue from contracts with customers in accordance with ASC 606, and as such, we recognize revenue in the period in which we satisfy our performance obligations under our contracts by transferring our promised services to our customers in amounts that reflect the consideration to which we expect to be entitled in exchange for providing patient care, which are the transaction prices allocated to the distinct services. The Company's cost of obtaining contracts is not material.

Revenues are recognized as performance obligations are satisfied, which varies based on the nature of the services provided. Our performance obligation is the delivery of patient care services in accordance with the nature and frequency of services outlined in physicians' orders, which are determined by a physician based on a patient's specific goals.

The Company's performance obligations relate to contracts with a duration of less than one year; therefore, the Company has elected to apply the optional exemption provided by ASC 606 and is not required to disclose the aggregate amount of the transaction price allocated to performance obligations that are unsatisfied or partially unsatisfied as of the end of the reporting period. The unsatisfied or partially unsatisfied performance obligations are generally completed when the patients are discharged, which generally occurs within days or weeks of the end of the reporting period.

We determine the transaction price based on gross charges for services provided, reduced by estimates for price concessions, which include items such as contractual adjustments provided to third-party payors, reserves provided for self-pay or uninsured patients or other payors, adjustments resulting from payment reviews and adjustments arising from our inability to obtain appropriate billing documentation, authorizations or face-to-face documentation. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (i.e. change in credit risk) are recorded as a provision for doubtful accounts.

We determine our estimates of contractual adjustments and reserves for self-pay, uninsured patients and other payors by major payor class based on contractual agreements with individual third-party payors, our historical collection experience, aged accounts receivable by payor and current economic conditions. The Company assesses its ability to collect for the healthcare services provided at the time of patient admission based on the Company's verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs. Medicare contributes to approximately 74% of the Company's consolidated net service revenue. The price concession included in estimating the transaction price represents the difference between amounts billed and amounts we expect to collect based on our collection history with similar payors.

Amounts due from third-party payors, primarily commercial health insurers and government programs (Medicare and Medicaid), include variable consideration for retroactive revenue adjustments due to settlements of audits and reviews. We determine our estimates for price concessions related to payment reviews based on our historical experience and success rates in the claim appeals and adjudication process. Revenue is recorded at amounts we estimate to be realizable for services provided.

We determine our estimates for price concessions related to our inability to obtain appropriate billing documentation, authorizations, or face-to-face documentation based on our historical experience, which primarily includes a historical collection rate of over 99% on Medicare claims.

Home Health Revenue Recognition

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system (“PPS”) based on an established Federal Medicare home health 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. Medicare rates are based on the severity of the patient's condition, service needs and goals, and other factors relating to the cost of providing services and supplies, bundled into an episode of care, not to exceed 60 days. An episode starts the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier, with multiple continuous episodes allowed.

The Medicare home health benefit requires that beneficiaries be homebound (meaning that the beneficiary is unable to leave their home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. All Medicare contracts are required to have a signed plan of care which represents a single performance obligation, comprising of the delivery of a series of distinct services that are substantially similar and have a similar pattern of transfer to the customer. Accordingly, the Company accounts for the series of services ("episode") as a single performance obligation satisfied over time, as the customer simultaneously receives and consumes the benefits of the goods and services provided. Expected Medicare revenue per episode is recognized based on a pro-rated service output method, utilizing our historical average length of episode prior to discharge.

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

The base episode payment can be adjusted based on each patient's health including clinical condition, functional abilities, and service needs, as well as for the applicable geographic wage index, low utilization, patient transfers and other factors. The services covered by the episode payment include all disciplines of care in addition to medical supplies. Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. In addition, we make adjustments to Medicare revenue if we find we are unable to obtain appropriate billing documentation, authorizations or face-to-face documentation. 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 price concession and a corresponding reduction to patient accounts receivable.

A portion of reimbursement from each Medicare episode is billed near the start of each episode, and cash is typically received before all services are rendered. The amount of revenue recognized for episodes of care which are incomplete at period end is based on the company's average percentage of days complete on episodes as of the end of the year. As of September 30, 2018 and 2017, 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 which generally range from 90% to 100% of Medicare rates.

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. 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. We also make adjustments to non-episodic revenue for any implicit price concessions, based on historical experience, to reflect the estimated transaction price. 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 predetermined 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 accounted for 98% and 97% of our total net Medicare hospice service revenue for each of the three and nine-month periods ended September 30, 2018, respectively, and 97% of our total net Medicare hospice service revenue for each of the three and nine-month periods ended September 30, 2017. There are two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, we may also receive a service intensity add-on (“SIA”). The SIA is based on visits made in the last seven days of life by a registered nurse (“RN”) or medical social worker (“MSW”) for patients in a routine level of care.

The performance obligation is the delivery of hospice services to the patient, as determined by a physician, each day the patient is on hospice care.

We make adjustments to Medicare revenue for our 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 a historical collection rate of over 99% on Medicare claims, and record it during the period services are rendered as an estimated price concession and as a reduction to our outstanding patient accounts receivable.

Additionally, our hospice service revenue is subject to certain limitations on payments from Medicare which are considered variable consideration. We are subject to an inpatient cap limit and an overall Medicare payment cap for each provider number. We monitor these caps on a provider-by-provider basis and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in accrued expenses within our condensed consolidated balance sheet. Beginning for the cap year ending October 31, 2017, providers are required to self-report and pay their estimated cap liability by February 28th of the following year. As of September 30, 2018, we have settled our Medicare hospice reimbursements for all fiscal years through October 31, 2012. As of September 30, 2018, we have recorded $1.6 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2013 through September 30, 2018. As of December 31,

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2017, we had recorded $0.9 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2013 through September 30, 2018.

Hospice Non-Medicare Revenue
Gross revenue is recorded 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. We also make adjustments to non-Medicare revenue for any implicit price concessions, based on historical experience, to reflect the estimated transaction price.

Personal Care Revenue Recognition

Personal Care Revenue
We generate net service revenues by providing our services directly to patients based on authorized hours, visits or units determined by the relevant agency, at a rate that is either contractual or fixed by legislation. Net service revenue is recognized at the time services are rendered based on gross charges for the services provided, reduced by estimates for price concessions. We receive payment for providing such services from payors, including state and local governmental agencies, managed care organizations, commercial insurers and private consumers. Payors include the following elder service agencies: Aging Services Access Points (ASAPs), Senior Care Options (SCOs), Program of All-Inclusive Care for the Elderly (PACE) and the Veterans Administration (VA).

Patient Accounts Receivable
We report accounts receivable from services rendered at their estimated transaction price, which includes price concessions based on the amounts expected to be due from payors. Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. As of September 30, 2018, there is only one single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables (approximately 11%). 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 write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible. We believe the collectibility risk associated with our Medicare accounts, which represent 55% and 59% of our patient accounts receivable at September 30, 2018 and December 31, 2017, 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.
We do not believe there are any significant concentrations of revenues from any payor that would subject us to any significant credit risk in the collection of our accounts receivable.

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

Medicare Hospice

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

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Non-Medicare Home Health, Hospice and Personal Care

For our non-Medicare patients, our pre-billing process primarily begins with verifying a patient's eligibility for services with the applicable payor. Once the patient has been confirmed for eligibility, we will provide services to the patient and bill the applicable payor. Our review and evaluation of non-Medicare accounts receivable includes a detailed review of outstanding balances and special consideration to concentrations of receivables from particular payors or groups of payors with similar characteristics that would subject us to any significant credit risk.

