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

For the fiscal year ended December 31, 2021

or

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

For the transition period from_____ to _____

Commission file number: 001-33989

LHC GROUP, INC.

(Exact name of registrant as specified in its charter)

Delaware	**71-0918189**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

901 Hugh Wallis Road South

Lafayette, Louisiana	**70508**
(Address of principal executive offices)	(Zip Code)

(337) 233-1307

(Registrant's telephone number, including area code)

Securities registered pursuant to Section 12(b) of the Exchange Act:

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Common Stock, par value $0.01 per share	LHCG	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Exchange Act:

None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ 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 ☒

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 ☒ No ☐

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

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

Large accelerated filer	☒	Accelerated filer	☐	Non-accelerated filer	☐	Smaller reporting company	☐
Emerging growth company	☐						

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

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

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404 (b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☐

As of June 30, 2021, the aggregate market value of the registrant's common stock held by non-affiliates of the registrant was $6.1 billion based on the closing sale price as reported on the NASDAQ Global Select Market. For purposes of this determination shares beneficially owned by officers, directors, and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

There were 31,682,604 shares of common stock, $0.01 par value, outstanding as of February 21, 2022.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Annual Report to Stockholders for the fiscal year ended December 31, 2021 are incorporated by reference in Part II of this Annual Report on Form 10-K. Portions of the Registrant's Proxy Statement for its 2021 Annual Meeting of Stockholders are incorporated by reference in Part III of this Annual Report on Form 10-K.

LHC GROUP, INC.

TABLE OF CONTENTS

CAUTIONARY STATEMENT REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K and the information incorporated by reference herein contain certain statements, including the potential future impact of the COVID-19 pandemic on our results of operations and liquidity, the potential impact of actions we have taken to mitigate the impact of the COVID-19 pandemic, and information that may constitute "forward-looking statements" within the meaning of Section 27A of the Securities Act of 1933 and Section 21E of the Securities Exchange Act of 1934 (the "Exchange Act"). Forward-looking statements relate to future plans and strategies, anticipated events or trends, future financial performance, and expectations and beliefs concerning matters that are not historical facts or that necessarily depend upon future events. The words "may," "should," "could," "would," "expect," "plan," "anticipate," "believe," "foresee," "estimate," "predict," "potential," "intend," and similar expressions are intended to identify forward-looking statements. Specifically, this Annual Report on Form 10-K contains, among others, forward-looking statements about:

- our expectations regarding financial condition or results of operations for periods after December 31, 2021;
- our critical accounting policies;
- our business strategies and our ability to grow our business;
- our participation in the Medicare and Medicaid programs;
- the reimbursement levels of Medicare and other third-party payors, including changes in reimbursement resulting from regulatory changes;
- the prompt receipt of payments from Medicare and other third-party payors;
- our future sources of and needs for liquidity and capital resources;
- the effect of any regulatory changes or anticipated regulatory changes;
- the effect of any changes in market rates on our operations and cash flows;
- our ability to obtain financing;
- our ability to make payments as they become due;
- the outcomes of various routine and non-routine governmental reviews, audits, and investigations;
- our expansion strategy, the successful integration of recent acquisitions and, if necessary, the ability to relocate or restructure our current facilities;
- the value of our proprietary technology;
- the impact of legal proceedings;
- our insurance coverage;
- our competitors and our competitive advantages;
- our ability to attract and retain valuable employees;
- the price of our stock;
- our compliance with environmental, health and safety laws and regulations;
- our compliance with health care laws and regulations;
- our compliance with Securities and Exchange Commission laws and regulations and Sarbanes-Oxley requirements;
- the impact of federal and state government regulation on our business; and
- the impact of changes in or future interpretations of fraud, anti-kickback or other laws.

The forward-looking statements included in this report reflect our current views and assumptions only as of the date this report is filed with the Securities and Exchange Commission. Except as required by law, we assume no responsibility and do not intend to release updates or revisions to forward-looking statements after the date they are made, whether as a result of new information, future events or otherwise. The occurrence of any of the events described in Part I, Item 1A. Risk Factors in this Annual Report on Form 10-K or incorporated by reference into this Annual Report on Form 10-K, and other events that we have not predicted or assessed, could have a material adverse effect on our earnings, financial condition, and business, and any such forward-looking statements should not be relied on as a prediction of future events.

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

You should read this Annual Report on Form 10-K, the information incorporated by reference into this Annual Report on Form 10-K and the documents filed as exhibits to this Annual Report on Form 10-K completely and with the understanding that our actual future results or achievements may differ materially from what we expect or anticipate.

Unless otherwise indicated, “LHC Group,” “we,” “us,” “our,” and “the Company,” refer to LHC Group, Inc. and its consolidated subsidiaries

Item 1. Business.

Overview

We provide quality, cost-effective post-acute health care services to our patients. As of December 31, 2021, we have 970 service providers in 37 states within the continental United States and the District of Columbia. Our services are classified into five segments: (1) home health services, (2) hospice services, (3) home and community-based services, (4) facility-based services, primarily offered through our long-term acute care hospitals ("LTACHs"), and (5) healthcare innovations ("HCI").

Our home health service locations offer a wide range of services, including skilled nursing, medically-oriented social services and physical, occupational, and speech therapy. The nurses, home health aides, and therapists in our home health agencies work closely with patients and their families to design and implement individualized treatment plans in accordance with a physician-prescribed plan of care. As of December 31, 2021, we operated 557 home health service locations, of which 344 are wholly-owned by us, 209 are majority-owned by us through equity joint ventures, two are under license lease arrangements, and the operations of the remaining two locations are managed by us.

Our hospices provide end-of-life care to patients with terminal illnesses through interdisciplinary teams of physicians, nurses, home health aides, counselors, and volunteers. We offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2021, we operated 170 hospice locations, of which 106 are wholly-owned by us, 62 are majority-owned by us through equity joint ventures, and two are under license lease arrangements.

Our home and community-based locations offer assistance with activities of daily living to elderly, chronically ill, and disabled patients, performed by skilled nursing and paraprofessional personnel. As of December 31, 2021, we operated 136 locations, of which 121 are wholly-owned by us and 15 are majority-owned by us through equity joint ventures.

Our LTACH locations provide services primarily to patients with complex medical conditions who have transitioned out of a hospital intensive care unit but whose conditions remain too severe for treatment in a non-acute setting. As of December 31, 2021, our LTACHs had 367 licensed beds. We operated 11 LTACHs with 12 locations, of which all but two are located within host hospitals. As part of our facility-based services segment, we also own and operate two skilled nursing facilities, a rural health clinic, two physician practices, one family health center, and 75 physical therapy clinics. Of these 93 facility-based services locations, 82 are wholly-owned by us and 11 are majority-owned by us through equity joint ventures.

Our HCI segment reports on our developmental activities outside its other business segments. The HCI segment includes (a) Imperium Health Management, LLC, an Accountable Care Organization ("ACO") enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, and (c) certain assets operated by Advance Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor's office. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision and technology enabled in-home clinical assessments. We have 14 HCI locations, 13 of which are wholly-owned and one is controlled by us through an equity joint venture.

Our net service revenue by segment for the years ended December 31, 2021, 2020 and 2019 was as follows (amounts in thousands):

	Year Ended December 31,		
	2021	2020	2019
Home Health	$ 1,551,542	$ 1,463,779	$ 1,503,393
Hospice	311,218	243,806	226,922
Home and Community-Based	189,561	194,584	208,455
Facility-Based	132,098	128,578	111,809
HCI	35,203	32,457	29,662
Consolidated Net Service Revenue	$ 2,219,622	$ 2,063,204	$ 2,080,241

For further information regarding the financial performance of our segments, see Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Our founders began operations in September 1994 as St. Landry Home Health, Inc. in Palmetto, Louisiana. After several years of expansion, our founders reorganized their business and began operating as Louisiana Healthcare Group, Inc. in June 2000. In March 2001, Louisiana Healthcare Group, Inc. reorganized and became a wholly owned subsidiary of The Healthcare Group, Inc., a Louisiana business corporation. In December 2002, The Healthcare Group, Inc. merged into LHC Group, LLC, a Louisiana limited liability company, with LHC Group, LLC being the surviving entity. In January 2005, LHC Group, LLC established a wholly owned Delaware subsidiary, LHC Group, Inc. and on February 9, 2005, LHC Group, LLC merged into LHC Group, Inc., a Delaware corporation with LHC Group, Inc. being the surviving entity. Our principal executive offices are located at 901 Hugh Wallis Road, South, Lafayette, Louisiana, 70508. Our telephone number is (337) 233-1307. Our website is www.lhcgroup.com. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Business Strategy

Our objective is to become the leading provider of in-home healthcare services in the United States, while also providing a complementary suite of other post-acute healthcare service offerings through our facility-based and HCI segments. To achieve this objective, we intend to:

Drive internal growth in existing markets. We intend to drive internal growth in our current markets by increasing the number of (health care) providers from whom we receive referrals and by expanding the breadth of our services in each market. We intend to achieve this growth by: (1) continuing to educate health care providers about the benefits of our services, (2) reinforcing the position of our agencies and facilities as community assets, (3) maintaining our emphasis on high-quality medical care for our patients, (4) identifying related products and services needed by our patients and their communities, and (5) providing a superior work environment for our employees.

Achieve margin improvement through the active management of costs Net service revenue generated from Medicare is under the Patient Driven Groupings Model ("PDGM"), which is paid at pre-determined rates based upon the patient's clinical condition. Because our profitability in a fixed payment system depends upon our ability to manage the costs of providing care, we will continue to pursue initiatives to improve our margins and net income.

Expand into new markets. We intend to continue expanding into new markets by utilizing our point of care technology, developing de novo locations, and acquiring existing Medicare and/or Medicaid-certified agencies in attractive markets throughout the United States. We will also continue our unique strategy of partnering with hospitals and health systems, as these ventures provide significant return on investment. In addition, we plan to continue acquiring freestanding agencies that can serve as growth platforms in markets we do not currently serve in order to support our growth into new markets.

Pursue strategic acquisitions and develop joint ventures. We will continue to identify and evaluate opportunities for strategic acquisitions in new and existing markets that will enhance our market position, increase our referral base, and expand the breadth of services we offer. We will aim to continue entering into joint ventures with hospitals to provide our current post-acute care services to their patients upon discharge from the hospital setting.

Services

We provide post-acute care services in the United States by providing quality, cost-effective health care services to patients within the comfort and privacy of their home, place of residence, or long-term acute care hospital facility. Our services can be broadly classified into five principal segments: (1) home health services, (2) hospice services, (3) home and community-based, (4) facility-based services offered through our LTACHs, and (5) HCI.

Home Health Services

Our registered nurses and licensed practical nurses provide a variety of medically necessary services to homebound patients who are suffering from acute or chronic illness, recovering from injury or surgery, or who otherwise require care, teaching or monitoring. These services include, but are not limited to:

- wound care and dressing changes,
- cardiac rehabilitation,
- infusion therapy,
- pain management,
- pharmaceutical administration,
- skilled observation and assessment, and
- patient education.

We have also designed proprietary clinical pathways to treat chronic diseases and conditions, including diabetes, hypertension, arthritis, Alzheimer’s disease, low vision, spinal stenosis, Parkinson’s disease, osteoporosis, complex wounds,

and chronic pain. Through our medical social workers, we counsel patients and their families with regard to financial, personal, and social concerns that arise from a patient's health-related problems. We provide skilled nursing, ventilator and tracheotomy services, extended care specialties, medication administration and management, and patient and family assistance and education. We also provide management services to third-party home nursing agencies, often as an interim solution until proper state and regulatory approvals for an acquisition can be obtained.

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

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

Hospice Services

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

Home and Community-Based Services

Our home and community-based operations offer a wide range of services to patients in their home or in a medical facility. The services range from assistance with grooming, medication reminders, meal preparation, assistance with feeding, light housekeeping, respite care, transportation, and errand services.

Facility-Based Services

LTACHs is a reporting unit within our Facility-Based services segment. Our LTACHs treat patients with severe medical conditions who require a high-level of care and frequent monitoring by physicians and other clinical personnel. Patients who receive our services in an LTACH have been diagnosed as being too medically unstable for treatment in a non-acute setting. For example, our LTACHs typically serve patients suffering from respiratory failure, neuromuscular disorders, cardiac disorders, non-healing wounds, renal disorders, cancer, head and neck injuries, and mental disorders. We also treat patients diagnosed with musculoskeletal impairments that restrict their ability to perform normal activities of daily living. We also operate two skilled nursing facilities, family health center, a rural health clinic, a physician practice, and physical therapy providers that staff both facilities and outpatient clinics.

Healthcare Innovations Services

Our HCI segment reports on our developmental activities outside our other business segments. The HCI segment includes (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, and (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor's office. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical

advancements, enhanced patient engagement and informed clinical decision and technology enabled in-home clinical assessments.

Operations

Financial information relating to the home health, hospice, home and community-based, facility-based, and HCI operating segments of our business, including their contributions to our net service revenue, operating income, and total assets for each of the twelve months ended December 31, 2021, 2020 and 2019, respectively, is found in Note 11 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Our home health agencies are operated in one segment that is separated into multiple geographical regions and further separated into individual operating markets or clusters. Our hospice agencies are operated in one segment that is separated into multiple geographical regions. Our home and community-based agencies are operated in one segment separated into multiple geographic regions. Each of our home health and hospice agencies are staffed with experienced clinical home health and administrative professionals who provide a wide range of patient care services. Each of our home health agencies, hospice agencies, and home and community-based agencies are licensed and certified by the state and federal governments. As of December 31, 2021, 523 of our 557 home health service locations, 110 of our 170 hospice service locations, and five of our 12 LTACH locations were accredited by the Joint Commission, a nationwide commission that establishes standards relating to the facilities, administration, quality of patient care, and operation of medical staffs of hospitals. Those not yet accredited are working towards achieving this accreditation, a process which can take up to six months. As we acquire companies, we apply for accreditation 12 to 18 months after completing the acquisition.

Our facility-based service locations are operated in one segment separated into multiple geographic regions. Our facility-based services, through our LTACHs, follow a clinical approach under which each patient is discussed in weekly, multidisciplinary team meetings. In these meetings, patient progress is assessed and compared to goals and future goals are set. We believe that this model results in higher quality care and more predictable discharge patterns and avoids unnecessary delays.

Our home health service locations use our Service Value Point system, a proprietary clinical resource allocation model and cost management system. The system is a quantitative tool that assigns a target level of resource units to a group of patients based upon their initial assessment and estimated skilled nursing and therapy needs. The Service Value Point system allows the Director of Nursing or Branch Manager to allocate adequate resources throughout the group of patients assigned to his or her care to allow for them to provide the highest quality care possible.

Patient care is coordinated on-site at the agency level of each home health service, hospice service, and home and community-based location. All coding, medical records, case management, utilization review, and medical staff credentialing are provided on-site at the hospital level of each facility-based service location. Centralized functions such as payroll, accounting, financial reporting, billing, collections, regulatory and legal compliance, risk management, information technology, and general clinical oversight accomplished by periodic on-site surveys are provided from our home offices.

Our HCI business lines primarily provide assessments and related services to the long-term care insurance industry and management services to ACOs with over 400,000 Medicare lives under management.

Equity Joint Ventures

As of December 31, 2021, we had 81 equity joint ventures including 74 with hospital and health systems, which are comprised of over 350 hospitals, four with physicians, and three with other parties.

Our equity joint ventures are generally structured as limited liability companies in which we own a majority equity interest and our partner(s) own(s) a minority equity interest. At the time of formation, each party contributes capital to the equity joint venture in the form of cash or property. We believe that the amount contributed by each party to the equity joint venture represents their pro-rata portion of the fair market value of the equity joint venture, and we maintain processes to confirm and document those determinations. None of our equity joint venture partners are required to make or influence referrals to our equity joint ventures. In fact, agreements with our hospital joint venture partners require that they follow the same Medicare discharge planning regulations that, among other things, require the hospitals to offer each Medicare patient a list of available Medicare-certified home nursing agency options and to allow the patient to choose his or her own provider.

We structure our equity joint ventures as either manager-managed or board-managed. We control our manager-managed joint ventures, since LHC Group, Inc. is typically designated as the manager to oversee the day-to-day operations of the joint venture. We control our board-managed joint ventures, since we typically hold a majority of the votes required to take board action and/or we control the senior officer positions, although a majority of our joint ventures require super majority board approval for certain actions. Our equity joint venture partners participate in the profits and losses of the joint venture in proportion to their equity interests. Distributions from our equity joint ventures are made pro-rata based on percentage ownership interests and are not based on referrals made to the equity joint venture by any of the partners.

Most of our equity joint ventures include a buy/sell option that grants to us and our equity joint venture partners the right to require the other party to either purchase all of the exercising member's membership interests or sell to the exercising member all of the non-exercising member's membership interests, at the non-exercising member's option, within 30 days of the receipt of notice of the exercise of the buy/sell option. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the parties but will be subject to a fair market valuation process.

Competition

The markets supporting post-acute care are highly fragmented. According to the Medicare Payment Advisory Commission ("MedPac"), an independent agency that advises Congress on various Medicare issues, there were approximately 11,356 Medicare-certified home nursing agencies in the United States in 2019. MedPac estimated that in 2019 approximately 18% of Medicare-certified home health agencies provided a majority of their services in rural areas, and 87% of agencies were proprietary. MedPac also disclosed that 4,840 hospice agencies were participating in the Medicare Program in 2018. We believe we are well positioned to build and maintain long-term relationships with local hospitals, physicians, and other health care providers and to become the highest quality post-acute provider in our markets. In our experience, because most rural areas do not have the population size to support more than one or two general acute care hospitals, the local community hospital often plays a significant role in rural market health care delivery systems. Rural patients who require home nursing frequently receive care from a small home care agency or an agency that, while owned and run by the local community hospital, is not an area of focus for that hospital. Similarly, patients in these markets who require services typically offered by LTACHs are more likely to remain in the community hospital because it is often the only local facility equipped to deal with severe and complex medical conditions. We choose to enter these rural markets through affiliations with local hospitals, since we typically experience significantly less competition for the services we provide.

As we expand into new markets, we may encounter competitors that have greater resources or greater access to capital. Generally, competition in our home health service markets comes from local and regional providers. These providers include facility- and hospital-based providers, visiting nurse associations, and nurse registries. We are unaware of any competitor offering our breadth of services and focusing on the needs of rural markets.

We believe our diverse service offerings, collaborative approach to working with health care providers, concentrated house of brands market strategy, our size as one of the nation's largest home care providers, business experience gained from focusing on rural markets, and patient-oriented operating model provide our principal competitive advantages over local providers.

Quality Assurance & Performance Improvement

The LHC Group Quality Assurance and Performance Improvement Department, overseen by our Chief Clinical Officer and Chief Medical Officer, is responsible for formulating quality of care indicators, identifying performance improvement priorities, and facilitating best practices for quality care. Company-wide, we have adopted a "Plan, Do, Check, Act" methodology for our quality/performance improvement activities and initiatives. We also set forth a quality platform that reviews:

- performance improvement audits,
- Joint Commission accreditation,
- state and regulatory surveys,
- publicly reported quality data, and
- patient perception of care.

The Quality Department is also responsible for ensuring that the infrastructure of the quality initiatives throughout the Company is appropriate, overseeing and evaluating the effectiveness of the quality plans and initiatives, and recommending appropriate quality and performance improvement initiatives.

The Clinical Quality Committee of the Board of Directors is responsible for advising our clinical leadership, monitoring the performance of our locations based on internal and external benchmarks, overseeing and evaluating the effectiveness of the performance improvement and quality plans, facilitating best practices based on internal and external comparisons, and fostering enhanced awareness of clinical performance by the Board of Directors.

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

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

- ongoing education of staff and quarterly continuous quality improvement meetings at each of our agencies, facilities, and principal home offices,
- monthly comprehensive audits of patient charts performed at each of our agencies and facilities,
- at least annually, a comprehensive survey readiness assessment on each of our agencies and facilities,
- review of Home Health Compare scores,
- assessment of patients' and/or family members' perception of care using third party data, and
- assessment of infection control practices and risk events.

We constantly expand and refine our continuous quality improvement programs. Specific written policies, procedures, training, and educational materials and programs, as well as auditing and monitoring activities, have been prepared and implemented to address the functional and operational aspects of our business. Our programs also address specific areas identified for improvement through regulatory interpretation and enforcement activities. We believe our consistent focus on continuous quality improvement programs provide us with a competitive advantage in the markets we serve.

With the January 2022 Home Health Compare update, 75% of our providers were 4 Stars or above for the quality of care rating and 64% of our providers are at or above 4 stars for the HHCAPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems) star rating.

Compliance

We have established and continually maintain a comprehensive compliance and ethics program that is designed to assist all of our employees to exceed applicable standards established by federal and state laws and regulations and industry practice. Our goal is to foster and maintain the highest standards of compliance, ethics, integrity, and professionalism in every aspect of our business dealings, and we utilize our compliance and ethics program to assist our employees toward achieving that goal.

The purpose of our compliance and ethics program is to promote and foster compliance with applicable legal and regulatory requirements, the requirements of the Medicare and Medicaid programs and other government healthcare programs, industry standards, our Code of Conduct and Ethics, and our other policies and procedures that support and enhance overall compliance within our Company. Our compliance and ethics program focuses on regulations related to the federal False Claims Act, the Stark Law, the federal Anti-Kickback Law, billing and overall adherence to health care regulations.

To ensure the independence of our compliance department staff, we have implemented the following:

- our Chief Compliance Officer reports to and has direct oversight by the Audit Committee and Quality Committee of the Board of Directors,
- our compliance department has its own operating budget, and
- our compliance department has the authority to independently investigate any compliance or ethical concerns, including, when deemed necessary, the authority to interview any company personnel, access any company property, including electronic communications, and engage counsel to assist in any investigation.

Among other activities, our compliance department staff is responsible for the following activities:

- drafting and revising the Company’s policies and procedures related to compliance and ethics issues,
- reviewing, making recommended revisions, disseminating and tracking attestations to our Code of Conduct and Ethics,
- measuring compliance with our policies and procedures, Code of Conduct and Ethics and legal and regulatory requirements related to the Medicare and Medicaid programs and other government healthcare programs, laws and regulations,
- developing and providing compliance-related training and education to all of our employees and, as appropriate, directors, contractors and other representatives and agents, including new-hire compliance training for all new employees, annual compliance training for all employees, sales compliance training to all members of our sales team, billing compliance training to all members of our billing and revenue cycle team and other job-specific and role-based compliance training of certain employees,
- performing a bi-annual company-wide risk assessment, with ongoing review and revision,
- implementing an annual compliance auditing and monitoring work plan and performing and following up on various risk-based auditing and monitoring activities, including both clinical and non-clinical auditing and monitoring activities at the corporate level and at the local agency/facility level,
- developing, implementing and overseeing our Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) privacy and security compliance program,
- monitoring, responding to and overseeing the resolution of issues and concerns raised through our anonymous compliance hotline,

- monitoring, responding to and resolving all compliance and ethics-related issues and concerns raised through any other form of communication, and
- ensuring that we take appropriate corrective and disciplinary action when noncompliant or improper conduct is identified.

All employees are required to report incidents, issues or other concerns that they believe in good faith may be in violation of our Code of Conduct and Ethics, our policies and procedures, applicable legal and regulatory requirements or the requirements of the Medicare and Medicaid programs and other government health care programs. All employees are encouraged to either contact our Chief Compliance Officer directly or to contact our 24-hour toll-free or web-based compliance hotline when they have questions or concerns about any compliance or ethics issues. All reports to our compliance hotline are kept confidential to the extent allowed by law, and employees have the option to remain anonymous. When cases reported to our compliance hotline involve a compliance or ethics issue or any possible violation of law or regulation, the matter is referred to the compliance department for investigation. Retaliation against employees in connection with reporting compliance or ethical concerns is considered a serious violation of our Code of Conduct and Ethics, and, if it occurs, will result in discipline, up to and including termination of employment.

