LHC Group, Inc
Form 10-K
March 17, 2008

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

Form 10-K

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

þ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the fiscal year ended December 31, 2007

or

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**
For the transition period from to

Commission file number: 0-8082
LHC GROUP, INC.
(Exact Name of Registrant as Specified in Charter)

Delaware	**71-0918189**
(State or Other Jurisdiction of Incorporation or Organization)	*(I.R.S. Employer Identification No.)*

420 West Pinhook Rd, Suite A
Lafayette, Louisiana 70503
(Address of principal executive offices)

(337) 233-1307
(Registrant s telephone number, including area code)
Securities registered pursuant to Section 12(b) of the Exchange Act:

Common Stock, par value $.001 per share	**NASDAQ Global Select Market**
(Title of each class)	**(Name of each exchange on which registered)**

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

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

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

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 þ No o

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

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

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

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

As of December 31, 2007, the aggregate market value of the registrant s common stock held by non-affiliates of the registrant was $368,067,910 based on the closing sale price as reported on the NASDAQ Global Select Market. For purposes of this determination shares beneficially owned by officers, directors and ten percent shareholders have been excluded, which does not constitute a determination that such persons are affiliates.

There were 18,085,329 shares of common stock, $.01 par value, issued and outstanding as of March 5, 2008.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant s Annual Report to stockholders for the fiscal year ended December 31, 2007 are incorporated by reference in Part II of this Form 10-K. Portions of the Registrant s Proxy Statement for its 2008 Annual Meeting of Stockholders are incorporated by reference in Part III of this annual report on Form 10-K.

LHC GROUP, INC.

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This report contains forward-looking statements. Forward-looking statements relate to our expectations, beliefs, future plans and strategies, anticipated events or trends and similar expressions concerning matters that are not historical facts or that necessarily depend upon future events. In some cases, you can identify forward-looking statements by words like may, will, should, could, would, expect, plan, anticipate, believe, estimate, predict, expressions. Specifically, this report contains, among others, forward-looking statements about:

- our expectations regarding financial condition or results of operations for periods after December 31, 2007;
- our critical accounting policies;
- our business strategies and our ability to grow our business;
- our participation in the Medicare and Medicaid programs;
- the reimbursement levels of Medicare and other third-party payors;
- the prompt receipt of payments from Medicare and other third-party payors;
- our future sources of and needs for liquidity and capital resources;
- our ability to obtain financing;
- our ability to make payments as they become due;
- the outcomes of various routine and non-routine governmental reviews, audits and investigations;
- our expansion strategy, the successful integration of recent acquisitions and, if necessary, the ability to relocate or restructure our current facilities;
- the value of our propriety technology;
- our ability to maintain a secure and current IT infrastructure;
- the impact of legal proceedings;
- our insurance coverage;
- the costs of medical supplies;
- our competitors and our competitive advantages;
- our ability to attract and retain valuable employees;
- the payment of dividends;
- the price of our stock;
- our compliance with environmental, health and safety laws and regulations;

our compliance with health care laws and regulations;

our compliance with SEC laws and regulations and Sarbanes-Oxley requirements;

the impact of federal and state government regulation on our business; and

the impact of changes in or future interpretations of fraud, anti-kickback or other laws.

The forward-looking statements included in this report reflect our current views about future events. They are based on assumptions and are subject to known and unknown risks and uncertainties. Many factors could cause actual results or achievements to materially differ from future results or achievements that may be expressed in or implied by our forward-looking statements. Many of the factors that will determine future events or achievements are beyond our ability to control or predict. Important factors that could cause actual results or achievements to materially differ from the results or achievements reflected in our forward-looking

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statements include, among other things, the factors discussed on pages 27 to 39 of this report under the heading Risk Factors.

You should read this report, the information incorporated by reference into this report and the documents filed as exhibits to this report completely and with the understanding that our actual future results or achievements may be materially different from what we expect or anticipate.

The forward-looking statements contained in this report reflect our views and assumptions only as of the date this report is filed with the Securities and Exchange Commission. Except as required by law, we assume no responsibility to update any forward-looking statements.

Before you invest in our common stock, you should understand that the occurrence of any of the events described in the Risk Factors section, located in Part I, Item 1A in this annual report on Form 10-K or incorporated by reference into this annual report on Form 10-K, and other events that we have not predicted or assessed could have a material adverse effect on our earnings, financial condition and business. If the events described in the Risk Factors or other unpredicted events occur, then the trading price of our common stock could decline and you may lose all or part of your investment.

We qualify all of our forward-looking statements by these cautionary statements. In addition, with respect to all of our forward-looking statements, we claim the protection of the safe harbor for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995.

Unless otherwise indicated, LHC Group, we, us, our and the Company refer to LHC Group, Inc. and our consoli subsidiaries.

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PART I

Item 1. *Business*

Overview

We provide post-acute health care services primarily to Medicare beneficiaries in non-urban markets in the United States. We provide home-based services, primarily through home nursing agencies and hospices and facility-based services, primarily through long-term acute care hospitals and outpatient rehabilitation clinics. Through our wholly and majority owned subsidiaries, equity joint ventures and controlled affiliates, we currently operate in Louisiana, Mississippi, Arkansas, Alabama, Texas, Kentucky, Florida, Tennessee, Georgia, West Virginia, Ohio and Missouri. As of December 31, 2007, we owned and operated 144 home nursing locations, nine hospices, a diabetes management company and a private duty agency. As of December 31, 2007, we also managed the operations of four home nursing agencies in which we do not have an ownership interest. With respect to our facility-based services operations, we owned and operated four long-term acute care hospitals with a total of seven locations, an outpatient rehabilitation clinic, a pharmacy, two medical equipment locations and a family health center as of December 31, 2007. We also manage the operations of one inpatient rehabilitation facility in which we have no ownership interest.

We provide home-based post-acute health care services through our home nursing agencies and hospices. Our home nursing locations offer a wide range of services, including skilled nursing, nursing, physical, occupational and speech therapy and medically-oriented social services. The nurses, home health aides and therapists in our home nursing agencies work closely with patients and their families to design and implement individualized treatments in accordance with a physician-prescribed plan of care. Our hospices provide palliative care to patients with terminal illnesses through interdisciplinary teams of physicians, nurses, home health aides, counselors and volunteers. Of our 155 home-based services locations, 90 are wholly-owned by us, 60 are majority-owned or controlled by us through joint ventures and five are operated through license lease arrangements. For the years ended December 31, 2007, 2006 and 2005, our home-based services provided $244.1 million, $164.7 million and $105.6 million, respectively, of our net service revenue.

We provide facility-based health care services through our long-term acute care hospitals, an outpatient rehabilitation clinic, a pharmacy, two medical equipment locations and a family health center. As of December 31, 2007, we owned and operated four long-term acute care hospitals in seven locations, with a total of 156 licensed beds. Our long-term acute care hospitals, six of which are within host hospitals, provide services primarily to patients with complex medical conditions who have transitioned out of a hospital intensive care unit but remain too severe for treatment in a non-acute setting. We provide outpatient rehabilitation services through physical therapists, occupational therapists and speech pathologists at our outpatient rehabilitation clinic in which we maintain an ownership interest. We also provide outpatient rehabilitation services on a contractual basis. In addition, we manage the operations of one inpatient rehabilitation facility in which we do not have an ownership interest. Of our 12 facility-based services locations in which we maintain an ownership interest, six are wholly-owned by us and six are majority-owned or controlled by us through joint ventures. For the years ended December 31, 2007, 2006 and 2005, our facility-based services provided $53.9 million, $53.8 million and $50.1 million, respectively, of our net service revenue.

Our founders began operations in September 1994 as St. Landry Home Health, Inc. in Palmetto, Louisiana. After several years of expansion, our founders reorganized their business and began operating as Louisiana Healthcare Group, Inc. in June 2000. In March 2001, Louisiana Healthcare Group, Inc. reorganized and became a wholly owned subsidiary of The Healthcare Group, Inc., a Louisiana business corporation. Effective December 2002, The Healthcare Group, Inc. merged into LHC Group, LLC, a Louisiana limited liability company, with LHC Group, LLC being the

surviving entity. In January 2005, LHC Group, LLC established a wholly owned Delaware subsidiary, LHC Group, Inc. Effective February 9, 2005, LHC Group, LLC merged into LHC Group, Inc. LHC Group, Inc. is a Delaware corporation and our principal executive offices are located at 420 West Pinhook Road, Suite A, Lafayette, Louisiana, 70503. Our telephone number is (337) 233-1307 and our website is www.lhcgroup.com.

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Industry and Market Opportunity

According to the Medicare Payment Advisory Committee (MedPAC), an independent federal body established in 1997 to advise Congress on issues affecting the Medicare program, approximately one-third of all general acute care hospital patients require additional care following their discharge from the hospital. Post-acute care currently comprises approximately 13 percent of Medicare s total spending. Some of these patients receive less intensive care in settings such as skilled nursing facilities, outpatient rehabilitation clinics or the home, while others receive continuing care in more intensive care settings such as inpatient rehabilitation facilities or long-term acute care hospitals that are either freestanding or co-located within general acute care facilities. According to MedPAC estimates, Medicare spending totaled $16.9 billion in 2005 for the two primary post-acute sectors in which we operate: home nursing and long-term acute care hospitals.

MedPAC estimates Medicare spending on home nursing services totaled $13.1 billion in 2006. The Centers for Medicare and Medicaid (CMS), estimates that there were approximately 8,813 Medicare-certified home nursing agencies in the United States in 2006, the majority of which are operated by small local or regional providers. MedPAC estimates that in 2005, 62 percent of freestanding home health agencies were urban, 12 percent were rural and 25 percent were mixed. Also, 16 percent were not-for-profit, 77 percent were for profit and 7 percent were government. CMS predicts that Medicare spending will increase at an average annual growth rate of 6.7 percent between 2007 and 2017. Growth is being driven by:

- a U.S. population that is getting older and living longer;
- patient preference for less restrictive care settings;
- incentives for general acute care hospitals to discharge patients into less intensive treatment settings as quickly as medically appropriate;
- higher incidences of chronic conditions and disease; and
- a continued movement of institutionalized people into home and community-based care.

Long-term acute care hospitals provide specialized medical and rehabilitative care to patients with complex medical conditions requiring higher intensity care and monitoring that cannot be provided effectively in other health care settings. These facilities typically serve as an intermediate step between the intensive care unit of a general acute care hospital and a less intensive treatment setting, such as a skilled nursing facility or the home. According to MedPAC estimates, Medicare spending for services provided by long-term acute care hospitals grew from $2.7 billion in 2004 to an estimated $4.5 billion in 2005.

According to the U.S. Census Bureau, rural areas have a higher percentage of residents over the age of 65, who, in 2005, accounted for 12.9 percent of the total population in rural markets compared to 11.8 percent in urban markets. Additionally, according to the American Public Health Association (APHA), rural areas typically do not offer the range of post-acute health care services that are available in urban or suburban markets. As such, patients in rural markets face challenges in accessing health care in a convenient and appropriate setting. For example, APHA estimates that although 20 percent of Americans live in rural areas, less than 11 percent of the nation s physicians practice in rural areas. According to APHA, individuals in rural areas may also have difficulty reaching health care facilities due to greater travel time or a lack of public transportation. The economic characteristics and population dispersion of rural markets also make these markets less attractive to health maintenance organizations and other managed care payors. Government studies cited by APHA have shown rural residents also tend to have more health complications than urban residents. Additionally, APHA has noted that residents in rural areas are less likely to use

preventive screening services and have a higher prevalence of disabilities, heart disease, cancer, diabetes and other chronic conditions when compared to urban residents. Therefore, we believe our post-acute service provides valuable alternatives to this underserved, rural patient population.

In our experience, because most rural areas have the population size to support only one or two general acute care hospitals, the local hospital often plays a significant role in rural market health care delivery systems. Rural patients who require home nursing frequently receive care from a small home care agency or an agency that, while owned and run by the hospital, is not an area of focus for that hospital. Similarly,

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patients in these markets who require services typically offered by long-term acute care hospitals are more likely to remain in the community hospital because it is often the only local facility equipped to deal with severe, complex medical conditions. By entering these markets through affiliations with local hospitals, we usually face less competition for the services we provide. Therefore, we believe we are well positioned to build and maintain long-term relationships with local hospitals, physicians and other health care providers and to become the highest quality post-acute provider in our markets.

Business Strategy

Our objective is to become the leading provider of post-acute services to Medicare beneficiaries in non-urban markets in the United States. To achieve this objective, we intend to:

Drive internal growth in existing markets. We intend to drive internal growth in our current markets by increasing the number of healthcare providers in each market from whom we receive referrals and by expanding the breadth of our services. We intend to achieve this growth by: (1) continuing to educate healthcare providers about the benefits of our services; (2) reinforcing the position of our agencies and facilities as community assets; (3) maintaining our emphasis on high-quality medical care for our patients; and (4) providing a superior work environment for our employees.