Property and Equipment

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

During the nine-month period ended September 30, 2018, we reviewed the balances of our property and equipment and as a result, eliminated those asset balances for which the asset was no longer in service. The following table summarizes the balances related to our property and equipment for the periods indicated (amounts in millions):

	As of September 30, 2018	As of December 31, 2017
Building and leasehold improvements	$ 8.7	$ 7.8
Equipment and furniture	55.9	72.9
Computer software	59.0	97.2
	123.6	177.9
Less: accumulated depreciation	(93.4)	(146.8)
	$ 30.2	$ 31.1

Fair Value of Financial Instruments

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

Financial Instrument	Carrying Value as of September 30, 2018	Fair Value at Reporting Date Using Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term obligations	$58.1	$ —	$ 60.2	$ —

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

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

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

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

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

Weighted-Average Shares Outstanding

Net 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 income attributable to Amedisys, Inc. common stockholders (amounts in thousands):

	For the Three-Month Periods Ended September 30,		For the Nine-Month Periods Ended September 30,	
	2018	2017	2018	2017
Weighted average number of shares outstanding - basic	31,815	33,838	33,075	33,640
Effect of dilutive securities:				
Stock options	561	271	464	279
Non-vested stock and stock units	315	254	313	336
Weighted average number of shares outstanding - diluted	32,691	34,363	33,852	34,255
Anti-dilutive securities	51	337	76	279

3. ACQUISITIONS

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

On March 1, 2018, we acquired the assets of Christian Care at Home which provides home health services to the state of Kentucky for a total purchase price of $2.3 million. The purchase price was paid with cash on hand on the date of the transaction. Based on our preliminary purchase price allocation, we recorded goodwill of $2.3 million in connection with the acquisition during the three-month period ended March 31, 2018.

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On May 1, 2018, we acquired the assets of East Tennessee Personal Care Services which owns and operates one personal-care care center servicing the state of Tennessee for a total purchase price of $2.0 million (subject to certain adjustments, of which $0.2 million was placed in a promissory note to be paid over 24 months, subject to any offsets or withholds for indemnification purposes). The purchase price was paid with cash on hand on the date of the transaction. During the three-month period ended June 30, 2018, we recorded goodwill of $1.9 million and other intangibles - non-compete agreements of $0.1 million in connection with the acquisition. The non-compete agreement will be amortized over a weighted-average period of 2.8 years.

4. LONG-TERM OBLIGATIONS

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

	September 30, 2018	December 31, 2017
$100.0 million Term Loan; principal payments plus accrued interest payable quarterly; interest rate at Base Rate plus Applicable Rate or Eurodollar Rate plus the Applicable Rate; due August 28, 2020	$ —	$ 90.0
$550.0 million Revolving Credit Facility; interest only payments; interest rate at Base Rate plus Applicable Rate or Eurodollar Rate plus the Applicable Rate (3.7% at September 30, 2018); due June 29, 2023	57.5	—
Promissory notes	0.6	0.7
Capital leases	1.7	—
Principal amount of long-term obligations	59.8	90.7
Deferred debt issuance costs	(3.7)	(1.9)
	56.1	88.8
Current portion of long-term obligations	(1.2)	(10.6)
Total	$ 54.9	$ 78.2

Credit Agreement

On June 29, 2018, we entered into our Amended and Restated Credit Agreement ("Credit Agreement") that provides for a senior secured revolving credit facility in an initial aggregate principal amount of up to $550.0 million (the “Revolving Credit Facility”). The Revolving Credit Facility provides for and includes within its $550.0 million limit a $25.0 million swingline facility and commitments for up to $60.0 million in letters of credit. Upon lender approval, we may increase the aggregate loan amount under the Revolving Credit Facility by either i) $125.0 million or ii) an unlimited amount subject to a leverage limit of 0.5x under the maximum allowable consolidated leverage ratio which is currently 3.0x per the Credit Agreement.

The funds available under the Revolving Credit Facility were used to pay off our existing indebtedness under our prior credit agreement, dated as of August 28, 2015 (the "Prior Credit Agreement"), with a principal balance of $127.5 million. The final maturity of the Revolving Credit Facility is June 29, 2023 and there is no mandatory amortization on the outstanding principal balances which are payable in full upon maturity. The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and our subsidiaries, including permitted acquisitions, as defined in the Credit Agreement.

The interest rate on borrowings under the Revolving Credit Facility shall be selected by us from the following: (i) the Base Rate plus the Applicable Rate or (ii) the Eurodollar Rate plus the Applicable Rate. The “Base Rate” means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Eurodollar Rate plus 1% per annum. The "Eurodollar Rate" means the quoted rate per annum equal to the London Interbank Offered Rate ("LIBOR") or a comparable successor rate approved by the Administrative Agent for an interest period of one, two, three or six months (as selected by us). The "Applicable Rate" is based on the consolidated leverage ratio and is presented in the table below. As of September 30, 2018, the Applicable Rate is 0.50% per annum for Base Rate Loans and 1.50% per annum for Eurodollar Rate Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Credit Agreement, as presented in the table below.

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Pricing Tier	Consolidated Leverage Ratio	Commitment Fee	Letter of Credit Fee	Eurodollar Rate Loans	Base Rate Loans
I	> 3.00 to 1.0	0.35%	2.00%	2.25%	1.25%
II	≤ 3.00 to 1.0 but > 2.00 to 1.0	0.30%	1.75%	2.00%	1.00%
III	≤ 2.00 to 1.0 but > 1.00 to 1.0	0.25%	1.50%	1.75%	0.75%
IV	≤ 1.00 to 1.0	0.20%	1.25%	1.50%	0.50%

The Credit Agreement requires maintenance of two financial covenants: (i) a consolidated leverage ratio of funded indebtedness to EBITDA, as defined in the Credit Agreement, and (ii) a consolidated interest coverage ratio of EBITDA to cash interest charges, as defined in the Credit Agreement. Each of these covenants is calculated over rolling four-quarter periods and also is subject to certain exceptions and baskets. The Credit Agreement also contains customary covenants, including, but not limited to, restrictions on: incurrence of liens, incurrence of additional debt, sales of assets and other fundamental corporate changes, investments, and declarations of dividends. These covenants contain customary exclusions and baskets as detailed in the Credit Agreement.

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

In connection with entering into the Credit Agreement, we entered into (i) a Security Agreement with the Administrative Agent dated June 29, 2018 and (ii) a Pledge Agreement with the Administrative Agent dated as of June 29, 2018 for the purpose of securing the payment of our obligations under the Credit Agreement. Pursuant to the Security Agreement and the Pledge Agreement, as of the effective date of the Credit Agreement, our obligations under the Credit Agreement are secured by (i) the grant of a first lien security interest in the non-real estate assets of substantially all of our direct and indirect, wholly-owned subsidiaries (subject to exceptions) and (ii) the pledge of the equity interests in (a) substantially all of our direct and indirect, wholly-owned corporate, limited liability company and limited partnership subsidiaries and (b) those joint ventures which constitute subsidiaries under the Credit Agreement (subject, in the case of the Pledge Agreement, to exceptions). In connection with our entry into the Credit Agreement, we recorded $2.4 million in deferred debt issuance costs as long-term obligations, less current portion within our condensed consolidated balance sheet during the three-month period ended June 30, 2018.

Our weighted average interest rate for our $100.0 million Term Loan, under our Prior Credit Agreement, was 3.2% and 3.0% for the three and nine-month periods ended September 30, 2017, respectively. Our weighted average interest rate for borrowings under our $550.0 million Revolving Credit Facility was 3.6% and 3.8% for the three and nine-month periods ended September 30, 2018, respectively.
As of September 30, 2018, our consolidated leverage ratio was 0.4, our consolidated interest coverage ratio was 57.6 and we are in compliance with our covenants under the Credit Agreement. 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 September 30, 2018, our availability under our $550.0 million Revolving Credit Facility was $458.1 million as we have $57.5 million outstanding in borrowings and $34.4 million outstanding in letters of credit.