We continually expand and refine our compliance and ethics programs. We promote a culture of compliance, ethics, integrity and professionalism within the Company through persistent messages from our senior leadership concerning the necessity of strict compliance with legal requirements and company policies and procedures. We believe our consistent focus on our compliance and ethics program provides us with a competitive advantage in the markets we serve.

Technology and Intellectual Property

Technology plays a key role in the day-to-day operation of our business, our ability to grow our business organically and through acquisitions, and in maintaining effective managerial oversight and controls. The technology solutions we use are highly scalable. We believe that our ability to implement, maintain, and leverage our technology solutions provides us with a competitive advantage that allows us to grow our business in a cost-efficient manner and provide better patient care.

Our Service Value Point system is a proprietary information system that assists us in, among other things, monitoring clinical utilization and other cost factors, supporting our health care management techniques, internal benchmarking, clinical analysis, outcomes monitoring and claims generation, revenue cycle management, and revenue reporting at our home nursing agencies. We were issued a patent for our Service Value Point system during 2009 by the U.S. Patent and Trademark Office. This proprietary home nursing clinical resource and cost management system is a quantitative tool that assigns a target level of resource units to each patient based upon our staff's initial assessment of the patient's estimated skilled nursing and therapy needs. We designed this system to empower our direct care employees to make appropriate day-to-day clinical care decisions while also allowing us to monitor and manage the quality and delivery of care across our system, including the cost of providing that care, on both a patient-specific and agency-specific basis. In 2019, we updated our Service Value Point system for the new PDGM payment system adopted by CMS and other payors.

All of our home nursing and hospice locations utilize our point of care ("POC") system. Our POC system allows a visiting clinician to access records and other information from the patient’s home or at the POC, complete required documentation at the POC and submit it electronically into our patient record system. HomeCare HomeBase is our solution of choice for home health and hospice operations. Currently, all of our home health and hospice locations are using HomeCare HomeBase. All of our home and community-based locations are using Continulink. Our advance practice services utilize eMD’s Aprima solution and our long-term acute care hospitals and skilled nursing facility services utilize WellSky’s HCS solution.

Each of these applications support their respective lines of business and locations with administrative, office, clinical, and operating information system needs, including assisting with the compliance of our operating systems with HIPAA requirements. Each application also assists our staff in gathering information to improve the quality of patient care, optimizing financial performance, promoting regulatory compliance, and enhancing staff efficiency. Each application (with the exception of WellSky’s HCS solution) is hosted by the vendor in a secure data center, with multiple redundancies for storage, power, bandwidth, and security. The WellSky’s HCS solution is hosted at a co-located data center that is managed by the Company.

We have built an enterprise data warehouse that aggregates data from our ERP solution, and various health record/billing systems in use. We use various third-party solutions and several LHC-developed applications to provide historical, current, and forward-looking operational performance analysis. Our dashboards and reports provide high-level and detailed, historical and current, views to measure performance against budget and deliver insights into factors that drive our execution against our financial, operational, and compliance goals. These dashboards and reports are available in summary and detailed views to accommodate user needs from senior management down to the operators in the field.

We utilize a variety of third-party solutions for human resource management and use their services and products to manage our payroll processing, leave of absence (“LOA”) processes, flexible spending account (“FSA”) administration, time, and

attendance. We also utilize third-party solutions for financial management, including budgeting, forecasting, and financial reporting, including but not limited to general ledger, accounts payable, and fixed assets.

We are also deploying solutions across all of our home health, hospice, and home and community-based locations to comply with the requirements for electronic visit verification ("EVV"). In order to comply with current and future state and federal regulations for EVV, we utilize several different solutions. In states with an "open" model, we are able to choose our EVV vendor, and we use Continulink, or HomeCare HomeBase (in partnership with CellTrak) as our preferred EVV solution provider. In "closed" systems where states mandate the EVV vendor, we utilize the state-mandated EVV solution provider. In all cases, we have built interfaces between the EVV solution providers and our electronic health record and billing systems.

Reimbursement

The following describes the payment models in effect during the year ended December 31, 2021. Such payment models have been subject to temporary adjustments made by CMS in response COVID-19 pandemic as described elsewhere in this Annual Report on Form 10-K.

Medicare

The federal government's Medicare program, governed by the Social Security Act of 1965 (the "Social Security Act"), reimburses health care providers for services furnished to Medicare beneficiaries. These beneficiaries generally include persons age 65 and older and those who are chronically disabled. The program is primarily administered by the Department of Health and Human Services ("HHS") and CMS. Medicare services accounted for 59.8%, 62.1%, and 64.1%, of our net service revenue for the years ended December 31, 2021, 2020 and 2019, respectively. Medicare reimburses us based upon the setting in which we provide our services or the Medicare category in which those services fall.

In 2011, sequestration was implemented in the Budget Control Act of 2011(BCA, P.L. 112-25) as a tool in federal budget control. The sequestration cut to Medicare payments began on April 1, 2013, and reduced Medicare payments for patients whose service dates ended on or after April 1, 2013 by 2%. In response to COVID-19, the U.S. Government enacted the Coronavirus Aid, Relief, and Economic Security ("CARES Act") on March 27, 2020. The CARES Act suspended the 2% sequestration payment adjustments on Medicare patient claims with periods that ended on May 1, 2020 through December 31, 2020. On April 14, 2021, Congress passed legislation to continue the suspension of the 2% sequestration payment adjustments on Medicare patient claims with dates of service through December 31, 2021. On December 10, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act legislation passed, which will continue the suspension of the sequestration payment adjustments for Medicare patient claims with dates of service through March 31, 2022. Medicare patient claims with dates of services between April 1 through June 30, 2022 will have a 1% sequestration adjustment and Medicare patient claims with dates of services beginning July 1, 2022 will have a 2% sequestration adjustment.

Home Health

The Medicare home nursing benefit is available to patients who need care following discharge from a hospital, as well as patients who suffer from chronic conditions that require skilled intermittent care. While the services received need not be rehabilitative or of a finite duration, patients who require full-time skilled nursing for an extended period of time generally do not qualify for Medicare home nursing benefits. As a condition of coverage under Medicare, beneficiaries must: (1) be homebound, meaning they are unable to leave their home without a considerable and taxing effort; (2) require intermittent skilled nursing, physical therapy, or speech therapy services that are covered by Medicare; and (3) receive treatment under a plan of care that is established and periodically reviewed by a physician. Qualifying patients also may receive reimbursement for occupational therapy, medical social services, and home health aide services if these additional services are part of a plan of care prescribed by a physician.

We record revenue as services are provided under PDGM. For each 30-day period, the patient is classified into one of 432 home health resource groups prior to receiving services. Each 30-day period is placed into a subgroup falling under the following categories: (i) timing being early or late, (ii) admission source being community or institutional, (iii) one of 12 clinical groupings based on the patient's principal diagnosis, (iv) functional impairment level of low, medium, or high, and (v) a co-morbidity adjustment of none, low, or high based on the patient's secondary diagnoses.

Each 30-day period payment from Medicare reflects base payment adjustments for case-mix and geographic wage differences. In addition, payments may reflect one of three retroactive adjustments to the total reimbursement: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment whereby the number of visits is dependent on the clinical grouping; and/or (c) a partial payment if the patient transferred to another provider or from another provider before completing the episode. The retroactive adjustments outlined above are recognized in net service revenue when the event causing the adjustment occurs and during the period in which the services are provided to the patient. We review these

adjustments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustments is subsequently resolved. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Under PDGM, the initial certification of Medicare patient eligibility, plan of care, and comprehensive assessment remains valid for 60-day episodes of care but payments for Medicare home health services are made based upon 30-day payment periods. The national, standardized 30-day Medicare payment amount was $1,901.12, resulting in a 1.9% increase in payments over fiscal year 2020. The rule implemented an annual inflation update of 2.3%, reduced by a 0.3% productivity adjustment and 0.1% reduction in the rural add-on percentages mandated by the Bipartisan Budget Act of 2018. The final rule also adjusted PDGM case-mix weights. For Medicare payments associated with low utilization payment adjustments ("LUPAs") under PDGM, the threshold varies for a 30-day period depending on the PDGM payment group. CMS finalized its proposal to eliminate request for anticipated payment ("RAP") payments for calendar year 2021, and required home health providers to submit "no pay" RAPs during 2021. Beginning January 1, 2021, home health providers were required to submit a Notice of Admission ("NOA") within five calendar days of the first 30-day period and within five calendar days of the day 31 for the second, subsequent 30-day period.

On November 2, 2021, CMS released the final rule for the calendar year 2022 to update base payment rates by 3.2%, which is based on a payment update of 2.6%, a 0.7% increase due to the reduction of the fixed-dollar loss ratio for outliers, and a 0.1% reduction due to the rural add-on percentages mandated by the Bipartisan Budget Act of 2018. The base 30 day payment rate is increased from $1,901.12 to $2,031.64. The final rule expanded the Home Health Value-Based Purchasing ("HHVBP") model nationally, with the first performance year beginning January 1, 2023. Starting in 2025, fee-for-service payments to home health agencies will be adjusted based on the quality of care provided to beneficiaries during the calendar year 2023 performance year.

We verify a patient's eligibility for home health benefits at the time of admission.

Home health payment rates are updated annually by the home health market basket percentage as adjusted by Congress. CMS establishes the home health market basket index, which measures inflation in the prices of an appropriate mix of goods and services included in home health services.

Hospice

In order for a Medicare beneficiary to qualify for the Medicare hospice benefit, two physicians must certify that, in their clinical judgment, the beneficiary has less than six months to live, assuming the beneficiary's disease runs its normal course. In addition, the Medicare beneficiary must affirmatively elect hospice care and waive any rights to other Medicare curative benefits related to his or her terminal illness. At the end of each benefit period (described below), a physician must recertify that the Medicare beneficiary's life expectancy is six months or less in order for the beneficiary to continue to qualify for and to receive the Medicare hospice benefit. The first two benefit periods are 90 days and subsequent benefit periods are 60 days. A Medicare beneficiary may revoke his or her election at any time and resume receiving traditional Medicare benefits. There is no limit on how long a Medicare beneficiary can receive hospice benefits and services, provided that the beneficiary continues to meet Medicare hospice eligibility criteria.

Medicare reimburses for hospice care using one of four predetermined daily rates based upon the level of care we furnish to a beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations. The base Medicare rate for services that we provide to a beneficiary depends upon which of the following four levels of care we provide to that beneficiary:

- ***Routine Care.*** Care that is not classified under any of the other levels of care, such as the work of nurses, social workers or home health aides.
- ***General Inpatient Care.*** Pain control or acute or chronic symptom management that cannot be managed in a setting other than an inpatient Medicare certified facility, such as a hospital, skilled nursing facility or hospice inpatient facility.
- ***Continuous Home Care.*** Care for patients experiencing a medical crisis that requires nursing services to achieve palliation and symptom control, if the agency provides a minimum of eight hours of care within a 24-hour period.
- ***Respite Care.*** Short-term, inpatient care to give temporary relief to the caregiver who regularly provides care to the patient.

Medicare limits the reimbursement we may receive for inpatient care services (both respite and general care) for hospice patients. Under the "80-20 rule," if the number of inpatient care days of hospice care furnished by us to Medicare hospice beneficiaries under a unique provider number exceeds 20% of the total days of hospice care furnished by us to all Medicare hospice beneficiaries for both inpatient and in-home care, Medicare payments to us for inpatient care days exceeding the inpatient cap will be reduced to the routine home care rate, with excess amounts due back to Medicare. This determination is

made annually based on the twelve-month period beginning on October 1 each year. Our Medicare hospice reimbursement is also subject to a cap amount calculated at the end of the hospice cap period, based on the twelve-month period beginning on October 1 each year, which determines the maximum allowable payments per provider.

On July 31, 2020, CMS released the final rule for fiscal year 2021 to update payment rates and the wage index. The hospice payment update was a 2.4% increase to the payment rates. The final rule applied a 5% cap on any decrease in a geographic area's wage index value from fiscal year 2020. No such cap will be applied in fiscal year 2022. In addition, the final rule increased the aggregate cap value of $30,683.93 for fiscal year 2021, compared to $29,964.78 for fiscal year 2020.

On July 29, 2021, CMS released the final rule for fiscal year 2022. The final hospice payment update is a 2.0% increase of payment rates, applying a 2.7% market basket update and a 0.7% decrease for productivity. The final rule also increases the aggregate cap value of $31,297.61 for fiscal year 2022.

Long-Term Acute Care Hospitals

All Medicare payments to our LTACHs are made in accordance with a PPS specifically applicable to LTACHs, referred to as "LTACH-PPS." The LTACH-PPS was established by CMS final regulations published in 2002, that require each patient discharged from an LTACH to be assigned a distinct long-term care diagnosis-related group ("MS-LTC-DRG"), which take into account (among other things) the severity of a patient's condition. Our LTACHs are paid a predetermined fixed amount based upon the assigned MS-LTC-DRG (adjusted for area wage differences), which includes adjustments for short stay and high cost outlier patients (described in further detail below). The payment amount for each MS-LTC-DRG classification is intended to reflect the average cost of treating a Medicare patient assigned to that MS-LTC-DRG in an LTACH.

Adjustments to MS-LTC-DRG payments might include:

- ***Short Stay Outlier Policy.*** CMS has established a modified payment methodology for Medicare patients with a length-of-stay less than or equal to five-sixths of the geometric average length-of-stay for that particular MS-LTC-DRG, referred to as a short stay outlier, or "SSO." When LTACH-PPS was established, SSO cases were paid based on the lesser of (1) 120% of the average cost of the case; (2) 120% of the LTC-DRG specific per diem amount multiplied by the patient's length-of-stay; or (3) the full LTC-DRG payment. CMS modified the payment methodology for discharges occurring on or after July 1, 2006, which changed the limitation in clause (1) above to reduce payment for SSO cases to 100% (rather than 120%) of the average cost of the case, and also added a fourth limitation, potentially further limiting payment for SSO cases at a per diem rate derived from blending 120% of the MS-LTC-DRG specific per diem amount with a per diem rate based on the general acute care hospital inpatient prospective payment system, or "IPPS". Under this methodology, as a patient's length-of-stay increases, the percentage of the per diem amount based upon the IPPS component will decrease and the percentage based on the MS-LTC-DRG component will increase.
- ***High Cost Outliers.*** Some cases are extraordinarily costly, producing losses that may be too large for healthcare providers to offset. Cases with unusually high costs, referred to as "high cost outliers," receive a payment adjustment to reflect the additional resources utilized. CMS provides an additional payment if the estimated costs for the patient exceed the adjusted MS-LTC-DRG payment plus a fixed-loss amount that is established in the annual payment rate update.
- ***Interrupted Stays.*** An interrupted stay occurs when an LTACH patient is admitted upon discharge to a general acute care hospital, inpatient rehab facility, skilled nursing facility or a swing-bed hospital and returns to the same LTACH within a specified period of time. If the length-of-stay at the receiving provider is equal to or less than the applicable fixed period of time, it is considered to be an interrupted stay case and is treated as a single discharge for the purposes of payment to the LTACH.

Freestanding, HwH and Satellite LTACHs

LTACHs may be organized and operated as freestanding facilities or as a hospital within a hospital, or "HwH". A HwH is an LTACH that is located on the "campus" of another hospital, meaning the physical area immediately adjacent to a hospital's main buildings, other areas and structures that are not strictly contiguous to a hospital's main buildings but are located within 250 yards of its main buildings, and any other area determined, on an individual case basis by the applicable CMS regional office, to be part of a hospital's campus. An LTACH that uses the same Medicare provider number of an affiliated "primary site" LTACH is known as a "satellite". Under Medicare policy, a satellite LTACH must be located within 35 miles of its primary site LTACH and be administered by such primary site LTACH. As of December 31, 2021, we had a total of 12 LTACH facilities, with 367 licensed beds. Ten of our LTACH facilities were classified as HwHs and two were classified as freestanding. Of the 12 facilities, eight were located in Metropolitan Statistical Area ("MSA") or urban areas and four were located in non-MSA or rural areas. One of our HwH facilities was a satellite location of a parent hospital located in an MSA. Both of our freestanding locations are in MSAs, with one being located adjacent to a tertiary care facility.

An LTACH must have an average inpatient length-of-stay for Medicare patients (including both Medicare covered and non-covered days) of greater than 25 days during each annual cost reporting period. LTACHs that fail to exceed an average length-of-stay of 25 days during any cost reporting period may be paid under the general acute care hospital IPPS.

Fiscal Year Rates

On September 2, 2020, CMS issued a final rule for the fiscal year 2021 LTACH-PPS. LTACH-PPS payments decreased by 1.1%, which reflected the continued statutory implementation of the revised LTACH-PPS payment system. LTACH-PPS payments for fiscal year 2021 for discharges paid using the standard LTACH-PPS payment rate increased by 2.2% primarily due to the annual standard Federal rate update of 2.3%.

LTACH-PPS payments for cases completed the statutory transition to the lower payment rates under the dual rate system decreased by 24%. This accounted for the LTACH site neutral payment rate cases that are no longer paid a blended payment rate for LTACH discharges occurring in cost reporting periods beginning in fiscal year 2020.

On August 2, 2021, CMS issued a final rule for the fiscal year 2022. LTACH-PPS payments will increase by 1.1% for fiscal year 2022. LTACH-PPS payments for fiscal year 2022 for discharges paid using the standard LTACH payment rate will increase by 0.9% due primarily to the annual standard Federal rate update for fiscal year 2022 of 1.9% and 0.8% decrease in high cost outlier payments. LTACH-PPS payments for fiscal year 2022 for discharges paid using the site neutral payment rate will increase by 3%.

In response to COVID-19, the CARES Act suspended the application of site-neutral payments for LTACH admissions that were admitted during the Public Health Emergency ("PHE"). On January 14, 2022, the U.S. Department of Health and Human Services extended the PHE until April 15, 2022.

Medicaid

Medicaid is a joint federal and state funded health insurance program for certain low-income individuals administered by the states. Medicaid reimburses health care providers using a number of different systems, including cost-based, prospective payment and negotiated rate systems. Rates are also subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies.

Non-Governmental Payors

Payments from non-governmental payor sources are based on episodic-based rates or per visit based rates depending upon the terms and conditions of the payor. This reimbursement category includes payors such as insurance companies, workers' compensation programs, health maintenance organizations, preferred provider organizations, other managed care companies and employers, as well as payments received directly from patients.

Patients are generally not responsible for any difference between customary charges for our services and amounts paid by Medicare and Medicaid programs and the non-governmental payors, but are responsible for services not covered by these programs or plans, as well as co-payments for deductibles and co-insurance obligations of their coverage. Patient out-of-pocket costs for the payment of deductibles and co-insurance have increased in recent years. Collection of amounts due from individuals is typically more difficult than collection of amounts due from government or business payors. Because the majority of our billed services are paid in full by Medicare, Medicaid or private insurance, co-payments from patients do not represent a material portion of our billed revenue and corresponding accounts receivable. To further reduce their health care costs, most commercial payors such as insurance companies, health maintenance organizations, preferred provider organizations and other managed care companies have negotiated discounted fee structures or fixed amounts for services performed, rather than paying health care providers the amounts normally billed.

In response to the challenges associated with collecting from commercial payors, we began negotiating higher reimbursement rates with a majority of our commercial payors. As of December 31, 2021, our managed care contracts included over 393 different payors between all of our divisions. If we are unable to continue negotiating higher reimbursement rates with commercial payors, if commercial payor continues to outpace traditional governmental payor growth, or if commercial payors reduce health care costs through reduction in home health reimbursement, it could have a material adverse impact on our financial results.

Human Capital Resources

Our culture and values, along with approximately 30,000 employees in 35 states and the District of Columbia, are our most valuable assets. In pursuit of our Company's purpose - It's All About Helping People - we strive to provide exceptional care and unparalleled service to patients and families who have placed their trust in us. We are led in this pursuit by our operating philosophy, rooted in the principles of service excellence, and our actions are guided by our Six Pillars of Excellence:

People: Ours is a business of people helping people.
Service: We are here to serve patients, families and communities.
Quality: In all we do, our focus is quality above all else.
Efficiency: We operate with discipline and efficiency to remain strong.
Growth: It is our obligation to care for as many as we can.
Ethics: We conduct ourselves with the highest standards of ethics, integrity and professionalism.

In order to ensure we live our values and our culture stays unique and strong, our Board of Directors and executive team have committed substantial efforts to focus on our human capital resources. These are some of the key aspects of our human capital strategy:

Employee Recruitment & Retention

We work diligently to attract the best talent from a diverse range of sources in order to meet the current and future demands of our businesses. We have established relationships with over 350 hospitals and hospital systems, world-class universities, trade schools, professional associations, and industry groups to proactively attract talent.

We provide a strong employee value proposition that leverages our unique culture, collaborative working environment, shared sense of purpose, and desire to do the right thing to attract talent to our Company.

As of December 31, 2021, we employed approximately 30,000 employees, which includes 15,300 in our home health operations, 3,700 in our hospice operations, 7,600 in our home and community-based services operations, and 1,000 in our LTACHs.

Diversity, Equity, and Inclusion

We aspire to be a diverse, equitable, and inclusive workplace, where people feel empowered and free to make the most of their talents. As we invest in our employees, diversity, equity, and inclusion ("DE&I") are major priorities. Women make up more than 87% of our workforce, and approximately 36% identify as a minority. Our senior management team is 62% women, and approximately 20% identify as a minority. In addition, our Board of Directors is 22% women and 11% minority, and women serve as the chairs of our Nominating and Governance Committee and Audit Committee.

The success of our Company has been, and will continue to be, highly dependent upon our ability to maintain a culture where we value, respect, and provide fair treatment and equal opportunities for all employees. By recognizing and celebrating our differences, we cultivate an environment that welcomes a diverse group of talented individuals.

In the interest of furthering these goals, the Company established the role of Vice President and Chief Diversity Officer in 2021. This individual serves as the chair for our Diversity and Inclusion Committee, which was established in 2020 to formulate and implement actionable diversity and inclusion initiatives for the Company in pursuit of our DE&I objectives:

- Provide opportunities to increase DE&I awareness and education.
- Increase diversity through hiring, retention, and promotion of employees.
- Demonstrate commitment to a diverse, inclusive work environment.
- Identify and reduce barriers impeding the employment, opportunity, or inclusion of individuals.

Compensation Programs and Employee Benefits

The main objective of our compensation and benefits programs is to provide a compensation and benefits package that will attract, retain, motivate, and reward employees who succeed in operating in a highly competitive and challenging environment. We seek to do this by linking annual changes in compensation to our overall performance, as well as each individual's contribution to the results achieved. The emphasis on our overall performance is intended to align the employee's interests with the provision of quality patient care and our success. We also seek fairness in total compensation that is competitive and consistent with employee positions, skill levels, knowledge, and geographic locations with reference to external comparisons, internal comparisons, and the relationship between management and non-management remuneration.

We are committed to providing comprehensive benefit options and it is our intention to offer benefits that will allow our employees and their families to live healthier and more secure lives. Some examples of our wide-ranging benefits offered are: medical insurance, participation in our 401 (k) plan, prescription drug benefits, dental insurance, vision insurance, hospital indemnity insurance, accident insurance, critical illness insurance, life insurance, disability insurance, health savings accounts, flexible spending accounts, and identity theft insurance.

Training and Education

All new employees and new contractors, and all existing employees and contractors on an annual basis, must complete a one-hour program on our corporate compliance and ethics program. We also require annual distribution of the Code of Conduct and Ethics, and require each employee, including contractors, to acknowledge their receipt, review, and attestation to abide by the terms of the Code.