Achieve margin improvement through the active management of costs. The majority of our net service revenue is generated under Medicare prospective payment systems (PPS) through which we are paid pre-determined rates based upon the clinical condition and severity of the patients in our care. Because our profitability in a fixed payment system depends upon our ability to manage the costs of providing care, we continue to pursue initiatives to improve our margins and net income.

Expand into new markets. We will continue expanding into new markets by developing de novo locations and by acquiring existing Medicare-certified home nursing agencies in attractive markets throughout the United States. We will continue our unique strategy of partnering with non-profit hospitals in home health services as these ventures provide significant return on investment and we will look to acquire larger freestanding agencies that can serve as growth platforms in markets that we do not currently serve in order to support our growth into new states.

Pursue strategic acquisitions. We will continue to identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position, increase our referral base and expand the breadth of services we offer.

Services

We provide post-acute health care services primarily to Medicare beneficiaries in non-urban markets in the United States. Our services can be broadly classified into two principal categories: (1) home-based services offered through our home nursing agencies and hospices; and (2) facility-based services offered through our long-term acute care hospitals and outpatient rehabilitation clinic.

Home-Based Services

Home Nursing. Our registered and licensed practical nurses provide a variety of medically necessary services to homebound patients who are suffering from acute or chronic illness, recovering from injury or surgery, or who otherwise require care or monitoring. These services include wound care and dressing changes, cardiac rehabilitation, infusion therapy, pain management, pharmaceutical administration, skilled observation and assessment and patient education. We have also designed guidelines to treat chronic diseases and conditions including diabetes, hypertension, arthritis, Alzheimer s disease, low vision, spinal stenosis, Parkinson s disease, osteoporosis, complex wound care and

chronic pain. Our home health aides provide assistance with daily activities such as housekeeping, meal preparation, medication management, bathing and walking. Through our medical social workers we counsel patients and their families with regard to financial, personal and social concerns that arise from a patient s health-related problems. We also provide skilled nursing, ventilator and tracheotomy services, extended care specialties, medication administration and

management and patient and family assistance and education. We also provide management services to third-party home nursing agencies, often as an interim solution until proper state and regulatory approvals for an acquisition can be obtained.

Our physical, occupational and speech therapists provide therapy services to patients in their home. Our therapists coordinate multi-disciplinary treatment plans with physicians, nurses and social workers to restore basic mobility skills such as getting out of bed, walking safely with crutches or a walker and restoring range of motion to specific joints. As part of the treatment and rehabilitation process, a therapist will stretch and strengthen muscles, test balance and coordination abilities and teach home exercise programs. Our therapists assist patients and their families with improving and maintaining a patient s ability to perform functional activities of daily living, such as the ability to dress, cook, clean and manage other activities safely in the home environment. Our speech and language therapists provide corrective and rehabilitative treatment to patients who suffer from physical or cognitive deficits or disorders that create difficulty with verbal communication or swallowing.

All of our home nursing agencies offer 24 hour personal emergency response and support services through Philips Lifeline for qualified patients who require close medical monitoring but who want to maintain an independent lifestyle. These services consist principally of a communicator that connects to the telephone line in the subscriber s home and a personal help button that is worn or carried by the individual subscriber and that, when activated, initiates a telephone call from the subscriber s communicator to Lifeline s central monitoring facilities. Lifeline s trained personnel identify the nature and extent of the subscriber s particular need and notify the subscriber s family members, neighbors and/or emergency personnel, as needed. Our use of the Lifeline system increases customer satisfaction and loyalty by providing our patients a point of contact between scheduled nursing visits. As a result, we offer our patients a more complete regimen of care management than our competitors in the markets in which we operate by offering this service to qualified patients as part of their home health plan of care.

Hospice. Our Medicare-certified hospice operations provide a full range of hospice services designed to meet the individual physical, spiritual and psychosocial needs of terminally ill patients and their families. Our hospice services are primarily provided in a patient s home but can also be provided in a nursing home, assisted living facility or hospital. Key services provided include pain and symptom management accompanied by palliative medication, emotional and spiritual support, inpatient and respite care, homemaker services, dietary counseling, social worker visits, spiritual counseling and bereavement counseling for up to 13 months after a patient s death.

Facility-Based Services

Long-term Acute Care Hospitals. Our long-term acute care hospitals treat patients with severe medical conditions who require high-level care along and provide frequent monitoring by physicians and other clinical personnel. Patients who receive our services in a long-term acute care hospital are too medically unstable to be treated in a non-acute setting. Examples of these medical conditions include respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds, renal disorders, cancer, head and neck injuries and mental disorders. These impairments often are associated with accidents, strokes, heart attacks and other serious medical conditions. We also treat patients diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living. As part of our facility-based services, we operate an institutional pharmacy, which focuses on providing a full array of institutional pharmacy services to our long-term acute care hospitals and inpatient rehabilitation facility.

Rehabilitation Services. We provide rehabilitation services in multiple settings, including both inpatient and outpatient settings. In our facilities and through our contractual relationships, we provide physical, occupational and speech rehabilitation services. We also provide certain specialized services such as hand therapy or sports performance enhancement that treat sports and work related injuries, musculoskeletal disorders, chronic or acute pain and orthopedic conditions. Our patients are often diagnosed with musculoskeletal impairments that restrict their ability

to perform normal activities of daily living. These impairments are often associated with accidents, sports injuries, strokes, heart attacks and other medical conditions. Our

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rehabilitation services are designed to help these patients minimize physical and cognitive impairments and maximize functional ability. We also design services to prevent short-term disabilities from becoming chronic conditions. Our rehabilitation services are provided by our physical, occupational and respiratory therapists and speech-language pathologists. We also provide management services to one inpatient rehabilitation facility and operate one health and wellness center.

Operations

Financial information relating to the home- and facility- based segments is found in the consolidated financial statements of the Company which are included in this report. All of our operations are based in the United States; therefore 100.0 percent of our revenues from external customers for the years ended December 31, 2007, 2006 and 2005 and 100.0 percent of our long-lived assets were attributed to the United States.

Home-Based Services

Each of our home nursing agencies is staffed with experienced clinical home health professionals who provide a wide range of patient care services. Our home nursing agencies are managed by a Director of Nursing or Branch Manager who is also a licensed registered nurse. Our Directors of Nursing and Branch Managers are overseen by State Managers who report to Division Vice Presidents. The Senior Vice President of Operations is accountable for the oversight of the aforementioned and directly reports to the President and Chief Operations Officer of the Company. Our patient care operating model for our home nursing agencies is structured on a base model that requires a Medicare patient minimum census of 50 patients. At the base model level, one registered nurse is responsible for all aspects of the management of each patient s plan of care. A home nursing agency based on this model is also staffed with an office manager, a field-registered nurse, a field-licensed professional nurse and a home health aide. We also contract with local community therapists and other clinicians as appropriate, to provide additional required services. As the size and patient census of a particular home nursing agency grows, these staffing patterns are increased appropriately.

Our home nursing agencies use our Service Value Point system, a proprietary clinical resource allocation model and cost management system. The system is a quantitative tool that assigns a target level of resource units to a group of patients based upon their initial assessment and estimated skilled nursing and therapy needs. The Service Value Point system allows the Director of Nursing or Branch Manager to allocate adequate resources throughout the group of patients assigned to his/her care, rather than focusing on the profitability of an individual patient.

Patient care is handled at the home nursing agency level. Functions that are centralized into the home office include payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management, pharmacy and general clinical oversight accomplished by periodic on-site surveys. Each of our home nursing agencies is licensed and certified by the state and federal governments and 34 of them also are accredited by the Joint Commission (JC). Those not yet accredited are working towards achieving this accreditation, a process which can take up to six months.

Facility-Based Services

Long-Term Acute Care Hospitals. Each of our long-term acute care hospital locations is managed by a hospital administrator, while the clinical operations are directed by a Director of Nursing who is also a licensed registered nurse. The individual hospital administrators are responsible for managing the day-to-day operating activities of the hospital within appropriate budgetary constraints. Each hospital administrator reports to the Vice President of Facility-Based Services. Each Director of Nursing reports directly to his or her respective hospital administrator as well as indirectly to our Clinical Operations Officer responsible for the oversight of the quality of patient care services. The medical management of each patient is overseen by a Medical Director who is responsible for ensuring

the appropriateness of admissions, as well as leading weekly patient care conferences.

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We follow a clinical approach under which each patient is discussed in weekly, multidisciplinary team meetings, at which patient progress is assessed, compared to goals and future goals are set. Attendees at these meetings include a patient s family and referring physician. We believe that this model results in higher quality care, predictable discharge patterns and the avoidance of unnecessary delays.

All coding, medical records, human resources, case management, utilization review and medical staff credentialing are provided at the hospital level. Centralized functions that are provided by the home office include payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management, pharmacy and general clinical oversight accomplished by periodic on-site surveys.

Rehabilitation Services. Our rehabilitation services are overseen by an administrator, who is a licensed physical therapist. Our clinic also has an on-site therapist responsible for addressing staffing needs and concerns as well as managing the day-to-day operations of the outpatient rehabilitation clinic.

As with our long-term acute care hospitals, all coding, medical records, human resources, charge/data entry, front end collections and marketing for our rehabilitation centers are provided at the individual center level. Centralized functions provided by the home office include payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management and general clinical oversight accomplished by periodic on-site surveys.

Joint Ventures

As of December 31, 2007, we had entered into 71 joint ventures with respect to the ownership and operation of 60 home nursing agency locations, five hospices and six long-term acute care hospital locations. Our joint ventures are structured either as equity joint ventures or agency leasing arrangements, as permitted by applicable state laws and subject to business considerations. As of December 31, 2007, we had 66 equity joint ventures and five agency leasing arrangements. Of these 66 joint ventures, 53 are with hospitals, seven are with physicians and six are with other parties. With respect to our seven joint ventures with physicians, six are for the ownership and operation of long-term acute care hospitals and one is for the ownership of a home nursing agency.

Equity Joint Ventures

As of December 31, 2007, we have entered into 66 equity joint ventures for the ownership and operation of home nursing agencies, hospices, outpatient rehabilitation clinics and long-term acute care hospitals. Our equity joint ventures are structured as limited liability companies in which we own a majority equity interest and our partners own a minority equity interest ranging from 1 to 49 percent. At the time of formation, we and our partners each contribute capital to the equity joint venture in the form of cash or property. We believe that the amount contributed by each party to the equity joint venture represents their pro rata portion of the fair market value of the equity joint venture. None of our partners are required to make or influence referrals to our equity joint ventures. In fact, each of our hospital joint venture partners must follow the same Medicare discharge planning regulations as they would if they owned 100.0 percent of the home health agency. For example, each of our hospital joint venture partners must offer each Medicare patient a list of available Medicare-certified home nursing agency options and must allow the patient to make their own choice of provider.

Generally, we serve as the manager of our equity joint ventures and oversee their day-to-day operations. In two of our equity joint ventures with parties other than hospitals or physicians, our partners provide business development services and, in one case, administrative services. The management of our equity joint ventures is typically governed by a management committee, which is comparable to a board of directors. We generally possess a majority of the total votes available to be cast by the members of the management committee. However, in three of these joint ventures where we have partnered with not-for-profit hospitals, the hospital controls a majority of the total management

committee votes. In such instances we possess the right to withdraw from the equity joint venture at any time upon notice to our partner in exchange for the receipt of a payment in an amount calculated in accordance with a predetermined fair market value formula. Each member of all but one of our equity joint ventures participates in profits and losses in proportion to their

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equity interests. We have one equity joint venture partner whose participation in the quarterly losses of the ventures are limited to three times the amount of rent paid monthly by the joint venture companies to the parent companies of our joint venture partners for space used in the operation of the joint ventures. The amounts of these monthly rental payments are currently $1,841 and $1,821 respectively. Distributions from our equity joint ventures are not based on referrals made to the equity joint venture by any of the members.

The 66 equity joint ventures individually contribute between 0.1 percent and 7.6 percent of our total net service revenue and only two of these equity joint ventures account for greater than 5 percent of our total net service revenue for the 12 months ended December 31, 2007. One of these is St. Landry Extended Care Hospital, a long-term acute care hospital equity joint venture in which we own 98.7 percent of the membership interests, with the remaining 1.3 percent ownership divided among four individual physicians. Any party may withdraw from this equity joint venture upon 90 days advance written notice. The second entity is Extended Care Hospital of Lafayette, a long-term acute care hospital in which we own 76.5 percent of the membership interests, with the remaining 23.5 percent ownership divided among 19 individual physicians. Any member may withdraw from this equity joint venture upon 90 days advance written notice.

In addition to these conversion rights, several of our equity joint ventures grant a buy/sell option that would require us to either purchase or our joint venture partner(s) to sell all of the exercising member s interests in the equity joint venture within 30 days of the receipt of notice of the exercise of the buy/sell option. The purchase price under these buy/sell provisions is typically based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised.