5. COMMITMENTS AND CONTINGENCIES

Legal Proceedings - Ongoing

We are involved in the following legal actions:

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Subpoena Duces Tecum Issued by the U.S. Department of Justice
On May 21, 2015, we received a Subpoena Duces Tecum (“Subpoena”) issued by the U.S. Department of Justice. The Subpoena requests the delivery of information regarding 53 identified hospice patients to the United States Attorney’s Office for the District of Massachusetts. It also requests the delivery of documents relating to our hospice clinical and business operations and related compliance activities. The Subpoena generally covers the period from January 1, 2011 through May 21, 2015. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.
Civil Investigative Demands Issued by the U.S. Department of Justice
On November 3, 2015, we received a civil investigative demand (“CID”) issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Morgantown, West Virginia area. The CID requests the delivery of information to the United States Attorney’s Office for the Northern District of West Virginia regarding 66 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Morgantown area. The CID generally covers the period from January 1, 2009 through August 31, 2015. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.

On June 27, 2016, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Parkersburg, West Virginia area. The CID requests the delivery of information to the United States Attorney’s Office for the Southern District of West Virginia regarding 68 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Parkersburg area. The CID generally covers the period from January 1, 2011 through June 20, 2016. We are fully cooperating with the U.S. Department of Justice with respect to this investigation. Based on the information currently available to us, we cannot predict the timing or outcome of this investigation or reasonably estimate the amount or range of potential losses, if any, which may arise from this matter.
In addition to the matters referenced in this note, we are involved in legal actions in the normal course of business, some of which seek monetary damages, including claims for punitive damages. We do not believe that these normal course actions, when finally concluded and determined, will have a material impact on our consolidated financial condition, results of operations or cash flows.
Legal Proceedings - Settled
Securities Class Action Lawsuits
As previously disclosed, between June 10 and July 28, 2010, several putative securities class action complaints were filed in the United States District Court for the Middle District of Louisiana (the “District Court”) against the Company and certain of our former senior executives. The cases were consolidated into the first-filed action Bach, et al. v. Amedisys, Inc., et al. Case No. 3:10-cv-00395, and the District Court appointed as co-lead plaintiffs the Public Employees’ Retirement System of Mississippi and the Puerto Rico Teachers’ Retirement System (the “Co-Lead Plaintiffs”).

The Plaintiffs were granted leave to file a First Amended Consolidated Complaint (the “First Amended Securities Complaint”) on behalf of all purchasers or acquirers of Amedisys’ securities between August 2, 2005 and September 30,

2011. The First Amended Securities Complaint alleged that the Company and seven individual defendants violated Section 10(b), Section 20(a), and Rule 10b-5 of the Securities Exchange Act of 1934 by materially misrepresenting the Company's financial results and concealing a scheme to obtain higher Medicare reimbursements and additional patient referrals by (1) providing medically unnecessary care to patients, including certifying and re-certifying patients for medically unnecessary 60-day treatment episodes; (2) implementing clinical tracks such as "Balanced for Life" and wound care programs that provided a pre-set number of therapy visits irrespective of medical need; (3) "upcoding" patients' Medicare forms to attribute a "primary diagnosis" to a medical condition associated with higher billing rates; and (4) providing improper and illegal remuneration to physicians to obtain patient certifications or re-certifications. The First Amended Securities Complaint sought certification of the case as a class action and an unspecified amount of damages, as well as interest and an award of attorneys' fees.

On June 12, 2017, the Company reached an agreement-in-principle to settle this matter. All parties to the action executed a binding term sheet that, subject to final documentation and court approval, provided in part for a settlement payment of approximately

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$43.7 million, which we accrued as of June 30, 2017, and the dismissal with prejudice of the litigation. Approximately $15.0 million of the settlement amount paid by the Company's insurance carriers during the three-month period ended September 30, 2017, was previously recorded within other current assets in our condensed consolidated balance sheet as of June 30, 2017. The net of these two amounts, $28.7 million, was recorded as a charge in our condensed consolidated statements of operations during the three-month period ended June 30, 2017 and paid with cash on hand during the three-month period ended September 30, 2017. On December 19, 2017, the Court entered the final order and judgment on the case.

Other Investigative Matters - Ongoing

Corporate Integrity Agreement

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

Third Party Audits - Ongoing

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

In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a Zone Program Integrity Contractor ("ZPIC") a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the "Review Period") to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC's findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the Medicare Administrative Contractor ("MAC") for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment. We dispute these findings, and our Florence subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturned. An administrative law judge ("ALJ") hearing was held in early January 2015. On January 18, 2016, we received a letter dated January 6, 2016 referencing the ALJ hearing decision for the overpayment issued on June 6, 2011. The decision was partially favorable with a new overpayment amount of $3.7 million with a balance owed of $5.6 million, including interest, based on 9 disputed claims (originally 16). We filed an appeal to the Medicare Appeals Council on the remaining 9 disputed claims and also argued that the statistical method used to select the sample was not valid. No assurances can be given as to the timing or outcome of the Medicare Appeals Council decision. As of September 30, 2018, Medicare has withheld payments of $5.7 million (including additional interest) as part of their standard procedures once this level of the appeal process has been reached. In the event we are not able to recoup this alleged overpayment, we are entitled to be indemnified by the prior owners of the hospice operations for amounts relating to the period prior to August 1, 2009. As of September 30, 2018, we have an indemnity receivable of approximately $4.9 million for the amount withheld related to the period prior to August 1, 2009.

In July 2016, the Company received a request for medical records from SafeGuard Services, L.L.C ("SafeGuard"), a ZPIC related to services provided by some of the care centers that the Company acquired from Infinity Home Care, L.L.C. The review period covers time periods both before and after our ownership of the care centers, which were acquired on December 31, 2015. In August 2017, the Company received Requests for Repayment from Palmetto GBA, LLC ("Palmetto") regarding Infinity Home Care of

Lakeland, LLC ("Lakeland Care Centers") and Infinity Home Care of Pinellas, LLC ("Clearwater Care Center"). The Palmetto letters are based on statistical extrapolation performed by SafeGuard which alleged an overpayment of $34.0 million for the Lakeland Care Centers on a universe of 72 Medicare claims totaling $0.2 million in actual claims payments using a 100% error rate and an overpayment of $4.8 million for the Clearwater Care Center on a universe of 70 Medicare claims totaling $0.2 million in actual claims payments using a 100% error rate.

The Lakeland Request for Repayment covers claims between January 2, 2014 and September 13, 2016. The Clearwater Request for Repayment covers claims between January 2, 2015 and December 9, 2016. As a result of partially successful Level I and Level II Administrative Appeals, the alleged overpayment for the Lakeland Care Centers has been reduced to $26.0 million and the alleged overpayment for the Clearwater Care Center has been reduced to $3.3 million. The Company has now filed Level III Administrative Appeals, and will continue to vigorously pursue its appeal rights, which include contesting the methodology used by the ZPIC contractor to perform statistical extrapolation. The Company is contractually entitled to indemnification by the prior owners for all claims prior to December 31, 2015, for up to $12.6 million.

At this stage of the review, based on the information currently available to the Company, the Company cannot predict the timing or outcome of this review. The Company estimates a low-end potential range of loss related to this review of $6.5 million (assuming the Company is successful in seeking indemnity from the prior owners and unsuccessful in demonstrating that the extrapolation method used by SafeGuard was erroneous). The Company has reduced its high-end potential range of loss from $38.8 million (the maximum amount Palmetto claims has been overpaid for both the Lakeland Care Centers and the Clearwater Care Center of which amount $12.6 million is subject to indemnification by the prior owners) to $29.3 million based on the partial success achieved by the Company in prosecuting its Level I and II Administrative Appeals.

As of September 30, 2018, we have an accrued liability of approximately $17.4 million related to this matter. We expect to be indemnified by the prior owners for approximately $10.9 million of the total $12.6 million available indemnification related to this matter and have recorded this amount within other assets in our condensed consolidated balance sheet as of September 30, 2018. The net of these two amounts, $6.5 million, was recorded as a reduction in revenue in our condensed consolidated statements of operations during the three-month period ended September 30, 2017. As of September 30, 2018, $1.6 million of receivables have been impacted by this payment suspension.