To empower employees to unleash their potential, we provide a range of development programs and opportunities, skills, and resources that our employees need and desire to be successful. For example, our iTrain platform provides additional specialized training in areas such as eligibility for home health and hospice, HIPAA, privacy and security, clinical and quality, coding, billing and reimbursement, and sales and marketing through webcasts, online courses and instructor-led sessions. Additionally, our Excellence By Design program provides a robust and formal curriculum for employees to obtain a deeper understanding of all facets of the Company, including accounting and finance, employee recruitment and retention, regulatory and licensure compliance, and supervisory management training, to support the development of the next generation of our management and leaders. Participants in our training programs are able to develop more advanced skills leading to higher contribution and satisfaction within their roles, while helping us to identify top performers, improve employee performance and retention, increase our organizational learning, and support the promotion of our current employees within our Company. During the twelve months ended December 31, 2021, a total of 38,408 employees received education and training through company-provided programs, with an average of 26 courses being completed by each participant over an average of 21 training hours.

We also maintain a full suite of compliance policies and procedures. We perform a routine review and revision of our policies and procedures to stay abreast of both internal and external developments. All employees receive updated policies and procedures for review, specifically those that are directly related to job function. Our compliance policies include a Code of Conduct related to sales, marketing, education, and entertainment activities with referral sources. These policies establish rules and procedures governing our employees' interactions with current and potential referral sources as well as those with the ability to influence or recommend a referral to one of our providers, helping ensure current regulations and laws are followed.

Corporate Social Responsibility

Our values, rooted in trust, integrity, and service, lay the foundation for our commitment to corporate social responsibility. Beyond providing quality healthcare to some of the most vulnerable members of our society, we believe that to be truly successful, it's crucial that we do our part to improve healthcare in the United States. For us, that means we are contributing our time, talent, and resources to strengthen the communities where we do business, and we are engaging in ethical practices. We are committed to the principle that when our local communities thrive, we succeed.

Across the country, our agencies and employees contribute to worthy causes both locally and nationally, including United Way, Boys & Girls Clubs, Toys for Tots, and the American Heart Association, among countless other worthy social organizations. In 2021, we made approximately $2.0 million in charitable contributions. From a national perspective, we are proud to be among a handful of global companies and brands that sponsor the American Red Cross at its highest sponsorship level – the Annual Disaster Giving Program, including monetary donations, volunteering, sponsorships, regular shared communications, shared trainings, and co-branded initiatives.

Compliance and Business Ethics

We are firmly committed to the highest standards of ethics, integrity, professionalism, and compliance. Our compliance and ethics program includes auditing and monitoring, enhanced lines of communication between the Chief Compliance Officer and employees, consistency in the standards we set for ethics, and compliance and increased awareness of these standards through a robust training and education program. We also operate an independent third-party "Integrity Line" that encourages employees to report any concerns about unethical behavior, conflicts of interest, harassment, discrimination, abuse, or workplace safety violations.

Our code of conduct and ethics provides guidance to all of our employees, contractors and board members on carrying out daily activities within appropriate ethical and legal standards. The code of conduct and ethics was developed to help ensure we meet our ethical standards and comply with applicable laws, rules and regulations. It is a critical component of our overall compliance and ethics program and is an important resource — especially in situations where questions may arise about determining the right thing to do.

Safety, Health, & Wellness

The health and safety of our clinicians and other employees is our highest priority, and this is consistent with our operating philosophy. For example, in response to the COVID-19 pandemic, we continue to maintain a cross-functional COVID-19 Task Force comprised of our leaders that continue to communicate with our clinicians and other employees concerning best practices and changes in our policies and procedures. We also maintain contingency planning policies, whereby many

employees in our home offices located in Louisiana and Kentucky may work remotely in compliance with CDC recommendations. We also continue to invest in technology and equipment that allows our remote work force to provide sustained and seamless functionality to our clinicians who continue to care for patients on service.

We continue to undertake numerous tangible measures to promote the safety of our clinicians and other employees. For example, we continue to provide our clinicians across the country with personal protective equipment and other supplies needed to properly treat our patients during the COVID-19 outbreak, remain prepared to immediately reinstitute social distancing guidelines for our agencies and our home offices located in Louisiana and Kentucky, continue extensive cleaning procedures at all locations, maintain plexiglass shields at work spaces that require a physical protective barrier, and remain prepared to reinstitute temperature check points in our agencies and home office campuses. In addition to offering health insurance benefits options to all full-time employees, we also offer numerous other health and wellness benefit options including dental insurance, optical insurance, company-paid time off, company-paid holidays, tuition reimbursement, an employee hardship financial-assistance program, employee discount programs for health and wellness service memberships, company-paid short term disability insurance, and preferred rates on life, disability, and other insurance programs.

Government Regulations

General

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

- Medicare and Medicaid participation and reimbursement regulations;
- the federal Anti-Kickback Statute and similar state laws;
- the federal Stark Law and similar state laws;
- false claims laws and regulations;
- HIPAA;
- laws and regulations imposing civil monetary penalties;
- environmental health and safety laws;
- licensing laws and regulations; and
- laws and regulations governing certificates of need and permits of approval.

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

Medicare Participation

To participate in the Medicare program and receive Medicare payments, our agencies and facilities must comply with regulations promulgated by CMS. Among other things, these requirements, known as “conditions of participation,” relate to the type of facility, its personnel, and its standards of medical care. While we intend to continue to participate in the Medicare reimbursement programs, we cannot guarantee that our agencies, facilities, and programs will continue to qualify for Medicare participation.

Federal Anti-Kickback Statute

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

The OIG has published numerous “safe harbors” that exempt some practices from enforcement action under the Anti-Kickback Statute. These safe harbors exempt specified activities, including bona-fide employment relationships, contracts

for the rental of space or equipment, personal service arrangements, and management contracts, so long as all of the requirements of the safe harbor are met. The OIG has recognized that the failure of an arrangement to satisfy all of the requirements of a particular safe harbor does not necessarily mean that the arrangement violates the Anti-Kickback Statute. Instead, each arrangement is analyzed on a case-by-case basis, which is very fact specific. While we operate our business to comply with the prohibitions of the Anti-Kickback Statute, we cannot guarantee that all our arrangements will satisfy a safe harbor or will ultimately be viewed as being compliant with the Anti-Kickback Statute.

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

Stark Law

Congress has passed significant prohibitions against physician self-referrals of patients for certain designated health care services, commonly known as the Stark Law, which prohibits a physician from making referrals for particular health care services (called designated health services) to entities with which the physician, or an immediate family member of the physician, has a financial relationship.

The term "financial relationship" is defined very broadly to include most types of ownership or compensation relationships. The Stark Law defines a financial relationship to include: (1) a physician's ownership or investment interest in an entity and (2) a compensation relationship between a physician and an entity. Under the Stark Law, financial relationships include both direct and indirect relationships. The Stark Law also prohibits the entity receiving the referral from seeking payment under the Medicare or Medicaid programs for services rendered pursuant to a prohibited referral. If an entity is paid for services rendered pursuant to a prohibited referral, it may incur civil penalties and could be excluded from participating in the Medicare or Medicaid programs. If an arrangement is covered by the Stark Law, the requirements of a Stark Law exception must be met for the physician to be able to make referrals to the entity for designated health services and for the entity to be able to bill for these services.

"Designated health services" under the Stark Law is defined to include home health services, inpatient and outpatient hospital services, clinical laboratory services, physical therapy services, occupational therapy services, radiology services (including magnetic resonance imaging, computerized axial tomography scans and ultrasound services), radiation therapy services and supplies, and the provision of durable medical equipment and supplies, parenteral and enteral nutrients, equipment and supplies, prosthetics, orthotics and prosthetic devices and supplies, and outpatient prescription drugs.

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

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

The Stark Law also includes an exception for a physician's ownership or investment interest in certain entities through the ownership of stock that is listed on the New York Stock Exchange or NASDAQ. If the ownership meets certain other requirements, the Stark Law will not apply to prohibit the physician from referring to the entity for designated health services. For example, this Stark Law exception requires that the entity issuing the stock have at least $75.0 million in stockholders' equity at the end of its most recent fiscal year or on average during the previous three fiscal years. As of December 31, 2021, 2020 and 2019, we have in excess of $75.0 million in stockholders' equity.

If an entity violates the Stark Law, it could be subject to civil penalties of up to $15,000 per prohibited claim and up to $100,000 for knowingly entering into certain prohibited referral schemes. The entity also may be excluded from participating in federal health care programs (including Medicare and Medicaid). There are no criminal penalties for violations of Stark Law. If the Stark Law was found to apply to our relationships with referring physicians and those relationships did not meet the requirement of an exception under the Stark Law, we would be required to restructure these relationships or refuse to accept referrals for designated health services from these physicians. If we were found to have submitted claims to Medicare or Medicaid for services provided pursuant to a referral prohibited by the Stark Law, we would be required to repay any amounts we received from Medicare for those services and could be subject to civil monetary penalties. Further, we could be excluded from participating in Medicare and Medicaid. If we were required to repay any amounts to Medicare, subjected to fines, or excluded from the Medicare and Medicaid Programs, our business and financial condition would be harmed significantly.

Many states have physician relationship and referral statutes that are similar to the Stark Law. Some of these laws generally apply without regard to whether the payor is a governmental body (such as Medicare) or a commercial party (such as an insurance company). While we believe that our operations are structured to comply with applicable state laws with respect to physician relationships and referrals, any finding that we are not in compliance with these state laws could require us to change our operations or could subject us to penalties. This, in turn, could have a significantly negative impact on our operations.

False Claims

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

Anti-fraud Provisions of the HIPAA

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

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

Administrative Simplification Provisions of HIPAA

HHS's final regulations governing electronic transactions involving health information are part of the administrative simplification provisions of HIPAA, commonly referred to as the Transaction Standards rule. The rule establishes standards for eight of the most common health care transactions by reference to technical standards promulgated by recognized standards publishing organizations. Under the rule, any party transmitting or receiving health transactions electronically must send and receive data in a single format, rather than the large number of different data formats currently used. This rule applies to us in connection with submitting and processing health claims, and also applies to many of our payors and to our relationships with those payors. We believe that our operations materially comply with the Transaction Standards rule.

These regulatory requirements impose significant administrative and financial obligations on companies like us that use or disclose electronic health information. We have modified our existing HIPAA privacy and security policies and procedures to comply with the HIPAA regulations.

Civil Monetary Penalties

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

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

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

- for physician services that the person or entity knew or should have known were rendered by a person who was unlicensed, or by a person who misrepresented either their qualifications in obtaining their license or their certification in a medical specialty;
- for services furnished by a person who was, at the time the claim was made, excluded from the program to which the claim was made; or
- that show a pattern of medically unnecessary items or services.

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

Governmental Review, Audits, and Investigations

DHHS, CMS, DOJ, and other federal and state agencies continue to impose intensive enforcement policies and conduct random and directed audits, reviews, and investigations designed to insure compliance with applicable healthcare program participation and payment laws and regulations. As a result, we are routinely the subject of such audits, reviews, and investigations.

In addition, CMS engages third party contractors to conduct Additional Documentation Requests ("ADR") and other third party firms, including Unified Program Integrity Contractors ("UPICs"), Zone Program Integrity Contractors (“ZPICs”) and Recovery Audit Contractors (“RACs”), to conduct extensive reviews of claims data and state and Federal Government health care program laws and regulations applicable to healthcare providers. These audits evaluate the appropriateness of billings submitted for payment. Audit contractors identify overpayments resulting from incorrect payment amounts, non-covered services, medically unnecessary services, incorrectly coded services, and duplicate services, and are paid on a contingency basis. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses in the future. These audits and investigations have caused and could potentially continue to cause delays in collections, recoupments, retroactive adjustment to amounts previously paid from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits and investigations may subject the Company to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), termination from the Medicare and Medicaid programs, bars on Medicare and Medicaid payments for new admissions, any of which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition and results of operations.

We cannot predict the ultimate outcome of any regulatory and other governmental audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Company’s costs to respond to and defend any such audits, reviews and investigations could be significant and are likely to increase in the current enforcement environment.

Environmental, Health, and Safety Laws

We are subject to federal, state, and local regulations governing the storage, use, and disposal of materials and waste products. Although we believe that our safety procedures for storing, handling, and disposing of these hazardous materials comply with the standards prescribed by law and regulation, we cannot completely eliminate the risk of accidental contamination or injury from those hazardous materials. In the event of an accident, we could be held liable for any damages that result, and any liability could exceed the limits or fall outside the coverage of our insurance. We may not be able to maintain insurance on acceptable terms, or at all. We could incur significant costs and the diversion of our management's attention to comply with current or future environmental laws and regulations. We are not aware of any violations related to compliance with environmental, health and safety laws through 2021.

Licensing

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

The institutional pharmacy operations within our facility-based services segment are also subject to regulation by the various states in which we conduct the pharmacy business, as well as by the federal government. The pharmacies are regulated under the Food, Drug and Cosmetic Act and the Prescription Drug Marketing Act, which are administered by the United States Food and Drug Administration. Under the Comprehensive Drug Abuse Prevention and Control Act of 1970, administered by the United States Drug Enforcement Administration, as a dispenser of controlled substances, our pharmacy operations must register with the Drug Enforcement Administration, file reports of inventories and transactions and provide adequate security measures. Failure to comply with such requirements could result in civil or criminal penalties. We are not aware of any violations of applicable laws relating to our institutional pharmacy operations through December 31, 2021.

Certificate of Need and Permit of Approval Laws

In addition to state licensing laws, some states require a provider to obtain a certificate of need or permit of approval prior to establishing, constructing, acquiring, or expanding certain health services, operations, or facilities. In these states, approvals are required for capital expenditures exceeding certain amounts that involve certain facilities or services, including home nursing agencies. The certificate of need or permit of approval issued by the state determines the service areas for the applicable agency or program. The following U.S. jurisdictions require certificates of need or permits of approval for home nursing agencies: Alabama, Alaska, Arkansas, Georgia, Hawaii, Kentucky, Maryland, Mississippi, Montana, New Jersey, New York, North Carolina, Rhode Island, South Carolina, Tennessee, Vermont, Washington, West Virginia, and the District of Columbia. In addition, the states of Louisiana and Mississippi continue to have state issued moratorium on the issuance of new licenses for home nursing agencies that we expect to remain in effect for 2022. As of December 31, 2021, we operated 397 home health and hospice locations in certificates of need or moratorium states, with the majority of locations being in Louisiana, Tennessee, Mississippi, Kentucky, and Alabama, respectively.

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

Accreditations

The Joint Commission is a nationwide commission that establishes standards relating to the physical plant, administration, quality of patient care and operation of medical staffs of health care organizations. Currently, Joint Commission accreditation of home nursing and hospice agencies is voluntary. However, some managed care organizations use Joint Commission accreditation as a credentialing standard for regional and state contracts. As of December 31, 2021, the Joint Commission had accredited 523 of our 557 home health locations, 110 of our 170 hospice locations, and five of our 12 LTACH locations. Those not yet accredited are working towards achieving this accreditation. As we acquire companies, we apply for accreditation 12 to 18 months after completing the acquisition.

Employees

As of December 31, 2021, we had approximately 30,000 employees, of which 16,000 were full-time. None of our employees are subject to a collective bargaining agreement. We consider our relationships with our employees and independent contractors to be good.

Insurance

We are subject to claims and legal actions in the ordinary course of our business. To cover claims that may arise, we maintain commercial insurance for healthcare professional liability, general liability, automobile liability, employed lawyers liability, fiduciary liability, crime liability, information security and privacy liabilities, and workers' compensation/employer's liability in amounts that we believe are appropriate and sufficient for our operations. We maintain claims-made healthcare professional liability and occurrence based general liability insurance that provides primary limits of $1.0 million per incident/ occurrence and $3.0 million in annual aggregate amounts. We maintain workers' compensation insurance that meets state statutory requirements and provides a primary employer liability limit of $1.0 million to cover claims that may arise in the states in which we operate, excluding Washington. Coverage for workers' compensation matters within the State of Washington is procured from the State's respective mandated program. Under our workers' compensation insurance policies, the Company maintains a deductible of the first $1.0 million in workers' compensation liability. We maintain automobile liability insurance for all owned, hired and non-owned autos with a primary limit of $1.0 million. In addition, we currently maintain multiple layers of umbrella coverage in the aggregate amount of $40.0 million that provides excess coverage for healthcare professional liability, general liability, automobile liability and employer's liability. We also maintain directors' and officers' liability insurance in the aggregate amount of $65.0 million. The cost and availability of insurance coverage has varied widely in recent years. While we believe that our insurance policies and coverage are adequate for a business enterprise of our type, we cannot guarantee that our insurance coverage is sufficient to cover all future claims or that it will continue to be available in adequate amounts or at a reasonable cost.

Available Information

Our Annual Reports on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K, proxy statements, and amendments to those reports are available free of charge on our internet website at http://investor.lhcgroup.com as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission ("SEC"). The SEC also maintains an internet site at www.sec.gov that contains such reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. These reports may also be obtained at the SEC's Public Reference Room at 100 F Street NE, Washington, D.C. 20549. Information on the operation of the Public Reference Room is available by calling the SEC at (800) SEC-0330. Information contained on our website is not part of or incorporated by reference into this Annual Report on Form 10-K.

Item 1A. Risk Factors.

The risks and uncertainties described below and elsewhere in this Annual Report on Form 10-K could cause our actual results to differ materially from past or expected results and are not the only ones we face. Other risks and uncertainties that we have not predicted or assessed may also adversely affect us.

If any of the negative effects associated with the following risks occur, our earnings, financial condition or business could be materially harmed and the trading price of our common stock could decline, resulting in the loss of all or part of stockholders' investments.

Risk Factors Related to Reimbursement and Government Regulation

We derive a majority of our consolidated net service revenue from Medicare. If there are changes in Medicare rates or methods governing Medicare payments for our services, or if we are unable to control our costs, our results of operations and cash flows could decline materially.

For the years ended December 31, 2021 and 2020, we received 59.8% and 62.1%, respectively, of our net service revenue from Medicare. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our net service revenue and net income to decline, perhaps materially. See Part I, Item 1. Reimbursement in this Annual Report on Form 10-K for additional information regarding reimbursements. Reductions in Medicare reimbursement could be caused by many factors, including:

- administrative or legislative changes to the base rates under the applicable prospective payment systems,
- the reduction or elimination of annual rate increases,
- the imposition or increase by Medicare of mechanisms shifting more responsibility for a portion of payment to beneficiaries, such as co-payments,
- adjustments to the relative components of the wage index used in determining reimbursement rates,
- changes to case mix or therapy thresholds,
- the reclassification of home health resource groups or long-term care diagnosis-related groups, or
- further limitations on referrals to long-term acute care hospitals from host hospitals.

We receive fixed payments from Medicare for our services based on the level of care provided to our patients. Consequently, our profitability largely depends upon our ability to manage the cost of providing these services. We cannot be assured that reimbursement payments under governmental payor programs, including Medicare, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Any such changes could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year.

Additionally, the CARES Act reversed prior reductions in Medicare reimbursement through the 2% sequestration mandated by earlier legislation, and legislation passed in 2022 to phase-in the 2% beginning with Medicare patient claims with dates of service beginning April 1, 2022. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted.

Additionally, on January 1, 2020, CMS implemented changes to the Home Health Prospective Payment System case-mix adjustment methodology through the use of a new PDGM for home health payments. This change also included a change in the unit of payment from a 60-day payment period to a 30-day payment period and eliminates the use of therapy visits in the determination of payments. While the changes are intended to be implemented in a budget-neutral manner to the industry, the ultimate impact varies by provider based on factors including patient mix and admission source. Additionally, in arriving at the calculation of a rate that is budget-neutral, CMS has made numerous assumptions about behavioral changes.

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

As a provider of health care services, we are subject to extensive regulation on the federal, state, and local levels The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we conduct business, the services we offer, and our interactions with patients and other providers. See Part I, Item 1. Government Regulations in this Annual Report on Form 10-K for additional information concerning applicable laws and

regulations. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws, regulations, their interpretations or the enactment of new laws or regulations could increase our costs of doing business, disrupt our business practices and cause our net income to decline. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state reimbursement programs. Furthermore, complying with these regulations requires significant compliance related costs.

We cannot predict the effect that health care reform and other changes in government programs may have on our business, financial condition, or results of operations.

The laws and regulations governing our operations are subject to constant change as a result of continued healthcare reform Health care reform and other changes can result in significant costs to us, require us to change our methods of doing business and may be difficult to comply with. While we cannot predict the extent of future health care reform and changing healthcare laws or its impact on our business, financial condition, or results of operations, such reform and changes could materially and adversely affect us. We also anticipate that the Biden Administration will pursue healthcare reform that is significantly different than the healthcare reform pursued by the Trump Administration and that such reform may result in additional regulations and compliance costs. Any proposed federal health care reforms could have a meaningful impact on our business.

In addition, various health care reform proposals similar to recent federal reforms have also emerged at the state level, including in several states in which we operate. We cannot predict with certainty what health care initiatives, if any, will be implemented at the state level, or what the ultimate effect of state health care reform or any future legislation or regulation may have on us or on our business and consolidated financial condition, results of operations and cash flows.

There are also continuing efforts to reform governmental health care programs that could result in major changes in the health care delivery and reimbursement system on a national and state level, including changes directly impacting the reimbursement systems for our home health and hospice care services. Though we cannot predict what, if any, reform proposals will be adopted, healthcare reform and legislation may have a material adverse effect on our business and our financial condition, results of operations, and cash flows through decreasing payments made for our services.

Changes in our "Quality of Patient Care Star Ratings" could adversely affect our business.

CMS has instituted a star rating methodology for home health agencies to meet the Patient Protection and Affordable Care Act's ("PPACA") call for more transparent public information on provider quality. All Medicare-certified home health agencies would be eligible to receive a star rating (from 1 to 5 stars) based on a number of quality measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring, and bathing, among others. The "Quality of Patient Care Star Ratings" were first published in July 2015, and are updated quarterly thereafter based upon new data that is published with the ratings on the "Home Health Compare" section of the medicare.gov website. While we are pleased with the ratings received by our home health agencies and are striving to improve our results, failing to maintain satisfactory star rating scores could affect our rates of reimbursement and have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows.

We face reviews, audits and investigations under our contracts with federal and state government agencies and private payors, and these audits could have adverse findings that may negatively impact our business.

We are subject to various routine and non-routine governmental reviews, audits and investigations. CMS engages third party contractors to conduct ADRs and other third party firms, including ZPICs and RACs, to conduct extensive reviews of claims data and non-medical and other records to identify potential improper payments under the Medicare program. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including with respect to referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Although we have invested substantial time and effort in implementing policies and procedures to comply with laws and regulations, we could be subject to liabilities arising from violations. A violation of the laws governing our operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, and the termination of our rights to participate in federal and state-sponsored programs or the suspension or revocation of our licenses to operate. Our costs to respond to and defend reviews, audits, and investigations may be significant and could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. Moreover, an adverse review, audit, or investigation could result in:

- required refunding or retroactive adjustment of amounts we have been paid pursuant to the federal or state programs or from private payors,
- state or federal agencies imposing fines, penalties, and other sanctions on us,

- loss of our right to participate in the Medicare program, state programs, or one or more private payor networks, or
- damage to our business and reputation in various markets.

These results could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

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

Our revenue may be negatively impacted by a failure to appropriately document services, resulting in delays in reimbursement.

Reimbursement to us is conditioned upon providing the correct administrative and billing codes and properly documenting the services themselves, including the level of service provided, and the necessity for the services. If incorrect or incomplete documentation is provided or inaccurate reimbursement codes are utilized, this could result in nonpayment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including exclusion from government healthcare programs, such as Medicare and Medicaid. In addition, third-party payors may disallow, in whole or in part, requests for reimbursement based on determinations that certain amounts are not covered, services provided were not medically necessary, or supporting documentation was not adequate.

