CHEMED CORP
Form 10-K
February 27, 2014

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, D.C. 20549

FORM 10-K

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

þ For the fiscal year ended December 31, 2013
o Transition Report Pursuant to Section 13 or 15(d) of the Securities Exchange Act of 1934

For the Transition Period from _____ to _____
Commission File Number: 1-8351

CHEMED CORPORATION
(Exact name of registrant as specified in its charter)

Delaware	31-0791746
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
Suite 2600, 255 East Fifth Street, Cincinnati, Ohio	45202-4726
(Address of principal executive offices)	(Zip Code)

(513) 762-6500
(Registrant's Telephone number, including area code)
Securities registered pursuant to Section 12(b) of the Act:

Title of Each Class	Name of each exchange on which registered
Capital Stock – Par Value $1 Per Share	New York Stock Exchange

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

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

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 ¨ 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 ¨

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, if definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. Yes o No þ

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definition of "accelerated filer, large accelerated filer and smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check One): Large accelerated filer þ Accelerated filer ¨ Non-accelerated filer ¨ Smaller reporting company ¨

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

The aggregate market value of the voting stock held by non-affiliates of the registrant, based upon the average bid and asked price of said stock on the New York Stock Exchange – Composite Transaction Listing on June 28, 2013 ($72.91 per share), was $1,322,373,045.

At February 14, 2014, 17,727,672 shares of Chemed Capital Stock (par value $1 per share) were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Document	Where Incorporated
2013 Annual Report to Stockholders (specified portions)	Parts I, II, and IV
Proxy Statement for Annual Meeting to be held May 19, 2014	Part III

CHEMED CORPORATION
2013 FORM 10-K ANNUAL REPORT

Table of Contents

Item 1. Business

General

Chemed Corporation (the Company or Chemed) was incorporated in Delaware in 1970 as a subsidiary of W.R. Grace & Co. and succeeded to the business of W.R. Grace & Co.'s Special Products Group as of April 30, 1971 and remained a subsidiary of W.R. Grace & Co. until March 10, 1982.

Chemed purchases, operates and divests subsidiaries engaged in diverse business activities for the purposes of maximizing shareholder value. The Company's operating businesses are managed on a decentralized basis. There are few integrated business functions (such as sales, marketing or purchasing). Chemed's corporate office management participates in and is ultimately responsible for significant capital allocation decisions, investment activities, financial reporting, tax, legal and the selection of the key executives of each of the operating businesses. Since its inception, the Company has engaged in twelve significant acquisitions or divestitures of diverse business units.

During 2013, Chemed conducted its business operations in two segments: the VITAS segment (VITAS) and the Roto-Rooter segment (Roto-Rooter). VITAS Healthcare Corporation provides hospice and palliative care services to its patients through a network of physicians, registered nurses, home health aides, social workers, clergy and volunteers. Roto-Rooter provides plumbing and drain cleaning services to both residential and commercial customers.

Forward Looking Statements

This Annual Report contains or incorporates by reference certain forward looking statements within the meaning of the Private Securities Litigation Reform Act of 1995. The Company intends such statements to be subject to the safe harbors created by that legislation. Such statements involve risks and uncertainties that could cause actual results of operations to differ materially from these forward looking statements.

Financial Information about Industry Segments

The required segment and geographic data for the Company's continuing operations (as described below) for three years ended December 31, 2011, 2012 and 2013 are shown in Note 5 of the Notes to Consolidated Financial Statements on pages 66-68 of the 2013 Annual Report to Stockholders and are incorporated herein by reference.

Description of Business by Segment

The information called for by this item is included within Note 5 of the Notes to Consolidated Financial Statements appearing on pages 66-68 of the 2013 Annual Report to Stockholders is incorporated herein by reference.

Product and Market Development

Each segment of the Company's business engages in a continuing program for the development and marketing of new services and products. While new products and services and new market development are important factors for the growth of each active segment of the Company's business, the Company does not expect that any new products and services or marketing effort, including those in the development stage, will require the investment of a material amount of the Company's assets.

Patents, Service Marks and Licenses

The Roto-Rooter® trademarks and service marks have been used and advertised since 1935 by Roto-Rooter Corporation, a wholly owned indirect subsidiary of the Company. The Roto-Rooter® marks are among the most highly recognized trademarks and service marks in the United States. The Company considers the Roto-Rooter® marks to be a valuable asset and a significant factor in the marketing of Roto-Rooter's franchises, products and services and the products and services provided by its franchises.

"VITAS" and "Innovative Hospice Care" are trademarks and servicemarks of VITAS Healthcare Corporation. The Company and its subsidiaries also own certain trade secrets including training manuals, cost information, customer information and software source codes. Certain states require certificates of need to conduct hospice operations. In those states, we consider certificates of need valuable assets.

Seasonality

Roto-Rooter's revenue and operating results are impacted by significant weather patterns across the United States. Periods of above average precipitation or below freezing temperatures in areas we have significant company-owned operations will generally improve the revenue and operating results at Roto-Rooter.

A significant portion of our VITAS business is operated in the state of Florida. As the vast majority of our patients are Medicare recipients, retirees relocating to Florida during the winter months generally result in higher admissions and revenue for our Florida programs during that period.

Customer Concentration

Roto-Rooter's business has a large and diverse customer base. Approximately 90% of VITAS' revenue is from the United States government through the Medicare program. The loss of a portion or all of our Medicare revenue would have a material adverse effect on the Company.

Competition

Roto-Rooter

All aspects of the sewer, drain and pipe cleaning and plumbing repair businesses are highly competitive. Competition is, however, fragmented in most markets with local and regional firms providing the primary competition. The principal methods of competition are advertising, range of services provided, name recognition, emergency-service availability, speed and quality of customer service, service guarantees, and pricing.

VITAS

Hospice care in the United States is competitive. Because programs for hospice services are generally uniform, VITAS competes primarily on the basis of its ability to deliver quality, responsive services. VITAS is one of the nation's largest providers of hospice services in a market dominated primarily by small, non-profit, community-based hospices. Approximately 32% of all hospices are not-for-profit. Because the hospice care market is highly fragmented, VITAS competes with a large number of organizations.

VITAS also competes with a number of national and regional hospice providers, including Gentiva Health Services, Inc., hospitals, nursing homes, home health agencies and other health care providers. Many providers offer home care to patients who are terminally ill, and some actively market palliative care and hospice-like programs. In addition, various health care companies have diversified into the hospice market. Some of these health care companies have greater financial resources than VITAS. Relatively few barriers to entry exist in the majority of markets served by VITAS. Accordingly, other companies that are not currently providing hospice care may enter these markets and expand the variety of services they offer to include hospice.

Research and Development

The Company engages in a continuous program directed toward the development of new services, products and processes, the improvement of existing services, products and processes, and the development of new and different uses of existing products. The research and development expenditures from continuing operations have not been nor are they expected to be material.

Government Regulations

Roto-Rooter

Roto-Rooter's franchising activities are subject to various federal and state franchising laws and regulations, including the rules and regulations of the Federal Trade Commission (the "FTC") regarding the offering or sale of franchises. The rules and regulations of the FTC require that Roto-Rooter provide all the prospective franchises with specific information regarding the franchise program and Roto-Rooter in the form of a detailed franchise offering circular. In addition, a number of states require Roto-Rooter to register its franchise offering prior to offering or selling franchises in the state. Various state laws also provide for certain rights in favor of franchisees, including (i) limitations on the franchisor's ability to terminate a franchise except for good cause, (ii) restrictions on the franchisor's ability to deny renewal of a franchise, (iii) circumstances under which the franchisor may be required to purchase certain inventory of franchisees when a franchise is terminated or not renewed in violation of such laws, and (iv) provisions relating to arbitration. Roto-Rooter's ability to engage in the plumbing repair business is also subject to certain limitations and restrictions imposed by state and local licensing laws and regulations.

VITAS

General. The health care industry and VITAS' hospice programs are subject to extensive federal and state regulation. VITAS' hospices are licensed as required under state law as either hospices or home health agencies, or both, depending on the regulatory requirements of each particular state. In addition, VITAS' hospices are required to meet certain conditions of participation to be eligible to receive payments as hospices under Medicare and Medicaid programs. All of VITAS' hospices, other than those currently in development, are certified for participation as hospices in the Medicare program, and are also eligible to receive payments as hospices from the Medicaid program in each of the states in which VITAS operates. VITAS' hospices are subject to periodic survey by governmental authorities or private accrediting entities to assure compliance with state licensing, certification and accreditation requirements.

Medicare Conditions of Participation. Federal regulations require that a hospice program satisfy certain Conditions Of Participation ("COP") to be certified and receive Medicare payment for the services it provides. Failure to comply with the conditions of participation may result in sanctions, up to and including decertification from the Medicare program. See "Surveys and Audits" below.

The Medicare COP for hospice programs include the following:

Governing Body. Each hospice must have a governing body that assumes full responsibility for the policies and the overall operation of the hospice and for ensuring that all services are provided in a manner consistent with accepted standards of practice. The governing body must designate one individual who is responsible for the day-to-day management of the hospice.

Medical Director. Each hospice must have a medical director who is a physician and who assumes responsibility for overseeing the medical component of the hospice's patient care program.

Direct Provision of Core Services. Medicare limits those services for which the hospice may use individual independent contractors or contract agencies to provide care to patients. Specifically, substantially all nursing, social work, and counseling services must be provided directly by hospice employees meeting specific educational and professional standards. During periods of peak patient loads or under extraordinary circumstances, the hospice may be permitted to use contract workers, but the hospice must agree in writing to maintain professional, financial and administrative responsibility for the services provided by those individuals or entities.

Professional Management of Non-Core Services. A hospice may arrange to have non-core services such as therapy services, home health aide services, medical supplies or drugs provided by a non-employee or outside entity. If the hospice elects to use an independent contractor to provide non-core services, however, the hospice must retain professional management responsibility for the arranged services and ensure that the services are furnished in a safe and effective manner by qualified personnel, and in accordance with the patient's plan of care.

Plan of Care. The patient's attending physician, the medical director or the designated hospice physician, and interdisciplinary team must establish an individualized written plan of care prior to providing care to any hospice patient. The plan must assess the patient's needs and identify services to be provided to meet those needs and must be reviewed and updated at specified intervals.

Continuation of Care. A hospice may not discontinue or reduce care provided to a Medicare beneficiary if the individual becomes unable to pay for that care.

Informed Consent. The hospice must obtain the informed consent of the hospice patient, or the patient's legal representative, that specifies the type of care services that may be provided as hospice care.

Training. A hospice must provide ongoing training for its employees.

Quality Assurance. A hospice must conduct ongoing and comprehensive self-assessments of the quality and appropriateness of care it provides and that its contractors provide under arrangements to hospice patients.

Interdisciplinary Team. A hospice must designate an interdisciplinary team to provide or supervise hospice care services. The interdisciplinary team develops and updates plans of care, and establishes policies governing the day-to-day provision of hospice services. The team must include at least a physician, registered nurse, social worker and spiritual or other counselor. A registered nurse must be designated to coordinate the plan of care.

Volunteers. Hospice programs are required to recruit and train volunteers to provide patient care services or administrative services. Volunteer services must be provided in an amount equal to at least five percent of the total patient care hours provided by all paid hospice employees and contract staff.

Licensure. Each hospice and all hospice personnel must be licensed, certified or registered in accordance with applicable federal, state and local laws and regulations.

Central Clinical Records. Hospice programs must maintain clinical records for each hospice patient that are organized in such a way that they may be easily retrieved. The clinical records must be complete and accurate and protected against loss, destruction and unauthorized use.

Surveys and Audits. Hospice programs are subject to periodic survey by federal and state regulatory authorities and private accrediting entities to ensure compliance with applicable licensing and certification requirements and accreditation standards. Regulators conduct periodic surveys of hospice programs and provide reports containing statements of deficiencies for alleged failure to comply with various regulatory requirements. Survey reports and statements of deficiencies are common in the healthcare industry. In most cases, the hospice program and regulatory authorities will agree upon any steps to be taken to bring the hospice into compliance with applicable regulatory requirements. In some cases, however, a state or federal regulatory authority may take a number of adverse actions against a hospice program, including the imposition of fines, temporary suspension of admission of new patients to the hospice's service or, in extreme circumstances, decertification from participation in the Medicare or Medicaid programs or revocation of the hospice's license.

From time to time VITAS receives survey reports containing statements of deficiencies. VITAS reviews such reports and takes appropriate corrective action. VITAS believes that its hospices are in material compliance with applicable licensure and certification requirements. If a VITAS hospice were found to be out of compliance and actions were taken against a VITAS hospice, they could materially adversely affect the hospice's ability to continue to operate, to provide certain services and to participate in the Medicare and Medicaid programs, which could materially adversely affect VITAS.

Billing Audits/ Claims Reviews. The Medicare program and its fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews and other reviews and audits of health care claims, including hospice claims. There is pressure from state and federal governments and other payors to scrutinize health care claims to determine their validity and appropriateness. In order to conduct these reviews, the payor requests documentation from VITAS and then reviews that documentation to determine compliance with applicable rules and regulations, including the eligibility of patients to receive hospice benefits, the appropriateness of the care provided to those patients and the documentation of that care. VITAS' claims have been subject to review and audit. We make appropriate provisions in our accounting records to reduce our revenue for anticipated denial of payment related to these audits and reviews. We believe our hospice programs comply with all payor requirements at the time of billing. However, we cannot predict whether future billing reviews or similar audits by payors will result in material denials or reductions in revenue.

Certificate of Need Laws and Other Restrictions. Some states, including Florida, have certificate of need or similar health planning laws that apply to hospice care providers. These states may require some form of state agency review or approval prior to opening a new hospice program, to adding or expanding hospice services, to undertaking significant capital expenditures or under other specified circumstances. Approval under these certificate of need laws is generally conditioned on the showing of a demonstrable need for services in the community. VITAS may seek to develop, acquire or expand hospice programs in states having certificate of need laws. To the extent that state agencies require VITAS to obtain a certificate of need or other similar approvals to expand services at existing hospice programs or to make acquisitions or develop hospice programs in new or existing geographic markets, VITAS' plans

could be adversely affected by a failure to obtain such certificate or approval. In addition, competitors may seek administratively or judicially to challenge such an approval or proposed approval by the state agency. Such a challenge, whether or not ultimately successful, could adversely affect VITAS.

Limitations on For-Profit Ownership. A few states have laws that restrict the development and expansion of for-profit hospice programs. For example, in New York, a hospice generally cannot be owned by a corporation that has another corporation as a stockholder. These types of restrictions could affect VITAS' ability to expand into New York, or in other jurisdictions with similar restrictions.

Limits on the Acquisition or Conversion of Non-Profit Health Care Organizations. A number of states have enacted laws that restrict the ability of for-profit entities to acquire or otherwise assume the operations of a non-profit health care provider. Some states may require government review, public hearings, and/or government approval of transactions in which a for-profit entity proposes to purchase certain non-profit healthcare organizations. Heightened scrutiny of these transactions may significantly increase the costs associated with future acquisitions of non-profit hospice programs in some states, otherwise increase the difficulty in completing those acquisitions or prevent them entirely. VITAS cannot assure that it will not encounter regulatory or governmental obstacles in connection with any proposed acquisition of non-profit hospice programs in the future.