Compliance

From time to time, the Company performs internal reviews of claims data to identify potential improper payments under the Medicare program. Any overpayments are recorded as a reduction in revenue in our condensed consolidated statements of operations. As of September 30, 2018, we have recorded $6.5 million to accrued expenses in our condensed consolidated balance sheet as a result of these reviews.

Insurance

We are obligated for certain costs associated with our insurance programs, including employee health, workers' compensation and professional liability. While we maintain various insurance programs to cover these risks, we are self-insured for a substantial portion of our potential claims. We recognize our obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. These costs have generally been estimated based on historical data of our claims experience. Such estimates, and the resulting reserves, are reviewed and updated by us on a quarterly basis. Our health insurance has an exposure limit of $1.0 million for any individual covered life. Our workers' compensation insurance has a retention limit of $0.5 million per incident and our professional liability insurance has a retention limit of $0.3 million per incident.

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AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

6. SEGMENT INFORMATION

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

AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

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

	For the Three-Month Period Ended September 30, 2018				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$294.9	$103.4	$ 19.0	$—	$417.3
Cost of service, excluding depreciation and amortization	181.8	53.4	14.5	—	249.7
General and administrative expenses	68.8	21.4	3.0	31.3	124.5
Depreciation and amortization	0.8	0.3	0.1	2.0	3.2
Operating expenses	251.4	75.1	17.6	33.3	377.4
Operating income (loss)	$43.5	$28.3	$ 1.4	$(33.3)	$39.9

	For the Three-Month Period Ended September 30, 2017				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$264.1	$95.9	$ 13.7	$—	$373.7
Cost of service, excluding depreciation and amortization	168.3	48.4	10.6	—	227.3
General and administrative expenses	70.8	19.0	3.1	25.9	118.8
Depreciation and amortization	0.9	0.2	—	3.1	4.2
Operating expenses	240.0	67.6	13.7	29.0	350.3
Operating income (loss)	$24.1	$28.3	$ —	$(29.0)	$23.4

	For the Nine-Month Period Ended September 30, 2018				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$870.5	$302.1	$ 55.6	$—	$1,228.2
Cost of service, excluding depreciation and amortization	532.7	155.2	42.7	—	730.6
General and administrative expenses	205.2	61.7	9.5	92.6	369.0
Depreciation and amortization	2.4	0.8	0.2	6.5	9.9
Operating expenses	740.3	217.7	52.4	99.1	1,109.5
Operating income (loss)	$130.2	$84.4	$ 3.2	$(99.1)	$118.7

	For the Nine-Month Period Ended September 30, 2017				
	Home Health	Hospice	Personal Care	Other	Total
Net service revenue	$802.0	$269.8	$ 41.5	$—	$1,113.3
Cost of service, excluding depreciation and amortization	496.1	136.7	31.3	—	664.1

General and administrative expenses	207.8	56.2	9.2	85.4	358.6
Depreciation and amortization	2.7	0.7	0.1	9.6	13.1
Securities Class Action Lawsuit settlement, net	—	—	—	28.7	28.7
Operating expenses	706.6	193.6	40.6	123.7	1,064.5
Operating income (loss)	$95.4	$76.2	$0.9	$(123.7)	$48.8

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AMEDISYS, INC. AND SUBSIDIARIES
NOTES TO THE CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited)

7. SHARE REPURCHASE

On June 4, 2018, we purchased 2,418,304 of our common shares from affiliates of KKR Credit Advisors (US) LLC ("KKR"), representing one-half of KKR's holdings in the Company and 7.1% of the aggregate outstanding shares of the Company's common stock for a total purchase price of $181.4 million including related direct costs. The Company repurchased the shares at $73.96 which represents 96% of the closing stock price of the Company's common stock on June 4, 2018.

8. SUBSEQUENT EVENTS

On October 1, 2018, we acquired certain personal care operations from Bring Care Home in Massachusetts for a purchase price of $5.8 million.

On October 9, 2018, we signed a definitive agreement to acquire Compassionate Care Hospice, a national hospice care provider headquartered in New Jersey, for a purchase price of $340 million, which is inclusive of $50 million in payments related to a tax asset and working capital. The acquisition is expected to close by February 1, 2019.

ITEM 2. MANAGEMENT’S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for the three and nine-month periods ended September 30, 2018. This discussion should be read in conjunction with the condensed consolidated financial statements and notes thereto included herein, and the consolidated financial statements and notes and the related Management’s Discussion and Analysis of Financial Condition and Results of Operations in our Annual Report on Form 10-K for the year ended December 31, 2017 filed with the Securities and Exchange Commission (“SEC”) on February 28, 2018 (the “Form 10-K”), which are incorporated herein by this reference. Historical results that appear in the condensed consolidated financial statements should not be interpreted as being indicative of future operations.

Unless otherwise provided, “Amedisys,” “we,” “our,” and the “Company” refer to Amedisys, Inc. and our consolidated subsidiaries.

Overview

We are a provider of high-quality in-home healthcare and related services to the chronic, co-morbid, aging American population, with approximately 73% and 74% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2018, respectively, and approximately 76% of our revenue derived from Medicare for the three and nine-month periods ended September 30, 2017.

Our operations involve servicing patients through our three reportable business segments: home health, hospice and personal care. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgery. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. Our personal care segment provides patients with assistance with the essential activities of daily living. As of September 30, 2018, we owned and operated 323 Medicare-certified home health care centers, 83 Medicare-certified hospice care centers and 15 personal-care care centers in 34 states within the United States and the District of Columbia.

Owned and Operated Care Centers (Includes Unconsolidated Joint Ventures)

	Home Health	Hospice	Personal Care
As of December 31, 2017	323	83	15
Acquisitions/Startups	1	—	1
Closed/Consolidated	(1)	—	(1)
As of September 30, 2018	323	83	15

Recent Developments

Governmental Inquiries and Investigations and Other Litigation

See Note 5 – Commitments and Contingencies to our condensed consolidated financial statements for additional information regarding our corporate integrity agreement and for a discussion of and updates regarding other legal proceedings and investigations we are involved in. No assurances can be given as to the timing or outcome of these items.

Payment

On August 6, 2018, the Centers for Medicare and Medicaid Services ("CMS") issued a final rule to update hospice payment rates and the wage index for fiscal year 2019. CMS estimates hospices serving Medicare beneficiaries would see an estimated 1.8% increase in payments. This increase is the result of a 2.9% market basket adjustment less a 0.8% productivity adjustment, less 0.3% as required under the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act (collectively, "PPACA"). CMS also increased the aggregate cap amount by 1.8% to $29,205.44. We expect our impact of the 2019 final rule to be in line with that of the hospice industry.

In July 2018, CMS issued proposed payment changes for Medicare home health providers for 2019 and 2020. For 2019, CMS estimates that the net impact of the payment provisions of the proposed changes will result in an increase of 2.1% in reimbursement to home health providers. This increase is the result of a 2.8% market basket increase less a

0.7% productivity adjustment. Additionally, the proposed rule includes changes to the home health prospective payment system ("HHPPS") case-mix adjustment methodology through the use of a new Patient-Driven Grouping Model ("PDGM") for home health payments. This change is proposed to be implemented January 1, 2020 and also includes a change in the unit of payment from 60-day episodes of care to

30-day periods of care and eliminates the use of therapy visits in the determination of payments. While the proposed rule is to be implemented in a budget neutral manner to the industry, the ultimate impact will vary by provider based on factors including patient mix and admission source. Additionally, in arriving at the calculation of a rate that is budget neutral, CMS has made assumptions about behavioral changes. We are currently evaluating the proposed rule's impact on our home health operations.