The inability of our long-term acute care hospitals to maintain their certification as long-term acute care hospitals could have an adverse effect on our results of operations and cash flows.

Following the expiration of exemptions provided under the CARES Act, if our LTACHs fail to meet or maintain the standards for Medicare certification as LTACHs, such as for average minimum patient length-of-stay and restrictions on sources of referral (e.g. the 25 Percent rule), they will receive reimbursement under the prospective payment system applicable to general acute care hospitals rather than the system applicable to long-term acute care hospitals. Payments at rates applicable to general acute care hospitals would likely result in our LTACHs receiving less Medicare reimbursement than they currently receive for their patient services. If any of our LTACHs were subject to payment as general acute care hospitals, our net service revenue and net income would decline.

Our hospice operations are subject to two annual Medicare caps. If any of our hospice providers exceeds such caps, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Overall payments made by Medicare to each hospice provider number (generally corresponding to each of our hospice agencies) are subject to an inpatient cap amount and an overall payment cap amount, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from October 1 through September 30. If payments received under any of our hospice provider numbers exceeds either of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If the structures or operations of our joint ventures are found to violate the law, it could have a material adverse impact on our financial condition and consolidated results of operations.

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

Despite our efforts to meet the safe harbor requirements where possible, our joint ventures may not satisfy all elements of the safe harbor requirements If any of our joint ventures were found to be in violation of federal or state anti-kickback or physician referral laws, we could be required to restructure them or refuse to accept referrals from the physicians or hospitals with which we have entered into a joint venture. We also could be required to repay to Medicare amounts we have received pursuant to any prohibited referrals, and we could suffer civil or criminal penalties, including the loss of our licenses to operate and our ability to participate in federal and state health care programs. If any of our joint ventures were subject to any of these penalties, our business could be materially adversely affected. If the structure of any of our joint ventures were found to violate federal or state anti-kickback statutes or physician referral laws, we may be unable to implement our growth strategy, which could have an adverse impact on our future net income and consolidated results of operations.

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

Our ability to expand operations in a state will depend on our ability to obtain a state license to operate. States may have a limit on the number of licenses they issue. For example, Louisiana currently has a moratorium on the issuance of new home nursing agency licenses. We cannot predict whether the moratorium in Louisiana will be extended. In addition, we cannot predict whether any other states in which we operate, or may wish to operate in the future, may adopt a similar moratorium.

As of December 31, 2021, we operated in 16 states that require health care providers to obtain prior approval, known as a certificate of need or a permit of approval, for the purchase, construction, or expansion of health care facilities, to make certain capital expenditures, or to make changes in services or bed capacity. The failure to obtain any requested certificate of need, permit of approval or other license could impair our ability to operate or expand our business.

Quality reporting requirements may negatively impact Medicare reimbursement.

Many of our business are subject to reporting requirements that if we fail to comply with may negatively impact future Medicare reimbursemen In particular, the PPACA established quality reporting requirements for hospice programs. Failure to submit required quality data will result in a 2 percentage point reduction to the market basket percentage increase for that fiscal year. The Improving Medicare Post-Acute Care Transformation Act of 2014 (the "IMPACT Act") established requirements for home health agencies and other providers to submit standardized data. Failure to report data as required by the IMPACT ACT will subject providers to a 2% reduction in market basket prices then in effect. Similarly, CMS established a new "Pay-for-Reporting Performance Requirement" with which provider compliance with quality reporting program requirements can be measured. Home health agencies that do not submit quality measure data to CMS are subject to a 2% reduction in their annual home health payment update percentage. There can be no assurance that all of our agencies will continue to meet quality reporting requirements in the future which may result in one or more of our agencies seeing a reduction in its Medicare reimbursements. Regardless, these reporting requirements are costly and we, like other healthcare providers, will incur meaningful expenses in an effort to comply with these and future quality reporting requirements.

Risk Factors Related to Operations and our Growth Strategy

The COVID-19 pandemic has materially impacted our business, and will likely continue to impact our business in the future.

The COVID-19 pandemic has adversely impacted economic activity and conditions worldwide, including work forces, liquidity, capital markets, consumer behavior, supply chains, and macroeconomic conditions, which in turn has materially impacted our business. While we expect the COVID-19 pandemic to continue to impact our business in the near term, the extent and duration of the continued effects of the COVID-19 pandemic on our business and results of operations is unknown and will depend on future developments, which are highly uncertain and outside our control. These developments include the scope, duration and severity further surges or variants of COVID-19, the timing and efficacy of initial vaccination and booster programs in the states and locales in which we operate, further actions taken by governmental authorities, including the establishment and enforcement of initial vaccination and booster requirements of our clinicians and other employees, in response to the pandemic and changing consumer, patient, and clinician behavior. It is also possible that the pandemic and its aftermath will lead to a prolonged economic slowdown, cost inflation, or recession in the U.S. economy. We may face interruption in the provision of our services and interruption in the availability of goods that we use in providing our services, and increased costs of such services and goods, any of which could have a material and adverse impact on our business, results of operations and financial condition.

The majority of the Company's revenues are derived from the provision of home health and hospice services While demand for our home health services have not been materially impacted by COVID-19 to date, such demand could suffer depending on the duration and severity of the pandemic due to heightened anxiety among our patients regarding the risk of exposure to COVID-19 as a result of home health visits. Additionally, many of our patients are prescribed home health services after discharge from the hospital or after other surgeries and medical procedures. The pandemic has resulted and could continue to

result in restrictions on or the avoidance or delay of health care visits and procedures. These and other factors related to COVID-19 could eventually reduce demand for our home health services.

Our ability to provide services to our patients depends first and foremost on the health and safety of our skilled nurses, home health aides, and therapists. While we continue to take significant precautions to enable our health care providers to continue to safely provide our important services to our patients during the pandemic and while we have not experienced material service interruptions to date during the pandemic, we could experience interruptions in our ability to continue to provide these services in the future. For example, if there is a reduction in our available healthcare providers due to concerns around COVID-19 related risks or if substantial numbers of our healthcare providers contract COVID-19 or otherwise be required to quarantine due to exposure to COVID-19, our ability to provide services to our patients may be significantly interrupted or suspended.

In addition to a number of factors that could adversely impact demand for our services and our ability to provide services to our patients, we may experience increased cost of care and reduced reimbursements as a result of COVID-19. In particular, we have experienced higher costs due to the higher utilization and cost of personal protective equipment as well as increased purchasing of other medical supplies, cleaning, and sanitization materials. If our patients suffer from increased incidence of and complications from illnesses, including COVID-19, our costs of providing care for our patients would increase. We may also face reduced reimbursement for our services through Medicare and commercial health care plans in the event that such plans do not adjust patient and other qualifications to address changes related to the continued and/or unexpected effects of the COVID-19 pandemic. In addition, if our healthcare providers are unable to obtain initial vaccines or boosters in a timely manner or are not willing to receive government-required COVID-19 vaccines or boosters, we may not have a sufficient supply of health care providers to care for our patients and provide our services.

In the event of an unexpected surge in COVID-19 and its variants, our employees may be again forced to work from home. While we have and continue to invest in technology and equipment that allows our remote work force to provide continued and seamless functionality to our clinicians who continue to care for patients on service, remote working may heighten cybersecurity, information security, and operational risks and affect the productivity of our employees. Despite our implementation and maintenance of cybersecurity programs designed to protect our IT and data systems from attacks, employees may be working from locations where our cybersecurity programs are less effective and IT security may be less robust. If any of our systems are damaged, fail to function properly, or otherwise become unavailable, we may incur substantial costs to repair or replace them and may experience loss or corruption of critical data and interruptions or delays in our ability to perform critical functions, which could adversely affect our business and results of operations. A significant failure, compromise, breach, or interruption in our systems, which may result from problems such as malware, computer viruses, hacking attempts, or other third-party malfeasance, could result in a disruption of our operations, patient dissatisfaction, damage to our reputation, and a loss of patients or revenues.

The extent to which the COVID-19 pandemic impacts our operations will continue to depend on future developments, which remain uncertain and cannot be predicted with confidence, including the scope, severity, and duration of the pandemic, the actions taken to contain the pandemic or mitigate its impact, and the direct and indirect economic effects of the pandemic and containment measures. The COVID-19 pandemic also may have the effect of heightening the other risk factors disclosed herein.

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

We compete with national, regional, and local home nursing and hospice companies, hospitals and other businesses that provide post-acute health care services, some of which are large, established companies that have significantly greater resources than we do. We expect our competitors to develop joint ventures with providers, referral sources, and payors, which could result in increased competition. The introduction by our competitors of new and enhanced service offerings, in combination with industry consolidation and the development of strategic relationships by our competitors, could cause a decline in our net service revenue and loss of market acceptance of our services. Future increases in competition from existing competitors or new entrants may limit our ability to maintain or increase our market share. Additionally, we compete with a number of non-profit organizations that can finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us. We may not be able to compete successfully against current or future competitors and competitive pressures may have a material adverse impact on our business, financial condition, and results of operations.

Managed care organizations and other third party payors continue to consolidate, which enhances their ability to influence the delivery of health care services. Consequently, the health care needs of patients in the United States are increasingly served by a smaller number of managed care organizations, and these organizations generally enter into service agreements with a limited number of providers. Our business and consolidated financial condition, results of operations, and cash flows could be materially adversely affected if these organizations do not contract with us as a provider and/or engage our competitors as a

preferred or exclusive providers. In addition, should private payors, including managed care payors, seek to negotiate additional discounted fee structures or the assumption by health care providers of all or a portion of the financial risk through prepaid capitation arrangements, our business and consolidated financial condition, results of operations, and cash flows could be materially adversely affected.

If we are unable to react competitively to new developments, our operating results may suffer. State certificates of need or permit of approval laws often limit the ability of competitors to enter into a given market, are not uniform throughout the United States and are frequently the subject of efforts to limit or repeal such laws. If states remove existing certificates of need or permit of approvals, we could face increased competition in these states. There can be no assurances that states will not seek to eliminate or limit their existing certificates of need or permit of approval programs, which could lead to increased competition in these states. Further, we may not be able to compete successfully against current or future competitors, which could have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows.

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

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

Our failure to negotiate favorable managed care contracts, or adapt to and comply with innovative reimbursement models, or our loss of existing favorable managed care contracts, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

One of our strategies is to diversify our payor sources by increasing the business we do with managed care companies, and we strive to secure favorable contracts with managed care payors. However, we may not be successful in these efforts and we may not successfully adapt to and comply with increasingly innovative reimbursement models being sought by payors. Additionally, there is a risk that any favorable managed care contracts that we can secure may be terminated on short notice, since managed care contracts typically permit the payor to terminate without cause, typically on 60 days' notice. Such provisions can provide payors with leverage to reduce volume or obtain favorable pricing. Our failure to negotiate, secure, and maintain favorable managed care contracts and our inability to adapt to and comply with innovative reimbursement models could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

We rely on our ability to attract and retain qualified nurses and other health care professionals. The availability of qualified nurses nationwide has declined in recent years and competition for these and other health care professionals has increased, especially under the healthcare and economic crises experienced throughout the COVID-19 pandemic, and, therefore, salary and benefit costs have risen accordingly. Our ability to attract and retain nurses and other health care professionals depends on several factors, including our ability to protect our staff during the COVID-19 pandemic by providing adequate personal protective equipment and provide desirable assignments and competitive benefits and salaries. We may not be able to attract and retain qualified nurses or other health care professionals in the future. During the COVID-19 pandemic, we have experienced increased costs to attract and retain qualified skilled nursing and paraprofessional personnel and faced challenges in staffing patient care due to reductions in available work force. If these increased costs of attracting and retaining these professionals and providing them with attractive benefit packages or we are unable to overcome the challenges with workforce availability, our net income could decline. Moreover, if we are unable to attract and retain qualified professionals, the quality of services offered to our patients may decline or our ability to grow may be constrained. In addition, if we expand our operations into geographic areas where health care providers historically have been unionized, or if any of our care center employees become unionized, being subject to a collective bargaining agreement may have a negative impact on our ability to timely and successfully recruit qualified personnel and may increase our operating costs.

Additionally, a number of states require that direct care workers, such as our nurses, receive state-mandated minimum wage and/or overtime pay. Opponents of such policies argue that the new protections will make in-home care more expensive for government programs that pay for such services, and that these new rules and regulations could result in a reduction in covered services. We will continue to evaluate the effect of these various new rules and regulations on our operations.

The loss of certain Board of Directors, executive management, or key employees could have a material adverse effect on our operations and financial performance.

Our success depends upon the continued service of our Board of Directors and employment of our executive management team and key employees and our ability to retain and motivate these individuals. If we lose the services of one or more of our

Board of Directors, executive officers, or key employees, we may not be able to successfully manage our business, achieve our business goals, or replace them with equally qualified personnel. The loss of any of our executive officers or key employees could have a material adverse effect on our operations and financial performance. Furthermore, while our board has undertaken succession planning there is no guarantee that such succession planning will be successful and any management succession or transition involves inherent risk that could hinder our strategic planning, execution and future performance.

We may close additional underperforming agencies in the future.

We regularly review the performance of our various agencies. Our review considers the current financial performance, market penetration, forecasted market growth and current and future reimbursement payment forecasts. We will continue to monitor the performance of our agencies on an ongoing basis, and closures may from time to time occur in the future. If we take any further action to close agencies, we will incur additional costs and expenses, which may require us to record significant charges in future periods. While any such closures would be made in connection with our constant efforts to improve our profitability, associated charges would have a negative impact on our revenue and possibly our operating results during the short-term.

Future acquisitions may be unsuccessful and could expose us to unforeseen liabilities. Further, our acquisition and internal development activity may impose strains on our existing resources.

Our growth strategy involves the acquisition of agencies throughout the United States. These acquisitions involve significant risks and uncertainties, including difficulties integrating acquired personnel and other corporate cultures into our business, the potential loss of key employees or patients of acquired agencies, the delay in payments associated with change in ownership, control, and the internal process of the Medicare fiscal intermediary, and the exposure to unforeseen liabilities of acquired agencies. Additionally, operations that we acquire must be integrated into our various information systems in an efficient and effective manner. If we are unable to integrate and transition any acquired business into our information systems, we could incur unanticipated expenses, suffer disruptions in service, experience regulatory issues, lose revenue from the operation of such business and fail to realize the anticipated benefits of such acquisitions.

Further, the financial benefits we expect to realize from many of our acquisitions are largely dependent upon our ability to improve clinical performance, overcome regulatory deficiencies, and improve the reputation of the acquired business in the community and control costs. We may not be able to fully integrate the operations of the acquired businesses with our current business structure in an efficient and cost-effective manner, having a material adverse effect on our operations. In addition, we may be exposed to unforeseen liabilities of an acquired company, which liabilities may not be covered by insurance or indemnification from sellers and may be material.

In addition, as we continue to expand our markets, our growth could strain our resources, including management, information and accounting systems, regulatory compliance, logistics, and other internal controls. Our resources may not keep pace with our anticipated growth. If we do not manage our expected growth effectively, our future prospects could be affected adversely.

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

We intend to continue growing through the acquisition of additional home-based and hospice agencies and the formation of joint ventures with hospitals for the operation of home-based and hospice agencies. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher prices for our acquisitions and joint ventures. We cannot guarantee that we will be able to identify suitable acquisition or joint venture opportunities in the future or that any such opportunities, if identified, will be consummated on favorable terms, if at all. Without successful acquisitions or joint ventures, our future growth rate could decline. In addition, we cannot guarantee that any future acquisitions or joint ventures, if consummated, will result in further growth.

Federal regulation may impair our ability to consummate acquisitions or open new agencies.

Changes in federal laws or regulations may materially adversely impact our ability to acquire home nursing agencies or open new start-up home nursing agencies. For example, CMS has adopted a regulation known as the “36 Month Rule” that is applicable to home health agency acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health agencies - those that either enrolled in Medicare or underwent a change in ownership fewer than 36 months prior to the acquisitions - from assuming the Medicare billing privileges of the acquired agency. Instead, the acquired home health agencies must enroll as new providers with Medicare. As a result, the 36 Month Rule may further increase competition for acquisition targets that are not subject to the rule, and may cause significant Medicare billing delays for the purchases of home health agencies that are subject to the rule.

We have invested in development stage companies which may require further funding to support their respective business plans, which may ultimately prove unsuccessful.

We have controlling interests in (a) Imperium Health Management, LLC, an Accountable Care Organization ("ACO") enablement and management company, (b) Long Term Solutions, Inc., a provider of in-home nursing assessments for the long-term care insurance industry, and (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for home-bound or home-limited patients with chronic and acute illnesses who have difficulty traveling to a doctor's office. These investments, which make up our HCI segment, remain speculative, and may ultimately provide no return or could lead to a total loss of our investment.

Furthermore, portions of our HCI segment compete in new and developing markets with new competitors or solutions developed and introduced to the market regularly. Such new products may capture market share more quickly or may have access to more capital than the capital we have allocated for such projects. Our efforts to bring new solutions to the market may prove unsuccessful, may prove to be unprofitable, or may prove to be costlier to bring to market than anticipated. Our investments in these activities are highly speculative in nature and subject to loss. Specifically, our assessment subsidiary competes with larger, better capitalized competitors, while also being particularly reliant on a small number of large customers, the loss of which could significantly and adversely impact its results.

Our HCI segment also primarily provides strategic health management services to ACOs that have been approved to participate in the Medicare Shared Savings Program ("MSSP") [and other risk-based reimbursement programs]. ACO's and their reimbursement programs are relatively new and are subject to meaningful regulation with various regulators having adopted or considering the adoption of new legislation, rules, regulations and guidance relating to formation and operation of ACOs. Failure to comply with legal or regulatory restrictions may result in CMS terminating the ACO's agreement with CMS and/or subjecting the ACO to loss of the right to engage in some or all business in a state, payments fines or penalties, or may implicate federal and state fraud and abuse laws relating to anti-trust, physician fee-sharing arrangements, anti-kickback prohibitions, prohibited referrals, any of which may adversely affect our HCI segment's operations and/or profitability.

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

We depend upon reliable and secure information systems to provide valuable tools by which we manage our business, comply with legal requirements, provide services, and bill and collect for our services. In addition to our Service Value Point system, our business is also substantially dependent on non-proprietary software provided by third-party vendors. For example, we utilize third-party software information systems for billing and maintaining patient claim receivables. Our business also depends on a comprehensive payroll and human resources system for basic payroll functions and reporting, payroll tax reporting, managing wage assignments and garnishments. Our business also supports the use of Electronic Visit Verification ("EVV") to collect visit submission information through our delivery of home and community-based, and we rely on third-party software vendors to provide continual maintenance, enhancements, as well as security of collected data. To the extent that our EVV vendors fail to support these processes, our internal operations could be negatively affected.

Our agencies also depend upon our information systems for accounting, billing, collections, risk management, quality assurance, payroll, education tracking, and operational performance. If we experience a reduction in the performance, reliability, availability, or accuracy of our information systems, our operations and financial performance, and ability to report timely and accurate information, could be adversely affected.

Our systems require constant maintenance, upgrades, and enhancements to preserve system capabilities and security and to meet our operational needs. Our information systems require an ongoing commitment of significant resources to maintain, protect, and enhance existing systems and develop new systems to keep pace with continuing changes in technology, evolving industry and regulatory standards, and changing customer preferences. Problems with, or the failure of, our information systems or software could negatively impact our clinical performance and our management and reporting capabilities. To the extent third-party software vendors fail to support our licensed software or systems, or if we lose our licenses, our operations could be materially and negatively affected. Any significant problems with or failures of our information systems or software could materially and adversely affect our operations and reputation, result in significant costs to us, cause delays in our ability to bill and collect from Medicare or other payors for our services, or impair our data capture, medical documentation, or ability to provide our services in the future. The costs incurred in correcting any errors or problems with our proprietary and non-proprietary software may be substantial and could adversely affect our net income.

Additionally, operations that we acquire must be integrated into our various information systems in an efficient and effective manner. For certain aspects, we rely upon third party contractors to assist us with those activities. If we are unable to integrate and transition any acquired business into our information systems, due to our failures or any failure of our third party contractors, we could incur unanticipated expenses, suffer disruptions in service, experience regulatory issues, and lose revenue from the operation of such business.

Our information systems are networked via public network infrastructure and standards based encryption tools that meet regulatory requirements for transmission of protected health information over such networks. We have built redundancy into our networks and installed privacy protection systems on our network and POC devices to prevent unauthorized access to

proprietary, sensitive, and legally protected information. However, our technology may fail to adequately secure the confidential health information and personally identifiable information we maintain in our databases. Additionally, threats from computer viruses, instability of the public network on which our data transit relies, or other instances that might render those networks unstable or disabled would create operational difficulties for us, including difficulties effectively transmitting claims and maintaining efficient clinical oversight of our patients, as well as disrupting revenue reporting and billing and collections management, which could adversely affect our business or operations. If personal information or protected information of our patients, employees, or others with whom we do business is tampered with, stolen, or otherwise improperly accessed, we may incur fines and penalties associated with the breach of security or be required to take other action in response to judicial or regulatory actions arising out of the incident, including under HIPAA or other judicial acts.

Our information systems are also subject to damage or service interruption due to natural disasters, floods, fires, loss of power, loss of telecommunications connectivity, and other events that may be beyond our immediate control. While we maintain and test various disaster recovery plans and procedures, our failure to successfully implement and execute upon such plans and procedures, and restore the full operational capabilities of our information systems and software in an effective and efficient manner, could have a material adverse effect on the functionality of our information systems and our business, financial condition, results of operations and cash flows, and cause a possible significant disruption of our operations and services.

We develop and maintain portions of our clinical systems in-house. Failure of, or problems with, these systems could harm our business and operating results.

We develop and maintain proprietary software systems to collect assessment data, log patient visits, generate medical orders, and monitor treatments and outcomes in accordance with established medical standards. These systems integrate billing and collections functionality as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. Problems with, or the failure of, such technologies and systems could negatively impact data capture, billing, collections, and management and reporting capabilities. Any such problems or failures could adversely affect our operations and reputation, result in significant costs to us, and impair our ability to provide our services in the future. The costs incurred in correcting any errors or problems may be substantial and could adversely affect our profitability.

Our ability to maintain the security of patient, employee, third-party, or company information could have an impact on our reputation, our financial position, and the results of our operations.

The risk of a disruption or breach of our operational systems, or the compromise of the data processed in connection with our operations, has increased as attempted attacks have advanced in sophistication and number around the world. We have been, and likely will continue to be, subject to attempts of computer hacking, vandalism and theft, malware, computer viruses, ransomware, and other malicious codes, phishing, employee error and malfeasance, catastrophes, unforeseen events, or other cyber-attacks. To date, we have seen no material impact on our business or operations from these attacks or events. Any future significant compromise or breach of our data security, whether external or internal, or misuse of patient, employee, third-party or Company data, could result in significant costs, lost revenue, fines, lawsuits, and damage to our reputation. The proliferation of ever-evolving threats mean that we and our third-party service providers and vendors must continually evaluate and adapt our respective systems and processes and overall security environment, as well as those of any operations we acquire, and incur significant expenses on such security measures. Efforts by us and our vendors to develop, implement, and maintain security measures, including malware and anti-virus software and controls, may not be successful in preventing these events from occurring, and any network and information systems-related events could require us to expend significant resources to remedy such event. In the future, we may be required to expend additional resources to continue to enhance our information security measures and/or to investigate and remediate information security vulnerabilities.