Agency Leasing Arrangements

As of December 31, 2007, we have entered into two agreements to lease, through our wholly-owned subsidiaries, the right to use the home health licenses necessary to operate four of our home nursing agency locations and one hospice. These leases are entered into in instances where state law would otherwise prohibit the alienation and sale of home nursing agencies or where the local hospital is reluctant to sell its home health agency due to state-imposed limits on the number of certificates of need or permits of approval. The leasing fees for one of these agency leasing arrangements is fixed at $162,000 per year for the initial term and the other arrangement is fixed at $5,000 per month for the initial term. Both of the initial terms for our two leasing arrangements expire in 2017. These leasing arrangements provide for ten-year terms with optional renewal periods. In the both leasing arrangements, we have a right of first refusal in the event that the lessor intends to sell the leased agency to a third party.

Management Services Agreements

As of December 31, 2007, we have five management services agreements under which we manage the operations of four home nursing agencies and one inpatient rehabilitation facility. We currently have no ownership interest in the agencies and facilities that are the subject of these management services agreements. In four of these arrangements, we are responsible for all direct and indirect costs associated with the operations and receive a management fee equal to the amount of our direct and indirect costs plus a percentage of the net income of those operations. Under the remaining agreement, we receive a flat fee for management. The term of these arrangements is typically five years, with an option to renew for an additional five-year term. The initial termination dates for our management services agreements range from September 29, 2008 to July 31, 2010.

Competition

The home health care market is highly fragmented. According to MedPac, there were approximately 8,813 Medicare-certified home nursing agencies in the United States in 2006, of which approximately 32 percent were

hospital-based or not-for-profit, freestanding agencies. MedPAC estimates that 37 percent of these home nursing agencies are located in non-urban markets. Although there are a small number of public home nursing companies with significant home nursing operations, they generally do not compete with us in

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the rural markets that we currently serve. As we expand into new markets, we may encounter public companies that have greater resources or greater access to capital. Competition in our markets comes primarily from small local and regional providers, many of which are undercapitalized. These providers include facility- and hospital-based providers, visiting nurse associations and nurse registries. We are unaware of any competitor offering our breadth of services and focusing on the needs of rural markets.

Although several public and private national and regional companies own or manage long-term acute care hospitals, they generally do not operate in the rural markets that we serve. Generally, the competition in our markets comes from local healthcare providers. We believe our principal competitive advantages over these local providers are our diverse service offerings, our collaborative approach to working with healthcare providers, our focus on rural markets and our patient-oriented operating model.

Compliance and Quality Control

We have had a Compliance Committee since 1996. Our Compliance Committee oversees a comprehensive company-wide compliance program that provides for:

- the appointment of a compliance officer and committee;
- adoption of codes of business conduct and ethics;
- employee education and training;
- monitoring of an internal system, including a toll-free hotline, for reporting concerns on a confidential, anonymous basis;
- ongoing internal compliance auditing and monitoring programs;
- means for enforcing the compliance programs policies; and
- a system to respond to and correct detected problems.

As part of our ongoing quality control, internal auditing and monitoring programs, we conduct internal regulatory audits and mock surveys at each of our agencies and facilities at least once a year. If an agency or facility does not achieve a satisfactory rating, we require that it prepares and implements a plan of correction. We then perform a follow-up audit and survey to verify that all deficiencies identified in the initial audit and survey have been corrected.

As required under the Medicare conditions of participation, we have a continuous quality improvement program, which involves:

- ongoing education of staff and quarterly continuous quality improvement meetings at each of our agencies and facilities and at our home office;
- quarterly comprehensive audits of patient charts performed by each of our agencies and facilities; and
- at least annually, a comprehensive audit of patient charts performed on each of our agencies and facilities by our home office staff.

If an agency or facility fails to achieve a satisfactory rating on a patient chart audit, we require that it prepares and implements a plan of correction. We then conduct a follow-up patient chart audit to verify that appropriate action has been taken to prevent future deficiencies.

The effectiveness of our compliance program is directly related to the legal and ethical training that we provide to our employees. Compliance education for new hires is initiated immediately upon employment through corporate video training and subsequently reinforced with a corporate orientation program at which the Chief Compliance Officer conducts a comprehensive compliance training seminar. In addition, all of our employees are required to receive continuing compliance education and training each year.

We continually expand and refine our compliance and quality improvement programs. Specific written policies, procedures, training and educational materials and programs, as well as auditing and monitoring

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activities, have been prepared and implemented to address the functional and operational aspects of our business. Our programs also address specific problem areas identified through regulatory interpretation and enforcement activities. Additionally, our policies, training, standardized documentation requirements, reviews and audits specifically address our financial arrangements with our referral sources, including fraud and abuse laws and physician self-referral laws. We believe our consistent focus on compliance and continuous quality improvement programs provide us with a competitive advantage in the market.

Technology and Intellectual Property

Our Service Value Point system is a proprietary information system that assists us in, among other things, monitoring use and other cost factors, supporting our health care management techniques, internal benchmarking, clinical analysis, outcomes monitoring and claims generation, revenue cycle management and revenue reporting. This proprietary home nursing clinical resource and cost management system is a quantitative tool that assigns a target level of resource units to each patient based upon their initial assessment and estimated skilled nursing and therapy needs. We designed this system to empower our direct care employees to make appropriate day-to-day clinical care decisions while also allowing us to manage the quality and delivery of care across our system and to monitor the cost of providing that care both on a patient-specific and agency-specific basis.

In addition to our Service Value Point system, our business is substantially dependent on other non-proprietary software. We utilize a third-party software information system for our long-term acute care hospitals. Our various home nursing agency databases were fully consolidated into an enterprise-wide system during the first half of 2005. These conversions have improved the accuracy, reliability and efficiency of processing and management reporting.

Further, we have two major patient billing systems that we use across the enterprise: one system for our home-based services and one for our facility-based services. Both of these systems are fully automated and contain functionality that allows us to calculate net service revenue at both the payor and patient level.

The software we use is based on client-server technology and is highly scalable. We believe our software and systems are flexible, easy-to-use and allow us to accommodate growth without difficulty. Technology plays a key role in our organization s ability to expand operations and maintain effective managerial control. We believe that building and enhancing our information and software systems provides us with a competitive advantage that will allow us to grow our business in a more cost-efficient manner and will result in better patient care.

Reimbursement

Medicare

The federal government s Medicare program, governed by the Social Security Act of 1965, reimburses healthcare providers for services furnished to Medicare beneficiaries. These beneficiaries generally include persons age 65 and older and those who are chronically disabled. The program is primarily administered by the Department of Health and Human Services (HHS) and CMS. Medicare payments accounted for 81.7 percent, 82.6 percent and 86.4 percent of our net service revenue for the years ended December 31, 2007, 2006 and 2005, respectively. Medicare reimburses us based upon the setting in which we provide our services or the Medicare category in which those services fall.

Home Nursing. The Medicare home nursing benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require ongoing but intermittent care. The services received need not be rehabilitative or of a finite duration; however, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home nursing benefits. As a condition of coverage under Medicare, beneficiaries must: (1) be homebound in that they are unable to leave their home without

considerable effort; (2) require intermittent skilled nursing, physical therapy, or speech therapy services that are covered by Medicare; and (3) receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive

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reimbursement for occupational therapy, medical social services and home health aide services if these additional services are part of a plan of care prescribed by a physician.

We receive a standard prospective Medicare payment for delivering care over a base 60-day period, or episode of care. There is no limit to the number of episodes a beneficiary may receive as long as he or she remains eligible. Most patients complete treatment within one payment episode. The base episode payment, established through federal legislation, is a flat rate that is adjusted upward or downward based upon differences in the expected resource needs of individual patients as indicated by clinical severity, functional severity and service utilization. The magnitude of the adjustment is determined by each patient s categorization into one of 153 payment groups, known as home health resource groups and the costliness of care for patients in each group relative to the average patient. Our payment is also adjusted for differences in local prices using the hospital wage index. We bill and are reimbursed for services in two stages: an initial request for advance payment when the episode commences and a final claim when it is completed. We receive 60.0 percent of the estimated payment for a patient s initial episode up-front (after the initial assessment is completed and upon initial billing) and the remaining 40.0 percent upon completion of the episode and after all final treatment orders are signed by the physician. In the event of subsequent episodes, reimbursement timing is 50.0 percent up-front and 50.0 percent upon completion of the episode. Final payments may reflect one of five retroactive adjustments to ensure the adequacy and effectiveness of the total reimbursement: (1) an outlier payment if the patient s care was unusually costly; (2) a low utilization adjustment if the number of visits was fewer than five; (3) a partial payment if the patient transferred to another provider before completing the episode; (4) a change-in-condition adjustment if the patient s medical status changes significantly, resulting in the need for more or less care; or (5) a payment adjustment based upon the level of therapy services required in the population base. Because the applicability of a change is dependent upon the completion date of the episode, changes in our reimbursement could impact our financial results up to 60 days in advance of the effective date and recognition of the change. We submit all Medicare claims through five fiscal intermediaries for the federal government.

We verify benefits at the time of admission and through this verification process are able to determine the payor source and eligibility for reimbursement for each patient. Accordingly, we do not have any material reimbursement amounts that are pending approval based on the eligibility of a patient to receive reimbursement from the applicable payor program. Further, we only provide limited services to patients who are ineligible for reimbursement from a third party payor; therefore, we do not have any material reimbursement from patients who are self-pay.

The base payment rate for Medicare home nursing in 2007 is $2,339 per 60-day episode. Since the inception of the prospective payment system in October 2000, the base episode rate payment has varied due to both the impact of annual market basket based increases and Medicare-related legislation. Home health payment rates are updated annually by either the full home health market basket percentage, or by the home health market basket percentage as adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

On August 22, 2007, CMS released a final rule finalizing certain updates and refinements to the basic case-mix adjustment system. CMS instituted these changes to the home health payment system to account for reported increases over the past several years in the home health case-mix, which CMS believes have been caused by changes in the coding practices and documentation by Home Health Agencies (HHAs) not by the treatment of more resource-intense patients. CMS thus designed the new case-mix model to better predict the resource-intensity required by home health beneficiaries over the 60-day episode of care, which would, in turn, improve the accuracy of Medicare reimbursement to HHAs. To effectuate these improvements, the new model does the following: (1) enables more precise coding for comorbidities and the differing health characteristics of longer-stay patients; (2) accounts more accurately for the impact of rehabilitation services on resource use; and (3) lessens the risk of overutilization of therapy services by replacing the single threshold (10 visits per

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episode) with three thresholds (at 6, 14 and 20 visits), as well as a graduated bonus system based on severity between each threshold.

Also to address the increases in case-mix that CMS views as unrelated to home health patients clinical conditions, the final rule implemented a reduction in the national standardized 60-day episode payment rate for four years. This 2.75 percent reduction will begin in calendar year (CY) 2008 and continue for three years, with a 2.71 percent reduction in the fourth year. Also in the final rule, CMS finalized the market basket increase of 3.0 percent, a 0.1 percent increase over the proposed rule. When the market basket update is viewed in conjunction with (1) the 2.75 percent reduction in home health payment rates for 2008; (2) the implementation of the new case-mix adjustment system; (3) the changes in the wage index; and (4) the other changes made in the final rule CMS predicts a 0.8 percent increase in payments for urban HHAs and a 1.77 percent decrease in payments for rural HHAs. Collectively, these changes in the final rule (not including the case-mix or wage index adjustments) decrease the national 60-day episode payment rate for HHAs from the 2007 level of $2,339.00 to $2,270.32 for 2008.

The Office of Inspector General (OIG) of HHS has a responsibility to report both to the Secretary of HHS and to Congress any program and management problems related to programs such as Medicare. The OIG s duties are carried out through a nationwide network of audits, investigations and inspections. The OIG has recently undertaken a study with respect to Medicare reimbursement rates. No estimate can be made at this time regarding the impact, if any, of the OIG s findings.

Hospice. In order for a Medicare beneficiary to qualify for the Medicare hospice benefit, two physicians must certify that, in the best judgment of the physician or medical director, the beneficiary has less than six months to live, assuming the beneficiary s disease runs its normal course. In addition, the Medicare beneficiary must affirmatively elect hospice care and waive any rights to other Medicare benefits related to his or her terminal illness. For each benefit period, a physician must recertify that the Medicare beneficiary s life expectancy is six months or less in order for the beneficiary to continue to qualify for and to receive the Medicare hospice benefit. The first two benefit periods are measured at 90-day intervals and subsequent benefit periods are measured at 60-day intervals. There is no limit on the number of periods that a Medicare beneficiary may be recertified. A Medicare beneficiary may revoke his or her election at any time and begin receiving traditional Medicare benefits. There is no limit on how long a Medicare beneficiary can receive hospice benefits and services, provided that the beneficiary continues to meet Medicare hospice eligibility criteria.

Medicare reimburses for hospice care using a prospective payment system. Under that system, we receive one of four predetermined daily or hourly rates based upon the level of care we furnish to the beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations. Our base Medicare rates effective October 1, 2007 depend upon which of the following four levels of care we provide:

Routine Home Care. The base rate is $135.11 per day for routine home care, adjusted by the hospice wage index depending on the geographic location. We are paid the routine home care rate for each day a patient is under our care and not receiving one of the other categories of hospice care. This rate is not adjusted for the volume or intensity of care provided on a given day. This rate is also paid when a patient is receiving hospital care for a condition unrelated to the terminal condition.