Acquisitions

On March 1, 2018, we acquired the assets of Christian Care at Home which provides home health services to the state of Kentucky.

On May 1, 2018, we acquired the assets of East Tennessee Personal Care Services which provides personal care services to the state of Tennessee.

On October 1, 2018, we acquired certain personal care operations from Bring Care Home in Massachusetts.

On October 9, 2018, we signed a definitive agreement to acquire Compassionate Care Hospice, a national hospice care provider headquartered in New Jersey. The acquisition is expected to close by February 1, 2019.

Results of Operations

Three-Month Period Ended September 30, 2018 Compared to the Three-Month Period Ended September 30, 2017

Consolidated

The following table summarizes our consolidated results of operations (amounts in millions):

	For the Three-Month Periods Ended September 30,			
	2018		2017	
Net service revenue	$417.3		$373.7	
Gross margin, excluding depreciation and amortization	167.6		146.4	
% of revenue	40.2	%	39.2	%
Other operating expenses	127.7		123.0	
% of revenue	30.6	%	32.9	%
Operating income	39.9		23.4	
Total other income, net	1.5		0.7	
Income tax expense	(9.8	)	(9.4	)
Effective income tax rate	23.7	%	39.0	%
Net income	31.6		14.7	
Net income attributable to noncontrolling interests	(0.2	)	(0.1	)
Net income attributable to Amedisys, Inc.	$31.4		$14.6	

Overall, our operating income increased $16 million on a revenue increase of $44 million driven by growth within all three of our segments. Our 2017 operating results were negatively impacted $9 million; these impacts included a $7 million reduction in revenue as a result of the Florida ZPIC audit (see Note 5 - Commitments and Contingencies to our condensed consolidated financial statements for additional information regarding this matter) and approximately $2 million in severance costs related to our home health closures and restructuring plan. Excluding the 2017 revenue reduction, our gross margin as a percentage of revenue remained flat despite a net reduction of $1 million in net service revenue and gross margin due to the impact of the 2018 changes in reimbursement and planned wage increases that became effective during the three-month period ended September 30, 2018. Our home health segment continues to see improvement in clinician productivity which positively impacted our gross margin. We also continue to remain focused on costs as our other operating expenses as a percentage of revenue declined significantly from prior year. Our income tax expense as a percentage of our income before income taxes decreased due to the enactment of H.R. 1 (Tax Cuts and Jobs Act) on December 22, 2017.

Home Health Segment

The following table summarizes our home health segment results of operations:

	For the Three-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$208.0	$191.4
Non-Medicare	86.9	72.7
Net service revenue	294.9	264.1
Cost of service	181.8	168.3
Gross margin	113.1	95.8
Other operating expenses	69.6	71.7
Operating income	$43.5	$24.1
Same Store Growth (1):		
Medicare revenue	10 %	(7 %)
Non-Medicare revenue	20 %	18 %
Total admissions	4 %	1 %
Total volume (2)	6 %	5 %
Total Episodic admissions (3)	3 %	1 %
Total Episodic volume (4)	5 %	3 %
Key Statistical Data - Total (5):		
Medicare:		
Admissions	46,371	46,823
Recertifications	28,551	26,996
Total volume	74,922	73,819
Completed episodes	73,114	71,454
Visits	1,301,090	1,259,156
Average revenue per completed episode (6)	$2,855	$2,820
Visits per completed episode (7)	17.6	17.4
Non-Medicare:		
Admissions	29,325	26,686
Recertifications	14,539	12,263
Total volume	43,864	38,949
Visits	698,181	592,742
Total (5):		
Visiting Clinician Cost per Visit	$82.78	$82.53
Clinical Manager Cost per Visit	8.18	8.30
Total Cost per Visit	$90.96	$90.83
Visits	1,999,271	1,851,898

(1) Same store information represents the percent increase (decrease) in our Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume for the period as a percent of the Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume of the prior period.

(2) Total volume includes all admissions and recertifications.

(3)

Total Episodic admissions includes admissions for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.

(4) Total Episodic volume includes admissions and recertifications for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.

(5) Total includes acquisitions.

(6) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care.

(7) Medicare visits per completed episode are the home health Medicare visits on completed episodes divided by the home health Medicare episodes completed during the period.

Operating Results

Overall, our operating income increased $19 million on a $31 million increase in net service revenue. The $19 million increase includes the $7 million reduction in revenue related to the Florida ZPIC audit in 2017 (see Note 5 - Commitments and Contingencies to our condensed consolidated financial statements for additional information regarding this matter). Our growth in volumes and increases in clinician productivity positively impacted our gross margin as a percentage of revenue which increased despite the 2018 change in reimbursement and planned wage increases that became effective during the three-month period ended September 30, 2018. The impact of the 2018 change in reimbursement was a reduction in net service revenue and gross margin of approximately $2 million.

Net Service Revenue

Our revenue increased $31 million on a 6% increase in total volumes which is inclusive of a 5% increase in episodic volumes. The volume growth was driven by a 4% increase in admissions and a 120 basis point increase in our Medicare recertification rate. In addition to the increase in volumes, our revenue per episode is up approximately $35 per episode as a result of an increase in the acuity level of our patients which offset the 70 basis point reimbursement reduction effective January 1, 2018. The increase in revenue for the three-month period ended September 30, 2018 was also positively impacted by a $9 million reduction in our revenue price concessions which is inclusive of the $7 million reduction in revenue related to the Florida ZPIC audit during the three-month period ended September 30, 2017.

Cost of Service, Excluding Depreciation and Amortization

Our cost per visit consists of costs associated with direct clinician care in the homes of our patients as well as the cost of clinical managers who monitor the overall delivery of care. Our cost of service increased 8% on an 8% increase in total visits. Our increase in total visits was driven by growth in volumes as well as an increase in visits per completed episode which is the result of an increase in the acuity level of our patients. Our cost per visit remained relatively flat as an increase in clinician productivity offset planned wage increases.

Other Operating Expenses

Other operating expenses decreased approximately $2 million primarily due to a decrease in salaries and benefits expense as 2017 operating expenses included approximately $2 million in severance costs related to our home health restructuring plan.

Hospice Segment

The following table summarizes our hospice segment results of operations:

	For the Three-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$98.0	$91.4
Non-Medicare	5.4	4.5
Net service revenue	103.4	95.9
Cost of service	53.4	48.4
Gross margin	50.0	47.5
Other operating expenses	21.7	19.2
Operating income	$28.3	$28.3
Same Store Growth (1):		
Medicare revenue	7 %	17 %
Non-Medicare revenue	19 %	11 %
Hospice admissions	8 %	7 %
Average daily census	11 %	14 %
Key Statistical Data - Total (2):		
Hospice admissions	6,765	6,257
Average daily census	7,768	7,026
Revenue per day, net	$144.71	$148.43
Cost of service per day	$74.72	$74.96
Average discharge length of stay	101	95

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

(2) Total includes acquisitions.

Operating Results

Overall, our operating income remained flat on an $8 million increase in net service revenue. We experienced a decrease in gross margin as a percentage of revenue primarily due to planned wage increases that became effective during the three-month period ended September 30, 2018 and an increase in our estimated price concessions and amounts due back to Medicare for hospice caps.

Net Service Revenue

Our hospice revenue increased $8 million on an 11% increase in our average daily census and a 1% increase in reimbursement effective for services provided from October 1, 2017. We experienced a $3 million increase in our revenue price concessions and cap which negatively impacted our revenue for the three-month period ended September 30, 2018.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $5 million (10%) as the result of an 11% increase in average daily census. Our cost of service per day decreased despite an increase in salary cost per day as a result of planned wage increases that became effective during the three-month period ended September 30, 2018.

Other Operating Expenses

Other operating expenses increased $3 million due to increases in other care center related expenses, primarily salaries and benefits expense and travel and training expense.