A cybersecurity or ransomware attack or other incident that affects our information systems security could cause a security breach that may lead to a material disruption to our information systems infrastructure or business and may involve a significant loss of business or patient health information. If a cybersecurity attack or other unauthorized attempt to access our systems or facilities were to be successful, it could result in the theft, destruction, loss, misappropriation, or release of confidential information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cybersecurity attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors, or other third parties and could subject us to substantial sanctions, fines, and damages and other additional civil and criminal penalties under HIPAA, HITECH, the Omnibus Rule and other federal and state privacy laws, in addition to litigation with those affected.

While we provide our employees with training and regular reminders on important measures they can take to prevent breaches or phishing schemes, given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations.

We may be required to expend significant capital and other resources to protect against the threat of security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems, and the introduction of computer viruses or other malicious software programs to our systems, and cyber-attacks, email phishing schemes, malware, and ransomware. Moreover, a security breach, or threat thereof, could require that we expend significant resources to repair or improve our information systems and infrastructure and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber-attack, the associated expenses and losses may exceed our current insurance coverage for such events. Some adverse consequences are not insurable, such as reputational harm and third-party business interruption. Failure to maintain proper function, security, or availability of our information systems or protect our data against unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows.

If we are subject to substantial malpractice or other similar claims, it could materially adversely impact our results of operations and financial condition.

The services we offer have an inherent risk of professional liability and substantial damage awards. At December 31, 2021, we have approximately 30,000 employees. In addition, we employ direct care workers on a contractual basis to support our existing workforce. We, and the nurses and other health care professionals who provide services on our behalf, may be the subject of medical malpractice claims. These nurses and other health care professionals could be considered our agents and, as a result, we could be held liable for their medical negligence. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We maintain malpractice liability insurance that provides primary coverage on a claims-made basis of $1.0 million per incident and $3.0 million in annual aggregate amounts. In addition, we maintain multiple layers of umbrella coverage in the aggregate amount of $40.0 million that provide excess coverage for professional malpractice and other liabilities. We are responsible for deductibles and amounts in excess of the limits of our coverage. Claims that could be made in the future in excess of the limits of such insurance, if successful, could materially adversely affect our financial condition. In addition, our insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms.

Risk Factors Related to Capital and Liquidity

Delays in reimbursement may cause liquidity problems.

Our business is characterized by delays in reimbursement, from the time we request payment for our services to the time we receive reimbursement or payment. If we have information system problems or issues arise with Medicare or other payors, we may encounter further delays in our payment cycle. For example, in the past we have experienced delays resulting from problems arising out of the implementation by Medicare of new or modified reimbursement methodologies or as a result of natural disasters, such as hurricanes. We have also experienced delays in reimbursement resulting from our implementation of new information systems related to our accounts receivable and billing functions.

In addition, timing delays in billings and collections may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in achieving our financial results and maintaining liquidity. It is possible that documentation support, system problems, Medicare, state Medicaid, or other payor issues, or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

Our implicit price concessions may not be sufficient to cover uncollectible amounts.

On an ongoing basis, we review historical net cash realization for Medicare, Medicaid, and private insurance revenue that we will not be able to collect. This allows us to calculate the expected loss on our revenue for the period we are reporting. Our implicit price concessions may underestimate actual uncollectible revenue for various reasons, including:

- adverse changes in our estimates as a result of changes in related collection rates,
- inability to collect funds due to missed filing deadlines or inability to prove that timely filings were made,
- adverse changes in the economy generally exceeding our expectations, or
- unanticipated changes in reimbursement from Medicare, Medicaid and private insurance companies.

If our implicit price concessions are insufficient to cover losses on our revenue, our business, financial position and results of operations could be materially adversely affected.

The condition of the financial markets, including volatility and weakness in the equity, capital, and credit markets, could limit the availability and terms of debt and equity financing sources to fund the capital and liquidity requirements of our business.

Financial markets may experience significant disruptions, which could impact liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt

financing. While we have not experienced any individual lender limitations to extend credit under our revolving credit facility, the obligations of each of the lending institutions in our revolving credit facility are independent and the availability of future borrowings under our revolving credit facility could be impacted by further volatility and disruptions in the financial credit markets or other events. Our inability to access our revolving credit facility or refinance the revolving credit facility would have a material adverse effect on our business, financial position, results of operations and liquidity.

Based on our current plan of operations, including acquisitions, we believe our existing cash balance, when combined with expected cash flows from operations and amounts available under our revolving credit facility, will be sufficient to fund our growth strategy and to meet our anticipated operating expenses, capital expenditures, and debt service obligations for at least the next 12 months. If our future net service revenue or cash flow from operations is less than we currently anticipate, we may not have sufficient funds to implement our growth strategy. Further, we cannot readily predict the timing, size, and success of our acquisition and internal development efforts and the associated capital commitments. If we do not have sufficient cash resources, our growth could be limited unless we are able to obtain additional equity or debt financing.

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

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

- incur more debt,
- redeem or repurchase stock, pay dividends or make other distributions,
- make certain investments,
- create liens,
- enter into transactions with affiliates,
- make unapproved acquisitions,
- enter into joint ventures,
- merge or consolidate,
- transfer or sell assets, and/or
- make fundamental changes in our corporate existence and principal business.

In addition, events beyond our control could affect our ability to comply with and maintain such financial tests and ratios. Any failure by us to comply with or maintain all applicable financial tests and ratios and to comply with all applicable covenants could result in an event of default with respect to our revolving credit facility or any other future debt agreements. An event of default could lead to the acceleration of the maturity of any outstanding loans and the termination of the commitments to make further extensions of credit. Even if we are able to comply with all applicable covenants, the restrictions on our ability to operate our business at our sole discretion could harm our business by, among other things, limiting our ability to take advantage of financing, mergers, acquisitions and other corporate opportunities.

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

Upon the occurrence of fundamental changes to the laws and regulations applicable to our joint ventures, or if a substantial number of our joint venture partners were to exercise the buy/sell provisions contained in many of our joint venture agreements, we may be obligated to purchase or sell the equity interests held by us or our joint venture partners. In some instances, the purchase price under these buy/sell provisions is based on a multiple of the historical or future earnings before income taxes, depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the joint ventures partners but will be subject to a fair market valuation process. In the event the buy/sell provisions are exercised and we lack sufficient capital to purchase the interest of our joint venture partners, we may be obligated to sell our equity interest in these joint ventures. If we are forced to sell our equity interest, we will lose the benefit of those particular joint venture operations. If these buy/sell provisions are exercised and we choose to purchase the interest of our joint venture partners, we may be obligated to expend significant capital in order to complete such acquisitions. If either of these events occurs, our net service revenue and net income could decline or we may not have sufficient capital necessary to implement our growth strategy.

We could be required to record a material non-cash charge to income if our recorded goodwill or intangible assets are impaired.

As of December 31, 2021, we had $2.1 billion of goodwill and intangible assets. We review goodwill and indefinite-lived intangible assets annually for impairment or whenever events or changes in circumstances indicate potential impairment. The

goodwill assessment includes comparing the estimated fair value of each reporting unit to the carrying value of the reporting unit. If we determine that the estimated fair value of our goodwill or intangible assets is less than the applicable book value or carrying value, we could be required to record a non-cash impairment charge to our consolidated statements of operations. Because goodwill and intangible assets represent a significant portion of the assets reflected on our consolidated balance sheets, any future impairment of these assets could result in a non-cash charge to our consolidated statements of operations and have a material adverse effect on our earnings, debt covenants, and ability to access capital.

Risk Factors Related to General Economic and Market Conditions

Current economic conditions and continued decline in spending by the federal and state governments could adversely affect our results of operations and cash flows.

While our services are not typically sensitive to general declines in the federal and state economies, the erosion in the tax base caused by a general economic downturn has caused, and will likely cause, restrictions on the federal and state governments' abilities to obtain financing and a decline in spending. As a result, we may face reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payors, which could adversely impact our results of operations and cash flows.

Adverse developments in the United States could lead to a reduction in federal government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the federal government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the federal government may stop or delay making payments on its obligations, including funding for government programs in which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by the United States Congress to complete the federal budget process and fund government operations may result in a federal government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Historically, state budget pressures have resulted in reductions in state spending. Given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services.

We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our patients.

The majority of our patients are older individuals and others with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or other public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable patients. For example, in connection with the COVID-19 pandemic, we suffered losses to our consumer population and faced reductions in the availability of our clinical and para-professional employees. Additionally, we incurred higher than expected labor costs for existing staff and were required to hire replacements for affected workers at higher costs. Accordingly, the occurrence of certain public health catastrophes, including an extended continuation of the current COVID-19 pandemic, could cause material adverse effect on our financial condition and results of operations.

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

Our operations along coastal areas in the United States are particularly susceptible to adverse weather events, such as hurricanes and flooding. Adverse weather events could disrupt our business and results of operations, result in damage to our properties, and negatively affect the local economies in which we operate. Furthermore, climate change may increase the frequency and severity of such adverse weather events. Although we maintain insurance coverage, we cannot guarantee that our insurance coverage will be adequate to cover any losses or that we will be able to maintain insurance at a reasonable cost in the future. If our losses from business interruption or property damage exceed the amount for which we are insured, our results of operations and financial condition would be adversely affected.

Certain provisions of our charter, bylaws, and Delaware law may delay or prevent a change in control of the Company.

Delaware law and our governing documents contain provisions that may enable our Board of Directors to resist a change in control of us. These provisions include:

- staggered terms for our Board of Directors,
- limitations on persons authorized to call a special meeting of stockholders,
- the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without stockholder approval,

- no cumulative voting for directors,
- director vacancies are filled by remaining directors (including vacancies resulting from removal), and
- advance notice procedures required for stockholders to nominate candidates for election as directors or to bring matters before an annual meeting of stockholders.

These anti-takeover defenses could discourage, delay, or prevent a transaction to acquire us and may permit our Board of Directors to choose not to entertain offers to purchase us, even if such offers include a substantial premium to the market price of our stock. Therefore, our stockholders may be deprived of opportunities to profit from a sale of control. These provisions could also discourage proxy contests and make it more difficult for stockholders to elect directors or cause us to take other corporate actions.

Item 1B. Unresolved Staff Comments.

We have no unresolved written comments from the staff of the SEC regarding our periodic or current reports filed under the Exchange Act.

Item 2. Properties.

Our principal executive office is located in Lafayette, Louisiana in a 270,000 square foot building. The Company owns the land and building, which houses the principal executive office. The home office expansion project was completed during 2021 for a total cost of $69 million.

Of our operating service locations, eight locations reside in buildings owned by us and the remaining locations are in leased facilities. Most of our operating service locations are located in general commercial office space. Generally, the office leases have initial terms ranging from one to five years. Most of the leases either contain multiple options to extend the lease period ranging in one to three year increments or convert to a month-to-month lease upon the expiration of the initial lease term.

Ten of our LTACHs are HwHs, meaning we have a lease or sublease for space with the host hospital. Generally, our leases or subleases for LTACHs have initial terms of five years, but range from three to ten years. Most of our leases and subleases for our LTACHs contain multiple options to extend the term in the range of one to five year increments.

We believe that our properties and facilities are well maintained and are generally suitable and adequate for the purposes for which they are used.

Item 3. Legal Proceedings.

We provide services in a highly regulated industry and are a party to various proceedings (regulatory and other governmental), and internal audits and investigations in the ordinary course of business (including audits by ZPICs, RACs, and investigations resulting from our obligation to self-report suspected violations of law). We cannot predict the ultimate outcome of any regulatory and other governmental and internal audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to our businesses in the future. These audits and investigations have caused and could potentially continue to cause delays in collections and recoupments from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits may subject us to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on our business and financial condition and results of operations.

We are involved in various legal proceedings arising in the ordinary course of business. Although the results of litigation cannot be predicted with certainty, we believe the outcome of pending litigation will not have a material adverse effect, after considering the effect of our insurance coverage, on our consolidated financial information.

Item 4. Mine Safety Disclosures.

Not applicable.

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

Sales of Unregistered Common Stock

None.

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market ("NASDAQ") under the symbol "LHCG." As of February 15, 2022, there were approximately 474 registered holders of record of our common stock.

Dividend Policy

We have not paid any dividends on our common stock since our initial public offering in 2005 and do not anticipate paying dividends in the foreseeable future. We currently intend to retain future earnings, if any, to support the development and growth of our business. Payment of future dividends, if any, will be at the discretion of our Board of Directors and subject to any requirements under our credit facility or any future debt instruments.

Price Range of Common Stock

The following table provides the high and low prices of our common stock during each quarter in 2021 and 2020 as quoted by NASDAQ:

	High	Low
2021		
Fourth Quarter	$ 154.64	$ 110.23
Third Quarter	215.29	156.91
Second Quarter	219.09	185.44
First Quarter	221.64	173.12
	High	**Low**
2020		
Fourth Quarter	$ 231.49	$ 195.65
Third Quarter	213.08	174.26
Second Quarter	174.32	121.01
First Quarter	158.93	104.81

The closing price of our common stock as reported by NASDAQ on February 18, 2022 was $125.20.

Performance Graph

This item is incorporated by reference from our Annual Report to Stockholders for the fiscal year ended December 31, 2021.

Issuer Purchases of Equity Securities

On December 6, 2021, our Board of Directors approved a share repurchase program authorizing management to repurchase up to $250.0 million of our common stock. We may purchase common stock in open market transactions, block or privately negotiated transactions, and may from time to time purchase shares pursuant to a trading plan in accordance with Rule 10b5-1 and Rule 10b-18 under the Exchange Act or by any combination of such methods, in each case subject to compliance with all SEC rules and other legal requirements. The number of shares to be purchased and the timing of the purchases are based on a variety of factors, including, but not limited to, the level of cash balances, credit availability, debt covenant restrictions, general business conditions, the market price of our stock and the availability of alternative investment opportunities. No time limit was set for completion of repurchases under the new authorization, and the program may be suspended or discontinued at any time.

The following table provides information regarding shares of our common stock, $0.01 par value per share, purchased in accordance with the stock repurchase plan during the twelve months ended December 31, 2021:

Period	(a) Total Number of Shares Repurchased	(b) Average Price Paid per Share	(c) Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares that May Yet Be Purchased Under the Plans or Programs
December 1, 2021- December 31, 2021	634,869	$ 131.89	634,869	$ 166,264,272
Total	634,869	$ 131.89	634,869	$ 166,264,272

Item 6. **Reserved**

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

The following discussion and analysis contains forward-looking statements about future revenues, operating results, plans and expectations. Forward-looking statements are based on a number of assumptions and estimates that are inherently subject to significant risks and uncertainties and our results could differ materially from the results anticipated by our forward-looking statements as a result of many known or unknown factors, including, but not limited to, those factors discussed in Part I, Item 1A. Risk Factors. Also, please read the "Cautionary Statement Regarding Forward-Looking Statements" set forth at the beginning of this Annual Report on Form 10-K.

In addition, read the following discussion in conjunction with Part 1 of this Annual Report on Form 10-K as well as our Consolidated Financial Statements and the related Notes contained elsewhere in this Annual Report on Form 10-K.

Overview

We provide post-acute health care services primarily to Medicare beneficiaries throughout the United States, through our home health agencies, hospice agencies, home and community-based, long-term acute care hospitals, and HCI. Our net service revenue increased $156.4 million to $2.220 billion for the year ending December 31, 2021 from $2.063 billion for the year ending December 31, 2020, largely due to acquired growth and offset by the impact from the COVID-19 pandemic. During 2021, we acquired 90 agencies, such that, as of December 31, 2021, we operated 970 locations in 37 states within the continental United States and the District of Columbia.

Segments

Our services are classified into five segments: (1) home health, (2) hospice, (3) home and community-based, (4) facility-based services, offered primarily through our LTACHs, and (5) HCI.

Through our home health services segment we offer a wide range of services, including skilled nursing, medically-oriented social services, and physical, occupational and speech therapy. As of December 31, 2021, we operated 557 home health service locations, of which 344 are wholly-owned by us, 209 are majority-owned or controlled by us through equity joint ventures, two are controlled by us through license lease arrangements, and the remaining two are only managed by us.

Through our hospice services segment, we offer a wide range of services, including pain and symptom management, emotional and spiritual support, inpatient and respite care, homemaker services, and counseling. As of December 31, 2021, we operated 170 hospice locations, of which 106 are wholly-owned by us, 62 are majority-owned by us through equity joint ventures and two, are controlled by us through license lease arrangements.

Through our home and community-based, our services are performed by paraprofessional personnel, and include assistance to elderly, chronically ill, and disabled patients with activities of daily living. As of December 31, 2021, we operated 136 community-based services locations, of which 121 are wholly-owned and 15 are majority-owned through an equity joint venture.

We provide facility-based services principally through our LTACHs. As of December 31, 2021, we operated 11 LTACHs with 12 locations, of which all but two are located within host hospitals. We also operate two skilled nursing facilities, a rural health clinic, one physician practice, one family health center, and 75 physical therapy clinics. Of these 93 facility-based services locations as of December 31, 2021, 82 are wholly-owned by us and 11 are controlled by us through equity joint ventures.

Our HCI segment reports on our developmental activities outside its other business segments. The HCI segment includes (a) Imperium Health Management, LLC, an ACO enablement and management company, (b) Long Term Solutions, Inc., an in-home assessment company serving the long-term care insurance industry, and (c) certain assets operated by Advanced Care House Calls, which provides primary medical care for patients with chronic and acute illnesses who have difficulty traveling to a doctor's office. These activities are intended ultimately, whether directly or indirectly, to benefit our patients and/or payors through the enhanced provision of services in our other segments. The activities all share a common goal of improving patient experiences and quality outcomes, while lowering costs. They include, but are not limited to, items such as: technology, information, population health management, risk-sharing, care-coordination and transitions, clinical advancements, enhanced patient engagement and informed clinical decision and technology enabled in-home clinical assessments. We have 14 HCI locations, with 13 being wholly-owned and one controlled by us through an equity joint venture.

The percentage of net service revenue contributed from each reporting segment for the each of the periods ended December 31, 2021, 2020 and 2019 was as follows:

Type of Segment	2021	2020	2019
Home Health	69.9 %	71.0 %	72.3 %
Hospice	14.0	11.8	10.9
Home and Community-Based	8.5	9.4	10.0
Facility-Based	6.0	6.2	5.4
Healthcare Innovations	1.6	1.6	1.4
	100.0 %	100.0 %	100.0 %

Development Activities

The following table provides a summary of our acquisitions, divestitures and internal development activities from January 1, 2020 through December 31, 2021. This table does not include two skilled nursing facilities, family health center, rural health clinic, physician practice, and physical therapy clinics through our facility-based services segment.

	Home Health Agencies	Hospice Agencies	Home and Community -Based Agencies	Long-Term Acute Care Hospitals	HCI
Total at January 1, 2020	553	110	107	13	10
Developed	1	6	16	—	2
Acquired	13	6	4	—	—
Divested/Merged	(30)	(2)	(3)	(1)	—
Total at December 31, 2020	537	120	124	12	12
Developed	—	1	13	—	2
Acquired	27	49	1	—	—
Divested/Merged	(7)	—	(2)	—	—
Total at December 31, 2021	557	170	136	12	14

Recent Developments

Coronavirus and Coronavirus Aid, Relief, and Economic Security Act

The COVID-19 outbreak has adversely impacted economic activity and conditions worldwide, including work forces, liquidity, capital markets, consumer behavior, supply chains, and macroeconomic conditions. After the declaration of a national emergency in the United States on March 13, 2020, in compliance with stay-at-home and physical distancing orders and other restrictions on movement and economic activity intended to reduce the spread of COVID-19, we continue to alter numerous clinical, operational, and business processes.

We continue to take precautions to protect the safety and well-being of our employees by purchasing and delivering additional supplies of personal protection equipment to our clinicians across the country. In response to the COVID-19 outbreak, we promptly convened a cross-functional COVID-19 task force comprised of our company's leaders that continually communicates with our clinicians and other employees concerning best practices and Company changes in policies and procedures.

We continually review and adjust to changes to adapt to the current environment associated with COVID-19. We remain fully functional and continue to provide our patients with critical services during the pandemic. In addition, we currently plan to continue to execute on our strategic business plans.

In response to COVID-19, the U.S. Government enacted the CARES Act on March 27, 2020. The following portions of the CARES Act impacted us during the twelve months ended December 31, 2021:

- *Provider Relief Fund:* During the twelve months ended December 31, 2020, we received $93.3 million from the Provider Relief Fund. We recognized no funds for the twelve months ended December 31, 2020 in our consolidated statements of income. We returned all funds to the government during the twelve months ended December 31, 2021.

- *Accelerated and Advance Payments Program (CAAP):* CAAP extended financial hardship relief to Medicare providers impacted by the COVID-19 pandemic in order to provide necessary funds when there is a disruption in claims submission and/or claims processing. During the twelve months ended December 31, 2020, we received $318 million of accelerated and advance payments. The recoupment of CAAP will occur under a tiered approach. Beginning at one year from the date the payment was issued and continuing for 11 months, Medicare payments owed to providers will be recouped at a rate of 25%. If any amount of CAAP funds that we received from CMS remain unpaid after the initial 11 month period, CMS will recoup 50% of Medicare payments otherwise owed to us during the following six months. Interest will be assessed on any amount of the CAAP funds that we received from CMS that remain unpaid following those recoupment periods. CMS will issue a repayment letter to the Company for any such outstanding amounts, which must be paid in full within 30 days from the date of the letter. We intend to repay the full amount outstanding before any interest accrues. During the twelve months December 31, 2021, $211.5 million was recouped by CMS and $106.5 million of contract liabilities - deferred revenue remains on our consolidated balance sheets as of December 31, 2021.
- *Suspension of the 2% sequestration payment adjustment.* CMS suspended the 2% sequestration payment adjustment for patient claims with dates of services or end of period dates from May 1 through December 31, 2020. The Consolidated Appropriations Act, 2021, signed into law on December 27, 2020, extended the suspension of the 2% sequestration payment adjustment to March 31, 2021. On April 14, 2021, Congress passed legislation to continue the suspension of the 2% sequestration payment adjustments on Medicare patient claims with dates of service through December 31, 2021. On December 10, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act legislation passed, which will continue the suspension of the sequestration payment adjustments for Medicare patient claims with dates of service through March 31, 2022. Medicare patient claims with dates of service between April 1 through June 30, 2022 will have a 1% sequestration adjustment and Medicare patient claims with dates of service beginning July 1, 2022 will have a 2% sequestration adjustment. During the twelve months ended December 31, 2021 and 2020, we recognized $26.8 million and $18.1 million, respectively, of net service revenue due to the suspension of the 2% sequestration payment adjustment.
- *Waiver of the application of site-neutral payment:* Under Section 1886(m)(6)(A)(i) of the Act, the claims processing systems will be updated to pay all LTACH cases admitted during the COVID-19 PHE period at the LTACH PPS standard federal rate, effective for claims with an admission date occurring on or after January 27, 2020 through the end of the PHE period. The PHE has been extended to April 15, 2022. During the twelve months ended December 31, 2021 and 2020, respectively, we recognized $25.7 million and $19.2 million of net service revenue due to the suspension of site-neutral payments.
- *Delaying payment of the employer portion of social security tax:* The Company deferred payments of the employer portion of social security tax for 2020, which will be due in 50% increments, with the first due by December 31, 2021 and the second 50% due by December 31, 2022. As of December 31, 2020, we deferred $51.9 million of social security tax payments. During the twelve months ended December 31, 2021, we paid $26.8 million of these deferred payments.

During the twelve months ended December 31, 2021, our utilization of contract labor increased due an increase in our clinicians being on quarantine from COVID-19 exposure or potential exposure. This resulted in an increase in overall costs. There is no guarantee that we won't experience such service disruption in the future or a decrease in demand for our services as a result of COVID-19. The rapid development and fluidity of this situation makes it difficult to predict the ultimate impact of COVID-19 on our business and operations. Nevertheless, COVID-19 presents a material uncertainty which could materially impact our business and results of operations in the future.