General Inpatient Care. The base rate is $601.02 per day for general inpatient care, adjusted by the hospice wage index depending on the geographic location.

Continuous Home Care. The base rate is $788.55 per day for continuous home care, adjusted by the hospice wage index depending on the geographic location. This daily continuous home care rate is divided by 24 in order to arrive at an hourly rate. The hourly rate is paid for every hour that continuous home care is furnished,

up to 24 hours in a single day. A minimum of eight hours must be provided in a single day to qualify for this rate.

Respite Care. The base rate is $139.76 per day for respite care, adjusted by the hospice wage index depending on the geographic location. Respite care is provided when the family or caregiver of a patient requires temporary relief from his or her care giving responsibilities for certain reasons. We can

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receive payment for respite care provided to a given patient for up to five consecutive days. Our payment for any additional days of respite care provided to the patient is limited to the routine home care rate.

Medicare limits the reimbursement we may receive for inpatient care services. Under the so-called 80-20 rule, if the number of inpatient care days furnished by us to Medicare beneficiaries exceeds 20.0 percent of the total days of hospice care furnished by us to Medicare beneficiaries, Medicare payments to us for inpatient care days exceeding the inpatient cap will be reduced to the routine home care rate. This determination is made annually based on the 12-month period beginning on November 1 each year. This limit is computed on a program-by-program basis. None of our hospices have exceeded the cap on inpatient care services during 2006 or 2005. We have not received notification that any of our hospices have exceeded the cap on inpatient care services during 2007.

Our Medicare hospice reimbursement is also subject to a cap amount calculated by the Medicare fiscal intermediary at the end of the hospice cap period, which runs from November 1 through October 31st of the following year. Total Medicare payments to us during this period are compared to the cap amount for this period. Payments in excess of the cap amount must be returned by us to Medicare. The cap amount is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation annually. The cap amount for the 12-month period ending October 31, 2007 was $21,410.04. The hospice cap amount is computed on a program-by-program basis. None of our hospices have exceeded the cap on per beneficiary limits during 2006 or 2005. We have not received notification that any of our hospices have exceeded the cap on per beneficiary limits during 2007.

We are required to file annual cost reports with HHS on each of our hospices for informational purposes and to submit claims on the basis of the location where we actually furnish the hospice services. These requirements permit Medicare to adjust payment rates for regional differences in wage costs.

Long-term Acute Care Hospitals. We are reimbursed by Medicare for services provided by our long-term acute care hospitals (LTACHs) under the LTACH prospective payment system (PPS), which was implemented on October 1, 2002. Although CMS regulations allowed for a phase-in period, we have elected to be paid solely on the basis of the long-term care diagnosis-related groups (DRGs) established by the new system. All of our eligible LTACHs have implemented the PPS.

Under the PPS, each patient discharged from our LTACHs is assigned a long-term care DRG. CMS establishes these long-term care DRGs by grouping diseases by diagnosis and each group reflects the amount of resources needed to treat a given disease. We are paid a pre-determined fixed amount applicable to the particular long-term care DRG to which that patient is assigned. This payment is intended to reflect the average cost of treating a Medicare patient classified in that particular long-term care DRG. For select patients, the amount may be further adjusted based on length of stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently readmitted, among other factors. Similar to other Medicare PPSs, the rate is also adjusted for geographic wage differences.

CMS has expressed its intention to develop LTACH patient-specific criteria to refine the definition of such facilities. To this end, CMS awarded a contract to Research Triangle Institute (RTI) for the purpose of evaluating patient- and facility-level characteristics for LTACHs in order to differentiate the role of LTACHs from general acute care hospitals. In January 2007, RTI released its study results, recommending the development and use of facility and patient criteria as a method of ensuring that patients admitted to LTACHs are medically complex and have a good chance of improvement. In December 2007, Congress passed the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) which, in line with RTI s recommendations, established new facility and medical review requirements (e.g., relating to patient screening for admissions, physician involvement with patient care, regular evaluation of patients) to ensure that patients receive appropriate levels of care at facilities. The MMSEA also imposed a limited

moratorium on the development of new LTACHs, but provided regulatory relief from certain payment policies (i.e., the very short-stay outlier policy, the one-time budget neutrality adjustment and the 25 percent rule with respect to certain LTACHs) for three years in order to ensure continued access to current LTACH services. Further, the MMSEA revised the standard federal rate for discharges occurring in the last quarter of rate year (RY) 2008 to match the

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standard federal rate for RY 2007 i.e., $38,086.04, a reduction from the rate that otherwise would have applied pursuant to the RY 2008 final rule ($38,356.45). Finally, the MMSEA requires the Secretary of HHS to conduct a study on LTACH facility and patient criteria.

In order to qualify for payment under the LTACH PPS, a facility must be certified as a hospital by Medicare, have an average Medicare inpatient length of stay of greater than 25 days and meet all the new facility criteria established by the MMSEA. Prior to qualifying under the LTACH PPS, facilities are classified as short-term acute care hospitals and therefore receive lower payments under the acute or inpatient rehabilitation facility prospective payments systems. New LTACHs continue to be paid under these systems for a minimum of six months while they establish the required average length of stay and meet certain additional Medicare LTACH requirements. All of our LTACHs are currently qualified to receive full payment under the LTACH PPS.

On January 22, 2008, CMS published a proposed rule proposing to set the Medicare payment rates for LTACHs at $39,076.28 for patient discharges taking place on or after July 1, 2008 through September 30, 2009. (CMS proposed a 15-month rate year for 2009 in order to align the timing of the annual update for the LTACH PPS with the annual update for the DRGs used for LTACH patients.) CMS also proposed to set the cost outlier fixed-loss threshold at $21,199. Further, CMS declined to apply its one-time budget neutrality adjustment, in accordance with the MMSEA, which prohibits the Secretary of HHS from making this one-time prospective adjustment until December 29, 2010. However, in the rule, CMS discussed a methodology it had developed prior to the enactment of the MMSEA for evaluating whether to propose this one-time adjustment and it requested comments on its proposed methodology. CMS indicated that, as December 29, 2010 approaches, it plans to use its finalized methodology to evaluate whether to propose a one-time budget neutrality adjustment at that time. (CMS also noted that, had the MMSEA not been enacted, CMS would have proposed to use the proposed methodology at this time and to make a one-time adjustment of 3.75 percent to the standard federal rate.) CMS indicated that other MMSEA LTACH provisions that were not addressed in the proposed rule (i.e., provisions relating to the 25 percent rule, the short-stay outlier policy, the establishment of new facilities and the expanded review of medical necessity for admission and continued stay at LTACHs would be the subject of future regulations.

LTACHs are typically operated either as stand-alone facilities or as separate provider units within traditional acute care hospitals. All but one of our LTACHs are located within host hospitals. These hospitals within a hospital (HwHs) must satisfy additional standards. An HwH must establish itself as a hospital separate from its host by, among other things, obtaining separate licensure and certification, not having common control with its host hospital or a common parent organization and having a separate chief executive officer, chief medical officer and medical staff. Further, an HwH faces financial penalties if it fails to limit the number of total Medicare patients discharged from the host hospital and subsequently readmitted to the HwH to no greater than 5.0 percent. None of our LTACHs exceeded this 5.0 percent limitation through the year ended December 31, 2007.

In August 2004, CMS announced final regulatory changes applicable to LTACHs operated as HwHs. Effective for cost reporting periods beginning on or after October 1, 2004, LTACH HwHs would have to limit the number of Medicare admissions from their co-located host hospital according to specified thresholds. Medicare discharges over the specified threshold would be paid at a reduced payment rate, specifically, the inpatient PPS rate. This new policy was subject to a four year phase-in period for existing LTACH HwHs, satellites and LTACHs under formation. All of our LTACHs met the requirements for the four year phase-in period. The first year of the phase-in period (cost reporting periods beginning on or after October 1, 2004 and before October 1, 2005) was a hold harmless year with no admission percentage threshold, which was

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scheduled to be followed by a percentage transition over the three years beginning in fiscal year 2006 (October 1, 2005 to September 30, 2006) as set forth in the table below:

Cost Report Period Beginning	Allowable Admissions from Host Hospital Before Payment Reduction	
	MSAs	Non-MSAs
Until September 30, 2005	100.0%	100.0%
October 1, 2005 September 30, 2006	75.0%	75.0%
October 1, 2006 September 30, 2007	50.0%	50.0%
October 1, 2007 and thereafter	25.0%	50.0%

The 2004 HwH rule specified that for HwHs located in rural or non- metropolitan statistical area (MSA) locations, the final year phase-in percentage would be 50 percent. For HwHs located in an MSA, the final phase-in percentage would be 25 percent.

In a final rule released on May 1, 2007, CMS expanded the policy to apply not only to LTACH HwHs and satellites but also to freestanding LTACHs and grandfathered LTACHs as well as to HwHs and satellites that admit Medicare patients from non-co-located hospitals. While this policy change was supposed to take effect for cost reporting periods beginning on or after July 1, 2007, the MMSEA delayed the implementation of the policy for three years with respect to freestanding LTACHs and grandfathered LTACHs. Further, the MMSEA set the percentage threshold at 50 percent for three years for HwHs and satellites located in urban areas that would otherwise be subject to a transition period and it established a 75 percent ceiling for HwHs and satellite facilities located in rural areas and those that receive referrals from MSA dominant hospitals or urban single hospitals.

We currently have a total of seven LTACHs. Six of our hospitals are classified as HwHs and one as freestanding. Of the six HwH facilities, four are located in rural or non-MSAs and are therefore subject to a final admission percentage of 50 percent at the end of the phase-in period. Two of our six HwH facilities are located in MSA or urban areas and will be subject to a final admission percentage of 25 percent at the end of the phase-in period. Of these six locations classified as HwHs, two facilities are satellite locations of a parent hospital located in an MSA and one is a satellite location of a parent hospital located in a non-MSA. Based on our discussions with CMS, we believe each of these satellite locations will be viewed as being located in a non-MSA regardless of the location of its parent hospital and will be treated independently from its parent for purposes of calculating its compliance with the admissions limitations. If the 25 percent rule is extended, as planned, to freestanding LTACHs after the three-year delay (established in the MMSEA), our current freestanding facility would not be affected because we currently do not receive more than 25 percent of our Medicare admissions from any single referring hospital.

For the 12 months ended December 31, 2007, on an individual basis, all of our LTACH locations admitted between 50.0 percent and 75.0 percent of their patients from their host hospitals. These hospitals came under the proper threshold as of September 30, 2007. Our remaining LTACH is not an HwH; therefore, it is not subject to these limits on host hospital referrals.

Outpatient Rehabilitation Services. Medicare requires that outpatient therapy services be reimbursed on a fee schedule, subject to annual limitations. Outpatient therapy providers receive a fixed fee for each procedure performed, adjusted by the geographical area in which the facility is located. Medicare also imposes annual per Medicare beneficiary caps. For 2007, these annual caps limited Medicare coverage to $1,780 for outpatient rehabilitation

services (including both physical therapy and speech-language pathology services) and $1,780 for outpatient occupational health services, including deductible and co-insurance amounts. These caps were replaced for 2008 by annual cap amounts of $1,810. Historically, Congress has acted to bypass the cap and impose a moratorium on its operation. The Deficit Reduction Act of 2005, the Tax Relief and Health Care Act of 2006 and the MMSEA all provided for an exceptions process that effectively prevents application of the caps. The exceptions process ends June 30, 2008. We are unable to predict whether Congress will extend

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the exceptions process beyond June 30, 2008. We cannot be assured that one or more of our outpatient rehabilitation clinics will not exceed the caps in the future.

Historically, outpatient rehabilitation services have been subject to scrutiny by the Medicare program for, among other things, medical necessity, appropriate documentation, supervision of therapy aides and students and billing for group therapy. CMS has issued guidance to clarify that services performed by a student are not reimbursable even if provided under line of sight supervision of the therapist. Likewise, CMS has reiterated that Medicare does not pay for services provided by aides regardless of the level of supervision. CMS also has issued instructions that outpatient physical and occupational therapy services provided simultaneously to two or more individuals by a practitioner should be billed as group therapy services.

Inpatient Rehabilitation Facilities. Inpatient rehabilitation facilities are paid under a PPS. Under this system, each patient discharged from an inpatient rehabilitation facility is assigned to a case-mix group containing patients with similar clinical problems that are expected to require comparable resources. An inpatient rehabilitation facility is generally paid a predetermined, fixed amount applicable to the assigned case-mix group (subject to certain case- and facility-level adjustments). The PPS for inpatient rehabilitation facilities also includes special payment policies that adjust the payments for some patients based on length of stay, facility costs, whether the patient was discharged and subsequently readmitted and other factors. MMSEA provided permanent relief from the so-called 75 percent rule, which had restricted inpatient rehabilitation facility admissions to certain categories of patients and set the new compliance threshold permanently at 60.0 percent.