Personal Care Segment

The following table summarizes our personal care segment results of operations:

	For the Three-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$—	$—
Non-Medicare	19.0	13.7
Net service revenue	19.0	13.7
Cost of service	14.5	10.6
Gross margin	4.5	3.1
Other operating expenses	3.1	3.1
Operating income	$1.4	$—
Key Statistical Data:		
Billable hours	810,427	616,036
Clients served	12,380	7,978
Shifts	357,382	281,904
Revenue per hour	$23.40	$22.21
Revenue per shift	$53.06	$48.54
Hours per shift	2.3	2.2

On October 1, 2017, we acquired the assets of Intercity Home Care, which owned and operated four personal-care care centers, three of which were subsequently consolidated with our existing personal-care care centers. On May 1, 2018, we acquired the assets of East Tennessee Personal Care Services, which owned and operated one personal-care care center. Acquisitions are included in our consolidated financial statements from their respective acquisition dates. As a result, our personal care operating results for 2018 and 2017 are not fully comparable.

Operating income related to our personal care segment increased $1 million on a $5 million increase in net service revenue. The increase in net service revenue includes revenues associated with our acquisitions. Gross margin increased despite the incurrence of additional costs associated with our acquisitions and the newly enacted Employer Medical Assistance Contribution ("EMAC") program that became effective in the state of Massachusetts on January 1, 2018. Other operating expenses remained flat on a 39% increase in net service revenue.

Corporate

The following table summarizes our corporate results of operations:

	For the Three-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Other operating expenses	$31.3	$25.9

Depreciation and amortization	2.0	3.1
Total operating expenses	$33.3	$29.0

Corporate expenses consist of costs relating to our executive management and corporate and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration. During the three-month period ended September 30, 2018, corporate operating expenses increased $4 million due to increases in salaries and benefits expense, professional fees and travel and training expense which were offset by a decrease in depreciation and amortization.

Nine-Month Period Ended September 30, 2018 Compared to the Nine-Month Period Ended September 30, 2017
Consolidated
The following table summarizes our consolidated results of operations (amounts in millions):

	For the Nine-Month Periods Ended September 30,			
	2018		2017	
Net service revenue	$1,228.2		$1,113.3	
Gross margin, excluding depreciation and amortization	497.6		449.2	
% of revenue	40.5	%	40.3	%
Other operating expenses	378.9		371.7	
% of revenue	30.9	%	33.4	%
Securities Class Action Lawsuit settlement, net	—		28.7	
Operating income	118.7		48.8	
Total other income (expense), net	3.7		2.9	
Income tax expense	(30.0	)	(17.3	)
Effective income tax rate	24.5	%	33.5	%
Net income	92.4		34.4	
Net income attributable to noncontrolling interests	(0.5	)	(0.2	)
Net income attributable to Amedisys, Inc.	$91.9		$34.1	

Overall, our operating income increased $70 million on a revenue increase of $115 million. Our 2017 operating results were negatively impacted $38 million; these impacts included our Securities Class Action Lawsuit settlement, a $7 million reduction in revenue as a result of the Florida ZPIC audit and approximately $2 million in severance costs related to our home health closures and restructuring plan. Excluding these 2017 impacts, operating income increased $32 million, driven by the improved performance of all three of our segments. In addition, our gross margin as a percentage of revenue was relatively flat despite a net reduction of $2 million in net service revenue and gross margin due to the impact of the 2018 changes in reimbursement and planned wage increases during the three-month period ended September 30, 2018. Our improvement in gross margin was driven by continued growth in our home health and hospice segments and increases in clinical productivity in our home health segment. We continue to maintain cost discipline as our other operating expenses increased only 2% on a 10% increase in net service revenue.
Our income tax expense as a percentage of our income before income taxes decreased due to the enactment of H.R. 1 (Tax Cuts and Jobs Act) on December 22, 2017.

Home Health Segment

The following table summarizes our home health segment results of operations:

	For the Nine-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$619.3	$588.4
Non-Medicare	251.2	213.6
Net service revenue	870.5	802.0
Cost of service	532.7	496.1
Gross margin	337.8	305.9
Other operating expenses	207.6	210.5
Operating income	$130.2	$95.4
Same Store Growth (1):		
Medicare revenue	7 %	(5 %)
Non-Medicare revenue	18 %	14 %
Total admissions	4 %	1 %
Total volume (2)	7 %	3 %
Total Episodic admissions (3)	3 %	1 %
Total Episodic volume (4)	6 %	3 %
Key Statistical Data - Total (5):		
Medicare:		
Admissions	142,884	143,711
Recertifications	84,218	78,878
Total volume	227,102	222,589
Completed episodes	220,726	217,190
Visits	3,933,290	3,794,001
Average revenue per completed episode (6)	$2,841	$2,811
Visits per completed episode (7)	17.5	17.3
Non-Medicare:		
Admissions	88,485	80,244
Recertifications	40,862	33,949
Total volume	129,347	114,193
Visits	2,049,662	1,727,618
Total (5):		
Visiting Clinician Cost per Visit	$81.06	$81.41
Clinical Manager Cost per Visit	7.98	8.42
Total Cost per Visit	$89.04	$89.83
Visits	5,982,952	5,521,619

(1) Same store information represents the percent increase (decrease) in our Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume for the period as a percent of the Medicare, Non-Medicare, Total and Episodic revenue, admissions or volume of the prior period.

(2) Total volume includes all admissions and recertifications.

(3) Total Episodic admissions includes admissions for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.

(4) Total Episodic volume includes admissions and recertifications for Medicare and Non-Medicare payors that bill on a 60-day episode of care basis.
(5) Total includes acquisitions.
(6) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care.
(7) Medicare visits per completed episode are the home health Medicare visits on completed episodes divided by the home health Medicare episodes completed during the period.

Operating Results

Overall, our operating income increased $35 million on a $69 million increase in net service revenue. The $35 million increase includes the $7 million reduction in revenue related to the Florida ZPIC audit in 2017. Our growth in volumes and increases in clinician productivity positively impacted our gross margin as a percentage of revenue, which increased despite the 2018 changes in reimbursement and planned wage increases that became effective during the three-month period ended September 30, 2018. The impact of the 2018 changes in reimbursement was a reduction in net service revenue and gross margin of approximately $5 million.

Net Service Revenue

Our revenue increased $69 million on a 7% increase in total volumes which is inclusive of a 6% increase in episodic volumes. The volume growth was driven by a 4% increase in admissions and a 190 basis point increase in our Medicare recertification rate. In addition to the increase in volumes, our revenue per episode is up $30 per episode as a result of an increase in the acuity level of our patients which offset the 70 basis point reimbursement reduction effective January 1, 2018. The increase in revenue for the nine-month period ended September 30, 2018 was also positively impacted by a $5 million decrease in our revenue price concessions. Excluding the $7 million reduction in revenue related to the Florida ZPIC audit in 2017, our revenue price concessions increased approximately $2 million during the nine-month period ended September 30, 2018.

Cost of Service, Excluding Depreciation and Amortization

Our cost of service increased 7% on an 8% increase in total visits. Our increase in total visits was driven by growth in volumes as well as an increase in visits per completed episode which is the result of an increase in the acuity level of our patients. Our cost per visit decreased 1% as an increase in clinician productivity offset planned wage increases.

Other Operating Expenses

Other operating expenses decreased approximately $3 million on a 9% increase in net service revenue primarily due to a decrease in salaries and benefits expense as 2017 operating expenses included approximately $2 million in severance costs related to our home health restructuring plan. Additionally, we experienced decreases in professional fees and telecommunications expense which were offset by increases in information technology expense and travel and training expense.