Home Health Services

On November 2, 2021, CMS released the final rule for the calendar year 2022 to update base payment rates by 3.2%, which is based on a payment update of 2.6%, a 0.7% increase due to the reduction of the fixed-dollar loss ratio for outliers, and a 0.1% reduction due to the rural add-on percentages mandated by the Bipartisan Budget Act of 2018. The base 30 day payment rate is increased from $1,901.12 to $2,031.64. The final rule expanded the Home Health Value-Based Purchasing ("HHVBP") model nationally, with the first performance year beginning January 1, 2023. Starting in 2025, fee-for-service payments to home health agencies will be adjusted based on the quality of care provided to beneficiaries during the calendar year 2023 performance year.

Hospice

On July 29, 2021, CMS released the final rule for fiscal year 2022 to update payment rates and the wage index. The final hospice payment update is a 2.0% increase to the payment rates. The final rule will apply a 2.7% market basket update and a

0.7 percentage point cut for productivity. In addition, the final rule increases the aggregate cap value of $31,297.61 for fiscal year 2022, as compared to $30,683.93 for fiscal year 2021.

The following are the final fiscal year 2022 base payment rates for various levels of care, which began on October 1, 2021 and will end on September 30, 2022 and fiscal year 2021 base payment rates for various levels of care, which began on October 1, 2020 and ended September 30, 2021 (payment rates for hospice providers not complying with the hospice quality reporting requirements will be 2% lower than the values referenced below):

Description		Fiscal Year 2022 Rate per patient day		Fiscal Year 2021 Rate per patient day
Routine Home Care days 1-60	$	203.40	$	199.25
Routine Home Care days 61+	$	160.74	$	157.49
Continuous Home Care	$	1,462.52	$	1,432.41
Full Rate = 24 hours of care $59.68 = hourly rate for 2021 $60.94 = hourly rate for 2022				
Inpatient Respite Care	$	473.75	$	461.09
General Inpatient Care	$	1,068.28	$	1,045.66

Facility-Based Services

On August 2, 2021, CMS issued a final rule for the fiscal year 2022 Long-Term Care Hospital Prospective Payment System ("LTACH-PPS"), which described that LTACH-PPS payments for fiscal year 2022 will increase by 1.1%. LTACH-PPS payments for fiscal year 2022 for discharges paid using the standard LTACH payment rate will increase by 0.9% due primarily to the annual standard Federal rate update for fiscal year 2022 of 1.9% and 0.8% decrease in high cost outlier payments. LTACH-PPS payments for fiscal year 2022 for discharges paid using the site neutral payment rate will increase by 3%.

Medicare Accountable Care Organizations

The Affordable Care Act established ACOs as a tool to improve quality and lower costs through increased care coordination in the Medicare fee-for-service ("FFS") program, also known as "Original Medicare." The Medicare FFS program covers approximately 70% of the Medicare recipients or approximately 36 million eligible Medicare beneficiaries. ACOs are typically formed as legal entities by groups of doctors and other healthcare providers who endeavor to work together to provide high quality services and care for their patients through three-year contracts with CMS. Provider and beneficiary participation in an ACO is purely voluntary and Medicare beneficiaries retain their current ability to seek treatment from any provider they wish. Beneficiaries are assigned to ACOs using an "attribution" model based on a plurality of services provided by the primary care physician. Beneficiaries retain the right to use any doctor or hospital who accepts Medicare, at any time.

CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare FFS beneficiaries and to reduce costs. Eligible providers, hospitals, and suppliers may participate in the MSSP by creating, participating in or contracting with an ACO. The MSSP is designed to improve beneficiary outcomes and increase value of care by (1) promoting accountability for the care of Medicare FFS beneficiaries, (2) requiring coordinated care for all services provided under Medicare FFS, and (3) encouraging investment in infrastructure and redesigned care processes. The MSSP will reward ACOs that provide healthcare services at a cost for the ACO's patients during a relevant measurement year that is below the ACO's benchmark costs established by CMS, while also meeting performance standards on quality of care. Under the final MSSP rules, Medicare is to reimburse individual providers and suppliers for specific items and services as Medicare currently does under the FFS payment methodologies. MSSP rules require CMS to develop a benchmark for savings to be achieved by each ACO, if the ACO is to receive shared savings or for ACOs that have elected to accept responsibility for losses. An ACO that meets the program's quality performance standards will be eligible to receive a share of the savings to the extent its assigned beneficiary medical expenditures are below its own medical expenditure benchmark provided by CMS. The Company's HCI services provides specialized management services to ACOs, and in return, the Company shares in any MSSP payments received by the ACO.

Operational Data

This section of this Annual Report on Form 10-K generally discusses 2021 and 2020 items and year-to-year comparisons between 2021 and 2020. Discussions of 2019 items and year-to-year comparisons between 2020 and 2019 that are not

included in this Annual Report on Form 10-K can be found in "Management's Discussion and Analysis of Financial Condition and Results of Operations" in Part II, Item 7 of the Company's Annual Report on Form 10-K for the fiscal year ended December 31, 2020 filed on February 26, 2021.

The following table sets forth, for the period indicated, each of our segment's data regarding census, admissions, billable hours and patient days:

	Three Months Ended March 31, 2021	Three Months Ended June 30, 2021	Three Months Ended September 30, 2021	Three Months Ended December 31, 2021
Home Health:				
Average census	83,938	85,554	84,258	86,228
Average Medicare census	45,237	45,134	43,675	43,325
Admissions	107,922	109,082	108,492	111,141
Medicare admissions	54,413	54,990	52,527	51,983
Hospice:				
Average census	4,457	4,454	5,697	7,024
Average Medicare census	4,163	4,173	5,334	6,516
Admissions	5,577	4,967	6,466	7,516
Medicare admissions	4,910	4,475	5,752	6,615
Patient days	401,119	405,339	524,099	646,231
Home and Community-Based:				
Billable hours	1,901,281	1,878,138	1,817,711	1,779,057
LTACHs:				
Patient days	21,160	20,199	22,722	22,443

	Three Months Ended March 31, 2020	Three Months Ended June 30, 2020	Three Months Ended September 30, 2020	Three Months Ended December 31, 2020
Home Health:				
Average census	76,978	77,530	82,254	83,686
Average Medicare census	46,093	44,811	47,120	47,219
Admissions	108,182	93,482	104,304	104,440
Medicare admissions	59,880	50,545	55,907	54,968
Hospice:				
Average census	4,290	4,329	4,393	4,320
Average Medicare census	3,996	4,022	4,091	4,032
Admissions	5,060	4,869	5,077	5,454
Medicare admissions	4,528	4,269	4,569	4,809
Patient days	390,369	398,283	404,214	397,456
Home and Community-Based:				
Billable hours	1,985,600	1,921,900	1,942,706	1,884,411
LTACHs:				
Patient days	20,161	23,658	24,275	21,836

Consolidated Results of Operations

The following table sets forth, for the period indicated, our consolidated results (amounts in thousands)

	Year Ended December 31,	
	2021	2020
Consolidated Services Data:		
Net service revenue	$ 2,219,622	$ 2,063,204
Cost of service revenue (excluding depreciation and amortization)	1,336,609	1,250,403

Gross margin	883,013	812,801
General and administrative expenses	696,435	632,847
Impairment of intangibles and other	937	1,849
Operating income	185,641	178,105
Interest expense	(4,338)	(4,129)
Income tax expense	37,687	36,043
Income attributable to noncontrolling interests	27,888	26,337
Net income available to LHC Group, Inc.'s common stockholders	$ 115,728	$ 111,596

The following table sets forth our consolidated results as a percentage of net service revenue, except income tax expense, which is presented as a percentage of income attributable to LHC Group, Inc's common stockholders:

	Year Ended December 31,	
	2021	2020
Consolidated Services Data:		
Cost of service revenue (excluding depreciation and amortization)	60.2 %	60.6 %
Gross margin	39.8	39.4
General and administrative expenses	31.4	30.7
Impairment of intangibles and other	0.1	0.1
Operating income	8.4	8.6
Interest expense	(0.2)	(0.2)
Income tax expense	24.6	24.4
Income attributable to noncontrolling interests	1.3	1.3
Net income attributable to LHC Group, Inc.'s common stockholders	5.2	5.4

Consolidated net service revenue for the year ended December 31, 2021 was $2.22 billion compared to $2.06 billion for the same period in 2020, an increase of $156.4 million, or 7.6%.

Consolidated net service revenue was comprised of the following for the periods ending December 31:

Segment	2021	2020
Home Health	69.9 %	71.0 %
Hospice	14.0	11.8
Home and Community-Based	8.5	9.4
Facility-Based	6.0	6.2
Healthcare Innovations	1.6	1.6
	100.0 %	100.0 %

The following table sets forth each of our segment's revenue growth or loss, along with key applicable statistical data, for the twelve months ended December 31, 2021 and the related change from the same period in 2020 (amounts in thousands, except statistical data, and revenue excludes implicit price concessions):

	Organic (1)	Organic Growth (Loss)%	Acquired (2)	Total	Total Growth (Loss) %
Home Health					
Revenue	$ 1,558,387	6.0 %	$ 18,980	$ 1,577,367	6.5 %
Revenue Medicare	$ 958,064	(1.3)	$ 14,300	$ 972,364	(0.7)
New admissions	429,959	5.5	6,678	436,637	6.4
New Medicare admissions	211,480	(3.7)	2,433	213,913	(3.3)
Average census	84,160	5.8	835	84,995	6.1
Average Medicare census	43,809	(4.6)	533	44,342	(4.2)

Home health episodes		333,750	(2.4)		5,315	339,065	(3.2)
Hospice							
Revenue	$	252,877	1.9	$	64,902	$ 317,779	28.6
Revenue Medicare	$	234,161	2.5	$	59,775	$ 293,936	29.3
New admissions		20,483	0.5		4,043	24,526	20.6
New Medicare admissions		18,295	0.8		3,457	21,752	20.0
Average census		4,301	(1.1)		1,107	5,408	24.5
Average Medicare census		4,033	(0.5)		1,014	5,047	24.7
Patient days		1,570,958	(1.4)		405,830	1,976,788	24.3
Home and Community-Based							
Revenue	$	190,087	(5.0)	$	1,015	$ 191,102	(5.8)
Billable hours		7,326,316	(3.8)		49,871	7,376,187	(4.6)
Facility-Based							
LTACHs							
Revenue	$	125,342	3.2	$	1,758	$ 127,100	2.9
Patient days		83,292	(6.6)		3,232	86,524	(4.7)
Other facility-based							
Revenue	$	8,126	(10.4)	$	—	$ 8,126	(10.4)
Healthcare Innovations							
Revenue	$	35,940	5.3	$	—	$ 35,940	5.3
Consolidated							
Revenue	$	2,170,759	4.3 %	$	86,655	$ 2,257,414	7.6 %

(1) Organic - combination of same store, a location that has been in service with us for greater than 12 months, and de novo, an internally developed location that has been in service for 12 months or less.
(2) Acquired - purchased locations that have been in service with us 12 months or less.

Organic growth is primarily generated by population growth in areas covered by mature agencies and by increased market share in acquired and developing agencies. Historically, acquired agencies have the highest growth in admissions and average census in the first 24 months after acquisition, and have the highest contribution to organic growth, measured as a percentage of growth, in the second full year of operation after the acquisition.

Cost of Service Revenue

The following table summarizes cost of service revenue (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

	2021		2020	
Home Health				
Salaries, wages, and benefits	$ 819,041	52.8 %	$ 756,483	51.7 %
Transportation	37,416	2.4	36,874	2.5
Supplies and services	45,228	2.9	55,306	3.8
Total	$ 901,685	58.1 %	$ 848,663	58.0 %
Hospice				
Salaries, wages, and benefits	$ 142,070	45.6 %	$ 107,539	44.1 %
Transportation	9,204	3.0	7,572	3.1
Supplies and services	43,621	14.0	35,564	14.6
Total	$ 194,895	62.6 %	$ 150,675	61.8 %
Home and Community-Based				
Salaries, wages, and benefits	$ 134,852	71.1 %	$ 145,150	74.6 %

Transportation		1,681	0.9		1,830	0.9
Supplies and services		1,319	0.7		3,398	1.7
Total	$	137,852	72.7 %	$	150,378	77.2 %
Facility-Based						
Salaries, wages, and benefits	$	66,067	50.0 %	$	62,360	48.5 %
Transportation		68	0.1		113	0.1
Supplies and services		23,135	17.5		23,354	18.2
Total	$	89,270	67.6 %	$	85,827	66.8 %
Healthcare Innovations						
Salaries, wages, and benefits	$	12,620	35.8 %	$	14,299	44.1 %
Transportation		220	0.6		264	0.8
Supplies and services		67	0.2		297	0.9
Total	$	12,907	36.6 %	$	14,860	45.8 %
Consolidated						
Salaries, wages, and benefits	$	1,174,650	52.9 %	$	1,085,831	52.6 %
Transportation		48,589	2.2		46,653	2.3
Supplies and services		113,370	5.1		117,919	5.7
Total	$	1,336,609	60.2 %	$	1,250,403	60.6 %

Consolidated cost of service revenue for the year ended December 31, 2021 was $1.34 billion compared to $1.25 billion for the same period in 2020, an increase of approximately $86.2 million, or 6.9%. During 2021, cost of service revenue was impacted by:

- an increase in our home health segment of nursing contract labor due to the high number of clinicians in quarantine for COVID-19.
- our acquisition activity in 2021 in the hospice segment increased net service revenue and total costs.
- a decrease in billable hours in our home and community-based segment due to lower patient volumes, which decreased net service revenue and total costs.
- an overall decrease in supplies as we incurred substantial costs in 2020 to acquire needed personal protective equipment to protect our clinicians during the start of the global pandemic. We continue to purchase additional personal protective equipment; however, we are observing an overall decline in utilization and an overall price per unit decline for these supplies.

General and Administrative Expenses

The following table summarizes general and administrative expenses (amounts in thousands, except percentages, which are percentages of the segment's respective net service revenue):

		2021			2020	
Home Health						
General and administrative	$	489,092	31.5 %	$	452,232	30.9 %
Depreciation and amortization		12,040	0.8		12,336	0.8
Total	$	501,132	32.3 %	$	464,568	31.7 %
Hospice						
General and administrative	$	86,781	27.9 %	$	64,369	26.4 %
Depreciation and amortization		2,912	0.9		2,085	0.9
Total	$	89,693	28.8 %	$	66,454	27.3 %
Home and Community-Based						
General and administrative	$	45,062	23.8 %	$	43,789	22.5 %
Depreciation		1,662	0.9		1,654	0.9
Total	$	46,724	24.7 %	$	45,443	23.4 %

Facility-Based					
General and administrative	$	41,975	31.8 %	$	39,464	30.7 %
Depreciation and amortization		3,329	2.5		3,971	3.1
Total	$	45,304	34.3 %	$	43,435	33.8 %
Healthcare Innovations					
General and administrative	$	12,608	35.8 %	$	11,744	36.2 %
Depreciation		974	2.8		1,203	3.7
Total	$	13,582	38.6 %	$	12,947	39.9 %
Consolidated					
General and administrative	$	675,518	30.4 %	$	611,598	29.6 %
Depreciation		20,917	0.9		21,249	1.0
Total	$	696,435	31.4 %	$	632,847	30.7 %

Consolidated general and administrative expenses for the year ended December 31, 2021 were $696.4 million compared to $632.8 million for the same period in 2020, an increase of approximately $63.6 million, or 10.0%. Our general and administrative expenses increased due to continued investments in our technology infrastructure and increased costs related to the completion of certain acquisitions during the latter part of 2020 and the twelve months ended 2021.

Income Tax Expense

Consolidated income tax expense for the year ended December 31, 2021 was $37.7 million compared to $36.0 million for the same period in 2020. The increase in income tax expense was primarily attributable to the increase in our results of operations in 2021 as compared to 2020.

Liquidity and Capital Resources

Our cash balance at December 31, 2021 was $9.8 million, compared to $286.6 million at December 31, 2020. The $276.8 million decrease in our cash position was due to $211.5 million recoupment of CAAP, $93.3 million payment to the government for the Provider Relief Fund, $26.8 million payment of deferred payroll taxes related to the CARES Act and offset with additional proceeds from our line of credit.

At December 31, 2021, we had $217.8 million of available liquidity from cash and our revolving credit facility, net of $106.5 million liabilities associated with the CAAP, as compared to December 31, 2020 of $529.9 million of available liquidity from cash and our revolving credit facility, net of $411.2 million liabilities associated with the CAAP and Provider Relief Fund. At December 31, 2021, we have additional capacity in our revolving credit facility of $300.0 million per our accordion expansion. Based on our current plan of operations, including acquisitions, we believe this amount, when combined with expected cash flows from operations, will be sufficient to fund our growth strategy and to meet our anticipated operating expenses, capital expenditures, and debt service obligations for at least the next 12 months.

Liquidity

Our reported cash flows are affected by various external and internal factors, including the following:

- ***Operating Results*** – Our net income has a significant effect on our operating cash flows. Any significant increase or decrease in our net income could have a material effect on our operating cash flows.

- ***Timing of Acquisitions*** – We use a portion of our operating and/or financing cash flows for acquisitions. When the acquisitions occur at or near the end of a period, our cash outflows significantly increase.

- ***Timing of Payroll*** – Some of our employees are paid bi-weekly on Fridays, while others are paid weekly on Fridays. Operating cash outflows increase in reporting periods that end on a Friday.

- ***Self-Insurance Plan Funding*** – We are self-funded for health insurance and workers compensation insurance. Any significant changes in the amount of insurance claims submitted could have a direct effect on our operating cash flows.

Cash used in investing activities primarily relates to acquisitions of home nursing, hospice agencies, and LTACHs, while cash used by financing activities primarily relates to borrowings or payments on outstanding debt agreements and payments to our noncontrolling interest partners.

The following table summarizes changes in cash flows (amounts in thousands)

	Year Ended December 31,	
	2021	2020
Net cash provided by (used in):		
Operating activities	$ (100,332)	$ 529,247
Investing activities	(607,778)	(82,500)
Financing activities	431,350	(191,850)
Change in cash	$ (276,760)	$ 254,897
Cash at beginning of period	286,569	31,672
Cash at end of period	$ 9,809	$ 286,569

The CARES Act provided additional cash during the twelve months ended December 31, 2020 and increased our net cash provided by operating activities by $318 million of CAAP and $51.9 million payment deferral of our portion of social security payroll tax. This was offset by use of increased prepaid medical supplies due to the need of obtaining personal protective equipment to our clinicians and increased costs of salaries, wages and benefits associated with the increased staffing demands associated with our response to COVID-19.

In 2021, CMS recouped $211.5 million of CAAP and we returned $93.3 million of Provider Relief Funds and $26.8 million of deferred payroll taxes back to the government. In addition, we paid $569.6 million for acquisitions and $74.5 million for our share repurchase plan.

Credit Facility

On March 30, 2018, we entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018. The Credit Agreement provided a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $500.0 million, which includes an additional $200.0 million accordion expansion feature, and a letter of credit sub-limit equal to $50.0 million. The expiration date of the Credit Agreement was March 30, 2023. On August 3, 2021, we entered into an Amended and Restated Senior Credit Facility (the "2021 Amended Credit Agreement"), which amends and restates in its entirety the Credit Agreement. The 2021 Amended Credit Agreement provided a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $800.0 million, which included an additional $500.0 million accordion expansion, and a letter of credit sub-limit equal to $75.0 million. On December 31, 2021, the aggregate commitment was increased to a maximum borrowing limit of $1.0 billion, with an additional $300.0 million accordion expansion. Our obligations under the 2021 Amended Credit Agreement are secured by substantially all of the assets of the Company and its wholly-owned subsidiaries, which assets include the Company's equity ownership of its wholly-owned subsidiaries and its equity ownership in joint venture entities. Our wholly-owned subsidiaries also guarantee the obligations of the Company under the 2021 Amended Credit Agreement.

Revolving loans under the 2021 Amended Credit Agreement bear interest at, as selected by us, either a (i) the prevailing London Interbank Offered Rate ("LIBOR") (with interest periods of one, three, or six months at the Company's option) plus a spread of 1.25% to 2.00% based on our quarterly consolidated Leverage Ratio or (ii) the prevailing prime or base rate plus a spread of 0.25% to 1.00% based on our quarterly consolidated Leverage Ratio. Swing line loans bear interest at the Base Rate. We are limited to 15 Eurodollar borrowings outstanding at any time. We are required to pay a commitment fee for the unused commitments at rates ranging from 0.15% to 0.30% per annum depending upon our quarterly consolidated Leverage Ratio. The Base Rate at December 31, 2021 was 3.75% and the Eurodollar Rate was 1.63%. As of December 31, 2021, the effective interest rate on outstanding borrowings under the 2021 Amended Credit Agreement was 1.81%.

On March 5, 2021, the ICE Benchmark Administration, the administrator of LIBOR, announced its intention to cease the publication of LIBOR settings for 1-month, 3-month, 6-month, and 12-month LIBOR borrowings immediately on June 30, 2023. JPMorgan Chase Bank, N.A will transition our 2021 Amended Credit Agreement to an alternate rate to CME Term SOFR Reference Rate ("SOFR"), which is administered by CME Group Benchmark Administration Ltd ("CME"). Due to the differences observed between LIBOR rates and SOFR published rates, JPMorgan Chase Bank, N.A. will use a credit spread adjustment ("CSA") in order to minimize value transfer and leave the existing margin applicable to our 2021

Amended Credit Agreement. The CSA used by JPMorgan Chase Bank, N.A. is based on the average of the differences between LIBOR and SOFR over a 12-month period and will be added to SOFR.

At December 31, 2021, we had $661.2 million drawn, letters of credit in the amount of $24.3 million outstanding under the credit facility, and $314.5 million remaining borrowing capacity available under the 2021 Amended Credit Agreement. At December 31, 2020, we had $20.0 million drawn and letters of credit outstanding in the amount of $25.4 million under our Credit Facility.

Under the terms of the 2021 Amended Credit Agreement, we are required to maintain certain financial ratios and comply with certain financial covenants. The 2021 Amended Credit Agreement permits us to make certain restricted payments, such as purchasing shares of its stock, within certain parameters, provided we maintain compliance with those financial ratios and covenants after giving effect to such restricted payments. We were in compliance with its debt covenants under the 2021 Amended Credit Agreement at December 31, 2021.

Borrowings accrue interest under the Credit Agreement at either the Base Rate or Eurodollar rate are subject to the applicable margins as set forth below:

Leverage Ratio	Eurodollar Margin	Base Rate Margin	Commitment Fee Rate
≤ 1.00:1.00	1.25 %	0.25 %	0.15 %
>1.00:1.00 ≤ 2.00:1.00	1.50 %	0.50 %	0.20 %
>2.00:1.00 ≤ 3.00:1.00	1.75 %	0.75 %	0.25 %
>3.00:1.00	2.00 %	1.00 %	0.30 %

Our 2021 Amended Credit Agreement contains customary affirmative, negative and financial covenants, which are subject to customary carve-outs, thresholds, and materiality qualifiers. These include bankruptcy and other insolvency events, cross-defaults to other debt agreements, a change in control involving us or any subsidiary guarantor and the failure to comply with certain covenants. The Credit Facility allows us to make certain restricted payments within certain parameters provided we maintain compliance with those financial ratios and covenants after giving effect to such restricted payments or, in the case of repurchasing shares of its stock, so long as such repurchases are within certain specified baskets.

At December 31, 2021, we were in compliance with all debt covenants contained in the Credit Agreement governing our credit facility.