Professional Licensure and Participation Agreements. Many hospice employees are subject to federal and state laws and regulations governing the ethics and practice of their profession, including physicians, physical, speech and occupational therapists, social workers, home health aides, pharmacists and nurses. In addition, those professionals who are eligible to participate in the Medicare, Medicaid or other federal health care programs as individuals must not have been excluded from participation in those programs at any time.

State Licensure of Hospice. Each of VITAS' hospices must be licensed in the state in which it operates. State licensure rules and regulations require that VITAS' hospices maintain certain standards and meet certain requirements, which may vary from state to state. VITAS believes that its hospices are in material compliance with applicable licensure requirements. If a VITAS hospice were found to be out of compliance and actions were taken against a VITAS hospice, they could materially adversely affect the hospice's ability to continue to operate, to provide certain services and to participate in the Medicare and Medicaid programs, which could materially adversely affect VITAS.

Overview of Government Payments—General. Over 90% of VITAS' revenue consisted of payments from the Medicare and Medicaid programs. Such payments are made primarily on a "per diem" basis. Under the per diem reimbursement methodology, VITAS is essentially at risk for the cost of eligible services provided to hospice patients. Profitability is therefore largely dependent upon VITAS' ability to manage the costs of providing hospice services to patients. Increases in operating costs, such as labor and supply costs that are subject to inflation and other increases, without a compensating increase in Medicare and Medicaid rates, could have a material adverse effect on VITAS' business in the future. The Medicare and Medicaid programs are increasing pressure to control health care costs and to decrease or limit increases in reimbursement rates for health care services. As with most government programs, the Medicare and Medicaid programs are subject to statutory and regulatory changes, possible retroactive and prospective rate and payment adjustments, administrative rulings, freezes and funding reductions, all of which may adversely affect the level of program payments and could have a material adverse effect on VITAS' business. VITAS' levels of revenues and profitability are subject to the effect of legislative and regulatory changes, including possible reductions in coverage or payment rates, or changes in methods of payment, by the Medicare and Medicaid programs.

Overview of Government Payments – Medicare

Medicare Eligibility Criteria. To receive Medicare payment for hospice services, the hospice medical director and, if the patient has one, the patient's attending physician, must certify and describe in a brief narrative that the patient has a life expectancy of six months or less if the illness runs its normal course. This determination is made based on the physician's clinical judgement. Due to the uncertainty of such prognoses, however, it is likely and expected that some percentage of hospice patients will not die within six months of entering a hospice program. The Medicare program (among other third-party payers) recognizes that terminal illnesses often do not follow an entirely predictable course, and therefore the hospice benefit remains available to beneficiaries so long as the hospice physician or the patient's attending physician continues to certify that the patient's life expectancy remains six months or less. Specifically, the Medicare hospice benefit provides for two initial 90-day benefit periods followed by an unlimited number of 60-day periods. In order to qualify for hospice care, a Medicare beneficiary must elect hospice care and waive any right to other Medicare benefits related to his or her terminal illness. A Medicare beneficiary may revoke his or her election of the Medicare hospice benefit at any time and resume receiving regular Medicare benefits. The patient may elect the hospice benefit again at a later date so long as he or she remains eligible. Increased regulatory scrutiny of compliance with the Medicare six-month eligibility rule has impacted the hospice industry. The Medicare program, however, has reaffirmed that Medicare hospice beneficiaries are not limited to six months of coverage and that there is no limit on how long a Medicare beneficiary can continue to receive hospice benefits and services, provided that the beneficiary continues to meet the eligibility criteria under the Medicare hospice program.

Levels of Care. Medicare pays for hospice services on a prospective payment system basis under which VITAS receives an established payment rate for each day that it provides hospice services to a Medicare beneficiary. These

rates are subject to annual adjustments for inflation and vary based upon the geographic location where the services are provided. The rate VITAS receives depends on which of the following four levels of care is being provided to the beneficiary:

Routine Home Care. The routine home care rate is paid for each day that a patient is in a hospice program and is not receiving one of the other categories of hospice care. The routine home care rate does not vary based upon the volume or intensity of services provided by the hospice program.

General Inpatient Care. The general inpatient care rate is paid when a patient requires inpatient services for a short period for pain control or symptom management which cannot be managed in other settings. General inpatient care services must be provided in a Medicare or Medicaid certified hospital or long-term care facility or at a freestanding inpatient hospice facility with the required registered nurse staffing.

Continuous Home Care. Continuous home care, which VITAS refers to as "Intensive Comfort Care," is provided to patients while at home, during periods of crisis when intensive monitoring and care, primarily nursing care, is required in order to achieve palliation or management of acute medical symptoms. Continuous home care requires a minimum of 8 hours of care within a 24-hour day, which begins and ends at midnight. The care must be predominantly nursing care provided by either a registered nurse or licensed practical nurse. While the published Medicare continuous home care rates are daily rates, Medicare actually pays for continuous home care in fifteen minute increments. This fifteen minute rate is calculated by dividing the daily rate by 96.

Respite Care. Respite care permits a hospice patient to receive services on an inpatient basis for a short period of time in order to provide relief for the patient's family or other caregivers from the demands of caring for the patient. A hospice can receive payment for respite care for a given patient for up to five consecutive days at a time, after which respite care is reimbursed at the routine home care rate.

Medicare Payment for Physician Services. Payment for direct patient care physician services delivered by hospice physicians is billed separately by the hospice to the Medicare fiscal intermediary and paid at the lesser of the actual charge or the Medicare allowable charge for these services. This payment is in addition to the per diem rates VITAS receives for hospice care. Payment for hospice physicians' administrative and general supervisory activities is included in the daily rates discussed above. Payments for attending physician professional services (other than services furnished by hospice physicians) are not paid to the hospice, but rather are paid directly to the attending physician by the Medicare fiscal intermediary. For fiscal 2013, approximately 2% of VITAS' net revenue was attributable to physician services.

Medicare Limits on Hospice Care Payments. Medicare payments for hospice services are subject to two additional limits or "caps". Each of VITAS' hospice programs is separately subject to both of these "caps". Both of these "caps" are determined on an annual basis for the period running from November 1 through October 31 of each year.

First, under a Medicare rule known as the "80-20" rule applicable to the Medicare inpatient services, if the number of inpatient care days furnished by a hospice to Medicare beneficiaries exceeds 20% of the total days of hospice care furnished by such hospice to Medicare beneficiaries, Medicare payments to the hospice for inpatient care days exceeding the cap are reduced to the routine home care rate.

Second, Medicare payments to a hospice are also subject to a separate cap based on overall average payments per admission. Any payments exceeding this overall hospice cap must be refunded by the hospice. This cap was set at $26,157.50 per admission for the twelve-month period ended on October 31, 2013, and is adjusted annually to account for inflation. VITAS' hospices may be subject to future payment reductions or recoupments as the result of this cap.

Medicare Managed Care Programs. The Medicare program has entered into contracts with managed care companies to provide managed care benefits to Medicare beneficiaries who elect to participate in managed care programs. These managed care programs are commonly referred to as Medicare HMOs, Medicare + Choice or Medicare risk products. VITAS provides hospice care to Medicare beneficiaries who participate in these managed care programs, and VITAS is paid for services provided to these beneficiaries in the same way and at the same rates as those of other Medicare beneficiaries who are not in a Medicare managed care program. Under current Medicare policy, Medicare pays the hospice directly for services provided to these managed care program participants and then reduces the standard per-member, per-month payment that the managed care program otherwise receives.

Overview of Government Payments – Medicaid

Medicaid Coverage and Reimbursements. State Medicaid programs are another source of VITAS' net patient revenue. Medicaid is a state-administered program financed by state funds and matching federal funds to provide medical assistance to the indigent and certain other eligible persons. In 1986, hospice services became an optional state Medicaid benefit. For those states that elect to provide a hospice benefit, the Medicaid program is required to pay the hospice at rates at least equal to the rates provided under Medicare and calculated using the same methodology. States maintain flexibility to establish their own hospice election procedures and to limit the number and duration of benefit periods for which they will pay for hospice services. Reimbursement from state Medicaid programs in 2013 accounted for 5% of VITAS' revenues.

Nursing Home Residents. For VITAS' patients who receive nursing home care under a state Medicaid program and who elect hospice care under Medicare or Medicaid, VITAS contracts with nursing homes for the nursing homes' provision of room and board services. In addition to the applicable Medicare or Medicaid hospice daily or hourly rate, the state generally must pay VITAS an amount equal to at least 95% of the Medicaid daily nursing home rate for room and board services furnished to the patient by the nursing home. Under VITAS' standard nursing home contracts, VITAS pays the nursing home for these room and board services at the Medicaid daily nursing home rate.

Adjustments to Medicare and Medicaid Payment Rates. Payment rates under the Medicare and Medicaid programs are adjusted annually based upon the Hospital Market Basket Index and the Consumer Price Index; however, the adjustments have historically been less than actual inflation. These base rates are further modified by the Hospice Wage Index to reflect local differences in wages according to the revised wage index. Effective April 1, 2013, the Federal government implemented a 2% reimbursement cut for all Medicare programs, including hospice. It is possible that there will be further modifications to the rate structure under which the Medicare or Medicaid programs pay for hospice care services. Any future reductions in the rate of increase or an actual decrease in Medicare and Medicaid payments may have an adverse impact on VITAS' net patient service revenue and profitability.

Other Healthcare Regulations

Federal and State Anti-Kickback Laws and Safe Harbor Provisions. The federal Anti-Kickback Law makes it a felony to knowingly and willingly offer, pay, solicit or receive any form of remuneration in exchange for referring, recommending, arranging, purchasing, leasing or ordering items or services covered by a federal health care program including Medicare or Medicaid. The Anti-Kickback Law applies regardless of whether the remuneration is provided directly or indirectly, in cash or in kind. Although the Anti-Kickback statute does not prohibit all financial transactions or relationships that providers of healthcare items or services may have with each other, interpretations of the law have been very broad. Under current law, courts and federal regulatory authorities have stated that this law is violated if even one purpose (as opposed to the sole or primary purpose) of the arrangement is to induce referrals.

Violations of the Anti-Kickback Law carry potentially severe penalties including imprisonment of up to five years, criminal fines of up to $25,000 per act, civil money penalties of up to $50,000 per act, and additional damages of up to three times the amounts claimed or remuneration offered or paid. Federal law also authorizes exclusion from the Medicare and Medicaid programs for violations of the Anti-Kickback Law.

The Anti-Kickback Law contains several statutory exceptions to the broad prohibition. In addition, Congress authorized the Office of Inspector General ("OIG") to publish numerous "safe harbors" that exempt some practices from enforcement action under the Anti-Kickback Law and related laws. These statutory exceptions and regulatory safe harbors protect various bona fide employment relationships, contracts for the rental of space or equipment, personal service arrangements, and management contracts, among other things, provided that certain conditions set forth in the statute or regulations are satisfied. The safe harbor regulations, however, do not comprehensively describe all lawful relationships between healthcare providers and referral sources, and the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not mean that the arrangement is unlawful. Failure to comply with the safe harbor provisions, however, may mean that the arrangement will be subject to scrutiny.

Many states, including states where VITAS does business, have adopted similar prohibitions against payments that are intended to induce referrals of patients, regardless of the source of payment. Some of these state laws lack explicit "safe harbors" that may be available under federal law. Sanctions under these state anti-kickback laws may include civil money penalties, license suspension or revocation, exclusion from the Medicare or Medicaid programs, and criminal fines or imprisonment. Little precedent exists regarding the interpretation or enforcement of these statutes.

VITAS is required under the Medicare conditions of participation and some state licensing laws to contract with numerous healthcare providers and practitioners, including physicians, hospitals and nursing homes, and to arrange for these individuals or entities to provide services to VITAS' patients. In addition, VITAS has contracts with other suppliers, including pharmacies, ambulance services and medical equipment companies. Some of these individuals or entities may refer, or be in a position to refer, patients to VITAS, and VITAS may refer, or be in a position to refer, patients to these individuals or entities. These arrangements may not qualify for a safe harbor. VITAS from time to time seeks guidance from regulatory counsel as to the changing and evolving interpretations and the potential applicability of these anti-kickback laws to its programs, and in response thereto, takes such actions as it deems appropriate. The Company generally believes that VITAS' contracts and arrangements with providers, practitioners and suppliers do not violate applicable anti-kickback laws. However, the Company cannot assure that such laws will ultimately be interpreted in a manner consistent with VITAS' practices.

HIPAA Anti-Fraud Provisions. HIPAA includes several revisions to existing health care fraud laws by permitting the imposition of civil monetary penalties in cases involving violations of the anti-kickback statute or contracting with excluded providers. In addition, HIPAA created new statutes making it a federal felony to engage in fraud, theft, embezzlement, or the making of false statements with respect to healthcare benefit programs, which include private, as well as government programs. In addition, federal enforcement officials have the ability to exclude from the Medicare and Medicaid programs any investors, officers and managing employees associated with business entities that have committed healthcare fraud, even if the investor, officer or employee had no actual knowledge of the fraud.

OIG Fraud Alerts, Advisory Opinions and Other Program Guidance. In 1976, Congress established the OIG to, among other things, identify and eliminate fraud, abuse and waste in HHS programs. To identify and resolve such problems, the OIG conducts audits, investigations and inspections across the country and issues public pronouncements identifying practices that may be subject to heightened scrutiny. There have been a number of hospice related audits and reviews conducted. These reviews and recommendations have included:

Ensuring that Medicare hospice eligibility determinations are made in accordance with the Medicare regulations; and

Revising the annual cap on hospice benefits to better reflect the cost of care provided.

From time to time, various federal and state agencies, such as HHS and the OIG, issue a variety of pronouncements, including fraud alerts, the OIG's Annual Work Plan and other reports, identifying practices that may be subject to heightened governmental scrutiny. The Company cannot predict what, if any, changes may be implemented in coverage, reimbursement, or enforcement policies as a result of these OIG reviews and recommendations.

In June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas, United States, et al. ex rel. Urick v. VITAS HME Solutions, Inc. et al., 5:08-cv-0663 ("Urick"). The U.S. Attorney filed a notice in May 2012 stating that it had decided not to intervene in the case at that time but indicating that it continues to investigate the allegations. In June 2012, the complaint was unsealed. The complaint asserts violations of the federal False Claims Act and the Texas Medicaid Fraud Prevention Act based on allegations of a conspiracy to submit to Medicare and Medicaid false claims involving hospice services for ineligible patients, unnecessary medical supplies, failing to satisfy certain prerequisites for payment, and altering patient records, including backdating patient revocations. The suit was brought by Barbara Urick, a registered nurse in VITAS's San Antonio program, against VITAS, certain of its affiliates, and several former VITAS employees, including physicians Justo Cisneros and Antonio Cavasos and nurses Sally Schwenk, Diane Anest, and Edith Reed. In September 2012 and July 2013, the plaintiff dismissed all claims against the individual defendants. The complaint was served on the VITAS entities on April 12, 2013.