Medicaid

Medicaid is a joint federal and state funded health insurance program for certain low-income individuals. Medicaid reimburses health care providers using a number of different systems, including cost-based, prospective payment and negotiated rate systems. Rates are also subject to adjustment based on statutory and regulatory changes, administrative rulings, interpretations of policy by individual state agencies and certain government funding limitations. Medicaid payments accounted for 5.5 percent, 5.7 percent and 4.9 percent of our net service revenue for the years ended December 31, 2007, 2006 and 2005, respectively.

Non-Governmental Payors

A portion of our net service revenue comes from private payor sources. These sources include insurance companies, workers compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as patients directly. Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs and the non-governmental payors, but are responsible for services not covered by these programs or plans, as well as for deductibles and co-insurance obligations of their coverage. The amount of these deductibles and co-insurance obligations on patients has increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. However, the majority of our billed services are paid in full by Medicare, Medicaid or private insurance. Accordingly, co-payments from patients do not represent a material portion of our billed revenue and corresponding accounts receivable. To further reduce their healthcare costs, most insurance companies, health maintenance organizations, preferred provider organizations and other managed care companies have negotiated discounted fee structures or fixed amounts for services performed, rather than paying healthcare providers the amounts billed. Our results of operations may be negatively affected if these organizations are successful in negotiating further discounts. During 2007, we evaluated our commercial, managed care and non PFFS Medicare Advantage (Commercial) plan payor contracts associated with home health services. We found these contracts to be unprofitable and difficult to collect. In response to the challenges associated with collecting from Commercial payors and the unprofitable reimbursement rates paid by Commercial payors, we

have terminated all Commercial contracts associated with home health services. These Commercial payors had reimbursement rates averaging 26 percent below cost, representing approximately 8 percent of our home health revenue, 16 percent of our home health admissions and 44 percent of our bad debt write-offs against home health revenue in fiscal year 2007. Payments from all non-governmental payors accounted for 12.8 percent,

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11.7 percent and 8.7 percent of our net service revenue for the years ended December 31, 2007, 2006 and 2005, respectively.

Government Regulations

General

The healthcare industry is highly regulated and we are required to comply with federal, state and local laws, which significantly affect our business. These laws and regulations are extremely complex and, in many instances, the industry does not have the benefit of significant regulatory or judicial interpretation. Regulations and policies frequently change and we monitor these changes through trade and governmental publications and associations. The significant areas of federal and state regulatory laws that could affect our ability to conduct our business include the following:

Medicare and Medicaid participation and reimbursement;

the federal Anti-Kickback Statute and similar state laws;

the federal Stark Law and similar state laws;

false and other improper claims;

the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

civil monetary penalties;

environmental health and safety laws;

licensing; and

certificates of need and permits of approval.

If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state healthcare programs. Although we believe we are in material compliance with all applicable laws, these laws are complex and a review of our practices by a court or law enforcement or regulatory authority could result in an adverse determination that could harm our business. Furthermore, the laws applicable to us are subject to change, interpretation and amendment, which could adversely affect our ability to conduct our business.

Medicare Participation

During the year ended December 31, 2007, 2006 and 2005, 81.7 percent, 82.6 percent and 86.4 percent, respectively, of our net service revenue was received from Medicare. We expect to continue to receive the majority of our net service revenue from serving Medicare beneficiaries. Medicare is a federally funded and administered health insurance program, primarily for individuals entitled to social security benefits who are 65 or older or who are disabled. To participate in the Medicare program and receive Medicare payments, our agencies and facilities must comply with regulations promulgated by CMS. Among other things, these requirements, known as conditions of participation, relate to the type of facility, its personnel and its standards of medical care. Although we intend to continue to participate in the Medicare reimbursement programs, we cannot assure you that our agencies and

programs will continue to qualify for participation.

Under Medicare rules, the designation provider-based refers to circumstances in which a subordinate facility (e.g., a separately-certified Medicare provider, a department of a provider or a satellite facility) is treated as part of a provider for Medicare payment purposes. In these cases, the services of the subordinate facility are included in the main provider s cost report and overhead costs of the main provider can be allocated to the subordinate facility, to the extent that they are shared. We operate three long-term acute care hospitals that are treated as provider-based satellites of certain of our other facilities. We also provide contract rehabilitation and management services to hospital rehabilitation departments that may be treated as provider-based. These facilities are required to satisfy certain operational standards in order to retain their provider-based status.

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Anti-Kickback Statute

Provisions of the Social Security Act of 1965, commonly referred to as the Anti-Kickback Statute, prohibit the payment or receipt of anything of value in return for the referral of patients or arranging for the referral of patients, or in return for the recommendation, arrangement, purchase, lease or order of items or services that are covered by a federal health care program such as Medicare and Medicaid. Violation of the Anti-Kickback Statute is a felony and sanctions include imprisonment of up to five years, criminal fines of up to $25,000, civil monetary penalties of up to $50,000 per act plus three times the amount claimed or three times the remuneration offered and exclusion from federal healthcare programs (including the Medicare and Medicaid programs). Many states have adopted similar prohibitions against payments that are intended to induce referrals of Medicaid and other third-party payor patients.

The OIG has published numerous safe harbors that exempt some practices from enforcement action under the federal Anti-Kickback Statute. These safe harbors exempt specified activities, including bona-fide employment relationships, contracts for the rental of space or equipment and personal service arrangements and management contracts, so long as all of the requirements of the safe harbor are met. The OIG has recognized that the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback statute. Nonetheless, we cannot assure you that arrangements that do not satisfy a safe harbor are not in violation of the Anti-Kickback Statute.

We are required under the Medicare conditions of participation and some state licensing laws to contract with numerous health care providers and practitioners, including physicians, hospitals and nursing homes and to arrange for these individuals or entities to provide services to our patients. In addition, we have contracts with other suppliers, including pharmacies, ambulance services and medical equipment companies. We have also entered into various joint ventures with hospitals and physicians for the ownership and management of home nursing agencies and long-term acute care hospitals. Some of these individuals or entities may refer, or be in a position to refer, patients to us and we may refer, or be in a position to refer, patients to these individuals or entities. We attempt to structure these arrangements in a manner which meets a safe harbor. However, some of these arrangements may not meet all of the requirements of a safe harbor. We believe that our contracts and arrangements with providers, practitioners and suppliers do not violate the Anti-Kickback Statute or similar state laws. We cannot assure you, however, that these laws will ultimately be interpreted in a manner consistent with our practices.

From time to time, various federal and state agencies, such as HHS, issue pronouncements, including fraud alerts, that identify practices that may be subject to heightened scrutiny. For example, the OIG s 2007 Work Plan describes, among other things, the government s intention to examine outlier payments to home health agencies, accuracy of claims coding for Medicare home health resources groups, payments to long-term acute care hospitals and average lengths of stay at long-term acute care hospitals.

In June 1995, the OIG issued a special fraud alert that focused on the home nursing industry and identified some of the illegal practices the OIG has uncovered. In March 1998, the OIG issued a special fraud alert titled, *Fraud and Abuse in Nursing Home Arrangements with Hospices.* This special fraud alert focused on payments received by nursing homes from hospices. We believe, but cannot assure you, that our operations comply with the principles expressed by the OIG in these special fraud alerts.

We endeavor to conduct our operations in compliance with federal and state healthcare fraud and abuse laws, including the Anti-Kickback Statute. However, our practices may be challenged in the future and the fraud and abuse laws may be interpreted in a way that finds us in violation of these laws. If we are found to be in violation of the Anti-Kickback Statute, we could be subject to civil and criminal penalties and we could be excluded from participating in federal health care programs such as Medicare and Medicaid. The occurrence of any of these events could significantly harm our business and financial condition.

Stark Law

Congress also passed significant prohibitions against certain physician referrals of patients for health care services. These prohibitions are commonly known as the Stark Law. The Stark Law prohibits a physician from

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making referrals for particular health care services (called designated health services) to entities with which the physician, or an immediate family member of the physician, has a financial relationship.

The term financial relationship is defined very broadly to include most types of ownership or compensation relationships. The Stark Law also prohibits the entity receiving the referral from seeking payment under the Medicare and Medicaid programs for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties and could be excluded from participating in the Medicare or Medicaid programs. If an arrangement is covered by the Stark Law, the requirements of a Stark Law exception must be met for the physician to be able to make referrals to the entity for designated health services and for the entity to be able to bill for these services.

Designated health services under the Stark Law is defined to include clinical laboratory services; physical therapy services; occupational therapy services; radiology services, including magnetic resonance imaging, computerized axial tomography scans and ultrasound services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. The Stark Law defines a financial relationship to include: (1) a physician s ownership or investment interest in an entity and (2) a compensation relationship between a physician and an entity. Under the Stark Law, financial relationships include both direct and indirect relationships.

Physicians refer patients to us for several Stark Law designated health services, including home health services, inpatient and outpatient hospital services and physical therapy services. We have compensation arrangements with some of these physicians or their professional practices in the form of medical director and consulting agreements. We also have operations owned by joint ventures in which physicians have an investment interest. In addition, other physicians who refer patients to our agencies and facilities may own our stock. As a result of these relationships, we could be deemed to have a financial relationship with physicians who refer patients to our facilities and agencies for designated health services. If so, the Stark Law would prohibit the physicians from making those referrals and would prohibit us from billing for the services unless a Stark Law exception applies.

The Stark Law contains exceptions for certain physician ownership or investment interests in and certain physician compensation arrangements with entities. If a compensation arrangement or investment relationship between a physician, or a physician s immediate family member, and an entity satisfies all requirements for a Stark Law exception, the Stark Law will not prohibit the physician from referring patients to the entity for designated health services. The exceptions for compensation arrangements cover employment relationships, personal services contracts and space and equipment leases, among others. The exceptions for a physician investment relationship include ownership in an entire hospital and ownership in rural providers. We believe our compensation arrangements with referring physicians and our physician investment relationships meet the requirements for an exception under the Stark Law and that our operations comply with the Stark Law.

The Stark Law also includes an exception for a physician s ownership or investment interest in certain entities through the ownership of stock. If a physician owns stock in an entity and the stock is listed on a national exchange or is quoted on NASDAQ and the ownership meets certain other requirements, the Stark Law will not apply to prohibit the physician from referring to the entity for designated health services. The requirements for this Stark Law exception include a requirement that the entity issuing the stock have at least $75.0 million in stockholders equity at the end of its most recent fiscal year or on average during the previous three fiscal years. As of December 31, 2007, 2006 and 2005, we have exceeded $75.0 million in stockholders equity.

If an entity violates the Stark Law, it could be subject to civil penalties of up to $15,000 per prohibited claim and up to $100,000 for knowingly entering into certain prohibited referral schemes. The entity also may be excluded from

participating in federal health care programs (including Medicare and Medicaid). If the Stark Law was found to apply to our relationships with referring physicians and no exceptions under the Stark Law were available, we would be required to restructure these relationships or refuse to accept referrals for designated health services from these physicians. If we were found to have submitted claims to Medicare or

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Medicaid for services provided pursuant to a referral prohibited by the Stark Law, we would be required to repay any amounts we received from Medicare for those services and could be subject to civil monetary penalties. Further, we could be excluded from participating in Medicare and Medicaid. If we were required to repay any amounts to Medicare, subjected to fines, or excluded from the Medicare and Medicaid Programs, our business and financial condition would be harmed significantly.

Many states have physician relationship and referral statutes that are similar to the Stark Law. These laws generally apply regardless of payor. We believe that our operations are structured to comply with applicable state laws with respect to physician relationships and referrals. However, any finding that we are not in compliance with these state laws could require us to change our operations or could subject us to penalties. This, in turn, could have a negative impact on our operations.

False and Improper Claims

The submission of claims to a federal or state health care program for items and services that are not provided as claimed may lead to the imposition of civil monetary penalties, criminal fines and imprisonment and/or exclusion from participation in state and federally funded health care programs, including the Medicare and Medicaid programs. These false claims statutes include the Federal False Claims Act. Under the Federal False Claims Act, actions against a provider can be initiated by the federal government or by a private party on behalf of the federal government. These private parties are often referred to as qui tam relators and relators are entitled to share in any amounts recovered by the government. Both direct enforcement activity by the government and qui tam actions have increased significantly in recent years. This development has increased the risk that a health care company like us will have to defend a false claims action, pay fines or be excluded from the Medicare and Medicaid programs as a result of an investigation arising out of false claims laws. Many states have enacted similar laws providing for the imposition of civil and criminal penalties for the filing of fraudulent claims. Because of the complexity of the government regulations applicable to our industry, we cannot assure that we will not be the subject of an action under the Federal False Claims Act or similar state law.

Anti-fraud Provisions of the HIPAA

In an effort to combat health care fraud, Congress included several anti-fraud measures in HIPAA. Among other things, HIPAA broadened the scope of certain fraud and abuse laws, extended criminal penalties for Medicare and Medicaid fraud to other federal health care programs and expanded the authority of the OIG to exclude persons and entities from participating in the Medicare and Medicaid programs. HIPAA also extended the Medicare and Medicaid civil monetary penalty provisions to other federal health care programs, increased the amounts of civil monetary penalties and established a criminal health care fraud statute.