Off-Balance Sheet Arrangements

We currently do not have any off-balance sheet arrangements with unconsolidated entities, financial partnerships or entities often referred to as structured finance or special purpose entities, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. In addition, we do not engage in trading activities involving non-exchange traded contracts. As such, we are not materially exposed to any financing, liquidity, market or credit risk that could arise if we had engaged in these relationships.

Recently Issued Accounting Pronouncements

For a discussion of recently issued accounting pronouncements, see Note 2 of the Notes to Consolidated Financial Statements included in this Annual Report on Form 10-K, which is incorporated herein by reference.

Critical Accounting Policies

The following discussion describes our critical accounting policy, which we believe requires the most significant judgment and estimates used in the preparation of our consolidated financial statements.

The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported revenue and expenses during the reporting period. Changes in the accounting estimates are reasonably likely to occur from period to period. Accordingly, actual results could differ materially from our estimates. To the extent that there are material differences between these estimates and actual results, our financial condition or results of operations will be affected. We base our estimates on past experience and other assumptions that we believe are reasonable under the circumstances and we evaluate these estimates on an ongoing basis.

Revenue Recognition

For a detailed discussion of revenue recognition, see Part I, Item 1. Reimbursement in this Annual Report on Form 10-K which is incorporated here by reference.

Net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under our contracts by transferring the requested services to our patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided in accordance with ASU 2014-09, *Revenue from Contracts with Customers ("Topic 606")* and ASU 2015-14, *Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date* (collectively, "ASC 606").

Net service revenue is recognized as performance obligations are satisfied, which can vary depending on the type of services provided. The performance obligation is the delivery of patient care in accordance with the requested services outlined in physicians' orders, which are based on specific goals for each patient.

The performance obligations are associated with contracts in duration of less than one year; therefore, the optional exemption provided by ASC 606 was elected resulting in us not being required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied as of the end of the reporting period. Our unsatisfied or partially unsatisfied performance obligations are primarily completed when the patients are discharged and typically occur within days or weeks of the end of the period.

We determine the transaction price based on gross charges for services provided, reduced by explicit price concessions and estimates of implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (i.e. change in credit risk) are recorded as a provision for doubtful accounts within general and administrative expenses.

Explicit price concessions are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third party payors and others for services provided.

Implicit price concessions are recorded for self-pay, uninsured patients and other payors by major payor class based on historical collection experience and current economic conditions, representing the difference between amounts billed and amounts expected to be collected. We assess our ability to collect for the healthcare services provided at the time of patient admission based on the verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs.

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

The following table sets forth the percentage of net service revenue earned by category of payor for the respective years ending December 31:

Payor	2021	2020	2019
Medicare	59.8 %	62.1 %	64.1 %
Medicaid	3.1	2.5	2.9
Other	37.1	35.4	33.0
	100.0 %	100.0 %	100.0 %

Medicare

The following describes the payment models in effect during the twelve months-ended December 31, 2021. Such payment models have been subject to temporary adjustments made by CMS in response to COVID-19 pandemic as described elsewhere in this Annual Report on Form 10-K.

Home Health Services

We record revenue as services are provided under PDGM. For each 30-day period, the patient is classified into one of 432 home health resource groups prior to receiving services. Each 30-day period is placed into a subgroup falling under the following categories: (i) timing being early or late, (ii) admission source being community or institutional, (iii) one of 12 clinical groupings based on the patient's principal diagnosis, (iv) functional impairment level of low, medium, or high, and (v) a co-morbidity adjustment of none, low, or high based on the patient's secondary diagnoses.

Each 30-day period payment from Medicare reflects base payment adjustments for case-mix and geographic wage differences.In addition, payments may reflect one of three retroactive adjustments to the total reimbursement: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment whereby the number of visits is dependent on the clinical grouping; and/or (c) a partial payment if the patient transferred to another provider or from another provider before completing the episode. The retroactive adjustments outlined above are recognized in net service revenue when the event causing the adjustment occurs and during the period in which the services are provided to the patient. We review these adjustments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustments is subsequently resolved. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

We record revenue based upon the date of service at amounts equal to the estimated payment rates. We receive one of four predetermined daily rates based upon the level of care provided by us, which can be routine care, general inpatient care, continuous home care and respite care. There are two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, we may also receive a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse or medical social worker for patients in a routine level of care.

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

Adjustments to Medicare revenue are made from regulatory reviews, audits, billing reviews and other matters. We estimate the impact of these adjustments based on our historical experience.

We are subject to variable consideration through an inpatient cap limit and an overall Medicare payment cap for each provider number. The inpatient cap relates to individual programs receiving more than 20% of their total Medicare reimbursement from inpatient care services, and the overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a "cap amount", determined by Medicare to be payment equal to 12 months of hospice care for the aggregate base of hospice patients, indexed for inflation. The determination for each cap is made annually based on the 12-month period ending on September 30 of each year. We monitor our limits on a provider-by-provider basis and record estimates of our liability for reimbursements in excess of the cap amount, if any, in the reporting period.

Facility-Based Services

Long-Term Acute Care Services

Gross revenue is recorded as services are provided under the LTACH prospective payment system. Each patient is assigned a long-term care diagnosis-related group. Payments are made at a predetermined fixed amount intended to reflect the average cost of treating a Medicare LTACH patient classified in that particular long-term care diagnosis-related group. For selected LTACH patients, the amount may be further adjusted based on length-of-stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently re-admitted, among other factors. We calculate the adjustments based on historical averages of these types of adjustments for LTACH claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Net service revenue adjustments resulting from reviews and audits of Medicare cost report settlements are considered implicit price concessions for LTACHs and are measured at expected value.

Medicaid, managed care and other payors

Other sources of net service revenue for all our segments fall into Medicaid, managed care or other payors of our services. Our Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as services are provided based on this fee schedule. Our managed care and other payors reimburse us based upon a predetermined fee schedule or an episodic basis, depending on the terms of the applicable contract. Accordingly, we recognize revenue from managed care and other payors as services are provided, such costs are incurred, and estimates of expected payments are known for each different payor, thus our revenue is recorded at the estimated transaction price.

Healthcare Innovations Services

The Company's HCI segment provides strategic health management services to ACOs that have been approved to participate in the MSSP. The HCI segment has service agreements with ACOs that provide for sharing of MSSP payments received by the ACO, if any. ACOs are legal entities that contract with CMS to provide services to the Medicare fee-for-service population for a specified annual period with the goal of providing better care for individuals, improving health for populations and lowering costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The generation of shared savings is the performance obligation of each ACO, which only become certain upon the final issuance of unembargoed calculations by CMS, generally in the third quarter of each year. During the years ended December 31, 2021 and 2020, the HCI segment recorded net service revenue of $12.1 million and $9.6 million, respectively, related to the 2020 and 2019 ACO respective service periods, as certain ACO's served by the HCI segment received unembargoed calculations from CMS confirming the performance obligation had been met.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk.

Our exposure to market risk relates to fluctuations in interest rates from borrowings under the credit facility. Our letter of credit fees and interest accrued on our debt borrowings are subject to the applicable Eurodollar Rate or Base Rate. A hypothetical 100 basis point increase in interest rates on the average daily amounts outstanding under the credit facility would have increased interest expense by $4.6 million and $1.0 million for the years ended December 31, 2021 and 2020, respectively.

Item 8. Financial Statements and Supplementary Data.

The consolidated financial statements and financial statement schedules in Part IV, Item 15. Exhibits, Financial Statement, Schedules of this Annual Report on Form 10-K are incorporated by reference into this Item 8.

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

None.

Item 9A. Disclosure Controls and Procedures.

Evaluation of Disclosure Control and Procedures

The Company maintains disclosure controls and procedures that are designed to ensure that information required to be disclosed by the Company in the reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to the Company's management, including its Chief Executive Officer and Chief Financial Officer, as appropriate to allow timely decisions regarding required disclosure.

Under the supervision and with the participation of the Company's Chief Executive Officer and Chief Financial Officer, the Company's management evaluated the effectiveness of the Company's disclosure controls and procedures as of December 31, 2021. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) under the Exchange Act, means controls and other procedures of an issuer that are designed to ensure that information required to be disclosed by an issuer in the reports that it files or submits under the Exchange Act, is recorded, processed, summarized, and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by an issuer in the reports that it files or submits under the Exchange Act is accumulated and communicated to the issuer's management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated,

can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on that evaluation, the Company's Chief Executive Officer and its Chief Financial Officer concluded that the Company's disclosure controls and procedures were effective as of December 31, 2021.

Management's Annual Report on Internal Control Over Financial Reporting

The Company's management is responsible for establishing and maintaining adequate internal control over financial reporting, as that term is defined in Rule 13a-15(f) of the Exchange Act. Under the supervision and with the participation of our management, including the Company's Chief Executive Officer and Chief Financial Officer, we conducted an evaluation of its internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Based on management's testing and evaluation under the framework in *Internal Control – Integrated Framework,* management concluded that our internal control over financial reporting was effective as of December 31, 2021.

The attestation report of KPMG LLP, the independent registered public accounting firm that audited the financial statements included in this Annual Report on Form 10-K, is included herein.

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 Rule 13a-15(f) of the Exchange Act, during the Company's fiscal quarter ended December 31, 2021 that have materially affected, or are reasonably likely to materially affect, the Company's internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
LHC Group, Inc.:

Opinion on Internal Control Over Financial Reporting

We have audited LHC Group, Inc. and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission. In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of the Company as of December 31, 2021 and 2020, the related consolidated statements of income, changes in stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2021, and the related notes (collectively, the consolidated financial statements), and our report dated February 24, 2022 expressed an unqualified opinion on those consolidated financial statements.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audit also included performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ KPMG LLP
KPMG LLP

Baton Rouge, Louisiana
February 24, 2022

Item 9B. Other Information.

None noted.

PART III

Item 10. Directors, Executive Officers and Corporate Governance.

The information required by this Item 10 regarding our directors and executive officers is incorporated by reference from the information contained under the heading "Information About Directors, Nominees and Management" in the definitive Proxy Statement relating to the Company's 2022 Annual Meeting of Stockholders.

The information required by this Item 10 regarding compliance with Section 16(a) of the Exchange Act is incorporated by reference from the information contained under the heading "Section 16(a) Beneficial Ownership Reporting Compliance" in the definitive Proxy Statement relating to the Company's 2022 Annual Meeting of Stockholders.

The information required by this Item 10 regarding our corporate governance Nominating Committee and Audit Committee is incorporated by reference from the information contained under the heading "The Board of Directors and Corporate Governance" in the definitive Proxy Statement relating to the Company's 2022 Annual Meeting of Stockholders.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees. This code is publicly available in the investor relations area of our website at www.lhcgroup.com. Any substantive amendments to this code, or any waivers granted for any directors or executive officers, including our principal executive officer, principal financial officer, principal accounting officer or controller, will be disclosed on our website and remain available there for at least 12 months. This code of ethics is not incorporated in this report by reference. Copies of our code of ethics will also be provided, without charge, upon written request to Investor Relations at LHC Group, Inc., 901 Hugh Wallis Road South, Lafayette, Louisiana, 70508.

Item 11. Executive Compensation.

The information required by this Item 11 regarding our executive compensation and Compensation Committee is incorporated by reference from the information contained under the heading "Executive Officer Compensation" in the definitive Proxy Statement relating to the Company's 2022 Annual Meeting of Stockholders.

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

The information required by this Item 12 regarding our securities authorized for issuance under equity compensation plans and security ownership of certain beneficial owners and management is incorporated by reference from the information contained under the headings "Security Ownership of Certain Beneficial Owners and Management" in the definitive Proxy Statement relating to the Company's 2022 Annual Meeting of Stockholders.

Equity Compensation Plan Information

The following table provides information as of December 31, 2021, regarding shares of common stock that may be issued under the Company's existing equity compensation plans:

	(a)	(b)	(c)
Plan Category	**Number of Shares to be Issued Upon Exercise of Outstanding Options, Warrants, and Rights**	**Weighted-Average Exercise Price of Outstanding Price of Outstanding Rights**	**Number of Shares Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column a) (1)**
Equity compensation plans approved by Stockholders:	—	$ —	1,851,123

Equity compensation plans not approved by Stockholders:	—	—	—
Total	—	$ —	1,851,123

(1) Includes 1,746,779 shares remaining available for issuance under the LHC Group, Inc. 2018 Long-Term Incentive Plan (all of which are available for issuance pursuant to grants of full-value stock awards) and 104,344 shares remaining available for issuance under the Amended and Restated LHC Group, Inc.'s 2006 Employee Stock Purchase Plan.

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

The information required by this Item 13 regarding transactions with related persons and the independence of our Directors is incorporated by reference from the information contained under the heading “Certain Relationships and Related Transactions” in the definitive Proxy Statement relating to the Company’s 2022 Annual Meeting of Stockholders.

Item 14. Principal Accountant Fees and Services.

Our independent registered public accounting firm is KPMG LLP, Baton Rouge, Louisiana, Auditor Firm ID: 185.

The information required by this Item 14 regarding accounting and audit fees is incorporated by reference from the information contained under the heading “Principal Accountant Fees and Services” in the definitive Proxy Statement relating to the Company’s 2022 Annual Meeting of Stockholders.

PART IV

Item 15. Exhibits, Financial Statement Schedules.

(a) Documents to be filed with Form 10-K:

(1) Financial Statements

(2) Financial Statement Schedules

There are no financial statement schedules included in this report.

(3) Exhibits

The Exhibits are listed in the Index of Exhibits required by Item 601 of Regulation S-K included herewith, which is incorporated by reference.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
LHC Group, Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of LHC Group, Inc. and subsidiaries (the Company) as of December 31, 2021 and 2020, the related consolidated statements of income, changes in stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2021, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2021 and 2020, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2021, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2021, based on criteria established in *Internal Control – Integrated Framework (2013)* issued by the Committee of Sponsoring Organizations of the Treadway Commission, and our report dated February 24, 2022 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

Basis for Opinion

These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

The critical audit matter communicated below is a matter arising from the current period audit of the consolidated financial statements that was communicated or required to be communicated to the audit committee and that: (1) relates to accounts or disclosures that are material to the consolidated financial statements and (2) involved our especially challenging, subjective, or complex judgments. The communication of a critical audit matter does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Evaluation of implicit price concessions for the Home Health segment

As discussed in Note 2 to the consolidated financial statements, net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under the contracts by transferring the requested services to patients in amounts that reflect the consideration which is expected to be received in exchange for providing patient care. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. The Company estimates implicit price concessions based on historical collection experience by major payor class. Estimates of implicit price concessions are periodically reviewed to ensure they are reflective of current business and economic conditions and trends and indicative of the Company's historical collections. The Company's net service revenue for the year ended December 31, 2021, was $1,557 million, which is net of implicit price concessions.

We identified the evaluation of implicit price concessions for the Home Health segment as a critical audit matter. A high degree of subjective auditor judgment was required to evaluate the implicit price concessions as they were based on estimated collection rates by major payor class. Specifically, evaluating the estimated transaction prices required knowledge of the payor mix and current business and economic conditions and trends.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the design and tested the operating effectiveness of certain internal controls over the Company's Home Health revenue process, including controls over the data used to support the estimated transaction prices. We assessed the outcome of the estimation of the implicit price concessions for the Home Health segment in the prior period financial statements by comparing a sample of current year collections to prior period accounts receivable to identify any circumstances or conditions that are relevant to the determination of the current year estimate. This assessment included testing a sample of accounts receivable that were written off in the current year. In addition, we evaluated the completeness and accuracy of the Company's collections on Home Health revenue recorded by major payor class by testing a sample of collections to assess the relevance and reliability of the current year estimated transaction prices.

/s/ KPMG LLP
KPMG LLP

We have served as the Company's auditor since 2008.

Baton Rouge, Louisiana
February 24, 2022

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED BALANCE SHEETS
(Amounts in thousands, except share data)

	As of December 31,	
	2021	2020
ASSETS		
Current assets:		
Cash	$ 9,809	$ 286,569
Receivables:		
Patient accounts receivable	348,820	301,209
Other receivables	13,780	11,522
Total receivables	362,600	312,731
Prepaid income taxes	7,531	—
Prepaid expenses	28,401	22,058
Other current assets	24,801	25,664
Total current assets	433,142	647,022
Property, building and equipment, net of accumulated depreciation of $98,394 and $82,721, respectively	153,959	138,366
Goodwill	1,748,426	1,259,147
Intangible assets, net of accumulated amortization of $ 19,152 and $17,659, respectively	400,002	315,355
Assets held for sale	—	1,900
Operating lease right of use asset	113,399	100,046
Other assets	46,693	21,518
Total assets	$ 2,895,621	$ 2,483,354
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and other accrued liabilities	$ 98,118	$ 64,864
Salaries, wages and benefits payable	100,532	88,666
Self insurance reserves	33,784	35,103
Government stimulus advance	—	93,257
Contract liabilities - deferred revenue	106,489	317,962
Current operating lease payable	37,630	32,676
Amounts due to governmental entities	5,447	1,516
Income taxes payable	—	21,464
Current liabilities - deferred employer payroll tax	26,790	25,928
Total current liabilities	408,790	681,436
Deferred income taxes	70,026	47,237
Income taxes payable	7,320	6,203
Revolving credit facility	661,197	20,000
Other long term liabilities	—	25,928
Operating lease payable	78,688	70,275
Total liabilities	1,226,021	851,079
Noncontrolling interest-redeemable	17,501	18,921
Commitments and contingencies		
Stockholders' equity:		
LHC Group, Inc. stockholders' equity:		
Preferred stock – $0.01 par value: 5,000,000 shares authorized; none issued or outstanding	—	—
Common stock – $0.01 par value: 60,000,000 shares authorized; 36,549,524 and 36,355,497 shares issued, and 30,634,414 and 31,139,840 shares outstanding, respectively	365	364
Treasury stock – 5,915,110 and 5,215,657 shares at cost, respectively	(164,790)	(69,011)
Additional paid-in capital	979,642	962,120
Retained earnings	751,025	635,297
Total LHC Group, Inc. stockholders' equity	1,566,242	1,528,770
Noncontrolling interest – non-redeemable	85,857	84,584
Total stockholders' equity	1,652,099	1,613,354
Total liabilities and stockholders' equity	$ 2,895,621	$ 2,483,354

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF INCOME
(Amounts in thousands, except share and per share data)

	For the year ended December 31,		
	2021	2020	2019
Net service revenue	$ 2,219,622	$ 2,063,204	$ 2,080,241
Cost of service revenue (excluding depreciation and amortization)	1,336,609	1,250,403	1,324,887
Gross margin	883,013	812,801	755,354
General and administrative expenses	696,435	632,847	596,006
Impairment of intangibles and other	937	1,849	7,734
Operating income	185,641	178,105	151,614
Interest expense	(4,338)	(4,129)	(11,155)
Income before income taxes and noncontrolling interests	181,303	173,976	140,459
Income tax expense	37,687	36,043	26,607
Net income	143,616	137,933	113,852
Less net income attributable to noncontrolling interests	27,888	26,337	18,126
Net income attributable to LHC Group, Inc.'s common stockholders	$ 115,728	$ 111,596	$ 95,726
Earnings per share - basic:			
Net income attributable to LHC Group, Inc.'s common stockholders	$ 3.71	$ 3.59	$ 3.09
Earnings per share - diluted:			
Net income attributable to LHC Group, Inc.'s common stockholders	$ 3.69	$ 3.56	$ 3.07
Weighted average shares outstanding:			
Basic	31,195,305	31,092,417	30,932,607
Diluted	31,396,658	31,365,765	31,209,824

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands, except share data)

	LHC Group, Inc.									
	Common Stock									
	Issued		Treasury		Additional paid-in capital	Retained earnings	Noncontrolling interest non-redeemable	Total equity	Non controlling interest redeemable	Net income
	Amount	Shares	Amount	Shares						
Balances at December 31, 2018	$ 358	35,835,348	$ (49,373)	5,029,429	$ 937,965	$ 427,975	$ 107,549	$ 1,424,474	$ 14,596	
Net income	—	—	—	—	—	95,726	6,855	102,581	11,271	113,852
Acquired noncontrolling interest	—	—	—	—	—	—	10,478	10,478	—	
Purchase of additional controlling interest	—	—	—	—	(2,183)	—	(18,382)	(20,565)	—	
Sale of noncontrolling interest	—	—	—	—	819	—	794	1,613	—	
Noncontrolling interest distributions	—	—	—	—	—	—	(13,366)	(13,366)	(10,716)	
Nonvested stock compensation	—	—	—	—	9,646	—	—	9,646	—	
Issuance of vested stock	2	210,986	—	—	—	—	—	2	—	
Treasury shares redeemed to pay income tax	—	—	(10,687)	107,461	1,008	—	—	(9,679)	—	
Exercise of stock options	1	63,051	—	—	—	—	—	1	—	
Issuance of common stock under Employee Stock Purchase Plan	—	19,895	—	—	2,066	—	—	2,066	—	
Balances at December 31, 2019	$ 361	36,129,280	$ (60,060)	5,136,890	$ 949,321	$ 523,701	$ 93,928	$ 1,507,251	$ 15,151	
Net income	—	—	—	—	—	111,596	12,150	123,746	14,187	137,933
Acquired noncontrolling interest	—	—	—	—	—	—	5,854	5,854	3,508	
Purchase of additional controlling interest	—	—	—	—	(1,709)	—	(22,204)	(23,913)	(382)	
Sale of noncontrolling interest	—	—	—	—	(860)	—	6,150	5,290	—	
Noncontrolling interest distributions	—	—	—	—	—	—	(11,294)	(11,294)	(13,543)	
Nonvested stock compensation	—	—	—	—	14,347	—	—	14,347	—	
Issuance of vested stock	3	195,618	—	—	—	—	—	3	—	
Treasury shares redeemed to pay income tax	—	—	(9,202)	71,439	—	—	—	(9,202)	—	
Exercise of stock options	—	16,286	251	7,328	(1,156)	—	—	(905)	—	
Issuance of common stock under Employee Stock Purchase Plan	—	14,313	—	—	2,177	—	—	2,177	—	
Balances at December 31, 2020	$ 364	36,355,497	$ (69,011)	5,215,657	$ 962,120	$ 635,297	$ 84,584	$ 1,613,354	$ 18,921	
Net income	—	—	—	—	—	115,728	15,945	131,673	11,943	143,616
Acquired noncontrolling interest	—	—	—	—	—	—	—	—	113	
Purchase of additional controlling interest	—	—	—	—	(951)	—	(789)	(1,740)	(373)	
Sale of noncontrolling interest	—	—	—	—	(83)	—	1,871	1,788	—	
Noncontrolling interest distributions	—	—	—	—	—	—	(15,754)	(15,754)	(13,103)	
Nonvested stock compensation	—	—	—	—	15,868	—	—	15,868	—	
Issuance of vested stock	1	180,235	—	—	—	—	—	1	—	
Treasury shares redeemed to pay income tax			(12,043)	64,584	216	—	—	(11,827)	—	
Repurchase of common stock	—	—	(83,736)	634,869	—	—	—	(83,736)	—	

Issuance of common stock under Employee Stock Purchase Plan	—	13,792	—	—	2,472	—	—	2,472	—
Balances at December 31, 2021	$ 365	36,549,524	$ (164,790)	5,915,110	$ 979,642	$ 751,025	$ 85,857	$ 1,652,099	$ 17,501

See accompanying Notes to the Consolidated Financial Statements

LHC GROUP, INC. AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(Amounts in thousands)

	For the year ended December 31,		
	2021	**2020**	**2019**
Operating activities:			
Net income	$ 143,616	$ 137,933	$ 113,852
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization expense	20,917	21,249	18,254
Amortization and impairment of operating lease right of use asset	37,506	34,546	33,368
Stock-based compensation expense	15,868	14,347	9,646
Deferred income taxes	22,789	(13,261)	18,400
(Gain) loss on disposal of assets	(1,134)	412	802
Impairment of intangibles and other	937	1,849	7,734
Changes in operating assets and liabilities, net of acquisitions:			
Receivables	(35,361)	(16,561)	(38,907)
Prepaid expenses	(5,902)	(754)	3,530
Other assets	(11,015)	(3,169)	(2,923)
Prepaid income taxes	(7,531)	9,652	(78)
Accounts payable and accrued expenses	12,345	(22,506)	(457)
Salaries, wages, and benefits payable and self-insurance reserves	3,004	6,482	(2,625)
Other long term liabilities	(26,758)	51,856	—
Contract liabilities - deferred revenue	(211,473)	317,962	—
Operating lease payable	(37,360)	(34,226)	(28,062)
Income tax payable	(20,347)	23,800	(431)
Net amounts due to/from governmental entities	(433)	(364)	(1,641)
Net cash (used in) provided by operating activities	(100,332)	529,247	130,462
Investing activities:			
Cash paid for acquisitions, net of cash acquired	(569,583)	(24,545)	(74,293)
Minority interest investments	(10,100)	—	—
Proceeds from sale of assets	3,350	7,920	—
Proceeds from sale of an entity	1,531	—	—
Purchases of property, building and equipment	(32,976)	(65,875)	(33,609)
Net cash used in investing activities	(607,778)	(82,500)	(107,902)
Financing activities:			
Proceeds from line of credit	1,025,559	296,229	267,000
Payments on line of credit	(384,362)	(529,229)	(249,000)
Government stimulus advance	(93,257)	93,257	—
Proceeds from employee stock purchase plan	2,472	2,177	2,066
Payments on debt	—	—	(7,650)
Payments on deferred financing fees	(3,556)	—	—
Payments on repurchasing common stock	(74,643)	—	—
Noncontrolling interest distributions	(28,857)	(24,837)	(24,082)
Purchase of additional controlling interest	(2,113)	(24,295)	(19,663)
Sale of noncontrolling interest	1,934	4,856	756
Withholding taxes paid on stock-based compensation	(11,827)	(10,008)	(10,687)
Exercise of options	—	—	1,009
Net cash provided by (used in) financing activities	431,350	(191,850)	(40,251)
Change in cash	(276,760)	254,897	(17,691)
Cash at beginning of period	286,569	31,672	49,363
Cash at end of period	$ 9,809	$ 286,569	$ 31,672

Supplemental disclosures of cash flow information			
Interest paid	$ 4,168	$ 5,011	$ 11,015
Income taxes paid	$ 43,728	$ 16,830	$ 10,109
Non-Cash Operating activity:			
Operating right of use assets in exchange for lease obligations	41,364	43,047	129,290
Non-Cash Investing activity:			
Accrued capital expenditures	417	2,922	2,729
Net working capital adjustment	890	—	—
Non-Cash Financing activity:			
Contribution of noncontrolling interest	—	230	—

See accompanying Notes to the Consolidated Financial Statements

1. Organization

LHC Group, Inc. (the "Company") is a health care provider specializing in the post-acute continuum of care. The Company provides services through five segments: home health, hospice, home and community-based services, facility-based services, the latter primarily through long-term acute care hospitals ("LTACHs"), and healthcare innovations ("HCI").