Also in June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Northern District of Illinois, United States, et al. ex rel. Spottiswood v. Chemed Corp., 1:07-cv-4566 ("Spottiswood"). In April 2012, the complaint was unsealed. The U.S. Attorney and Attorney General for the State of Illinois filed notices in April and May 2012, respectively, stating that they had decided not to intervene in the case at that time but indicating that they continue to investigate the allegations. Plaintiff filed an amended complaint in November 2012. The complaint asserts violations of the federal False Claims Act and the Illinois Whistleblower Reward and Protection Act based on allegations that VITAS fraudulently billed Medicare and Medicaid for providing unwarranted continuous care services. The suit was brought by Laura Spottiswood, a former part-time pool registered nurse at VITAS, against Chemed, VITAS, and a VITAS affiliate. The complaint was served on the defendants on April 12, 2013. On May 29 and June 4, 2013, respectively, the Court granted the government's motion to partially intervene in Spottiswood and in Urick on the allegations that VITAS submitted or caused to be submitted false or fraudulent claims for continuous care and routine home care on behalf of certain ineligible

Medicare beneficiaries. The Court also transferred them to the U.S. District Court for the Western District of Missouri under docket Nos. 4:13-cv-505 and 4:13-cv-563, respectively.

On May 2, 2013, the government filed a False Claims Act complaint against the Company and certain of its hospice-related subsidiaries in the U.S. District Court for the Western District of Missouri, United States v. VITAS Hospice Services, LLC, et al., 4:13-cv-00449-BCW (the "2013 Action"). Prior to that date, the Company received various subpoenas from the U.S. Department of Justice and OIG that have been previously disclosed. The 2013 Action alleges that, since at least 2002, VITAS, and since 2004, the Company, submitted or caused the submission of false claims to the Medicare program by (a) billing Medicare for continuous home care services when the patients were not eligible, the services were not provided, or the medical care was inappropriate, and (b) billing Medicare for patients who were not eligible for the Medicare hospice benefit because they did not have a life expectancy of six months or less if their illnesses ran their normal course. This complaint seeks treble damages, statutory penalties, and the costs of the action, plus interest. On August 1, 2013, the government filed its First Amended Complaint in the 2013 Action. The First Amended Complaint changed and supplemented some of the allegations, but did not otherwise expand the causes of action or the nature of the relief sought against VITAS. The defendants filed a motion to dismiss on September 24, 2013.

On May 6, 2013, the U.S. District Court for the Western District of Missouri, at the request of the government, unsealed a qui tam complaint against VITAS and VITAS Healthcare Corporation of California, United States ex rel. Charles Gonzales v. VITAS Healthcare Corporation, et al., CV 12-0761-R ("Gonzales"). The case was transferred from the Central District of California to the Western District of Missouri under docket No. 4:13-cv-344. The government partially intervened in Gonzales. The Gonzales complaint alleges that VITAS' Los Angeles program falsely certified and recertified patients as eligible for the Medicare Hospice Benefit. It alleges violations of the False Claims Act and seeks treble damages, civil penalties, recovery of costs, attorneys' fees and expenses, and pre- and post-judgment interest.

On September 25, 2013, the Court granted a joint motion by the government, the relators, and VITAS to consolidate the Spottiswood, Urick, and Gonzales complaints with the 2013 Action. As a result, the First Amended Complaint will govern the consolidated claims brought by the United States and the relators for all purposes. The relators and VITAS have stipulated that certain non-intervened claims will not be pursued by the relators.

VITAS has also received document subpoenas in related state matters. In February 2010, VITAS received a civil investigative demand ("CID") from the Texas Attorney General seeking documents from January 1, 2002 through the date of the CID, and interrogatory responses in connection with an investigation of possible fraudulent submission of Medicaid claims for non-qualifying patients and fraudulent shifting of costs from VITAS to the State of Texas and the United States. The CID requested similar information sought by prior Department of Justice subpoenas, including policy and procedure manuals and information concerning Medicare and Medicaid billing, patient statistics and sales and marketing practices, together with information concerning record-keeping and retention practices, and medical records concerning 117 patients. In September 2010, VITAS received a second CID from the Texas Attorney General seeking additional documents concerning business plans and results, revocation forms for certain patients, and electronic documents of 10 current and former employees. In July 2012, VITAS received an investigative subpoena from the Florida Attorney General seeking documents previously produced in the course of prior government investigations as well as, for the period January 1, 2007 through the date of production, billing records and procedures: information concerning business results, plans, and strategies; documents concerning patient eligibility for hospice care; and certain information concerning employees and their compensation.

The net costs to comply with these investigations were $2.1 million and $1.2 million for the years ending December 31, 2013 and 2012, respectively. Regardless of the outcome of any of the preceding matters, responding to the subpoenas and dealing with the various regulatory agencies can adversely affect us through defense costs, diversion of management time, and related publicity.

Federal False Claims Acts. The federal law includes several criminal and civil false claims provisions, which provide that knowingly submitting claims for items or services that were not provided as represented may result in the imposition of multiple damages, administrative civil money penalties, criminal fines, imprisonment, and/or exclusion from participation in federally funded healthcare programs, including Medicare and Medicaid. In addition, the OIG may impose extensive and costly corporate integrity requirements upon a healthcare provider that is the subject of a false claims judgement or settlement. These requirements may include the creation of a formal compliance program, the appointment of a government monitor, and the imposition of annual reporting requirements and audits conducted by an independent review organization to monitor compliance with the terms of the agreement and relevant laws and regulations.

The Civil False Claims Act prohibits the known filing of a false claim or the known use of false statements to obtain payments. Penalties for violations include fines ranging from $5,500 to $11,000, plus treble damages, for each claim filed. Provisions in the Civil False Claims Act also permit individuals to bring actions against individuals or businesses in the name of the government as so called "qui tam" relators. If a qui tam relator's claim is successful, he or she is entitled to share the government's recovery.

Both direct enforcement activity by the government and qui tam actions have increased significantly in recent years and have increased the risk that a healthcare company may have to defend a false claims action, pay fines or be excluded from the Medicare and/or Medicaid programs as a result of an investigation arising out of this type of an action. Because of the complexity of the government regulations applicable to the healthcare industry, the Company cannot assure that VITAS will not be the subject of other actions under the False Claims Act.

State False Claims Laws. Several states in which VITAS currently operates have adopted state false claims laws that mirror to some degree the federal false claims laws. While these statutes vary in scope and effect, the penalties for violating these false claims laws include administrative, civil and/or criminal fines and penalties, imprisonment, and the imposition of multiple damages.

The Stark Law and State Physician Self-Referral Laws. Section 1877 of the Social Security Act, commonly known as the "Stark Law", prohibits physicians from referring Medicare or Medicaid patients for "designated health services" to entities in which they hold an ownership or investment interest or with whom they have a compensation arrangement, subject to a number of statutory and regulatory exceptions. Penalties for violating the Stark Law are severe and include:

Denial of payment;

Civil monetary penalties of $15,000 per referral or $1,000,000 for "circumvention schemes;"

Assessments equal to 200% of the dollar value of each such service provided; and

Exclusion from the Medicare and Medicaid programs.

Hospice care itself is not specifically listed as a designated health service; however, certain services that VITAS provides, or in the future may provide, are among the services identified as designated health services for purposes of the self-referral laws. The Company cannot assure that future regulatory changes will not result in hospice services becoming subject to the Stark Law's ownership, investment or compensation prohibitions in the future.

Many states where VITAS operates have laws similar to the Stark Law, but with broader effect because they apply regardless of the source of payment for care. Penalties similar to those listed above as well as the loss of state licensure may be imposed in the event of a violation of these state self-referral laws. Little precedent exists regarding the interpretation or enforcement of these statutes.

Civil Monetary Penalties. The Civil Monetary Penalties Statute provides that civil penalties ranging between $10,000 and $50,000 per claim or act may be imposed on any person or entity that knowingly submits improperly filed claims for federal health benefits or that offers or makes payment to induce a beneficiary or provider to reduce or limit the use of health care services or to use a particular provider or supplier. Civil monetary penalties may be imposed for violations of the anti-kickback statute and for the failure to return known overpayments, among other things.

Prohibition on Employing or Contracting with Excluded Providers. The Social Security Act and federal regulations state that individuals or entities that have been convicted of a criminal offense related to the delivery of an item or service under Medicare or Medicaid programs or that have been convicted, under state and federal law, of a criminal offense relating to neglect or abuse of residents in connection with the delivery of a healthcare item or service cannot participate in any federal health care programs, including Medicare and Medicaid. Additionally, individuals and entities convicted of fraud, that have had their licenses revoked or suspended, or that have failed to provide services of adequate quality also may be excluded from the Medicare and Medicaid programs. Federal regulations prohibit Medicare providers, including hospice programs, from submitting claims for items or services or their related costs if an excluded provider furnished those items or services. The OIG maintains a list of excluded persons and entities. Nonetheless, it is possible that VITAS might unknowingly bill for services provided by an excluded person or entity with whom it contracts. The penalty for contracting with an excluded provider may range from civil monetary penalties of $50,000 and damages of up to three times the amount of payment that was inappropriately received.

Corporate Practice of Medicine and Fee Splitting. Most states have laws that restrict or prohibit anyone other than a licensed physician, including business entities such as corporations, from employing physicians and/or prohibit payments or fee-splitting arrangements between physicians and corporations or unlicensed individuals. Penalties for violations of corporate practice of medicine and fee-splitting laws vary from state to state, but may include civil or criminal penalties, the restructuring or termination of the business arrangements between the physician and unlicensed

individual or business entity, or even the loss of the physician's license to practice medicine. These laws vary widely from state to state both in scope and origin (e.g. statute, regulation, Attorney General opinion, court ruling, agency policy) and in most instances have been subject to only limited interpretation by the courts or regulatory bodies.

VITAS employs or contracts with physicians to provide medical direction and patient care services to its patients. VITAS has made efforts in those states where certain contracting or fee arrangements are restricted or prohibited to structure those arrangements, including its palliative care offerings, in compliance with the applicable laws and regulations. Despite these efforts, however, the Company cannot assure that agency officials charged with enforcing these laws will not interpret VITAS' contracts with employed or independent contractor physicians as violating the relevant laws or regulations. Future determinations or interpretations by individual states with corporate practice of medicine or fee splitting restrictions may force VITAS to restructure its arrangements with physicians in those locations.

Health Information Practices. There currently are numerous legislative and regulatory initiatives at both the state and federal levels that address patient privacy concerns. In particular, federal regulations issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") require VITAS to protect the privacy and security of patients' individual health information. HIPAA does not automatically preempt applicable state laws and regulations concerning VITAS' use, disclosure and maintenance of patient health information, which means that VITAS is subject to a complex regulatory scheme that, in many instances, requires VITAS to comply with both federal and state laws and regulations.

Additional Federal and State Regulation. Federal and state governments also regulate various aspects of the hospice industry. In particular, VITAS' operations are subject to federal and state health regulatory laws covering professional services, the dispensing of drugs and certain types of hospice activities. Some of VITAS' employees are subject to state laws and regulations governing the ethics and professional practice of medicine, respiratory therapy, pharmacy and nursing.

Compliance with Health Regulatory Laws. VITAS maintains an internal regulatory compliance review program and from time to time retains regulatory counsel for guidance on compliance matters. The Company cannot assure, however, that VITAS' practices, if reviewed, would be found to be in compliance with applicable health regulatory laws, as such laws ultimately may be interpreted, or that any non-compliance with such laws would not have a material adverse effect, including an effect on its brand reputation, on VITAS.

Environmental Matters

Roto-Rooter's operations are subject to various federal, state, and local laws and regulations regarding environmental matters and other aspects of the operation of a sewer and drain cleaning, HVAC and plumbing services business. For certain other activities, such as septic tank and grease trap pumping, Roto-Rooter is subject to state and local environmental health and sanitation regulations.

At December 31, 2013, the Company's accrual for its estimated liability for potential environmental cleanup and related costs arising from the 1991 sale of DuBois Chemicals Inc. ("DuBois") amounted to $1.7 million. Of this balance, $901,000 is included in other liabilities and $826,000 is included in other current liabilities. The Company is contingently liable for additional DuBois-related environmental cleanup and related costs up to a maximum of $14.9 million. On the basis of a continuing evaluation of the Company's potential liability, and in consultation with the Company's environmental attorney, management believes that it is not probable this additional liability will be paid. Accordingly, no provision for this contingent liability has been recorded. Although it is not presently possible to reliably project the timing of payments related to the Company's potential liability for environmental costs, management believes that any adjustments to its recorded liability will not materially adversely affect its financial position or results of operations.

The Company, to the best of its knowledge, is currently in compliance in all material respects with the environmental laws and regulations affecting its operations. Such environmental laws, regulations and enforcement proceedings have not required the Company to make material increases in or modifications to its capital expenditures and they have not had a material adverse effect on sales or net income. Capital expenditures for the purpose of complying with environmental laws and regulations during 2014 and 2015 with respect to continuing operations are not expected to be material in amount; there can be no assurance, however, that presently unforeseen legislative enforcement actions will not require additional expenditures.

Employees

On December 31, 2013, Chemed Corporation had a total of 13,952 employees.

Available Information

The Company's Internet address is www.chemed.com . The Company's Annual Report on Form 10-K, quarterly reports on Form 10-Q, and current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act are electronically available through the SEC (http://www.sec.gov) or the Company's website as soon as reasonably practicable after such reports are filed with, or furnished to, the SEC.

Annual reports, press releases, Board Committee charters, Code of Ethics, Corporate governance guidelines and other printed materials may be obtained from the website or from Chemed Investor Relations without charge by writing to, 255 East Fifth Street, Suite 2600, Cincinnati, Ohio 45202 or by calling 800-2CHEMED or 800-224-3633. The Company intends to satisfy the disclosure requirement under Item 5.05 of Form 8-K by posting such information on its website.

Item 1A. Risk Factors

You should carefully consider the risks described below. They are not the only ones facing the Company. Other risks and uncertainties not currently known to us or that we deem to be immaterial may also materially and adversely affect our business, financial condition, or results of operations.

GENERAL

We have incurred debt to finance the operations of the Company.

We have debt which is due in May 2014 that is convertible into shares based on the Company's stock price. This could significantly dilute the ownership percentage of current stockholders.

The Company has debt service obligations that may restrict our operating flexibility. We cannot assure you that our cash flow from operations will be sufficient to service our debt, which may require us to borrow additional funds, or restructure or otherwise refinance our debt. In addition, the Company has the ability to expand its debt and borrowing capacity subject to various restrictions and covenants defined by its creditors. The interest rate the Company pays will fluctuate from time to time based upon a number of factors including current LIBOR rates and Company operating performance. Significant changes in these factors could result in a material change in the Company's interest expense.