Federal health care offenses under HIPAA include health care fraud and making false statements relating to health care matters. Under HIPAA, among other things, any person or entity that knowingly and willfully defrauds or attempts to defraud a health care benefit program is subject to a fine, imprisonment or both. Also under HIPAA, any person or entity that knowingly and willfully falsifies or conceals or covers up a material fact or makes any materially false or fraudulent statements in connection with the delivery of or payment of health care services by a health care benefit plan is subject to a fine, imprisonment or both. HIPAA applies not only to governmental plans but also to private payors.

Administrative Simplification Provisions of HIPAA

HHS s final regulations governing electronic transactions involving health information are part of the administrative simplification provisions of HIPAA. These regulations are commonly referred to as the Transaction Standards rule.

The rule establishes standards for eight of the most common health care transactions by reference to technical standards promulgated by recognized standards publishing organizations. Under the new standards, any party transmitting or receiving health transactions electronically must send and receive data in a single format, rather than the large number of different data formats currently used. This rule will apply to us in connection with submitting and processing health claims. The Transaction Standards rule

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also applies to many of our payors and to our relationships with those payors. Since many of our payors might not have been able to accept transactions in the format required by the Transaction Standards rule by the original compliance date, we filed a timely compliance extension plan with HHS. We believe that our operations materially comply with the Transaction Standards rule.

HHS also has final regulations implementing HIPAA that set forth standards for the privacy of individually-identifiable health information, referred to as protected health information. The regulations cover health care providers, health care clearinghouses and health plans. The privacy regulations require companies covered by the regulations to use and disclose protected health information only as allowed by the privacy regulations. Specifically, the privacy regulations require companies such as us to do the following, among other things:

obtain patient authorization prior to certain uses or disclosures of protected health information;

provide notice of privacy practices to patients and obtain an acknowledgement that the patient has received the notice;

respond to requests from patients for access to or to obtain a copy of their protected health information;

respond to patient requests for amendments of their protected health information;

provide an accounting to patients of certain disclosure of their protected health information;

enter into agreements with the companies business associates through which the business associates agree to use and disclose protected health information only as permitted by the agreement and the requirements of the privacy regulations;

train the companies workforce in privacy compliance;

designate a privacy officer;

use and disclose only the minimum necessary information to accomplish a particular purpose; and

establish policies and procedures with respect to uses and disclosures of protected health information.

These regulatory requirements impose significant administrative and financial obligations on companies that use or disclose individually identifiable health information relating to the health of a patient. We have implemented new policies and procedures to maintain patient privacy and comply with HIPAA s privacy regulations. The privacy regulations are extensive and we may need to change some of our practices to comply with them as they are interpreted and as we deal with issues that arise.

In February 2003, HHS published the final security regulations implementing HIPAA that govern the security of health information. The compliance date for the security regulations was April 21, 2005. The security regulations require the implementation of policies and procedures that establish administrative, physical and technical safeguards for electronic protected health information. Companies covered by the security regulations are required to ensure the confidentiality, integrity and availability of electronic protected health information. Specifically, among others things, companies are required to:

conduct a thorough assessment of the potential risks and vulnerabilities to confidentiality, integrity and availability of electronic protected health information and to reduce the risks and vulnerabilities to a reasonable

and appropriate level as required by the security regulations;

designate a security officer;

establish policies relating to access by the companies workforce to electronic protected health information;

enter into agreements with the companies business associates whereby business associates agree to establish administrative, physical and technical safeguards for electronic protected health information received from or on behalf of the companies;

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create a disaster and contingency plan to ensure the availability of electronic protected health information;

train the companies workforce in security compliance;

establish physical controls for electronic devices and media containing or transmitting electronic protected health information;

establish policies and procedures regarding the use of workstations with access to electronic protected health information; and

establish technical controls for the information systems maintaining or transmitting electronic protected health information.

These regulatory requirements impose significant administrative and financial obligations on companies like us that use or disclose electronic health information. Our operations are in compliance with the security regulations.

Civil Monetary Penalties

The Secretary of HHS may impose civil monetary penalties on any person or entity that presents, or causes to be presented, certain ineligible claims for medical items or services. The amount of penalties varies depending on the offense, from $2,000 to $50,000 per violation, plus treble damages for the amount at issue and exclusion from federal health care programs (including Medicare and Medicaid).

HHS also can impose penalties on a person or entity who offers inducements to beneficiaries for program services, who violates rules regarding the assignment of payments or who knowingly gives false or misleading information that could reasonably influence the discharge of patients from a hospital. Persons who have been excluded from a federal health care program and who retain ownership in a participating entity and persons who contract with excluded persons may be penalized.

HHS also can impose penalties for false or fraudulent claims and those that include services not provided as claimed. In addition, HHS may impose penalties on claims:

for physician services that the person or entity knew or should have known were rendered by a person who was unlicensed, or misrepresented either (1) his or her qualifications in obtaining his or her license or (2) his or her certification in a medical specialty;

for services furnished by a person who was, at the time the claim was made, excluded from the program to which the claim was made; or

that show a pattern of medically unnecessary items or services.

Penalties also are applicable in certain other cases, including violations of the federal Anti-Kickback Statute, payments to limit certain patient services and improper execution of statements of medical necessity.

Environmental Health and Safety Laws

We are subject to federal, state and local regulations governing the storage, use and disposal of materials and waste products. Although we believe that our safety procedures for storing, handling and disposing of these hazardous

materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management s attention in order to comply with current or future environmental laws and regulations. We do not have any violations related to compliance with environmental, health and safety laws through calendar year 2007.

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Licensing

Our agencies and facilities are subject to state and local licensing regulations ranging from the adequacy of medical care to compliance with building codes and environmental protection laws. In order to assure continued compliance with these various regulations, governmental and other authorities periodically inspect our agencies and facilities. Additionally, health care professionals at our agencies and facilities are required to be individually licensed or certified under applicable state law. We take steps to ensure that our employees and agents possess all necessary licenses and certifications.

The institutional pharmacy operations within our facility-based services segment are subject to regulation by the various states in which business is conducted as well as by the federal government. The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the United States Food and Drug Administration. Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, which is administered by the United States Drug Enforcement Administration, dispensers of controlled substances must register with the Drug Enforcement Administration, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties. We do not have any violations related to Comprehensive Drug Abuse Prevention and Control Act of 1970 through calendar year 2007.

The JC is a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of hospitals. Currently, JC accreditation of home nursing agencies is voluntary. However, managed care organizations use JC accreditation as a minimum standard for regional and state contracts. As of December 31, 2007, the JC had accredited 36 of our home nursing agencies. Those not yet accredited are working towards achieving this accreditation.

Certificate of Need and Permit of Approval Laws

In addition to state licensing laws, some states require a provider to obtain a certificate of need or permit of approval prior to establishing or expanding certain health services or facilities. States with certificate of need or permit of approval laws place limits on both the construction and acquisition of health care facilities and operations and the expansion of existing facilities and services. In these states, approvals are required for capital expenditures exceeding certain amounts that involve certain facilities or services, including home nursing agencies. The certificate of need or permit of approval issued by the state determines the service areas for the applicable agency or program. The states that currently issue certificate of need or permits of approval are: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, South Carolina, Tennessee, Vermont, Washington, West Virginia and the District of Columbia. In addition, the state of Louisiana has imposed a moratorium on the issuance of new licenses for home nursing agencies that is effective until July 1, 2008.

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

Employees

As of December 31, 2007 we had 4,498 employees, of which 3,090 were full-time and 1,408 were part-time, and approximately 925 independent contractors. None of our employees are subject to a collective bargaining agreement. We consider our relationships with our employees and independent contractors to be good.

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Insurance

We are subject to claims and legal actions in the ordinary course of our business. To cover claims that may arise, we maintain professional malpractice liability insurance, general liability insurance, automobile liability insurance and workers compensation/employer s liability in amounts that we believe are appropriate and sufficient for our operations. We maintain professional malpractice and general liability insurance that provide primary coverage on a claims-made basis of $1.0 million per incident and $3.0 million in annual aggregate amounts. We maintain workers compensation insurance that meets state statutory requirements with a primary employer liability limit of $1.0 million for Louisiana, Mississippi, Alabama, Arkansas, Texas, Tennessee, Georgia, Florida and Kentucky and $500,000 in West Virginia. We maintain Automobile Liability for all owned, hired and non-owned autos with a primary limit of $2.0 million. In addition, we currently maintain multiple layers of umbrella coverage in the aggregate amount of $25.0 million that provides excess coverage for professional malpractice, general liability, automobile liability and employer s liability. We also currently maintain Directors and Officers liability insurance in the aggregate amount of $15.0 million. The cost and availability of such coverage has varied widely in recent years. While we believe that our insurance policies and coverage are adequate for a business enterprise of our type, we cannot assure you that our insurance coverage is sufficient to cover all future claims or that it will continue to be available in adequate amounts or at a reasonable cost.

Available Information

Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements and amendments to those reports are available free of charge on our internet website (www.lhcgroup.com) as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission (SEC). The SEC also maintains an internet site (www.sec.gov) that contains reports, proxy and information statements and other information regarding issuers that file electronically with the SEC.

Item 1A. ***Risk Factors***

You should carefully consider the risks described below before investing in the Company. The risks and uncertainties described below ***are not*** *the only ones we face. Other risks and uncertainties that we have not predicted or assessed may also adversely affect us.*

If any of the following risks occurs, our earnings, financial condition or business could be materially harmed and the trading price of our common stock could decline, resulting in the loss of all or part of your investment.

More than 80 percent of our net service revenue is derived from Medicare. If there are changes in Medicare rates or methods governing Medicare payments for our services, or if we are unable to control our costs, our net service revenue and net income could decline materially.

For the years ended December 31, 2007, 2006 and 2005, we received 81.7 percent, 82.6 percent and 86.4 percent, respectively, of our net service revenue from Medicare. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our net service revenue and net income to decline, perhaps materially. Reductions in Medicare reimbursement could be caused by many factors, including:

- administrative or legislative changes to the base rates under the applicable prospective payment systems;
- the reduction or elimination of annual rate increases;
- the imposition or increase by Medicare of mechanisms, such as co-payments, shifting more responsibility for a portion of payment to beneficiaries;

adjustments to the relative components of the wage index used in determining reimbursement rates;

changes to case mix or therapy thresholds;

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the reclassification of home health resource groups or long-term care diagnosis-related groups; or

further limitations on referrals to long-term acute care hospitals from host hospitals.

We generally receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure category of the Consumer Price Index, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. Our base episode rate for home nursing services is also subject to an annual market basket adjustment. For 2008, the home health market basket percentage increase is 3.0 percent. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our net income could be adversely impacted.

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

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

agency, facility and professional licensure and certificates of need and permits of approval;

conduct of operations, including financial relationships among health care providers, Medicare fraud and abuse and physician self-referral;

maintenance and protection of records, including HIPAA;

environmental protection, health and safety;

certification of additional agencies or facilities by the Medicare program; and

payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer and our interactions with patients and other providers. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws, regulations, their interpretations or the enactment of new laws or regulations could increase our costs of doing business and cause our net income to decline. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state reimbursement programs.

We are subject to various routine and non-routine governmental reviews, audits and investigations. In recent years federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including with respect to referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. A violation or change in the interpretation of

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

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

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

In addition, if our long-term acute care hospitals fail to meet or maintain the standards for Medicare certification as long-term acute care hospitals, such as for average minimum length of patient stay, they will receive reimbursement under the prospective payment system applicable to general acute care hospitals rather than the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our long-term acute care hospitals receiving less Medicare reimbursement than they currently receive for their patient services. Moreover, all of our long-term acute care hospitals are subject to additional Medicare criteria because they operate as separate hospitals located in space leased from and located in, a general acute care hospital, known as a host hospital. This is known as a hospital within a hospital model. These additional criteria include requirements concerning financial and operational separateness from the host hospital. If several of our long-term acute care hospitals were subject to payment as general acute care hospitals or fail to comply with the separateness requirements, our net service revenue and net income would decline.

CMS has adopted regulations that could materially and adversely impact the revenue and net income of our long-term acute care hospitals.

In a final rule released on May 1, 2007, CMS expanded the policy to apply not only to LTACH HwHs and satellites but also to freestanding LTACHs and grandfathered LTACHs as well as to HwHs and satellites that admit Medicare patients from non-co-located hospitals. While this policy change was supposed to take effect for cost reporting periods beginning on or after July 1, 2007, the MMSEA delayed the implementation of the policy for three years with respect to freestanding LTACHs and grandfathered LTACHs. Further, the MMSEA set the percentage threshold at 50 percent for three years for HwHs and satellites located in urban areas that would otherwise be subject to a transition period and it established a 75 percent ceiling for HwHs and satellite facilities located in rural areas and those that receive referrals from MSA dominant hospitals or urban single hospitals.