Hospice Segment

The following table summarizes our hospice segment results of operations:

	For the Nine-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$286.7	$257.9
Non-Medicare	15.4	11.9
Net service revenue	302.1	269.8
Cost of service	155.2	136.7
Gross margin	146.9	133.1
Other operating expenses	62.5	56.9
Operating income	$84.4	$76.2
Same Store Growth (1):		
Medicare revenue	11 %	18 %
Non-Medicare revenue	28 %	(1 %)
Hospice admissions	7 %	13 %
Average daily census	12 %	15 %
Key Statistical Data - Total (2):		
Hospice admissions	20,444	19,010
Average daily census	7,514	6,705
Revenue per day, net	$147.28	$147.43
Cost of service per day	$75.65	$74.78
Average discharge length of stay	98	92

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

(2) Total includes acquisitions.

Operating Results

Overall, our operating income increased $8 million on a $32 million increase in net service revenue. The 12% increase in net service revenue was partially offset by a lower gross margin as a percentage of revenue primarily related to planned wage increases that became effective during the three-month period ended September 30, 2018, an increase in revenue price concessions and amounts due back to Medicare for hospice caps and an increase in other operating expenses.

Net Service Revenue

Our hospice revenue increased $32 million on a 12% increase in our average daily census and a 1% increase in reimbursement effective for services provided from October 1, 2017. We experienced a $3 million increase in our revenue price concessions and cap which negatively impacted our revenue for the nine-month period ended September 30, 2018.

Cost of Service, Excluding Depreciation and Amortization

Our hospice cost of service increased $18 million (14%) as the result of a 12% increase in average daily census. Our cost of service per day increased 1% primarily due to an increase in salary cost per day as a result of planned wage increases that became effective during the three-month period ended September 30, 2018.

Other Operating Expenses

Other operating expenses increased $6 million on a 12% increase in net service revenue. The increase was related to other care center related expenses, primarily salaries and benefits expense, advertising expense, information technology expense, professional fees and travel and training expense as a result of the addition of resources to support census growth.

Personal Care Segment

The following table summarizes our personal care segment results of operations:

	For the Nine-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Medicare	$—	$ —
Non-Medicare	55.6	41.5
Net service revenue	55.6	41.5
Cost of service	42.7	31.3
Gross margin	12.9	10.2
Other operating expenses	9.7	9.3
Operating income	$3.2	$ 0.9
Key Statistical Data:		
Billable hours	2,357,608	1,822,653
Clients served	15,731	10,980
Shifts	1,062,422	830,151
Revenue per hour	$23.57	$ 22.76
Revenue per shift	$52.30	$ 49.98
Hours per shift	2.2	2.2

Operating income related to our personal care segment increased approximately $2 million on a $14 million increase in net service revenue. The increase in net service revenue includes revenues associated with the acquisitions of Intercity Home Care and East Tennessee Personal Care Services, both of which occurred after September 30, 2017. The segment experienced a decrease in gross margin as a percentage of revenue related to additional costs associated with these acquisitions and the EMAC program that became effective in the state of Massachusetts on January 1, 2018. Other operating expenses remained relatively flat on a 34% increase in net service revenue.

Corporate

The following table summarizes our corporate results of operations:

	For the Nine-Month Periods Ended September 30,	
	2018	2017
Financial Information (in millions):		
Other operating expenses	$92.6	$85.4
Depreciation and amortization	6.5	9.6
Total operating expenses before Securities Class Action Lawsuit settlement, net	99.1	95.0

Securities Class Action Lawsuit settlement, net	—	28.7
Total operating expenses	$99.1	$123.7

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Excluding the Securities Class Action Lawsuit settlement accrual during the nine-month period ended September 30, 2017, corporate operating expenses increased 4% on a 10% increase in net service revenue. Increases in salaries and benefits expense, travel and training expense and a loss on disposal of assets were offset by decreases in personnel costs, telecommunications expense, professional fees and depreciation and amortization.

Liquidity and Capital Resources

Cash Flows

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

	For the Nine-Month Periods Ended September 30,	
	2018	2017
Cash provided by operating activities	$159.4	$73.5
Cash used in investing activities	(12.6)	(32.9)
Cash used in financing activities	(219.2)	(4.7)
Net (decrease) increase in cash and cash equivalents	(72.4)	35.9
Cash and cash equivalents at beginning of period	86.4	30.2
Cash and cash equivalents at end of period	$14.0	$66.1

Cash provided by operating activities increased $85.9 million during the nine-month period ended September 30, 2018 compared to the nine-month period ended September 30, 2017 primarily due to an increase in our net income and cash collections as compared to 2017. In addition, during 2017, operating cash flows were negatively impacted by $28.7 million related to the Securities Class Action Lawsuit settlement (see Note 5 - Commitments and Contingencies to our condensed consolidated financial statements). For additional information regarding our operating performance and our days revenue outstanding, see “Results of Operations” and “Outstanding Patient Accounts Receivable,” respectively.

Cash used in investing activities decreased $20.3 million during the nine-month period ended September 30, 2018 compared to the nine-month period ended September 30, 2017 primarily due to a decrease in our acquisition activity ($20.1 million) and a decrease in capital expenditures ($3.4 million) offset by an increase in equity method investments ($3.0 million).

Cash used in financing activities increased $214.5 million during the nine-month period ended September 30, 2018 compared to the nine-month period ended September 30, 2017 primarily due to our repurchase of company stock and the repayment of borrowings under our Term Loan and Revolving Credit Facility offset by borrowings under our new Credit Agreement.

Liquidity

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

During the nine-month period ended September 30, 2018, we spent $5.7 million in capital expenditures as compared to $9.1 million during the nine-month period ended September 30, 2017. Our capital expenditures for 2018 are expected to be approximately $7.0 million to $9.0 million.

As of September 30, 2018, we had $14.0 million in cash and cash equivalents and $458.1 million in availability under our $550.0 million Revolving Credit Facility.

Based on our operating forecasts and our debt service requirements, we believe we will have sufficient liquidity to fund our operations, capital requirements and debt service requirements.

Outstanding Patient Accounts Receivable

Our patient accounts receivable decreased $6.2 million from December 31, 2017 to September 30, 2018. Our cash collection as a percentage of revenue was 104% and 102% for the nine-month periods ended September 30, 2018 and 2017, respectively. Our days revenue outstanding at September 30, 2018 was 40.6 days which is a decrease of 3.4

days from December 31, 2017.

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

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

	0-90	91-180	181-365	Over 365	Total
At September 30, 2018:					
Medicare patient accounts receivable	$93.3	$ 9.2	$ 2.6	$ 1.8	$106.9
Other patient accounts receivable:					
Medicaid	14.2	2.4	1.2	(1.4)	16.4
Private	56.7	8.5	4.3	2.2	71.7
Total	$70.9	$ 10.9	$ 5.5	$ 0.8	$88.1
Total patient accounts receivable					$195.0
Days revenue outstanding (1)					40.6

	0-90	91-180	181-365	Over 365	Total
At December 31, 2017:					
Medicare patient accounts receivable	$95.9	$ 16.1	$ 6.6	$ 0.6	$119.2
Other patient accounts receivable:					
Medicaid	13.8	3.2	1.3	(1.1)	17.2
Private	51.0	7.5	4.1	2.2	64.8
Total	$64.8	$ 10.7	$ 5.4	$ 1.1	$82.0
Total patient accounts receivable					$201.2
Days revenue outstanding (1)					44.0

(1) Our calculation of days revenue outstanding is derived by dividing our ending patient accounts receivable at September 30, 2018 and December 31, 2017 by our average daily patient revenue for the three-month periods ended September 30, 2018 and December 31, 2017, respectively.

Indebtedness

Credit Agreement

On June 29, 2018, we entered into our Amended and Restated Credit Agreement ("Credit Agreement") that provides for a senior secured revolving credit facility in an initial aggregate principal amount of up to $550.0 million (the “Revolving Credit Facility”). The funds available under the Revolving Credit Facility were used to pay off our existing indebtedness under our prior credit agreement, dated as of August 28, 2015 (the "Prior Credit Agreement"), with a principal balance of $127.5 million.