Our ability to repay or to refinance our indebtedness and to pay interest on our indebtedness will depend on our operating performance, which may be affected by factors beyond our control. These factors could include operating difficulties, increased operating costs, our competitors' actions and regulatory developments. Our ability to meet our debt service and other obligations may depend in significant part on the extent to which we successfully implement our business strategy. We cannot assure you that we will be able to implement our strategy fully or that the anticipated results of our strategy will be realized. Credit market conditions may make it difficult for us to obtain new financing or refinance our current debt on terms and conditions acceptable to us.

If our cash flows and capital resources are insufficient to fund our debt service obligations, we may be forced to reduce or delay capital expenditures, sell assets, seek additional equity capital or restructure our debt. We cannot assure you that our cash flows and capital resources will be sufficient to make scheduled payments of principal and interest on our indebtedness in the future or that alternative measures would successfully meet our debt service obligations.

The agreements and instruments governing our outstanding debt contain restrictions and limitations that could significantly impact our ability to operate our business and adversely affect the price of our Capital Stock.

The operating and financial restrictions and covenants in our instruments of indebtedness restrict our ability to incur additional debt; issue and sell capital stock of subsidiaries; sell assets; engage in transactions with affiliates; restrict distributions from subsidiaries; incur liens; engage in business other than permitted businesses; engage in sale/leaseback transactions; engage in mergers or consolidations; make capital expenditures; make guarantees; make investments and acquisitions; enter into operating leases; hedge interest rates; and prepay other debt.

Moreover, if we are unable to meet the terms of the financial covenants or if we breach any of these covenants, a default could result under one or more of these agreements. A default, if not waived by our lenders, could accelerate repayment of our outstanding indebtedness. If acceleration occurs, we may not be able to repay our debt and it is unlikely that we would be able to borrow sufficient additional funds to refinance such debt on acceptable terms. In the event of any default under our credit facilities, the lenders thereunder could elect to declare all outstanding borrowings, together with accrued and unpaid interest and other fees, to be due and payable, and to require us to apply

all of our available cash to repay these borrowings, any of which would be an event of default.

We depend on our management team and the loss of their service could have a material adverse effect on our business, financial condition and results of operations.

Our success depends to a large extent upon the continued services of our executive management team. The loss of key personnel could have a material adverse effect on our business, financial condition, results of operations and cash flows. Additionally, we cannot assure you that we will be able to attract or retain other skilled personnel in the future.

Environmental compliance costs and liabilities could increase our expenses and adversely affect our financial condition.

Our operations are subject to numerous environmental, health and safety laws and regulations that prohibit or restrict the discharge of pollutants into the environment and regulate employee exposure to hazardous substance in the workplace. Failure to comply with these laws could subject us to material costs and liabilities, including civil and criminal fines, costs to cleanup contamination we cause and, in some circumstances, costs to cleanup contamination we discover on our own property but did not cause.

Because we use and generate hazardous materials in some of our operations, we are potentially subject to material liabilities relating to the cleanup of contamination and personal injury claims. In addition, we have retained certain environmental liabilities in connection with the sale of former businesses. We are currently funding the cleanup of historical contamination at one of our former properties and contributing to the cleanup of third-party sites as a result of our sale of our former subsidiary DuBois Chemicals Inc. Although we have established a reserve for these liabilities, actual cleanup costs may exceed our current estimates due to factors beyond our control, such as the discovery of additional contamination or the enforcement of more stringent cleanup requirements. New laws and regulations or their stricter enforcement, the discovery of presently unknown conditions or the receipt of additional claims for indemnification could require us to incur costs or become the basis for new or increased liabilities including impairment of our brand that could have a material adverse effect on our business, financial condition and results of operations.

We are subject to certain anti-takeover statutes that might make it more difficult to effect a change in control of the Company.

We are subject to the anti-takeover provisions of Section 203 of the Delaware General Corporation Law, which prohibits us from engaging in a “business combination” with an “interested stockholder” for a period of three years after the date of the transaction in which the person became an interested stockholder, unless the business combination is approved in a prescribed manner. The application of Section 203 could have the effect of delaying or preventing a change of control that could be advantageous to stockholders.

An adverse ruling against us in certain litigation could have an adverse effect on our financial condition and results of operations.

We are involved in litigation incidental to the conduct of our business currently and from time to time. The damages claimed against us in some of these cases are substantial. See the “Legal Proceedings” sections of this 10-K for discussion of particular matters. We cannot assure you that we will prevail in pending cases. Regardless of the outcome, such litigation is costly to manage, investigate and defend, and the related defense costs, diversion of management’s time and related publicity may adversely affect the conduct of our business and the results of our operations.

ROTO-ROOTER

We face intense competition from numerous, fragmented competitors. If we do not compete effectively, our business may suffer.

We face intense competition from numerous competitors. The sewer, drain and pipe cleaning, excavation and plumbing repair businesses are highly fragmented, with the bulk of the industries consisting of local and regional competitors. We compete primarily on the basis of advertising, range of services provided, name recognition, availability of emergency service, speed and quality of customer service, service guarantees and pricing. Our

competitors may succeed in developing new or enhanced products and services more successful than ours and in marketing and selling existing and new products and services better than we do. In addition, new competitors may emerge. We cannot make any assurances that we will continue to be able to compete successfully with any of these companies.

Our operations are subject to numerous laws and regulations, exposing us to potential claims and compliance costs that could adversely affect our business.

We are subject to federal, state and local laws and regulations relating to franchising, insurance and other aspects of our business. These are discussed in greater detail under "Government Regulations" in the Description of Business section hereof. If we fail to comply with existing or future laws and regulations, we may be subject to governmental or judicial fines and sanctions. Our franchising activities are subject to various federal and state franchising laws and regulations, including the rules and regulations of the FTC regarding the offering or sale of franchises. These rules and regulations require us to provide all of our prospective franchisees with specific information regarding us and our franchise program in the form of a detailed franchise offering circular. In addition, a number of states require us to register our franchise offering prior to offering or selling franchises in such states. Various state laws also provide for certain rights in favor of franchisees, including (i) limitations on the franchisor's ability to terminate a franchise except for good cause, (ii) restrictions on the franchisor's ability to deny renewal of a franchise, (iii) circumstances under which the franchisor may be required to purchase certain inventory of franchisees when a franchise is terminated or not renewed in violation of such laws and (iv) provisions relating to arbitration. The ability to engage in the plumbing repair business is also subject to certain limitations and restrictions imposed by the state and local licensing laws and regulations. We cannot predict what legislation or regulations affecting our business will be enacted in the future, how existing or future laws or regulations will be enforced, administered and interpreted, or the amount of future expenditures that may be required to comply with these laws or regulations. Compliance costs associated with governmental regulations could have a material adverse effect on our business, financial condition and results of operations.

Roto-Rooter’s loss of key management personnel or its inability to hire and retain skilled employees could adversely affect its business, financial condition and results of operations.

Roto-Rooter’s future success significantly depends upon the continued service of its senior management personnel. The loss of one or more of Roto-Rooter’s key senior management personnel or its inability to hire and retain new skilled employees could negatively impact its ability to maintain or increase customer calls and jobs, a key aspect of its growth strategy, and could adversely affect its future operating results.

Competition for skilled employees, particularly licensed plumbers, is intense, and the process of locating and recruiting skilled employees with the combination of qualifications and attributes required to adequately perform plumbing duties can be difficult and lengthy. We cannot assure you that Roto-Rooter will be successful in attracting, retaining or training highly skilled personnel. Roto-Rooter’s business could be disrupted and its growth and profitability negatively impacted if it is unable to attract and retain skilled employees.

Cybersecurity

In the normal course of business, our information technology systems hold sensitive customer information including names, addresses and partial credit card information. Additionally, we utilize those same systems to perform our day-to-day activities, such as receiving customer calls, dispatching technicians to jobs and maintaining an accurate record of all transactions. We have not experienced any known attacks on our information technology systems that compromised customer data or the Company’s proprietary data. We maintain our information technology systems with safeguard protection against cyber-attacks including passive intrusion protection, firewalls and virus detection software. Additionally, on a quarterly basis, we test our information technology systems using cyber-attack software and methods to learn how a successful attack may be made. We remedy any issues encountered during these tests. However, these safeguards do not ensure that a significant cyber-attack could not occur. A successful attack on our information technology systems could have significant consequences to the business including liability for compromised customer information and business interruption.

Roto-Rooter’s success is highly dependent on its brand reputation

Roto-Rooter's national reputation and brand image for performing necessary, high quality services in a timely manner is critical to Roto-Rooter's continued success. Adverse publicity, litigation or on-line negative reviews focused on the Roto-Rooter brand could negatively impact Roto-Rooter's national reputation resulting in decreased future demand for Roto-Rooter branded services. Roto-Rooter maintains a reputation management risk program however, a loss of brand reputation at Roto-Rooter could adversely affect consumer willingness to use our service and thus, adversely affect our future operating performance.

VITAS

VITAS is highly dependent on payments from Medicare and Medicaid. If there are changes in the rate or methods governing these payments, VITAS’ net patient service revenue and profits could materially decline.

In excess of 90% of VITAS’ net patient service revenue consists of payments from the Medicare and Medicaid programs. Such payments are made primarily on a “per diem” basis, subject to annual reimbursement caps. Because VITAS receives a per diem fee to provide eligible services to all patients, VITAS’ profitability is largely dependent upon its ability to manage the costs of providing hospice services to patients. Increases in operating costs, such as labor and supply costs that are subject to inflation, without a compensating increase in Medicare and Medicaid rates, could have a material adverse effect on VITAS’ business in the future. Medicare and Medicaid currently adjust the various hospice payment rates annually based primarily on the increase or decrease of the hospital wage index basket,

regionally adjusted. However, the increases may be less than actual inflation. VITAS' profitability could be negatively impacted if this adjustment were eliminated or reduced, or if VITAS' costs of providing hospice services increased more than the annual adjustment. In addition, cost pressures resulting from shorter patient lengths of stay and the use of more expensive forms of palliative care, including drugs and drug delivery systems, could negatively impact VITAS' profitability. Many payors are increasing pressure to control health care costs. In addition, both public and private payors are increasing pressure to decrease, or limit increases in, reimbursement rates for health care services. VITAS' levels of revenue and profitability will be subject to the effect of possible reductions in coverage or payment rates by third-party payors, including payment rates from Medicare and Medicaid.

Each state that maintains a Medicaid program has the option to provide reimbursement for hospice services at reimbursement rates generally required to be at least as much as Medicare rates. All states in which VITAS operates cover Medicaid hospice services; however, we cannot assure you that the states in which VITAS is presently operating or states into which VITAS could expand operations will continue to cover Medicaid hospice services. In addition, the Medicare and Medicaid programs are subject to statutory and regulatory changes, retroactive and prospective rate and payment adjustments, administrative rulings, freezes and funding reductions, all of which may adversely affect the level of program payments and could have a material adverse effect on VITAS' business. We cannot assure that Medicare and/or Medicaid payments to hospices will not decrease. Reductions in amounts paid by government programs for services or changes in methods or regulations governing payments could cause VITAS' net patient service revenue and profits to materially decline.

Approximately 20% of VITAS' days of care are provided to patients who reside in nursing homes. Changes in the laws and regulations regarding payments for hospice services and "room and board" provided to VITAS' hospice patients residing in nursing homes could reduce its net patient service revenue and profitability.

For VITAS' hospice patients receiving nursing home care under certain state Medicaid programs who elect hospice care under Medicare and Medicaid, the state generally must pay VITAS, in addition to the applicable Medicare or Medicaid hospice per diem rate, an amount equal to at least 95% of the Medicaid per diem nursing home rate for "room and board" furnished to the patient by the nursing home. VITAS contracts with various nursing homes for the nursing homes' provision of certain "room and board" services that the nursing homes would otherwise provide Medicaid nursing home patients. VITAS bills and collects from the applicable state Medicaid program an amount equal to approximately 95% of the amount that would otherwise have been paid directly to the nursing home under the state's Medicaid plan. Under VITAS' standard nursing home contracts, it pays the nursing home for these "room and board" services at approximately 100% of the Medicaid per diem nursing home rate.

The reduction or elimination of Medicare and Medicaid payments for hospice patients residing in nursing homes would reduce VITAS' net patient service revenue and profitability. In addition, changes in the way nursing homes are reimbursed for "room and board" services provided to hospice patients residing in nursing homes could affect VITAS' ability to serve patients in nursing homes.

If VITAS is unable to maintain relationships with existing patient referral sources or to establish new referral sources, VITAS' growth and profitability could be adversely affected.

VITAS' success is heavily dependent on referrals from physicians, long-term care facilities, hospitals and other institutional health care providers, managed care companies, insurance companies and other patient referral sources in the communities that its hospice locations serve, as well as on its ability to maintain good relations with these referral sources. VITAS' referral sources may refer their patients to other hospice care providers or not to a hospice provider at all. VITAS' growth and profitability depend significantly on its ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of hospice care by its referral sources and their patients. We cannot assure you that VITAS will be able to maintain its existing relationships or that it will be able to develop and maintain new relationships in existing or new markets. VITAS' loss of existing relationships or its failure to develop new relationships could adversely affect its ability to expand or maintain its operations and operate profitably. Moreover, we cannot assure you that awareness or acceptance of hospice care will increase or remain at current levels.

VITAS operates in an industry that is subject to extensive government regulation and claims reviews, and changes in law and regulatory interpretations could reduce its net patient service revenue and profitability and adversely affect its financial condition and results of operations.

15

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

Payment for services;

Conduct of operations, including fraud and abuse, anti-kickback prohibitions, self-referral prohibitions and false claims;

Privacy and security of medical records;

Employment practices; and

Conduct of operations, including fraud and abuse, anti-kickback prohibitions, self-referral prohibitions and false claims;

Various state approval requirements, such as facility and professional licensure, certificate of need, compliance surveys and other certification or recertification requirements.

Changes in these laws, rules and regulations or in interpretations thereof could reduce VITAS' net patient service revenue and profitability. VITAS' ability to comply with such regulations is a key factor in determining the success of its business. See the "Government Regulations" section of this 10-K for a greater description of these matters.

Fraud and Abuse Laws. VITAS contracts with a significant number of health care providers and practitioners, including physicians, hospitals and nursing homes and arranges for these entities to provide services to VITAS' patients. Some of these health care providers and practitioners may refer, or be in a position to refer, patients to VITAS (or VITAS may refer patients to them). These arrangements may not qualify for a safe harbor. VITAS from time to time seeks guidance from regulatory counsel as to the changing and evolving interpretations and the potential applicability of the Anti-Kickback Law to its programs, and in response thereto, takes such actions as it deems appropriate. VITAS generally believes that its contracts and arrangements with providers, practitioners and suppliers should not be found to violate the Anti-Kickback Law. However, we cannot assure you that such laws will ultimately be interpreted in a manner consistent with VITAS' practices.