We currently have a total of seven LTACHs. Six of our hospitals are classified as HwHs and one as freestanding. Of the six HwH facilities, four are located in rural or non-MSAs and are therefore subject to a final admission percentage of 50 percent at the end of the phase-in period. Two of our six HwH facilities are located in MSA or urban areas and will be subject to a final admission percentage of 25 percent at the end of the phase-in period. Of these six locations classified as HwHs, two facilities are satellite locations of a parent hospital located in an MSA and one is a satellite location of a parent hospital located in a non-MSA. Based on our discussions with CMS, we believe each of these satellite locations will be viewed as being located in a non-MSA regardless of the location of its parent hospital and will be treated independently from its parent for purposes of calculating its compliance with the admissions limitations. If the 25 percent rule is extended, as planned, to freestanding LTACHs after the three-year delay

(established in the MMSEA), our current freestanding facility would not be affected because we currently do not receive more than 25 percent of our Medicare admissions from any single referring hospital.

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For the 12 months ended December 31, 2007, on an individual basis, all of our LTACH locations admitted between 50.0 percent and 75.0 percent of their patients from their host hospitals. These hospitals came under the proper threshold as of September 30, 2007. Our remaining LTACH is not an HwH; therefore, it is not subject to these limits on host hospital referrals.

Our ability to quantify the potential reduction in our reimbursement rates resulting from the implementation of these new regulations is contingent upon a variety of factors, such as our ability to reduce the percentage of admissions that are derived from our host hospitals and, if necessary, our ability to relocate our existing long-term acute care hospitals to freestanding locations. We may not be able to successfully restructure or relocate these operations without incurring significant expense or in a manner that avoids reimbursement reductions. If these new regulations result in lower reimbursement rates, our net service revenue and net income could decline. As a result of these new rules, we do not intend to expand the number of hospital within a hospital long-term acute care hospitals that we operate.

We are reimbursed by Medicare for services we provide in our long-term acute care hospitals based on the long-term care diagnosis-related group assigned to each patient. CMS establishes these long-term care diagnosis-related groups by grouping diseases by diagnosis, which group reflects the amount of resources needed to treat a given disease. These new rules reclassify certain long-term care diagnosis-related groups, which could result in a decrease in reimbursement rates. Further, the new rules kept in place the financial penalties associated with the failure to limit the total number of Medicare patients discharged from a host hospital and subsequently readmitted to a long-term acute care hospital located within the host hospital to no greater than 5.0 percent. If we fail to comply with these readmission rates or if our reimbursement rates decline due to the reclassification of certain long-term care diagnosis-related groups, our net service revenue and net income could decline.

Legislative initiatives could negatively impact our operations and financial results.

In recent years, an increasing number of legislative initiatives have been introduced or proposed in Congress and in state legislatures that would result in major changes in the health care system, either at the national or state level. Many of these proposals have been introduced in an effort to reduce costs. For example, the Medicare Modernization Act of 2003 (MMA) allocated significant additional funds to Medicare managed care providers in order to promote greater participation in those plans by Medicare beneficiaries. If these increased funding levels achieve their intended result, the rate of growth in the Medicare fee-for-service market could decline. For the years ended December 31, 2007, 2006 and 2005, we received 81.7 percent, 82.6 percent and 86.4 percent, respectively, of our net service revenue from the Medicare fee-for-service market. Among other proposals that have been introduced are insurance market reforms to increase the availability of group health insurance to small businesses, requirements that all businesses offer health insurance coverage to their employees and the creation of government health insurance or plans that would cover all citizens and increase payments by beneficiaries. We cannot predict whether any of the above proposals, or any other future proposals, will be adopted. If adopted, we could be forced to expend considerable resources to comply with and implement such reforms.

More than 50 percent of our net service revenue is currently generated in Louisiana, making us particularly sensitive to economic and other conditions in that state.

Our Louisiana agencies and facilities accounted for approximately 50.9 percent, 64.1 percent and 78.6 percent of net service revenue during the years ended December 31, 2007, 2006 and 2005, respectively. Any material change in the current economic or competitive conditions in Louisiana could have a disproportionate effect on our overall business results.

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

Our market areas in the southern United States are particularly susceptible to hurricanes. Such weather events can disrupt our operations, result in damage to our properties and negatively affect the local economies

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in which we operate. In late summer 2005, Hurricane Katrina and Hurricane Rita struck the Gulf Coast region of the United States and caused extensive and catastrophic physical damage to those areas. While we believe we have recovered from the effects of Hurricane Katrina and Hurricane Rita, future hurricanes could affect our operations or the economies in those market areas and result in damage to certain of our facilities, the equipment located at such facilities or equipment rented to customers in those areas. Our business or results of operations may be adversely affected by these and other negative effects of future hurricanes.

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

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

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement from the time we request payment for our services to the time we receive reimbursement or payment. A portion of our estimated reimbursement (60.0 percent for an initial episode of care and 50.0 percent for subsequent episodes of care) for each Medicare episode is billed at the commencement of the episode and we typically receive payment within approximately 12 days. The remaining reimbursement is billed upon completion of the episode and is typically paid within 14 to 17 days from the billing date. If we have information system problems or issues arise with Medicare or other payors, we may encounter further delays in our payment cycle. For example, in the past we have experienced delays resulting from problems arising out of the implementation by Medicare of new or modified reimbursement methodologies or as a result of natural disasters, such as hurricanes. We have also experienced delays in reimbursement resulting from our implementation of new information systems related to our accounts receivable and billing functions. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our consolidated results of operations and liquidity. Our working capital management procedures may not successfully negate this risk. Significant delays in payment or reimbursement could have an adverse impact on our liquidity and financial condition.

The termination of a large number of managed care contracts in the fourth quarter of 2007 may lead to a decrease in revenues.

In response to the challenges associated with collecting from Commercial payors and the unprofitable reimbursement rates paid by many Commercial payors, the Company terminated or sent notice of termination to 285 Commercial payors for home health services in the fourth quarter of 2007. These 285 Commercial payors had reimbursement rates averaging 26 percent below cost, representing approximately 8 percent of the Company s home health revenue, 16 percent of the Company s home health admissions and 44 percent of the Company s bad debt write-offs against home health revenue in 2007. The termination of these contracts may cause a decrease in our revenues.

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

On an ongoing basis, we estimate the amount of Medicare, Medicaid and private insurance receivables that we will not be able to collect. This allows us to calculate the expected loss on our receivables for the

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period we are reporting. Our allowance for contractual adjustments and doubtful accounts may underestimate actual unpaid receivables for various reasons, including:

adverse changes in our estimates as a result of changes in payor mix and related collection rates;

inability to collect funds due to missed filing deadlines or inability to prove that timely filings were made;

adverse changes in the economy generally exceeding our expectations; or

unanticipated changes in reimbursement from Medicare, Medicaid and private insurance companies.

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

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

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

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

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

incur more debt;

redeem or repurchase stock, pay dividends or make other distributions;

make certain investments;

create liens;

enter into transactions with affiliates;

make unapproved acquisitions;

merge or consolidate;

transfer or sell assets; and

make fundamental changes in our corporate existence and principal business.

In addition, events beyond our control could affect our ability to comply with and maintain these financial tests and ratios. Any failure by us to comply with or maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to our credit facility or any other future debt

agreements. This could lead to the acceleration of the maturity of any outstanding loans and the termination of the commitments to make further extensions of credit. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business at our sole discretion could harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

If the structures or operations of our joint ventures are found to violate the law, our financial condition and consolidated results of operations could be materially adversely impacted.

As of December 31, 2007, we had entered into 71 joint ventures with respect to the ownership and operation of 60 home nursing agency locations, five hospices and six long-term acute care hospital locations.

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Our joint ventures are structured either as equity joint ventures or agency leasing arrangements, as permitted by applicable state laws and subject to business considerations. As of December 31, 2007, we had 66 equity joint ventures and five agency leasing arrangements. Of these 66 joint ventures, 53 are with hospitals, seven are with physicians and six are with other parties. With respect to our seven joint ventures with physicians, six are for the ownership and operation of long-term acute care hospitals and one is for the ownership of a home nursing agency.

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

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

Although we have sought to satisfy as many safe harbor requirements as possible, our joint ventures may not satisfy all elements of the safe harbor requirements.

Our seven joint ventures with physicians are also governed by the Stark Law and similar state laws, which restrict physicians from making referrals for particular health care services to entities with which the physicians or their families have a financial relationship. We also believe we have structured our physician joint ventures in a way that meets applicable exceptions under the Stark Law and similar state physician referral laws. For example, we believe our one physician joint venture for a home nursing agency comply with the rural provider exception to the Stark Law and that our six physician joint ventures for long-term acute care hospitals comply with the whole hospital exception to the Stark Law.

If any of our joint ventures were found to be in violation of federal or state anti-kickback or physician referral laws, we could be required to restructure them or refuse to accept referrals from the physicians or hospitals with which we have entered into a joint venture. We also could be required to repay to Medicare amounts we have received pursuant to any prohibited referrals and we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs. If any of our joint ventures were subject to any of these penalties, our business could be damaged. In addition, our growth strategy is, in part, based on the continued development of new joint ventures with rural hospitals for the ownership and operation of home nursing agencies. If the structure of any of these joint ventures were found to violate federal or state anti-kickback statutes or physician referral laws, we may be unable to implement our growth strategy, which could have an adverse impact on our future net income and consolidated results of operations.

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

Upon the occurrence of fundamental changes to the laws and regulations applicable to our joint ventures, or if a substantial number of our joint venture partners were to exercise the buy/sell provisions contained in

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many of our joint venture agreements, we may be obligated to purchase or sell the equity interests held by us or our joint venture partners. The purchase price under these buy/sell provisions is typically based on a multiple of the historical or projected earnings before income taxes, depreciation and amortization of the joint venture at the time the buy/sell option is exercised. In the event the buy/sell provisions are exercised and we lack sufficient capital to purchase the interest of our joint venture partners, we may be obligated to sell our equity interest in these joint ventures. If we are forced to sell our equity interest, we will lose the benefit of those particular joint venture operations. If these buy/sell provisions are exercised and we choose to purchase the interest of our joint venture partners, we may be obligated to expend significant capital in order to complete such acquisitions. If either of these events occurs, our net service revenue and net income could decline or we may not have sufficient capital necessary to implement our growth strategy.

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

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

The loss of certain senior management could have a material adverse effect on our operations and financial performance.

Our success depends upon the continued employment of certain members of our senior management, including our co-founder, Chief Executive Officer and Chairman, Keith G. Myers, our Senior Vice President, Chief Financial Officer and Treasurer, Peter J. Roman, and our President, Chief Operating Officer, Secretary and Director, John L. Indest. We have entered into an employment agreement with each of these officers in an effort to further secure their employment. The loss of service of any of these officers could have a material adverse effect on our operations if we were unable to find a suitable replacement.

If we are subject to substantial malpractice or other similar claims, our net income could be materially, adversely impacted.

The services we offer have an inherent risk of professional liability and related, substantial damage awards. We, and the nurses and other health care professionals who provide services on our behalf, may be the subject of medical malpractice claims. These nurses and other health care professionals could be considered our agents and, as a result, we could be held liable for their medical negligence. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We maintain malpractice liability insurance that provides primary coverage on a claims-made basis of $1.0 million per incident and $3.0 million in annual aggregate amounts. In addition, we maintain multiple layers of umbrella coverage in the aggregate amount of $25.0 million that provide excess coverage for professional malpractice and other liabilities. We are responsible for deductibles and amounts in excess of the limits of our coverage. Claims that could be made in the future in excess of the limits of such insurance, if successful, could materially, adversely affect our ability to conduct business or manage our assets. In addition, our insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

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

Our ability to expand operations in a state will depend on our ability to obtain a state license to operate. States may have a limit on the number of licenses they issue. For example, as of December 31, 2007 we operated 42 home nursing agencies in Louisiana. Louisiana currently has a moratorium on the issuance of new home nursing agency licenses through July 1, 2008. We cannot predict whether this moratorium will be extended beyond this date or whether any other states in which we currently operate, or may wish to operate in the future, may adopt a similar moratorium.

In addition to the moratorium imposed by the state of Louisiana, nine of the states in which we currently operate, or plan to operate in the future, require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction or expansion of health care facilities, to make certain capital expenditures or to make changes in services or bed capacity. The states that currently issue certificate of need or permits of approval are: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, South Carolina, Tennessee, Vermont, Washington, West Virginia and the District of Columbia. In granting approval, these states consider the need in the service area for additional or expanded health care facilities or services. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

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

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

If we are unable to protect the proprietary nature of our software systems and methodologies, our business and financial condition could be harmed.

We have developed a proprietary software system, which we refer to as our Service Value Point system, that allows us to collect assessment data, establish treatment plans, monitor patient treatment and evaluate our clinical and financial performance. In addition, we rely on other proprietary methodologies or information to which others may obtain access or independently develop. To protect our proprietary information, we require certain employees, consultants, financial advisors and strategic partners to enter into confidentiality and non-disclosure agreements. These agreements may not ultimately provide meaningful protection for our proprietary information in the event of any unauthorized use, misappropriation or disclosure. If our competitors were able to replicate our Service Value Point system, it could allow them to improve their operations and thereby compete more effectively in the markets in which we provide our services. If we are unable to protect the proprietary nature of our Service Value Point system or our other proprietary information or methodologies, our business and financial performance could be harmed.