The final maturity of the Revolving Credit Facility is June 29, 2023 and there is no mandatory amortization on the outstanding principal balances which are payable in full upon maturity. The Revolving Credit Facility may be used to provide ongoing working capital and for general corporate purposes of the Company and our subsidiaries, including permitted acquisitions, as defined in the Credit Agreement.

Our weighted average interest rate for our $100.0 million Term Loan, under our Prior Credit Agreement, was 3.2% and 3.0% for the three and nine-month periods ended September 30, 2017, respectively. Our weighted average interest rate for borrowings under our $550.0 million Revolving Credit Facility was 3.6% and 3.8% for the three and nine-month periods ended September 30, 2018, respectively.

As of September 30, 2018, our consolidated leverage ratio was 0.4, our consolidated interest coverage ratio was 57.6 and we are in compliance with our covenants under the Credit Agreement.

As of September 30, 2018, our availability under our $550.0 million Revolving Credit Facility was $458.1 million as we have $57.5 million outstanding in borrowings and $34.4 million outstanding in letters of credit.

See Note 4 - Long Term Obligations to our condensed consolidated financial statements for additional details on our outstanding long-term obligations.

Share Repurchase

On June 4, 2018, we purchased 2,418,304 of our common shares from affiliates of KKR Credit Advisors (US) LLC ("KKR"), representing one-half of KKR's holdings in the Company and 7.1% of the aggregate outstanding shares of the Company's common stock for a total purchase price of $181.4 million including related direct costs. The Company repurchased the shares at $73.96 which represents 96% of the closing stock price of the Company's common stock on June 4, 2018.

Inflation

We do not believe inflation has significantly impacted our results of operations.

Critical Accounting Estimates

See Part II, Item 7 – Critical Accounting Estimates and our consolidated financial statements and related notes in Part II, Item 8 of our 2017 Annual Report on Form 10-K, for accounting policies and related estimates we believe are the most critical to understanding our condensed consolidated financial statements, financial condition and results of operations and which require complex management judgment and assumptions, or involve uncertainties. These critical accounting estimates include revenue recognition, patient accounts receivable, insurance, goodwill and other intangible assets, and income taxes. There have not been any changes to our significant accounting policies or their application since we filed our 2017 Annual Report on Form 10-K except for the changes related to the implementation of Accounting Standards Updates 2014-09 and 2015-14 as disclosed in Note 2 - Summary of Significant Accounting Policies to our condensed consolidated financial statements.

ITEM 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk from fluctuations in interest rates. Our Revolving Credit Facility carries a floating interest rate which is tied to the Eurodollar rate (i.e. LIBOR) and the Prime Rate and therefore, our condensed consolidated statements of operations and our condensed consolidated statements of cash flows are exposed to changes in interest rates. As of September 30, 2018, the total amount of outstanding debt subject to interest rate fluctuations was $57.5 million. A 1.0% interest rate change would cause interest expense to change by approximately $0.6 million annually.

ITEM 4. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures which are designed to provide reasonable assurance of achieving their objectives and to ensure that information required to be disclosed in our reports filed under the Securities Exchange Act of 1934 as amended (the “Exchange Act”) is recorded, processed, summarized, disclosed and reported within the time periods specified in the SEC’s rules and forms. This information is also accumulated and communicated to our management and Board of Directors to allow timely decisions regarding required disclosure.

In connection with the preparation of this Quarterly Report on Form 10-Q, as of September 30, 2018, under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15d-15(e) promulgated under the Exchange Act.

Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures were effective at a reasonable assurance level as of September 30, 2018, the end of the period covered by this Quarterly Report.

Changes in Internal Controls

There have been no changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that have occurred during the quarter ended September 30, 2018, that have materially impacted, or are reasonably likely to materially impact, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our principal executive officer and principal financial officer, does not expect that our disclosure controls or our internal controls over financial reporting will prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of controls' effectiveness to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies and procedures. Our disclosure controls and procedures are designed to provide reasonable assurance of achieving their objectives and, based on an evaluation of our controls and procedures, our principal executive officer and our principal financial officer concluded our disclosure controls and procedures were effective at a reasonable assurance level as of September 30, 2018, the end of the period covered by this Quarterly Report.

PART II. OTHER INFORMATION

ITEM 1. LEGAL PROCEEDINGS

See Note 5 - Commitments and Contingencies to the condensed consolidated financial statements for information concerning our legal proceedings.

ITEM 1A. RISK FACTORS

In addition to other information set forth in this Quarterly Report on Form 10-Q, you should carefully consider the risk factors included in Part I, Item 1A. – Risk Factors of our Annual Report on Form 10-K. These risk factors could materially impact our business, financial condition and/or operating results. Additional risks and uncertainties not currently known to us or that we currently deem to be immaterial also may materially adversely impact our business, financial condition and/or operating results.

ITEM 2. UNREGISTERED SALES OF EQUITY SECURITIES AND USE OF PROCEEDS

The following table provides the information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended September 30, 2018:

Period	(a) Total Number of Shares (or Units) Purchased		(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs
July 1, 2018 to July 31, 2018	24,094		$ 94.97	—	$ —
August 1, 2018 to August 31, 2018	—		—	—	—
September 1, 2018 to September 30, 2018	2,457		122.22	—	—
	26,551	(1)	$ 97.50	—	$ —

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

ITEM 3. DEFAULTS UPON SENIOR SECURITIES

None.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

ITEM 5. OTHER INFORMATION

None.

ITEM 6. EXHIBITS

The exhibits marked with the cross symbol (†) are filed and the exhibits marked with a double cross (††) are furnished with this Form 10-Q. Any exhibits marked with the asterisk symbol (*) are management contracts or compensatory plans or arrangements filed pursuant to Item 601(b)(10)(iii) of Regulation S-K.

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
†2.1	Stock Purchase Agreement, dated as of October 9, 2018, by and among Milton Heching, the Heching 2012 Exempt Irrevocable Trust, Amedisys Hospice, L.L.C., Compassionate Care Hospice Group, Inc., and solely for purposes of Sections 3.4, 4.3(a), 4.15 and Article VIII thereof, Amedisys, Inc. (Schedules and other similar attachments have been omitted pursuant to Item 601(b)(2) of Regulation S-K. The Company hereby undertakes to furnish supplementally copies of any of the omitted schedules and attachments upon request by the SEC.)			
3.1	Composite of Certificate of Incorporation of the Company inclusive of all amendments through June 14, 2007	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007	0-24260	3.1
3.2	Composite of By-Laws of the Company inclusive of all amendments through April 20, 2016	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016	0-24260	3.2
*†10.1	Amendment to the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan, dated September 25, 2018			
*†10.2	Amedment to the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan, dated September 25, 2018			
*10.3	Amended and Restated Employment Agreement, dated as of September 27, 2018, by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Paul B. Kusserow	The Company's Current Report on Form 8-K filed on October 3, 2018	0-24260	10.1
†31.1	Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002			
†31.2	Certification of Scott G. Ginn, Chief Financial Officer (principal financial officer), pursuant to Section 302 of the			

	Sarbanes-Oxley Act of 2002
††32.1	Certification of Paul B. Kusserow, President and Chief Executive Officer (principal executive officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
††32.2	Certification of Scott G. Ginn, Chief Financial Officer (principal financial officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
†101.INS	XBRL Instance
†101.SCH	XBRL Taxonomy Extension Schema Document
†101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document
†101.DEF	XBRL Taxonomy Extension Definition Linkbase
†101.LAB	XBRL Taxonomy Extension Labels Linkbase Document
†101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document

SIGNATURES

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

AMEDISYS, INC.
(Registrant)

By: /s/ SCOTT G. GINN
Scott G. Ginn,
Principal Financial Officer and
Duly Authorized Officer
Date: October 30, 2018

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