Several health care reform proposals have included an expansion of the Anti-Kickback Law to include referrals of any patients regardless of payor source, which is similar to the scope of certain laws that have been enacted at the state level. In addition, a number of states in which VITAS operates have laws, which vary from state to state, prohibiting certain direct or indirect remuneration or fee-splitting arrangements between health care providers, regardless of payor source, for the referral of patients to a particular provider.

The federal Ethics in Patient Referral Act, Section 1877 of the Social Security Act (commonly known as the "Stark Law") prohibits physicians from referring Medicare or Medicaid patients for "designated health services" to entities in which they hold an ownership or investment interest or with whom they have a compensation arrangement, subject to certain statutory or regulatory exceptions. We cannot assure you that future statutory or regulatory changes will not result in hospice services being subject to the Stark Law's ownership, investment, compensation or referral prohibitions. Several states in which VITAS operates have similar laws which likewise are subject to change. Any such changes could adversely affect the business, financial condition and operating results of VITAS.

Further, under separate statutes, submission of claims for items or services that are "not provided as claimed" may lead to civil money penalties, criminal fines and imprisonment and/or exclusion from participation in Medicare, Medicaid and other federally funded state health care programs. These false claims statutes include the federal False Claims

Act, which allows any person to bring suit on behalf of the federal government, known as a qui tam action, alleging false or fraudulent Medicare or Medicaid claims or other violations of the statute and to share in any amounts paid by the entity to the government in fines or settlement. See the discussion of the governmental investigations and litigation pending against VITAS under Other Healthcare Regulations, above and Legal Proceedings, below.

Certificate of Need Laws. Many states, including Florida, have certificate of need laws or other similar health planning laws that apply to hospice care providers. These states may require some form of state agency review or approval prior to opening a new hospice program, to adding or expanding hospice services, to undertaking significant capital expenditures or under other specified circumstances. Approval under these certificate of need laws is generally conditioned on the showing of a demonstrable need for services in the community. VITAS may seek to develop, acquire or expand hospice programs in states having certificate of need laws. To the extent that state agencies require VITAS to obtain a certificate of need or other similar approvals to expand services at existing hospice programs or to make acquisitions or develop hospice programs in new or existing geographical markets, VITAS' plans could be adversely affected by a failure to obtain a certificate or approval. In addition, competitors may seek administratively or judicially to challenge such an approval or proposed approval by the state agency. Such a challenge, whether or not ultimately successful, could adversely affect VITAS.

Other Federal and State Regulations. The federal government and all states regulate various aspects of the hospice industry and VITAS' business. In particular, VITAS' operations are subject to federal and state health regulatory laws, including those covering professional services, the dispensing of drugs and certain types of hospice activities. Certain of VITAS' employees are subject to state laws and regulations governing professional practice. VITAS' operations are subject to periodic survey by governmental authorities and private accrediting entities to assure compliance with applicable state licensing, and Medicare and Medicaid certification and accreditation standards, as the case may be. From time to time in the ordinary course of business, VITAS receives survey reports noting deficiencies for alleged failure to comply with applicable requirements. VITAS reviews such reports and takes appropriate corrective action. The failure to effect such action could result in one of VITAS' hospice programs being terminated from the Medicare hospice program. Any termination of one or more of VITAS' hospice locations from the Medicare hospice program could adversely affect VITAS' net patient service revenue and profitability and adversely affect its financial condition and results of operations. The failure to obtain, renew or maintain any of the required regulatory approvals, certifications or licenses could materially adversely affect VITAS' business and could prevent the programs involved from offering products and services to patients. In addition, laws and regulations often are adopted to regulate new products, services and industries. We cannot assure you that either the states or the federal government will not impose additional regulations on VITAS' activities, which might materially adversely affect VITAS, including impairing the value of its brand.

Claims Review. The Medicare and Medicaid programs and their fiscal intermediaries and other payors periodically conduct pre-payment or post-payment reviews and other reviews and audits of health care claims, including hospice claims. As a result of such reviews or audits, VITAS could be required to return any amounts found to be overpaid, or amounts found to be overpaid could be recouped through reductions in future payments. There is pressure from state and federal governments and other payors to scrutinize health care claims to determine their validity and appropriateness. VITAS' claims have been subject to review and audit. We cannot assure you that reviews and/or similar audits of VITAS' claims will not result in material recoupments, denials or other actions that could have a material adverse effect on VITAS' business, financial condition and results of operations. See the discussion of OIG investigations pending against VITAS under Other Health Care Regulations, above.

Regulation and Provision of Continuous Home Care. VITAS provides continuous home care to patients requiring such care. Continuous home care is provided to patients while at home, during periods of crisis when intensive monitoring and care, primarily nursing care, is required in order to achieve palliation or management of acute medical symptoms. Continuous home care requires a minimum of 8 hours of care within a 24-hour day, which begins and ends at midnight. The care must be predominantly nursing care provided by either a registered nurse or licensed practical nurse.

Continuous home care can be challenging for a hospice to provide for a number of reasons, including the need to have available sufficient skilled and trained staff to furnish such care, the need to manage the staffing and provision of such care, and a shortage of nurses that can make it particularly difficult to attract and retain nurses that are required to furnish a majority of such care. Medicare reimbursement for continuous home care has been calculated by multiplying the applicable continuous home care hourly rate by the number of hours of care provided. If the care was provided for less than one hour, Medicare requires reporting in 15-minute increments of care provided, with no rounding.

Medicare reimbursement for continuous home care is subject to a number of requirements posing further challenges for a hospice providing such care. For example, if a patient requires skilled interventions for palliation or symptom management that can be accomplished in less than 8 aggregate hours within the 24-hour period, if the majority of care can be accomplished by someone other than a registered nurse or a licensed practical nurse (e.g., if a majority of care is furnished by a home health aide or homemaker), or if for any reason less than 8 hours of direct care are provided (such as when a patient dies before 8 AM even if 7 or more hours of care has been provided), the care rendered cannot be reimbursed by Medicare at the continuous home care rate (although the care instead may be eligible for Medicare

reimbursement at the reduced routine home care day rate). As a result of such requirements, VITAS may incur the costs of providing services intended to be continuous home care services yet be unable to bill or be reimbursed for such services at the continuous home care rate. We cannot assure you that challenges in providing continuous home care will not cause VITAS' net patient service revenue and profits to materially decline or that reviews and/or similar audits of VITAS' claims will not result in material recoupments, denials or other actions that could have a material adverse effect on VITAS' business, financial condition and results of operations.

Compliance. VITAS maintains an internal regulatory compliance review program and from time to time retains regulatory counsel for guidance on compliance matters. We cannot assure you, however, that VITAS' practices, if reviewed, would be found to be in compliance with applicable health regulatory laws, as such laws ultimately may be interpreted, or that any non-compliance with such laws would not have a material adverse effect on VITAS.

Federal and state legislative and regulatory initiatives could require VITAS to expend substantial sums on acquiring, implementing and supporting new information systems, which could negatively impact its profitability.

There are currently numerous legislative and regulatory initiatives at both the state and federal levels that address patient privacy concerns. We cannot predict the total financial or other impact of the regulations on VITAS' operations. In addition, although VITAS' management believes it is in compliance with the requirement of patient privacy regulations, we cannot assure you that VITAS will not be found to have violated state and federal laws, rules or guidelines surrounding patient privacy. Compliance with current and future HIPAA requirements or any other federal or state privacy initiatives could require VITAS to make substantial investments, which could negatively impact its profitability and cash flows.

VITAS' growth strategies may not be successful, which could adversely affect its business.

A significant element of VITAS' growth strategy is expected to include expansion of its business in new and existing markets. This aspect of VITAS' growth strategy may not be successful, which could adversely impact its growth and profitability. We cannot assure you that VITAS will be able to:

Identify markets that meet its selection criteria for new hospice locations;

Hire and retain qualified management teams to operate each of its new hospice locations;

Manage a large and geographically diverse group of hospice locations;

Become Medicare and Medicaid certified in new markets;

Generate sufficient hospice admissions in new markets to operate profitably in these new markets;

Compete effectively with existing hospices in new markets; or

Obtain state licensure and/or a certificate of need from appropriate state agencies in new markets.

In addition to growing existing locations and developing new hospice locations, VITAS' growth is expected to include expansion through acquisition of other hospices. We cannot assure you that VITAS' acquisition strategy will be successful. The success of VITAS' acquisition strategy depends upon a number of factors, including:

Its ability to identify suitable acquisition candidates;

Its ability to negotiate favorable acquisition terms, including purchase price, which may be adversely affected due to increased competition with other buyers;

The availability of financing on favorable terms, or at all;

Its ability to integrate effectively the systems and operations of acquired hospices;

Its ability to retain key personnel of acquired hospices; and

Its ability to obtain required regulatory approvals.

Acquisitions involve a number of other risks, including diversion of management's attention from other business concerns and assuming known or unknown liabilities of acquired hospices, including liabilities for failure to comply with health care laws and regulations. Integrating acquired hospices may place significant strains on VITAS' current operating and financial systems and controls. VITAS may not successfully overcome these risks or any other problems encountered in connection with its acquisition strategy.

In addition, since 1990, VITAS has acquired hospice programs, some of which involved acquisitions of hospice programs from not-for-profit entities. VITAS believes that acquisitions of not-for-profit programs are generally more complex than acquisitions from for-profit entities and that a substantial number of acquisition opportunities are likely to involve acquisitions from not-for-profit entities. Such acquisitions are subject to provisions of the Internal Revenue Code and, in certain states, state attorney general powers, which have been interpreted to require that the consideration paid for the assets purchased be at fair market value and, where applicable, that any fees paid for services be reasonable. In many states there is no mechanism for state attorney general pre-clearance of transactions to assure that applicable standards have been met. Entities that acquired not-for-profit hospices could face potential liability if the acquisition transaction is not structured to comply with Internal Revenue Code and state law requirements, and in some cases the transaction could be enjoined or subject to rescission. The acquisition of not-for-profit businesses, including the fairness of the purchase price paid, has received increasing regulatory scrutiny by state attorneys general and other regulatory authorities. Although VITAS believes that reasonable actions have been taken to date to establish the fair market value of assets purchased in prior acquisitions of hospice operations from not-for-profit entities and the reasonableness of fees paid for services, we cannot assure you that such transactions or any future similar transactions will not be challenged or that, if challenged, the results of such challenge would not have a material adverse effect on VITAS' business.

VITAS' loss of key management personnel or its inability to hire and retain skilled employees could adversely affect its business, financial condition and results of operations.

VITAS' future success significantly depends upon the continued service of its senior management personnel. The loss of one or more of VITAS' key senior management personnel or its inability to hire and retain new skilled employees could negatively impact VITAS' ability to maintain or increase patient referrals, a key aspect of its growth strategy, and could adversely affect its future operating results.

Competition for skilled employees is intense, and the process of locating and recruiting skilled employees with the combination of qualifications and attributes required to care effectively for terminally ill patients and their families can be difficult and lengthy. We cannot assure you that VITAS will be successful in attracting, retaining or training highly skilled nursing, management, community education, operations, admissions and other personnel. VITAS' business could be disrupted and its growth and profitability negatively impacted if it is unable to attract and retain skilled employees.

A nationwide shortage of qualified nurses could adversely affect VITAS' profitability, growth and ability to continue to provide quality, responsive hospice services to its patients as nursing wages and benefits increase.

Approximately 40% of VITAS' workforce is licensed nurses. VITAS depends on qualified nurses to provide quality, responsive hospice services to its patients. The current nationwide shortage of qualified nurses impacts some of the markets in which VITAS provides hospice services. In response to this shortage, VITAS has adjusted its wages and benefits to recruit and retain nurses and to engage contract nurses. VITAS' inability to attract and retain qualified nurses could adversely affect its ability to provide quality, responsive hospice services to its patients and its ability to increase or maintain patient census in those markets. Increases in the wages and benefits required to attract and retain qualified nurses or an increase in reliance on contract nurses could negatively impact profitability.

VITAS may not be able to compete successfully against other hospice providers, and competitive pressures may limit its ability to maintain or increase its market position and adversely affect its profitability, financial condition and results of operations.

Hospice care in the United States is highly competitive. In many areas in which VITAS' hospices are located, they compete with a large number of organizations, including:

Community-based hospice providers;

National and regional companies;

Hospital-based hospice and palliative care programs;

Physician groups;

Nursing homes;

Home health agencies;

Infusion therapy companies; and

Nursing agencies.

19

Various health care companies have diversified into the hospice market. Other companies, including hospitals and health care organizations that are not currently providing hospice care, may enter the markets VITAS serves and expand the variety of services offered to include hospice care. We cannot assure you that VITAS will not encounter increased competition in the future that could limit its ability to maintain or increase its market position, including competition from parties in a position to impact referrals to VITAS. Such increased competition could have a material adverse effect on VITAS' business, financial condition and results of operations.

Changes in rates or methods of payment for VITAS' services could adversely affect its revenues and profits.

Managed care organizations have grown substantially in terms of the percentage of the population they cover and their control over an increasing portion of the health care economy. Managed care organizations have continued to consolidate to enhance their ability to influence the delivery of health care services and to exert pressure to control health care costs. VITAS has a number of contractual arrangements with managed care organizations and other similar parties.

VITAS provides hospice care to many Medicare beneficiaries who receive their non-hospice health care services from health maintenance organizations ("HMOs") under Medicare risk contracts. Under such contracts between HMOs and the federal Department of Health and Human Services, the Medicare payments for hospice services are excluded from the per-member, per-month payment from Medicare to HMOs and instead are paid directly by Medicare to the hospices. As a result, VITAS' payments for Medicare beneficiaries enrolled in Medicare risk HMOs are processed in the same way with the same rates as other Medicare beneficiaries. We cannot assure, however, that payment for hospice services will continue to be excluded from HMO payment under Medicare risk contracts and similar Medicare managed care plans or that if not excluded, managed care organizations or other large third-party payors would not use their power to influence and exert pressure on health care providers to reduce costs in a manner that could have a material adverse effect on VITAS' business, financial condition and results of operations.

Liability claims may have an adverse effect on VITAS, and its insurance coverage may be inadequate.

Participants in the hospice industry are subject to lawsuits alleging negligence, product liability or other similar legal theories, many of which involve large claims and significant defense costs. From time to time, VITAS is subject to such and other types of lawsuits. See the description below under Legal Proceedings. The ultimate liability for claims, if any, could have a material adverse effect on its financial condition or operating results. Although VITAS currently maintains liability insurance intended to cover the claims, we cannot assure you that the coverage limits of such insurance policies will be adequate or that all such claims will be covered by the insurance. In addition, VITAS' insurance policies must be renewed annually and may be subject to cancellation during the policy period. While VITAS has been able to obtain liability insurance in the past, such insurance varies in cost, and may not be available in the future on terms acceptable to VITAS, if at all.

A successful claim in excess of the insurance coverage could have a material adverse effect on VITAS. Claims, regardless of their merit or eventual outcome, also may have a material adverse effect on VITAS' business and reputation due to the costs of litigation, diversion of management's time and related publicity.