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

In addition to our Service Value Point system, our business is substantially dependent on other non-proprietary software. We utilize a third-party software information system for our long-term acute care hospitals. Our various home nursing agency databases were fully consolidated into an enterprise-wide system during the first half of 2005. Problems with, or the failure of, these systems could negatively impact our clinical performance and our management and reporting capabilities. Any such problems or failure could materially and adversely affect our operations and reputation, result in significant costs to us, cause delays in our ability to bill Medicare or other payors for our services, or impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems with regard to our proprietary and non-proprietary software may be substantial and could adversely affect our net income.

Our information systems are networked via public network infrastructure and standards based encryption tools that meet regulatory requirements for transmission of protected health care information over such networks. However, threats from computer viruses, instability of the public network on which our data transit relies, or other instances that might render those networks unstable or disabled would create operational difficulties for us, including the ability to effectively transmit claims and maintain efficient clinical oversight of our patients as well as the disruption of revenue reporting and billing and collections management, which could adversely affect our business or operations.

Future acquisitions may be unsuccessful and could expose us to unforeseen liabilities.

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

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

Our acquisition and internal development activity may impose strains on our existing resources.

We have grown significantly over the past four years. As we continue to expand our markets, our growth could strain our resources, including management, information and accounting systems, regulatory compliance, logistics and other internal controls. Our resources may not keep pace with our anticipated growth. If we do not manage our expected growth effectively, our future prospects could be affected adversely.

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

We intend to continue growing through the acquisition of additional home nursing agencies and the formation of joint ventures with rural hospitals for the operation of home nursing agencies. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher prices for our acquisitions and joint ventures. Recently, we have observed an increase in the

acquisition prices for select home nursing agencies. We cannot assure you that we will be able to identify suitable acquisition or joint venture opportunities in the future or that any such opportunities, if identified, will be consummated on favorable terms, if at all. Without

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successful acquisitions or joint ventures, our future growth rate could decline. In addition, we cannot assure you that any future acquisitions or joint ventures, if consummated, will result in further growth.

We may be unable to secure the additional capital necessary to implement our growth strategy.

As of December 31, 2007, we had $1.2 million in cash. Based on our current plan of operations, including acquisitions, we believe this amount, when combined with a revolving line of credit totaling $37.5 million available under our credit facility, which, subject to certain conditions, may be increased to $50.0 million, will be sufficient to fund our growth strategy and to meet our currently anticipated operating expenses, capital expenditures and debt service obligations for at least the next 12 months. If our future net service revenue or cash flow from operations is less than we currently anticipate, we may not have sufficient funds to implement our growth strategy. Further, we cannot readily predict the timing, size and success of our acquisition and internal development efforts and the associated capital commitments. If we do not have sufficient cash resources, our growth could be limited unless we are able to obtain additional equity or debt financing.

We are a holding company with no operations of our own.

We are a holding company with no operations of our own. Accordingly, our ability to service our debt and pay dividends, if any, is dependent upon the earnings from the business conducted by our subsidiaries. The distributions of those earnings or advances or other distributions of funds by these subsidiaries to us are contingent upon the subsidiaries earnings and are subject to various business considerations. In addition, distributions by subsidiaries could be subject to statutory restrictions, including state laws requiring that the subsidiary be solvent, or contractual restrictions. If our subsidiaries are unable to make sufficient distributions or advances to us, we may not have the cash resources necessary to service our debt or pay dividends.

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

Our executive officers and directors and individuals or entities affiliated with them, beneficially own an aggregate of approximately 18.5 percent of our outstanding common stock as of December 31, 2007. The interests of these stockholders may differ from your interests. If they were to act together, these stockholders would be able to significantly influence all matters that our stockholders vote upon, including the election of directors, business combinations, the amendment of our certificate of incorporation and other significant corporate actions.

Certain provisions of our charter, bylaws Delaware law and our stockholder s rights plan may delay or prevent a change in control of our company.

Delaware law and our corporate documents contain provisions that may enable our board of directors to resist a change in control of our company. These provisions include:

a staggered board of directors;

limitations on persons authorized to call a special meeting of stockholders;

the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval

advance notice procedures required for stockholders to nominate candidates for election as directors or to bring matters before an annual meeting of stockholders; and

a stockholder s rights plan that includes a 20 percent threshold for triggering events, a three-year term for directors, an independent director evaluation provision (commonly known as a TIDE provision) and a stockholder redemption feature allowing stockholders to vote at a special meeting that would be called to consider qualified takeover offers.

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

Our stock price may be volatile and your investment in our common stock could suffer a decline in value.

The price at which our common stock will trade may be volatile. The stock market has from time to time experienced significant price and volume fluctuations that have affected the market prices of securities, particularly securities of health care companies. The market price of our common stock may be influenced by many factors, including:

- our operating and financial performance;
- variances in our quarterly financial results compared to research analyst expectations;
- the depth and liquidity of the market for our common stock;
- future sales of our common stock or the perception that sales could occur;
- investor perception of our business, acquisitions and our prospects;
- developments relating to litigation or governmental investigations;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters; or
- general economic and stock market conditions.

In addition, the stock market, and the NASDAQ Global Select Market, or NASDAQ, in particular, has experienced price and volume fluctuations that have often been unrelated or disproportionate to the operating performance of health care provider companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. In the past, securities class-action litigation has often been brought against companies following periods of volatility in the market price of their respective securities. We may become involved in this type of litigation in the future. Litigation of this type is often expensive to defend and may divert the attention of our senior management as well as resources from the operation of our business.

We currently do not intend to pay dividends on our common stock and, consequently, your only opportunity to achieve a return on your investment is if the price of our common stock appreciates and you sell your shares.

We do not plan to declare dividends on shares of our common stock in the foreseeable future. Consequently, your only opportunity to achieve a return on your investment in our common stock will be if the market price of our common stock appreciates and you sell your shares at a profit. There is no guarantee that the price of our common stock will ever exceed the price that you pay.

We incur costs as a result of being a public company.

As a public company, we incur significant legal, accounting and other expenses associated with our public company reporting requirements and corporate governance requirements, including requirements under the Sarbanes-Oxley Act of 2002 (Sarbanes-Oxley) and the rules of the SEC and NASDAQ. We expect these requirements to continue

increasing our legal and financial compliance costs and to make some activities more time-consuming and costly. For example, we expect to continue incurring significant costs in connection with the assessment of our internal controls. We also expect these rules and regulations may make it more expensive for us to obtain director and officer liability insurance. We are currently evaluating and monitoring developments with respect to these new rules and we cannot predict or estimate the amount of additional costs we may incur or the timing of such costs.

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

Beginning with our annual report for the year ending December 31, 2006, we are required to report on the effectiveness of our internal control over financial reporting as required by Section 404 of Sarbanes-Oxley. Under Section 404, we are required to assess the effectiveness of our internal control over financial reporting and report our conclusion in our annual report. Our auditor is also required to report its conclusion regarding the effectiveness of our internal control over financial reporting. The existence of one or more material weaknesses would require us and our auditor to conclude that our internal control over financial reporting is not effective. If there are identified deficiencies in our internal control over financial reporting, we could be subject to regulatory scrutiny and a loss of public confidence in our financial reporting, which could have an adverse effect on our business and our stock price. We reported a material weakness at December 31, 2007, and our auditor reported our internal control over financial reporting was ineffective at December 31, 2007.

Item 1B. ***Unresolved Staff Comments***

Not applicable.

Item 2. ***Properties***

As of December 31, 2007 we owned or managed 58 locations in Louisiana, 27 in Mississippi, 22 in Kentucky, 14 in Arkansas, 11 in Alabama, 11 in West Virginia, eight in Texas, eight in Tennessee, seven in Florida, five in Georgia and one in Ohio. Our home office is located in Lafayette, Louisiana in 19,159 square feet of leased office space under a lease that commenced on March 1, 2004 and expires February 28, 2014. Typically, our home nursing agencies are located in leased facilities. Generally, the leases for our home nursing agencies have initial terms of one year, but range from one to five years. Most of the leases either contain multiple options to extend the lease period in one-year increments or convert to a month-to-month lease upon the expiration of the initial term. Six of our long-term acute care hospitals locations are hospitals within a hospital, meaning we have a lease or sublease for space with the host hospital. Generally, our leases or subleases for long-term acute care hospitals have initial terms of five years, but range from three to ten years. Most of our leases and subleases for our long-term acute care hospitals contain multiple options to extend the term in one-year increments.

Item 3. ***Legal Proceedings***

We are involved in litigation and proceedings in the ordinary course of our business. We do not believe that the outcome of any of the matters in which we are currently involved, individually or in the aggregate, will have a material adverse effect upon our business, financial condition or results of operations.

Item 4. ***Submission of Matters to a Vote of Security Holders***

No matters were submitted to a vote of the Company s stockholders during the fourth quarter of 2007.

PART II

Item 5. ***Market for Registrant s Common Equity and Related Stockholder Matters and Issuer Purchases of Equity Securities***

Holders

The Company s common stock trades on the NASDAQ Global Select Market under the symbol LHCG. As of March 5, 2008, there were approximately 142 registered holders of record of the Company s common stock and the Company believes there are approximately 13,500 beneficial holders.

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Dividend Policy

The Company has not paid any dividends on its common stock since the initial public offering in 2005 and does not anticipate paying dividends in the foreseeable future. We currently intend to retain future earnings, if any, to support the development and growth of our business. Payment of future dividends, if any, will be at the discretion of our board of directors.

Price Range of Common Stock

The following table provides the high and low prices of the Company s Common Stock during 2007 and 2006 as quoted by NASDAQ Global Select Market.

	High	Low
2007		
Fourth Quarter	$ 26.17	$ 20.28
Third Quarter	27.06	18.58
Second Quarter	33.14	24.52
First Quarter	33.00	24.15

	High	Low
2006		
Fourth Quarter	$ 29.67	$ 22.23
Third Quarter	24.78	18.70
Second Quarter	21.35	15.73
First Quarter	18.39	13.70

The closing price of our common stock as reported by NASDAQ on March 5, 2008 was $17.01

Performance Graph

This item is incorporated by reference to our annual report to stockholders for the fiscal year ended December 31, 2007.

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Item 6. ***Selected Financial Data***

The selected consolidated financial data presented below is derived from our audited consolidated financial statements for each of the years ended December 31, 2003 through December 31, 2007. The financial data for the years ended December 31, 2007, 2006 and 2005 should be read together with our consolidated financial statements and related notes and Management s Discussion and Analysis of Financial Condition and Consolidated Results of Operations included herein.

	Year Ended December 31,				
	2007	2006	2005	2004	2003
	(In thousands except share and per share data)				
Consolidated Statements of Income Data:					
Net service revenue	$ 298,031	$ 218,535	$ 155,687	$ 116,090	$ 68,515
Cost of service revenue	152,577	112,095	82,996	57,672	34,455
Gross margin	145,454	106,440	72,691	58,418	34,060
General and administrative expenses	106,795	71,115	46,519	35,168	23,411
Impairment loss					31
Equity-based compensation expense(1)			3,856	1,788	864
Operating income	38,659	35,325	22,316	21,462	9,754
Interest expense	376	325	1,067	1,328	1,223
Non-operating (income) loss, including gain on sale of assets	(1,073)	(2,033)	(574)	13	(106)
Income from continuing operations before income taxes and minority interest and cooperative endeavor allocations	39,356	37,033	21,823	20,121	8,637
Income tax expense	12,147	10,817	6,052	6,111	2,400
Minority interest and cooperative endeavor allocations	5,984	4,795	4,545	4,158	2,837
Income from continuing operations	21,225	21,421	11,226	9,852	3,400
Loss from discontinued operations, net	(1,667)	(1,464)	(1,124)	(851)	(557)
Gain on sale of discontinued operations, net	31	637		312	
Net income	19,589	20,594	10,102	9,313	2,843
Change in the redemption value of redeemable minority interests	193	1,163	(1,476)		
Net income available to common stockholders	$ 19,782	$ 21,757	$ 8,626	$ 9,313	$ 2,843
Earnings per share-basic(2):					
Income from continuing operations	$ 1.19	$ 1.25	$ 0.77	$ 0.82	$ 0.28
Loss from discontinued operations	(0.09)	(0.09)	(0.08)	(0.07)	(0.04)
Gain on sale of discontinued operations, net		0.04		0.02	

Net income	1.10	1.20	0.69	0.77	0.24
Change in the redemption value of redeemable minority interests	0.01	0.07	(0.10)		
Net income available to common stockholders	$ 1.11	$ 1.27	$ 0.59	$ 0.77	$ 0.24
Earnings per share-diluted(2):					
Income from continuing operations	$ 1.19	$ 1.25	$ 0.77	$ 0.81	$ 0.27
Loss from discontinued operations	(0.09)	(0.09)	(0.08)	(0.07)	(0.04)
Gain on sale of discontinued operations, net		0.04		0.02	
Net income	1.10	1.20	0.69	0.76	0.23
Change in the redemption value of redeemable minority interests	0.01	0.07	(0.10)		
Net income available to common stockholders	$ 1.11	$ 1.27	$ 0.59	$ 0.76	$ 0.23