VITAS procures professional liability coverage on a claims-made basis. The insurance contracts specify that coverage is available only during the term of each insurance contract. VITAS' management intends to renew or replace the existing claims-made policy annually but such coverage is difficult to obtain, may be subject to cancellation and may be written by carriers that are unable, or unwilling to pay claims. During fiscal 2001, VITAS was notified that one of its prior carriers was ordered into rehabilitation, and in early fiscal 2002, into liquidation, creating the possibility that certain prior year claims could be underinsured or uninsured. Certain claims have been asserted where the coverage would be the responsibility of this prior carrier and/or other carriers that may not have the financial wherewithal to

satisfy the claims. Additionally, some risks and liabilities, including claims for punitive damages, are not covered by insurance.

Cybersecurity

In the normal course of business, our information technology systems hold sensitive patient information including patient demographic data, eligibility for various medical plans including Medicare and Medicaid and protected health information. Additionally, we utilize those same systems to perform our day-to-day activities, such as receiving referrals, assigning medical teams to patients, documenting medical information and maintaining an accurate record of all transactions. We have not experienced any known attacks on our information technology systems that have compromised patient data or the Company's proprietary data. We maintain our information technology systems with safeguard protection against cyber-attacks including passive intrusion protection, firewalls and virus detection software. As discussed previously, we are subject to and comply with HIPPA regulations. However, these safeguards do not ensure that a significant cyber-attack could not occur. A successful attack on our information technology systems could have significant consequences to the business including liability for compromised patient information and business interruption.

VITAS' success is highly dependent on its brand reputation

VITAS' reputation for performing quality routine and high acuity patient hospice care within the regulations mandated by Medicare, Medicaid and commercial payors is critical to our success. Failure to provide quality patient care within the regulations mandated by our third-party payors, or the perception of inappropriate care resulting in adverse publicity, litigation or a campaign of negative on-line reviews are some of the factors that could negatively impact VITAS' national reputation. VITAS maintains a reputation management risk program however, a loss of brand reputation at VITAS could adversely affect referral sources' willingness to refer our service and thus, adversely affect our future operating performance.

VITAS' headquarters and a significant portion of its operations are in south Florida

The occurrence of a natural disaster in any region that VITAS has significant operations could have a negative impact on the business. VITAS' headquarters are located in Miami, Florida. In addition, two of our largest programs are in south Florida. The location of our headquarters and these large programs increases our exposure to hurricanes. A major hurricane in south Florida could impede our ability to bill for our services, operate our businesses and serve our patients' in the affected area. VITAS maintains a disaster recovery program to mitigate this risk however, natural disasters could have an adverse affect on our future operating performance.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

The Company's corporate offices and the headquarters for Roto-Rooter are located in Cincinnati, Ohio. Roto-Rooter has manufacturing and distribution center facilities in West Des Moines, Iowa and has 109 leased and owned office and service facilities in 30 states. VITAS, headquartered in Miami, operates 51 programs from 154 leased facilities and 37 inpatient units in 18 states and the District of Columbia.

All "owned" property is held in fee and is subject to the security interests of the holders of our debt instruments. The leased properties have lease terms ranging from one year to nine years. Management does not foresee any difficulty in renewing or replacing the remainder of its current leases. The Company considers all of its major operating properties to be maintained in good operating condition and to be generally adequate for present and anticipated needs.

Item 3. Legal Proceedings

In February 2010, Chemed and Roto-Rooter were named as defendants in a lawsuit filed in the United States District Court for the Eastern District of New York, Anthony Morangelli, et al., v. Chemed Corp. and Roto-Rooter Services Co., No. 10-CV-00876 (BMC). The named plaintiffs, current and former technicians employed by Roto-Rooter who were paid on a commission basis, asserted against Chemed and Roto-Rooter claims for violation of the Fair Labor Standards Act ("FLSA") and claims for violations of the labor laws of multiple states. In June 2013 the parties reached an agreement to settle the case for $14.3 million plus applicable payroll taxes ($9.0 million after tax). As such, $14.8 million is recorded as other operating expense in the year ended December 31, 2013 Statement of Income and is included in accrued legal at December 31, 2013.

VITAS is party to a class action lawsuit filed in the Superior Court of California, Los Angeles County in September 2006 by Bernadette Santos, Keith Knoche and Joyce White, Bernadette Santos, et al. v. VITAS Healthcare Corporation of California, BC359356. This case alleges failure to pay overtime and failure to provide meal and rest

periods to a purported class of California admissions nurses, chaplains and sales representatives. The case seeks payment of penalties, interest and Plaintiffs' attorney fees. In December 2009, the trial court denied Plaintiffs' motion for class certification. In July 2011, the Court of Appeals affirmed denial of class certification on the travel time, meal and rest period claims, and reversed the trial court's denial on the off-the-clock and sales representation exemption claims. Plaintiffs filed an appeal of this decision. In September 2012, in response to an order of reconsideration, the Court of Appeals reiterated its previous rulings. In March 2013, the Court granted summary judgment dismissing the sales representatives' claims as they are exempt employees. In October 2013 we reached agreement to settle the case for $10.3 million plus applicable payroll taxes ($6.5 million aftertax). As such, $10.5 million is recorded as other operating expense in the year ended December 31, 2013 Statement of Income. This settlement was paid in 2013.

On January 12, 2012, a putative class action lawsuit was filed in the U.S. District Court for the Southern District of Ohio against the Company, Kevin McNamara, David Williams, and Timothy O'Toole, In re Chemed Corp. Securities Litigation, Civil Action No. 1:12-cv-28 (S.D. Ohio). On June 18, 2012, an amended complaint was filed alleging violation of Section 10(b) of the Securities Exchange Act of 1934 and Rule 10b-5 against all Defendants, and violation of Section 20(a) of the Securities Exchange Act of 1934 against Messrs. McNamara, Williams, and O'Toole. The suit's allegations concern the VITAS hospice segment of the Company's business. Plaintiffs seek, on behalf of a putative class of purchasers of Chemed Capital Stock, compensatory damages in an unspecified amount and attorneys' fees and expenses, arising from Defendants' alleged failure to disclose an alleged fraudulent scheme at VITAS to enroll ineligible hospice patients and to fraudulently obtain payments from the federal government. Defendants filed motions to dismiss the amended complaint on August 17, 2012, which were pending when the parties reached an agreement to settle the action. On June 7, 2013, following the filing of U.S. v. VITAS, discussed below, Plaintiffs filed a motion for leave to file a second amended complaint. Defendants opposed this motion. On September 16, 2013 Plaintiffs, executed a Settlement Term Sheet with Defendants, reaching an agreement in principle to settle this case subject to court approval. On February 6, 2014, Plaintiffs, on behalf of a putative class of purchasers of Chemed Capital Stock between February 15, 2010 and May 2, 2013, inclusive, executed a stipulation of settlement with Defendants, agreeing to settle this case in full and with prejudice, and to provide Defendants with full releases of all claims that are or could have been asserted by Plaintiffs in exchange for payment of $6.0 million by our insurer into a settlement fund for the benefit of the putative settlement class ("Settlement"). The Settlement has been recorded as an accrual and offsetting prepaid in the accompanying Balance Sheet. This Settlement is subject to Court approval. Defendants agreed to enter into this Settlement in order to eliminate the burden, expense and distraction of further litigation.

In June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Western District of Texas, United States, et al. ex rel. Urick v. VITAS HME Solutions, Inc. et al., 5:08-cv-0663 ("Urick"). The U.S. Attorney filed a notice in May 2012 stating that it had decided not to intervene in the case at that time but indicating that it continues to investigate the allegations. In June 2012, the complaint was unsealed. The complaint asserts violations of the federal False Claims Act and the Texas Medicaid Fraud Prevention Act based on allegations of a conspiracy to submit to Medicare and Medicaid false claims involving hospice services for ineligible patients, unnecessary medical supplies, failing to satisfy certain prerequisites for payment, and altering patient records, including backdating patient revocations. The suit was brought by Barbara Urick, a registered nurse in VITAS's San Antonio program, against VITAS, certain of its affiliates, and several former VITAS employees, including physicians Justo Cisneros and Antonio Cavasos and nurses Sally Schwenk, Diane Anest, and Edith Reed. In September 2012 and July 2013, the plaintiff dismissed all claims against the individual defendants. The complaint was served on the VITAS entities on April 12, 2013.

Also in June 2011, the U.S. Attorney provided the Company with a partially unsealed qui tam complaint filed under seal in the U.S. District Court for the Northern District of Illinois, United States, et al. ex rel. Spottiswood v. Chemed Corp., 1:07-cv-4566 ("Spottiswood"). In April 2012, the complaint was unsealed. The U.S. Attorney and Attorney General for the State of Illinois filed notices in April and May 2012, respectively, stating that they had decided not to intervene in the case at that time but indicating that they continue to investigate the allegations. Plaintiff filed an amended complaint in November 2012. The complaint asserts violations of the federal False Claims Act and the Illinois Whistleblower Reward and Protection Act based on allegations that VITAS fraudulently billed Medicare and Medicaid for providing unwarranted continuous care services. The suit was brought by Laura Spottiswood, a former part-time pool registered nurse at VITAS, against Chemed, VITAS, and a VITAS affiliate. The complaint was served on the defendants on April 12, 2013. On May 29 and June 4, 2013, respectively, the Court granted the government's motion to partially intervene in Spottiswood and in Urick on the allegations that VITAS submitted or caused to be submitted false or fraudulent claims for continuous care and routine home care on behalf of certain ineligible Medicare beneficiaries. The Court also transferred them to the U.S. District Court for the Western District of Missouri under docket Nos. 4:13-cv-505 and 4:13-cv-563, respectively.

On May 2, 2013, the government filed a False Claims Act complaint against the Company and certain of its hospice-related subsidiaries in the U.S. District Court for the Western District of Missouri, United States v. VITAS Hospice Services, LLC, et al., No. 4:13-cv-00449-BCW (the "2013 Action"). Prior to that date, the Company received various subpoenas from the U.S. Department of Justice and OIG that have been previously disclosed. The 2013 Action alleges that, since at least 2002, VITAS, and since 2004, the Company, submitted or caused the submission of false claims to the Medicare program by (a) billing Medicare for continuous home care services when the patients were not eligible, the services were not provided, or the medical care was inappropriate, and (b) billing Medicare for patients who were not eligible for the Medicare hospice benefit because they did not have a life expectancy of six months or less if their illnesses ran their normal course. This complaint seeks treble damages, statutory penalties, and the costs of the action, plus interest. On August 1, 2013, the government filed its First Amended Complaint in the 2013 Action. The First Amended Complaint changed and supplemented some of the allegations, but did not otherwise expand the causes of action or the nature of the relief sought against VITAS. The defendants filed a motion to dismiss on September 24, 2013.

On May 6, 2013, the U.S. District Court for the Western District of Missouri, at the request of the government, unsealed a qui tam complaint against VITAS and VITAS Healthcare Corporation of California, United States ex rel. Charles Gonzales v. VITAS Healthcare Corporation, et al., CV 12-0761-R ("Gonzales"). The case was transferred from the Central District of California to the Western District of Missouri under docket No. 4:13-cv-344. The government partially intervened in Gonzales. The Gonzales complaint alleges that VITAS' Los Angeles program falsely certified and recertified patients as eligible for the Medicare Hospice Benefit. It alleges violations of the False Claims Act and seeks treble damages, civil penalties, recovery of costs, attorneys' fees and expenses, and pre- and post-judgment interest.

On September 25, 2013, the Court granted a joint motion by the government, the relators, and VITAS to consolidate the Spottiswood, Urick, and Gonzales complaints with the 2013 Action. As a result, the First Amended Complaint will govern the consolidated claims brought by the United States and the relators for all purposes. The relators and VITAS have stipulated that certain non-intervened claims will not be pursued by the relators.

VITAS has also received document subpoenas in related state matters. In February 2010, VITAS received a civil investigative demand ("CID") from the Texas Attorney General seeking documents from January 1, 2002 through the date of the CID, and interrogatory responses in connection with an investigation of possible fraudulent submission of Medicaid claims for non-qualifying patients and fraudulent shifting of costs from VITAS to the State of Texas and the United States. The CID requested similar information sought by prior Department of Justice subpoenas, including policy and procedure manuals and information concerning Medicare and Medicaid billing, patient statistics and sales and marketing practices, together with information concerning record-keeping and retention practices, and medical records concerning 117 patients. In September 2010, VITAS received a second CID from the Texas Attorney General seeking additional documents concerning business plans and results, revocation forms for certain patients, and electronic documents of 10 current and former employees. In July 2012, VITAS received an investigative subpoena from the Florida Attorney General seeking documents previously produced in the course of prior government investigations as well as, for the period January 1, 2007 through the date of production, billing records and procedures; information concerning business results, plans, and strategies; documents concerning patient eligibility for hospice care; and certain information concerning employees and their compensation.

In November 2013, two shareholder derivative lawsuits were filed against the Company's current and former directors, as well as certain of its officers both of which are covered by the company's commercial insurance. On November 6, 2013, KBC Asset Management NV filed suit in the United States Distrct Court for the District of Delaware, KBC Asset Management NV, derivatively on behalf of Chemed Corp. v. McNamara, et al., No. 13 Civ. 1854 (LPS) (D. Del.). It sued Kevin McNamara, Joel Gemunder, Patrick Grace, Thomas Hutton, Walter Krebs, Andrea Lindell, Thomas Rice, Donald Saunders, Arthur Tucker, Jr., George Walsh III, Frank Wood, Timothy O'Toole, David Williams and Ernest Mrozek, together with the Company as nominal defendant. Plaintiff alleges that since at least 2004, Chemed, through VITAS, has submitted or caused the submission of false claims to Medicare. The suit alleges a claim for breach of fiduciary duty against the individual defendants, and seeks (a) a declaration that the individual defendants breached their fiduciary duties to the Company; (b) an order requiring those defendants to pay compensatory damages, restitution and exemplary damages, in unspecified amounts, to the Company; (c) an order directing the Company to implement new policies and procedures; and (d) costs and disbursements incurred in bringing the action, including attorneys' fees.

On November 14, 2013, Mildred A. North filed suit in the United States District Court for the Southern District of Ohio, North, derivatively on behalf of Chemed Corp. v. Kevin McNamara, el al., No. 13 Civ. 833 (MDB) (S.D. Ohio). She sued Kevin McNamara, David Williams, Timothy O'Toole, Joel Gemunder, Patrick Grace, Walter Krebs, Andrea Lindell, Thomas Rice, Donald Saunders, George Walsh III, Frank Wood and Thomas Hutton, together with the Company as nominal defendant. Plaintiff alleges that, between February 2010 and the present, the individual defendants breached their fiduciary duties as officers and directors of Chemed by, among other things, (a) allegedly

causing VITAS to submit improper and ineligible claims to Medicare and Medicaid; and (b) allegedly misrepresenting the state of Chemed's internal controls. The suit alleges claims for breach of fiduciary duty, abuse of control and gross mismanagement against the individual defendants. The complaint also alleges unjust enrichment and insider trading against Messrs. McNamara, Williams and O'Toole. Plaintiff seeks (a) a declaration that the individual defendants breached their fiduciary duties to the Company; (b) an order requiring those defendants to pay compensatory damages, restitution and exemplary damages, in unspecified amounts, to the Company; (c) an order directing the Company to implement new policies and procedures; and (d) costs and disbursements incurred in bringing the action, including attorneys' fees.

On December 20, 2013, Plaintiff in the North action filed a motion before the Judicial Panel on Multidistrict Litigation seeking centralized treatment of her action and the KBC action in the U.S. District Court for the Southern District of Ohio. Defendants in both cases, as well as with Plaintiff KBC, opposed that motion, consistent with Chemed's By-law 8.07, which requires all derivative suits brought in Chemed's name to proceed in federal or state court in Delaware. The MDL Panel has yet to rule on that motion. On January 29, 2014 Defendants filed motions to transfer North to Delaware under 28 U.S.C. § 1404 and to stay the case until after resolution of that motion and the MDL motion.

The Company intends to defend vigorously against the allegations in each of the above lawsuits. The Company had a net recovery for these OIG investigations, due to a one-time insurance reimbursement of $1.0 million for certain legal costs, for the ended December 31, 2013. The net costs to comply with these OIG investigations were $2.1 million, $1.2 million and $1.2 million for the years ending December 31, 2013, 2012 and 2011, respectively. Regardless of the outcome of any of the preceding matters, responding to the subpoenas and dealing with the various regulatory agencies and opposing parties can adversely affect us through defense costs, potential payments, diversion of management time, and related publicity. Although the Company intends to defend them vigorously, there can be no assurance that those suits will not have a material adverse effect on the Company.

See also the OIG matters pending against VITAS under Other Healthcare Regulations, above.

Item 4. Mine Safety Disclosures

None

Executive Officers of the Company

Name	Age	Office	First Elected
Kevin J. McNamara	60	President and Chief Executive Officer	August 2, 1994 (1)
Timothy S. O'Toole	58	Executive Vice President	May 18, 1992 (2)
Spencer S. Lee	58	Executive Vice President	May 15, 2000 (3)
David P. Williams	53	Executive Vice President and Chief Financial Officer	March 5, 2004 (4)
Arthur V. Tucker, Jr.	64	Vice President and Controller	February 1, 1989 (5)

(1) Mr. K. J. McNamara is President and Chief Executive Officer of the Company and has held these positions since August 1994 and May 2001, respectively. Previously, he served as an Executive Vice President, Secretary and General Counsel of the Company, since November 1993, August 1986 and August 1986, respectively. He previously held the position of Vice President of the Company, from August 1986 to May 1992.

(2) Mr. T.S. O'Toole is an Executive Vice President of the Company and has held this position since May 1992. He is also Chief Executive Officer of VITAS, a wholly owned subsidiary of the Company, and has held this position since February 24, 2004. Previously, from May 1992 to February 24, 2004, he also served the Company as Treasurer.

(3) Mr. S. S. Lee is an Executive Vice President of the Company and has held this position since May 15, 2000. Mr. Lee is also Chairman and Chief Executive Officer of Roto-Rooter Services Company, a wholly owned subsidiary of the Company, and has held this position since January 1999. Previously, he served as a Senior Vice President of Roto-Rooter Services Company from May 1997 to January 1999.

(4) Mr. D. P. Williams is an Executive Vice President and the Chief Financial Officer of the company and has held these positions since August 10, 2007 and March 5, 2004, respectively. Mr. Williams is also Senior Vice President and Chief Financial Officer of Roto-Rooter Group, Inc., and has held these positions since January 1999.

(5) Mr. A. V. Tucker, Jr. is a Vice President and Controller of the Company and has held these positions since February 1989. From May 1983 to February 1989, he held the position of Assistant Controller of the Company.

Each executive officer holds office until the annual election at the next annual organizational meeting of the Board of Directors of the Company which is scheduled to be held on May 19, 2014.

PART II

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

The Company's Capital Stock (par value $1 per share) is traded on the New York Stock Exchange under the symbol CHE. The range of the high and low sale prices on the New York Stock Exchange and dividends paid per share for each quarter of 2012 and 2013 are set forth below.

	Closing		Dividends Paid
	High	Low	Per Share
2012			
First Quarter	$63.87	$51.18	$0.16
Second Quarter	64.30	54.78	0.16
Third Quarter	71.59	59.45	0.18
Fourth Quarter	70.92	62.70	0.18
2013			
First Quarter	$79.98	70.31	$0.18
Second Quarter	81.79	63.90	0.18
Third Quarter	75.88	66.04	0.20
Fourth Quarter	79.93	66.14	0.20

Future dividends are necessarily dependent upon the Company's earnings and financial condition, compliance with certain debt covenants and other factors not presently determinable.

As of February 14, 2014, there were approximately 2,053 stockholders of record of the Company's Capital Stock. This number only includes stockholders of record and does not include stockholders with shares beneficially held in nominee name or within clearinghouse positions of brokers, banks or other institutions.

During 2013, the number of shares of Capital Stock repurchased by the Company, the weighted average price paid for each share, the cumulative shares repurchased under each program and the dollar amounts remaining under each program were as follows:

Company Purchase of Shares of Capital Stock

	Total Number of Shares Repurchased	Weighted Average Price Paid Per Share	Cumulative Shares Repurchased Under the Program	Dollar Amount Remaining Under The Program
February 2011 Program				
January 1 through January 31, 2013	-	$ -	3,535,541	$ 14,739,197
February 1 through February 28, 2013	-	-	3,535,541	114,739,197
March 1 through March 31, 2013	-	-	3,535,541	$ 114,739,197
First Quarter Total	-	$ -		
April 1 through April 30, 2013	-	$ -	3,535,541	$ 114,739,197
May 31 through May 31, 2013	280,701	65.72	3,816,242	96,291,009
June 1 through June 30, 2013	-	-	3,816,242	$ 96,291,009
Second Quarter Total	280,701	$ 65.72		
July 1 through July 31, 2013	219,830	$ 70.66	4,036,072	$ 80,758,769
August 1 through August 31, 2013	49,522	71.02	4,085,594	77,241,690
September 1 through September 30, 2013	763,402	68.26	4,848,996	$ 25,128,231
Third Quarter Total	1,032,754	$ 68.91		
October 1 through October 31, 2013	-	$ -	4,848,996	$ 25,128,231
November 1 through November 30, 2013	-	-	4,848,996	25,128,231
December 1 through December 31, 2013	42,889	76.95	4,891,885	$ 21,828,041
Fourth Quarter Total	42,889	$ 76.95		

On February 21, 2014, our Board of Directors authorized an additional $100 million under February 2011 Repurchase Program.

26

As of December 31, 2013, the number of stock options outstanding under the Company's equity compensation plans, the weighted average exercise price of outstanding options, and the number of securities remaining available for issuance were as follows:

EQUITY COMPENSATION PLAN INFORMATION

Plan Category	Number of securities to be issued upon exercise of outstanding warrants and rights	Weighted-average exercise price of outstanding options, warrants and rights	Number of securities remaining available for future issuance under equity compensation plans (excluding securities reflected in column)
Equity compensation plans approved by stockholders (1)	2,198,710	$ 60.73	492,131
Equity compensation plans not approved by stockholders (2)	3,500	45.14	-
Total	2,202,210	$ 60.71	492,131

(1) Amount includes 16,149 shares allocated to certain employees which vest upon attainment of specified earnings per share targets for the three-year period ending December 31, 2015 and 16,149 shares which vest upon attainment of specified total shareholder return targets for the three-year period ending December 31, 2015.

(2) In May 1999 the Board of Directors adopted the 1999 Long-Term Employee Incentive Plan without stockholder approval. This plan permits the Company to grant up to 500,000 shares of non-qualified options and stock awards to a broad base of salaried and hourly employees (excluding officers and directors) of the Company. Except for the exclusion of officers and directors, this plan has the same general terms and provisions as the 2006 Stock Incentive Plan. In addition, pursuant to this plan no individual may be granted more than 50,000 stock options in a calendar year, the aggregate number of the shares of Capital Stock which may be issued pursuant to stock incentives in the form of Stock Awards shall not be more than 270,000, and no stock incentives shall be granted under the plan after May 17, 2009.

Comparative Stock Performance

The graph below compares the yearly percentage change in the Company's cumulative total stockholder return on Capital Stock (as measured by dividing (i) the sum of (A) the cumulative amount of dividends for the period December 31, 2008, to December 31, 2013, assuming dividend reinvestment, and (B) the difference between the Company's share price at December 31, 2008 and December 31, 2013; by (ii) the share price at December 31, 2008) with the cumulative total return, assuming reinvestment of dividends, of the (1) S&P 500 Stock Index and (2) Dow Jones Industrial Diversified Index.

December 31,	2008	2009	2010	2011	2012	2013
Chemed Corporation	100.00	121.62	162.53	132.36	179.27	202.35
S&P 500	100.00	126.46	145.51	148.59	172.37	228.19
Dow Jones Diversified Industrials	100.00	113.50	139.44	140.56	169.80	241.34

Item 6. Selected Financial Data

The information called for by this Item for the five years ended December 31, 2013 is set forth on page 84 of the 2013 Annual Report to Stockholders and is incorporated herein by reference.

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

The information called for by this Item is set forth on pages 88 through 104 of the 2013 Annual Report to Stockholders and is incorporated herein by reference.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

The Company's primary market risk exposure relates to interest rate risk exposure through its variable interest line of credit. At December 31, 2013 the Company had no variable rate debt outstanding. For each $10 million dollars borrowed under the credit facility, an increase or decrease of 100 basis points (1% point), increases or decreases the Company's annual interest expense by $100,000.

The Company continually evaluates this interest rate exposure and periodically weighs the cost versus the benefit of fixing the variable interest rates through a variety of hedging techniques.

The market value of the Company's long-term debt at December 31, 2013 is approximately $193.0 million versus a carrying value of $183.6 million.

Item 8. Financial Statements and Supplementary Data

The consolidated financial statements, together with the report thereon of PricewaterhouseCoopers LLP dated February 27, 2014, appearing on pages 51 through 81 of the 2013 Annual Report to Stockholders, along with the Supplementary Data (Unaudited Summary of Quarterly Results) appearing on pages 82-83, are incorporated herein by reference.

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

None.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

The Company's management, under the supervision of and with the participation of the Company's President and Chief Executive Officer, Executive Vice President and Chief Financial Officer and Vice President and Controller, has evaluated the effectiveness of the Company's disclosure controls and procedures, as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (the "Exchange Act"), as of the end of the period covered by this report. Based on such evaluation, the Company's President and Chief Executive Officer, Executive Vice President and Chief Financial Officer and Vice President and Controller have concluded that, as of the end of such period, the Company's disclosure controls and procedures are effective and are reasonably designed to ensure that all material information relating to the Company required to be included in the Company's reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the rules and forms of the Securities and Exchange Commission and that such information is accumulated and communicated to management, including the President and Chief Executive Officer, Executive Vice President and Chief Financial Officer and Vice President and Controller, as appropriate, to allow timely decisions regarding required disclosure.

Management's Report on Internal Control Over Financial Reporting

Refer to Management's Report on Internal Control over Financial Reporting and Report of Independent Registered Public Accounting Firm on pages 51 and 52 of the Company's 2013 Annual Report to Stockholders, which are incorporated herein by reference.

Changes in Internal Control Over Financial Reporting

There have not been any changes in the Company's internal control over financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act during the Company's fiscal quarter ended December 31, 2013 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Item 9B. Other Information

Not applicable.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The directors of the Company are:

Kevin J. McNamara
Joel F. Gemunder
Patrick P. Grace
Thomas C. Hutton
Walter L. Krebs
Andrea R. Lindell
Thomas P. Rice
Donald E. Saunders
George J. Walsh III
Frank E. Wood

The additional information required under this Item is set forth in the Company's 2014 Proxy Statement and in Part I hereof under the caption "Executive Officers of the Registrant" and is incorporated herein by reference.

The Company has adopted a Code of Ethics that applies to the Company's principal executive officer, principal financial officer, principal accounting officer, directors and employees. A copy of this Code of Ethics is incorporated with this report as Exhibit 14 and it is also posted on the Company's Web site, www.chemed.com.

Item 11. Executive Compensation

Information required under this Item is set forth in the Company's 2014 Proxy Statement, which is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Information required under this Item is set forth in the Company's 2014 Proxy Statement, which is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions and Director Independence.

Information required under this Item is set forth in the Company's 2014 Proxy Statement, which is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services

Audit Fees

PricewaterhouseCoopers LLP billed the Company $1,677,000 for 2012 and $1,890,000 for 2013. These fees were for professional services rendered for the integrated audit of the Company's annual financial statements and of its internal

control over financial reporting, review of the financial statements included in the Company's Forms 10-Q and review of documents filed with the SEC.

Audit-Related Fees

PricewaterhouseCoopers LLP billed the Company $128,492 and $127,800 for 2012 and 2013, respectively, for audit-related services. These services were related primarily to the audit of one of VITAS' Florida subsidiaries.

Tax Fees

No such services were rendered in 2012 or 2013.

All Other Fees

No such other services were rendered in 2012 or 2013.

The Audit Committee has adopted a policy which requires the Committee's pre-approval of audit and non-audit services performed by the independent auditor to assure that the provision of such services does not impair the auditor's independence. The Audit Committee pre-approved all of the audit and non-audit services rendered by PricewaterhouseCoopers LLP as listed above.

PART IV

Item 15 Exhibits and Financial Statement Schedule

Exhibits

3.1	Certificate of Incorporation of Chemed Corporation.*
3.2	Certificate of Amendment to Certificate of Incorporation.*
3.3	By-Laws of Chemed Corporation, as amended August 2, 2013.*
10.1	1999 Long-Term Employee Incentive Plan as amended through May 20, 2002.*,**
10.2	2002 Executive Long-Term Incentive Plan, as amended May 18, 2004.*,**
10.3	2004 Stock Incentive Plan.*,**
10.4	2006 Stock Incentive Plan, as amended August 11, 2006.*,**
10.5	2010 Stock Incentive Plan.*,**
10.6	Repurchase Agreement dated May 8, 2007 by and among Chemed Corporation, J.P. Morgan Securities Inc. and Citigroup Global Markets, Inc.*
10.7	Convertible Senior Note Indenture dated May 14, 2007 for 1.875% Convertible Senior Notes due 2014 by and among Chemed Corporation, the Subsidiary Guarantors and LaSalle Bank NA, as Trustee.*
10.8	Employment Agreement with David P. Williams dated December 1, 2006.*,**
10.9	First Amendment to Employment Agreement with David P. Williams dated July 9, 2009.*,**
10.10	Employment Agreement with Timothy S. O'Toole dated May 6, 2007.*,**
10.11	First Amendment to Employment Agreement with Timothy S. O'Toole dated July 9, 2009.*,**
10.12	Employment Agreement with Kevin J. McNamara dated May 3, 2008.*,**
10.13	First Amendment to Employment Agreement with Kevin J. McNamara dated July 9, 2009.*,**
10.14	Registration Rights Agreement, dated May 14, 2007 by and among Chemed Corporation, J.P. Morgan Securities, Inc. and Citigroup Global Markets Inc.*

10.15	Confirmation of Convertible Note Hedge, dated May 8, 2007 between Chemed Corporation and J.P. Morgan Chase Bank, NA.*
10.16	Confirmation of Convertible Note Hedge, dated May 8, 2007 between Chemed Corporation and Citibank, NA.*
10.17	Form of Convertible Note Warrant Transaction, dated May 8, 2007 between Chemed Corporation and Citibank NA.*
10.18	Form of Convertible Note Warrant Transaction, dated May 8, 2007 between Chemed Corporation and J.P. Morgan Chase Bank, NA.*
10.19	Excess Benefits Plan, as restated and amended, effective June 1, 2001.*,**

10.20	Amendment No. 1 to Excess Benefits Plan, effective July 1, 2001.*,**
10.21	Amendment No. 2 to Excess Benefits Plan, effective November 7, 2003.*,**
10.22	Non-Employee Directors' Deferred Compensation Plan.*,**
10.23	Chemed/Roto-Rooter Savings & Retirement Plan, effective January 1, 1999.*,**
10.24	First Amendment to Chemed/Roto-Rooter Savings & Retirement Plan, effective September 6, 2000.*,**
10.25	Second Amendment to Chemed/Roto-Rooter Savings & Retirement Plan, effective January 1, 2001.*,**
10.26	Third Amendment to Chemed/Roto-Rooter Savings & Retirement Plan, effective December 12, 2001.*,**
10.27	Directors Emeriti Plan.*,**
10.28	Chemed Corporation Change in Control Severance Plan, as amended July 9, 2009.*,**
10.29	Chemed Corporation Senior Executive Severance Policy, as amended July 9, 2009.*,**
10.30	Roto-Rooter Deferred Compensation Plan No. 1, as amended January 1, 1998.*,**
10.31	Roto-Rooter Deferred Compensation Plan No. 2.*,**
10.32	Form of Performance-Based Restricted Stock Units Award**
10.33	Form of Restricted Stock Award.*,**
10.34	Form of Stock Option Grant, pre-2013.*,**
10.35	Form of Stock Option Grant, 2013.**
10.36	Amended and Restated Credit Agreement - $350,000,000 Revolving Credit Facility, originally dated May 2, 2007, by and among JP Morgan Chase Bank, NA and Chemed Corporation as of March 1, 2011, exhibits and schedules thereto.
10.37	Second Amended and Restated Credit Agreement by and among Chemed Corporation, JP Morgan Chase Bank NA, and other lenders as of January 18, 2013, exhibits and schedules thereto.
12	Computation of Ratio of Earnings to Fixed Charges.

13	2013 Annual Report to Stockholders.
14	Policies on Business Ethics of Chemed Corporation, as revised 10/14/13.
21	Subsidiaries of Chemed Corporation.
23	Consent of Independent Registered Public Accounting Firm.
24	Powers of Attorney.

31.1	Certification by Kevin J. McNamara pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.
31.2	Certification by David P. Williams pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.
31.3	Certification by Arthur V. Tucker, Jr. pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.
32.1	Certification by Kevin J. McNamara pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification by David P. Williams pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.3	Certification by Arthur V. Tucker, Jr. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document*
101.SCH	XBRL Extension Schema*
101.CAL	XBRL Taxonomy Extension Calculation Linkbase*
101.DEF	XBRL Taxonomy Extension Definition Linkbase*
101.LAB	XBRL Taxonomy Extension Label Linkbase*
101.PRE	XBRL Taxonomy Extension Presentation Linkbase*

*	This exhibit is being filed by means of incorporation by reference (see Index to Exhibits on page E-1). Each other exhibit is being filed with this Annual Report on Form 10-K.
**	Management contract or compensatory plan or arrangement.

Financial Statement Schedule

See Index to Financial Statements and Financial Statement Schedule on page S-1.

SIGNATURES

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

February 27, 2014 CHEMED CORPORATION

By /s/ Kevin J. McNamara
Kevin J. McNamara
President and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Kevin J. McNamara Kevin J. McNamara	President and Chief Executive Officer and a Director (Principal Executive Officer)	
/s/ David P. Williams David P. Williams	Executive Vice President and Chief Financial Officer (Principal Financial Officer)	
/s/ Arthur V. Tucker, Jr. Arthur V. Tucker, Jr.	Vice President and Controller (Principal Accounting Officer)	February 27, 2014
Joel F. Gemunder* Patrick P. Grace* Thomas C. Hutton* Walter L. Krebs* Andrea R. Lindell*	Thomas P. Rice* Donald E. Saunders* George J Walsh III* Frank E. Wood*	- - Directors

* Naomi C. Dallob by signing her name hereto signs this document on behalf of each of the persons indicated above pursuant to powers of attorney duly executed by such persons and filed with the Securities and Exchange Commission.

February 27, 2014 /s/ Naomi C. Dallob

Date Naomi C. Dallob
(Attorney-in-Fact)

CHEMED CORPORATION AND SUBSIDIARY COMPANIES

INDEX TO FINANCIAL STATEMENTS AND FINANCIAL STATEMENT SCHEDULE
2011, 2012 AND 2013

* Indicates page numbers in Chemed Corporation 2013 Annual Report to Stockholders

The consolidated financial statements of Chemed Corporation listed above, appearing in the 2013 Annual Report to Stockholders, are incorporated herein by reference. The Financial Statement Schedule should be read in conjunction with the consolidated financial statements listed above. Schedules not included have been omitted because they are not applicable or the required information is shown in the financial statements or notes thereto as listed above.

Report of Independent Registered Public Accounting
Firm on Financial Statement Schedule

To the Board of Directors and Stockholders of Chemed Corporation:

Our audits of the consolidated financial statements and of the effectiveness of internal control over financial reporting referred to in our report dated February 27, 2014 appearing in the 2013 Annual Report to Stockholders of Chemed Corporation (which report and consolidated financial statements are incorporated by reference in this Annual Report on Form 10-K) also included an audit of the financial statement schedule listed in Item 15 of this Form 10-K. In our opinion, this financial statement schedule presents fairly, in all material respects, the information set forth therein when read in conjunction with the related consolidated financial statements.

/s/ PricewaterhouseCoopers LLP
PricewaterhouseCoopers LLP
Cincinnati, Ohio
February 27, 2014

SCHEDULE II

CHEMED CORPORATION AND SUBSIDIARY COMPANIES
VALUATION AND QUALIFYING ACCOUNTS
(IN THOUSANDS)
DR/(CR)

DESCRIPTION	BALANCE AT BEGINNING OF PERIOD	ADDITIONS (CHARGED) CREDITED TO COSTS AND EXPENSES	(CHARGED) CREDITED TO OTHER ACCOUNTS	DEDUCTIONS (a)	BALANCE AT END OF PERIOD
Allowances for doubtful accounts (b)					
For the year 2013	$ (10,892)	$ (10,690)	$ (1,318)	$ 10,310	$ (12,590)
For the year 2012	$ (11,524)	$ (9,233)	$ (1,326)	$ 11,191	$ (10,892)
For the year 2011	$ (13,332)	$ (8,686)	$ (786)	$ 11,280	$ (11,524)
Allowances for doubtful accounts - notes receivable (c)					
For the year 2013	$ (132)	$ (217)	$ (29)	$ -	$ (378)
For the year 2012	$ (305)	$ 122	$ 51	$ -	$ (132)
For the year 2011	$ (368)	$ 123	$ (60)	$ -	$ (305)

(a) With respect to allowances for doubtful accounts, deductions include accounts considered uncollectible or written off, payments, companies divested, etc.

(b) Classified in consolidated balance sheet as a reduction of accounts receivable.

(c) Classified in consolidated balance sheet as a reduction of other assets.

INDEX TO
EXHIBITS

Exhibit Number		File No. and Filing Date	Page Number or Incorporation by Reference Previous Exhibit No.
3.1	Certificate of Incorporation of Chemed Corporation	Form S-3 Reg. No. 33-44177 11/26/91	4.1
3.2	Certificate of Amendment to Certificate of Incorporation	Form 8-K 5/16/06	3.1
3.3	By-Laws of Chemed Corporation as amended August 2, 2013	Form 8-K 8/5/13	3.1
10.1	1999 Long Term Employee Incentive Plan as amended through May 20, 2002	Form 10-K 3/28/03, **	10.16
10.2	2002 Executive Long-Term Incentive Plan, as amended May 18, 2004	Form 10-Q 8/19/04, **	10.16
10.3	2004 Stock Incentive Plan	Proxy Statement 3/25/04, **	A
10.4	2006 Stock Incentive Plan, as amended August 11, 2006	Form 10-Q 8/14/06, **	10.1
10.5	2010 Stock Incentive Plan	Form 8-K 5/18/10, **	99.1
10.6	Repurchase Agreement dated May 8, 2007 by and among Chemed Corporation, J.P. Morgan Securities Inc. and Citigroup Global Markets, Inc.	Form 8-K 5/17/07	1.1
10.7	Convertible Senior Note Indenture dated May 14, 2007 for 1.875% Convertible Senior Notes due 2014 by and among Chemed Corporation, the	Form 8-KA 5/22/07	4.1

	Subsidiary Guarantors and LaSalle Bank NA, as Trustee.		
10.8	Employment Agreement with David P. Williams dated December 1, 2006.	Form 8-K 12/1/06, **	10.01

10.9	First Amendment to Employment Agreement with David P. Williams dated July 9, 2009.	Form 10-Q 10/30/09, **	10.2
10.10	Employment Agreement with Timothy S. O'Toole dated May 6, 2007.	Form 8-K 5/7/07, **	10.02
10.11	First Amendment to Employment Agreement with Timothy S. O'Toole dated July 9, 2009.	Form 10-Q 10/30/09, **	10.3
10.12	Employment Agreement with Kevin J. McNamara dated May 3, 2008.	Form 8-K 5/6/08, **	10.01
10.13	First Amendment to Employment Agreement with Kevin J. McNamara dated July 9, 2009.	Form 10-Q 10/30/09, **	10.1
10.14	Registration Rights Agreement, dated May 14, 2007 by and among Chemed Corporation, J.P. Morgan Securities, Inc. and Citigroup Global Markets Inc.	Form 8-K 5/17/07	10.5
10.15	Confirmation of Convertible Note Hedge, dated May 8, 2007 between Chemed Corporation and J.P. Morgan Chase Bank, NA.	Form 8-K 5/17/07	10.1
10.16	Confirmation of Convertible Note Hedge, dated May 8, 2007 between Chemed Corporation and Citibank, NA.	Form 8-K 5/17/07	10.2
10.17	Form of Convertible Note Warrant Transaction, dated May 8, 2007 between Chemed Corporation and Citibank, NA.	Form 8-K 5/17/07	10.4
10.18	Form of Convertible Note Warrant Transaction, dated May 8, 2007 between Chemed Corporation and J.P. Morgan Chase Bank, NA.	Form 8-K 5/17/07	10.5
10.19	Excess Benefits Plan, as restated and amended, effective June 1, 2001	Form 10-K 3/12/04, **	10.24

10.20	Amendment No. 1 to Excess Benefits Plan, effective July 1, 2002	Form 10-K 3/12/04, **	10.25
10.21	Amendment No. 2 to Excess Benefits Plan, effective November 7, 2003	Form 10-K 3/12/04, **	10.26
10.22	Non-Employee Directors' Deferred Compensation Plan	Form 10-K 3/24/88, **	10.10

10.23	Chemed/Roto-Rooter Savings & Retirement Plan, effective January 1, 1999	Form 10-K 3/25/99, **	10.25
10.24	First Amendment to Chemed/ Roto-Rooter Savings & Retirement Plan effective September 6, 2000	Form 10-K 3/28/02, **	10.22
10.25	Second Amendment to Chemed/ Roto-Rooter Savings & Retirement Plan effective January 1, 2001	Form 10-K 3/28/02, **	10.23
10.26	Third Amendment to Chemed/ Roto-Rooter Savings & Retirement Plan effective December 12, 2001	Form 10-K 3/28/02, **	10.24
10.27	Directors Emeriti Plan	Form 10-Q 5/12/88, **	10.11
10.28	Change in Control Severance Plan as amended July 9, 2009.	Form 10-Q 10/30/09, **	10.5
10.29	Senior Executive Severance Policy as amended July 9, 2009.	Form 10-Q 10/30/09, **	10.4
10.30	Roto-Rooter Deferred Compensation Plan No. 1, as amended January 1, 1998	Form 10-K 3/28/01, **	10.37
10.31	Roto-Rooter Deferred Compensation Plan No. 2	Form 10-K 3/28/01, **	10.38
10.32	Form of Performance Based Restricted Stock Unit Award	*	
10.33	Form of Restricted Stock Award	Form 10-K 3/28/05, **	10.50
10.34	Form of Stock Option Grant Pre-2013	Form 10-K	10.51
10.35	Form of Stock Option Grant - 2013	*	
10.36	Amended and Restated Credit Agreement - $350,000,000 Revolving Credit Facility, originally dated May 2, 2007, by and among JP Morgan Chase Bank, N.A. and Chemed Corporation as of March 1, 2011,	Form 10-Q 4/29/11	10.1

	Exhibits and schedules thereto.		
10.37	Second Amended and Restated Credit Agreement by and among Chemed Corporation, JP Morgan Chase Bank NA, and other lenders As of January 18, 2013 exhibits and schedules thereto.	Form 8-K 1/22/13	10.1
12	Computation of Ratio of Earnings to Fixed Charges	*	

13	2013 Annual Report to Stockholders	*
14	Policies on Business Ethics of Chemed Corporation, as revised 10/14/13.	*
21	Subsidiaries of Chemed Corporation	*
23	Consent of Independent Registered Public Accounting Firm	*
24	Powers of Attorney	*
31.1	Certification by Kevin J. McNamara pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.	*
31.2	Certification by David P. Williams pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.	*
31.3	Certification by Arthur V. Tucker, Jr. pursuant to Rule 13a-14(a)/15d-14(a) of the Exchange Act of 1934.	*
32.1	Certification by Kevin J. McNamara pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	*
32.2	Certification by David P. Williams pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	*
32.3	Certification by Arthur V. Tucker, Jr. pursuant to Section 906 of the Sarbanes-Oxley Act of 2002	*
101.INS	XBRL Instance Document	*
101.SCH	XBRL Extension Schema	*
101.CAL	XBRL Taxonomy Extension Calculation Linkbase	*
101.DEF	XBRL Taxonomy Extension Definition Linkbase	*
101.LAB	XBRL Taxonomy Extension Label Linkbase	*

101.PRE	XBRL Taxonomy Extension Presentation Linkbase	*

* Filed herewith.

** Management contract or compensatory plan or arrangement.