As of December 31, 2021, the Company, through its wholly and majority-owned subsidiaries, equity joint ventures, controlled affiliates, and management agreements, operated 970 service providers in 37 states within the continental United States and the District of Columbia.

COVID-19 Update

SARS-CoV-2 ("COVID-19") continues to spread and various responses related to stay-at-home restrictions, travel restrictions, and other public health and safety measures continue to evolve. We communicate with our clinicians and other employees all updated policies and procedures as we monitor changes related to the pandemic. Policies and procedures related to social distancing and cleaning procedures remain in place as the safety of our patients and employees are vital. The effects of COVID-19 continue to materially impact our business. As a result, operating results for the twelve months ended December 31, 2021 may not be directly comparable to operating results for the twelve months ended December 31, 2020.

CARES Act

In response to COVID-19, the U.S. Government enacted the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") on March 27, 2020. The CARES Act was passed to provide $100 billion of Provider Relief Funds for distribution to eligible providers who provided diagnoses, testing, or care for individuals with a possible or actual case of COVID-19, specifically to reimburse providers for health care related expenses related to the prevention of the spread of COVID-19, preparations for treating cases of COVID-19 positive patients, and for lost revenues attributable to COVID-19. The CARES Act also provided financial hardship relief to Medicare providers impacted by the COVID-19 pandemic in order to provide necessary funds when there is a disruption in Medicare claims submission and/or Medicare claims processing by distributing funds through the Accelerated and Advanced Payments Program ("CAAP").

In addition, the CARES Act suspended the 2% sequestration payment adjustments on Medicare patient claims with dates of service from May 1 through December 31, 2020, suspended the application of site-neutral payment for LTACH admissions that were admitted during the Public Health Emergency ("PHE"), and delayed payment of the employer portion of social security tax. On April 14, 2021, Congress passed legislation to continue the suspension of the 2% sequestration payment adjustments on Medicare patient claims with dates of service through December 31, 2021. On December 10, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act legislation passed, which will continue the suspension of the sequestration payment adjustments for Medicare patient claims with dates of service through March 31, 2022. Medicare patient claims with dates of service between April 1 through June 30, 2022 will have 1% sequestration adjustment and Medicare patient claims with dates of service beginning July 1, 2022 will have 2% sequestration adjustment. On January 14, 2022, the U.S. Department of Health and Human Services extended the PHE until April 15, 2022.

Provider Relief Fund

During the twelve months ended December 31, 2020, the Company received $93.3 million in payments from the Provider Relief Fund, which was recorded as a short-term liability in government stimulus advance in our consolidated balance sheets. The Company returned all Provider Relief Funds received of $93.3 million to the government during the twelve months ended December 31, 2021.

CAAP

During the twelve months ended December 31, 2020, the Company received $318.0 million of accelerated payments under the CAAP, which was recorded in contract liabilities - deferred revenue in our consolidated balance sheets in accordance with Accounting Standards Update ("ASU") 2014-09, *Revenue from Contracts with Customers ("Topic 606")*. On October 1, 2020, the repayment and recoupment terms for CAAP funds were amended by the Continuing Appropriations Act, 2021 and Other Extensions Act, which provides that recoupment will begin one year from the date the CAAP funds were received. The repayment terms begin one year starting from the date the CAAP funds were issued and continues 11 months, with CMS recouping the initial 25% of Medicare payments otherwise owed to the Company. If any amount of CAAP funds that we received from CMS remain unpaid after the initial 11 month period, CMS will recoup 50% of Medicare payments otherwise owed to the Company during the following six months. Interest will begin accruing on any amount of the CAAP funds that we received from CMS that remain unpaid following those recoupment periods. CMS will issue a repayment letter to the

Company for any such outstanding amounts, which must be paid in full within 30 days from the date of the letter. The Company intends to repay the full amount before any interest accrues. During the twelve months ended December 31, 2021, $211.5 million was recouped by CMS and $106.5 million of contract liabilities - deferred revenue remains on our consolidated balance sheets as of December 31, 2021.

Other

During the twelve months ended December 31, 2021 and 2020, the Company recognized $26.8 million and $18.1 million of net service revenue, respectively, due to the suspension of the 2% sequestration payment adjustment. During the twelve months ended December 31, 2021 and 2020, the Company recognized $25.7 million and $19.2 million of net service revenue, respectively, due to the suspension of LTACH site-neutral payments.

As of December 31, 2020, the Company deferred $51.9 million of employer social security taxes and during the twelve months ended December 31, 2021, assumed $1.7 million of such deferred taxes related to acquisitions. During the twelve months ended December 31, 2021, $26.8 million was paid back to the government and $26.8 million was recorded in current liabilities - deferred employer payroll tax on our consolidated balance sheets as of December 31, 2021.

2. Summary of Significant Accounting Policies

Use of Estimates

The preparation of financial statements in conformity with U.S. generally accepted accounting principles ("US GAAP") requires management to make estimates and assumptions that affect the reported amounts of the Company's accompanying consolidated financial statements and notes to the consolidated financial statements. Actual results could differ from those estimates.

A description of the significant accounting policies and a discussion of the significant estimates and judgments associated with such policies are described below.

Principles of Consolidation

The consolidated financial statements include all subsidiaries and entities controlled by the Company through direct ownership of majority interest or controlling member ownership of such entities. Third party equity interests in the consolidated joint ventures are reflected as noncontrolling interests in the Company’s consolidated financial statements.

All significant intercompany accounts and transactions have been eliminated in consolidation. All business combinations accounted for under the acquisition method have been included in the consolidated financial statements from the respective dates of acquisition.

The Company consolidates equity joint venture entities as the Company has controlling interests, has voting control over these entities, or has ability to exercise significant influence in these entities. The members of the Company's equity joint ventures participate in profits and losses in proportion to their equity interests.

The Company, through wholly owned subsidiaries, leases home health licenses necessary to operate certain of its home nursing and hospice agencies. As with wholly owned subsidiaries, the Company owns 100% of the equity of these entities and consolidates them based on such ownership.

Revenue Recognition

Basis of Presentation

Net service revenue from contracts with customers is recognized in the period the performance obligations are satisfied under the Company's contracts by transferring the requested services to patients in amounts that reflect the consideration to which is expected to be received in exchange for providing patient care, which is the transaction price allocated to the services provided in accordance with Topic 606 and ASU 2015-14*, Revenue from Contracts with Customers (Topic 606): Deferral of the Effective Date* (collectively, "ASC 606").

Net service revenue is recognized as performance obligations are satisfied, which can vary depending on the type of services provided. The performance obligation is the delivery of patient care in accordance with the requested services outlined in physicians' orders, which are based on specific goals for each patient.

The performance obligations are associated with contracts in duration of less than one year; therefore, the optional exemption provided by ASC 606 was elected resulting in the Company not being required to disclose the aggregate amount of the transaction price allocated to the performance obligations that are unsatisfied or partially unsatisfied as of the end of the reporting period. The Company's unsatisfied or partially unsatisfied performance obligations are primarily completed when the patients are discharged and typically occur within days or weeks of the end of the period.

The Company determines the transaction price based on gross charges for services provided, reduced by explicit price concessions and estimates for implicit price concessions. Explicit price concessions include contractual adjustments provided to patients and third-party payors. Implicit price concessions include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from regulatory reviews, audits, billing reviews and other matters. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay (i.e. change in credit risk) are recorded as a provision for doubtful accounts within general and administrative expenses.

Explicit price concessions are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third party payors and others for services provided.

Implicit price concessions are recorded for self-pay, uninsured patients and other payors by major payor class based on historical collection experience, and current business and economic conditions, representing the difference between amounts billed and amounts expected to be collected. The Company assesses the ability to collect for the healthcare services provided at the time of patient admission based on the verification of the patient's insurance coverage under Medicare, Medicaid, and other commercial or managed care insurance programs.

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

The following table sets forth the percentage of net service revenue earned by category of payor for each segment for the years ending December 31:

	2021	2020	2019
Home Health:			
Medicare	62.1 %	66.8 %	70.2 %
Managed Care, Commercial, and Other	37.9	33.2	29.8
	100.0 %	100.0 %	100.0 %
Hospice:			
Medicare	94.2 %	93.1 %	92.0 %
Managed Care, Commercial, and Other	5.8	6.9	8.0
	100.0 %	100.0 %	100.0 %
Home and Community-Based:			
Medicaid	31.5 %	21.4 %	23.2 %
Managed Care, Commercial, and Other	68.5	78.6	76.8
	100.0 %	100.0 %	100.0 %
Facility-Based:			
Medicare	49.9 %	55.0 %	56.2 %
Managed Care, Commercial, and Other	50.1	45.0	43.8
	100.0 %	100.0 %	100.0 %
Healthcare Innovations:			
Medicare	12.4 %	19.2 %	21.6 %
Managed Care, Commercial, and Other	87.6	80.8	78.4
	100.0 %	100.0 %	100.0 %

Medicare

The following describes the payment models in effect during the twelve months ended December 31, 2021. Such payment models have been subject to temporary adjustments made by CMS in response to COVID-19 pandemic as described elsewhere in this Annual Report on Form 10-K. The 2% sequestration reduction adjustment was suspended for patient claims with dates of service that began May 1, 2020 through December 31, 2021.

Home Health Services

The Company records revenue as services are provided under the Patient Driven Groupings Model ("PDGM"). For each 30-day period, the patient is classified into one of 432 home health resource groups prior to receiving services. Each 30-day period is placed into a subgroup falling under the following categories: (i) timing being early or late, (ii) admission source being community or institutional, (iii) one of 12 clinical groupings based on the patient's principal diagnosis, (iv) functional impairment level of low, medium, or high, and (v) a co-morbidity adjustment of none, low, or high based on the patient's secondary diagnoses.

Each 30-day period payment from Medicare reflects base payment adjustments for case-mix and geographic wage differences.In addition, payments may reflect one of three retroactive adjustments to the total reimbursement: (a) an outlier payment if the patient's care was unusually costly; (b) a low utilization adjustment whereby the number of visits is dependent on the clinical grouping; and/or (c) a partial payment if the patient transferred to another provider or from another provider before completing the episode. The retroactive adjustments outlined above are recognized in net service revenue when the event causing the adjustment occurs and during the period in which the services are provided to the patient. The Company reviews these adjustments to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustments is subsequently resolved. Net service revenue and related patient accounts receivable are recorded at amounts estimated to be realized from Medicare for services rendered.

Hospice Services

The Company records revenue based upon the date of service at amounts equal to the estimated payment rates. The Company receives one of four predetermined daily rates based upon the level of care provided by the Company, which can be routine care, general inpatient care, continuous home care, and respite care. There are two separate payment rates for routine care: payment for the first 60-days of care and care beyond 60-days. In addition to the two routine rates, the Company may also receive a service intensity add-on ("SIA"). The SIA is based on visits made in the last seven days of life by a registered nurse or medical social worker for patients in a routine level of care.

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

Adjustments to Medicare revenue are made from regulatory reviews, audits, billing reviews and other matters. The Company estimates the impact of these adjustments based on our historical experience.

Hospice payments are subject to variable consideration through an inpatient cap and an overall Medicare payment cap. The inpatient cap relates to individual programs receiving more than 20% of its total Medicare reimbursement from inpatient care services and the overall Medicare payment cap relates to individual programs receiving reimbursements in excess of a "cap amount," determined by Medicare to be payment equal to 12 months of hospice care for the aggregate base of hospice patients, indexed for inflation. The determination for each cap is made annually based on the 12-month period ending on September 30 of each year. The Company monitors its limits on a provider-by-provider basis and records an estimate of its liability for reimbursements received in excess of the cap amount, if any, in the reporting period.

Facility-Based Services

Gross revenue is recorded as services are provided under the LTACH prospective payment system. Each patient is assigned a long-term care diagnosis-related group. The Company is paid a predetermined fixed amount intended to reflect the average cost of treating a Medicare LTACH patient classified in that particular long-term care diagnosis-related group. For selected LTACH patients, the amount may be further adjusted based on length-of-stay and facility-specific costs, as well as in instances where a patient is discharged and subsequently re-admitted, among other factors. The Company calculates the adjustment based on a historical average of these types of adjustments for LTACH claims paid. Similar to other Medicare prospective payment systems, the rate is also adjusted for geographic wage differences. Net service revenue adjustments resulting from reviews and audits of Medicare cost report settlements are considered implicit price concessions for LTACHs and are measured at expected value.

Non-Medicare Revenue

Other sources of net service revenue for all segments fall into Medicaid, managed care or other payors of the Company's services. Medicaid reimbursement is based on a predetermined fee schedule applied to each service provided. Therefore, revenue is recognized for Medicaid services as services are provided based on this fee schedule. The Company's managed care and other payors reimburse the Company based upon a predetermined fee schedule or an episodic basis, depending on the terms of the applicable contract. Accordingly, the Company recognizes revenue from managed care and other payors as services are provided, such costs are incurred, and estimates of expected payments are known for each different payer, thus the Company's revenue is recorded at the estimated transaction price.

Contingent Service Revenues

The HCI segment provides strategic health management services to Affordable Care Organizations ("ACOs") that have been approved to participate in the Medicare Shared Savings Program ("MSSP"). The HCI segment has service agreements with ACOs that provide for sharing of MSSP payments received by the ACO, if any. ACOs are legal entities that contract with CMS to provide services to the Medicare fee-for-service population for a specified annual period with the goal of providing better care for the individual, improving health for populations and lowering costs. ACOs share savings with CMS to the extent that the actual costs of serving assigned beneficiaries are below certain trended benchmarks of such beneficiaries and certain quality performance measures are achieved. The generation of shared savings is the performance obligation of each ACO, which only become certain upon the final issuance of unembargoed calculations by CMS, generally in the third quarter of each year. During the years ended December 31, 2021, 2020 and 2019, the HCI segment recorded net service revenue of $12.1 million, $9.6 million and $2.9 million, respectively, related to the 2020, 2019 and 2018 ACO respective service periods, as certain ACOs served by the HCI segment received a MSSP payment from CMS confirming the performance obligation has been met.

Patient Accounts Receivable

The Company reports patient accounts receivable from services rendered at their estimated transaction price, which includes price concessions based on the amounts expected to be due from payors. The Company's patient accounts receivable is uncollateralized and primarily consist of amounts due from Medicare, Medicaid, other third-party payors, and to a lesser degree patients. The credit risk from other payors is limited due to the significance of Medicare as the primary payor. The Company believes the credit risk associated with its Medicare accounts is limited due to (i) the historical collection rate from Medicare and (ii) the fact that Medicare is a U.S. government payor. The Company does not believe that there are any other significant concentrations from any particular payor that would subject it to any significant credit risk in the collection of patient accounts receivable.

The following table sets forth the percentage of patient accounts receivable by payor for the years ended December 31:

	2021	2020
Medicare	60.3 %	55.3 %
Medicaid	7.5	9.2
Managed Care, Commercial, and Other	32.2	35.5
Total patient accounts receivable	100.0 %	100.0 %

Business Combinations

The Company accounts for its acquisitions in accordance with ASC 805, "Business Combinations" ("ASC 805") using the acquisition method of accounting. Assets typically acquired consist primarily of Medicare licenses, trade names, certificates of need, and/or non-compete agreements. The assets acquired and liabilities assumed, if any, are measured at fair value on the acquisition date using the appropriate valuation method. The noncontrolling interest associated with joint venture acquisitions is also measured and recorded at fair value as of the acquisition date. Goodwill represents the excess of the cost of an acquired entity over the net amounts assigned to assets acquired and liabilities assumed. The operations of the acquisitions are included in the consolidated financial statements from their respective dates of acquisition. Acquisition transactions that occurred in 2021 and 2020 are further described in Note 3 and Note 4 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Insurance Programs

The Company bears significant risk under its large-deductible workers' compensation insurance program and its self-insured employee health program. Under the workers' compensation insurance program, the Company bears risk up to $1.0 million per incident, after which stop-loss coverage is maintained. The Company purchases stop-loss insurance for the employee health plan and bear risk up to $0.5 million per incident.

Malpractice and general patient liability claims for incidents which may give rise to litigation have been asserted against the Company by various claimants. The claims are in various stages of processing and some may ultimately be brought to trial. The Company currently carries professional liability insurance coverage on a claims made basis and general liability insurance coverage on an occurrence basis for this exposure with a $0.3 million deductible. The Company also carries Directors and Officers coverage (also on a claims made basis) for potential claims against the Company's directors and officers, including securities actions, with a deductible of $2.5 million.

The Company records estimated liabilities for its insurance programs based on information provided by the third-party plan administrators, historical claims experience, the life cycle of claims, expected costs of claims incurred but not paid, and expected costs to settle unpaid claims. The Company monitors its estimated insurance-related liabilities and recoveries, if any, on a monthly basis and records amounts due under insurance policies in other current assets, while recording the estimated carrier liability in self-insurance reserves. As facts change, it may become necessary to make adjustments that could be material to the Company's results of operations and financial condition.

Goodwill and Intangible Assets

Goodwill

Goodwill represents the excess of amounts paid for acquisitions over the fair value of net identifiable assets acquired less liabilities assumed. The Company assigns assets acquired, including goodwill, and liabilities assumed to one or more reporting units as of the date of the acquisition. The Company's reporting units are home health, hospice, home and community-based, LTACHs, and HCI. The LTACHs are incorporated in the Company's facility-based operating segment. The other locations within the facility-based segment do not share in the economic benefits of the LTACH reporting unit, and as such, are excluded from the annual impairment testing.

Goodwill and purchased intangible assets with indefinite useful live are not amortized. ASC 350, "Intangibles - Goodwill and Other" ("ASC 350") requires that all indefinite-lived intangible assets, such as goodwill, be tested for impairment at least annually or sooner whenever events or changes in circumstances indicate that the asset is impaired. An entity may perform a qualitative assessment to determine whether it is necessary to perform the quantitative impairment test. In assessing whether the asset is impaired, the Company assess all relevant events and circumstances for each of the Company's reporting units.

The Company performs its annual impairment review of goodwill at November 30, and when a triggering event occurs between annual impairment tests. The Company assessed and reviewed factors such as: labor cost; financial performance, such as cash flows and planned revenue; regulatory factors; market considerations, such as market-dependent multiples; and access of capital. For 2021, the Company performed a qualitative assessment of goodwill for its reporting units of home health, hospice, home and community-based, and HCI. The Company performed a quantitative assessment of goodwill for its LTACH reporting unit based on current market considerations and market-dependent multiples. The Company determined that it is not more likely than not that the fair values of its reporting units are less than the carrying amounts. The Company has not recognized any goodwill impairment charges in 2021, 2020 or 2019 related to the annual impairment testing.

Components of the Company's reporting units are collections of markets of similar service offerings that operate collaboratively under a house of brands, i.e. multiple brands are used across markets, states, and segments. The Company recognized an impairment of $0.02 million, $0.5 million and $0.6 million, respectively, for the twelve months ended December 31, 2021, 2020 and 2019 related to goodwill associated with the closure of underperforming locations. The impairments were determined using prices of comparable businesses in respective markets.

Intangible assets: Indefinite-lived assets

The Company also has indefinite-lived assets that are not subject to amortization expense such as trade names, certificates of need, and Medicare licenses to conduct specific operations within geographic markets. The Company has concluded that trade names, certificates of need, and licenses have indefinite lives, because there are no legal, regulatory, contractual, economic or other factors that would limit the useful lives of these intangible assets and the Company intends to renew and operate the certificates of need and licenses and use the trade names indefinitely. In some cases, the value of licenses and certificates of need is increased by moratoriums in effect. These indefinite-lived intangible assets are reviewed annually for impairment or more frequently if circumstances indicate impairment may have occurred. The Company performed a qualitative assessment and determined that it is not more likely than not that the fair values of these assets are less than the carrying amounts. During the twelve months ended December 31, 2021, 2020, and 2019, the Company did not record an impairment charge related to indefinite-lived intangible assets in the annual impairment testing.

During the twelve months ended December 31, 2021, 2020, and 2019, the Company closed underperforming locations and impaired certificates of need or Medicare licenses for these providers. The Company recognized an impairment of $0.9 million, $0.7 million, $7.1 million, respectively. During the year ended December 31, 2019, the impairment recognized of $7.1 million included $6.1 million related to impairment due to changes in moratorium regulations and $1.0 million related to the closure of underperforming locations. During 2019, CMS removed all federal moratoria with regard to Medicare provider enrollments in four states. The Medicare licenses were deemed impaired upon the notice of removal. The amounts of impairment of the Medicare licenses was its carrying value at the time of closure.

Intangible assets: Definite-lived assets

Included in intangible assets are definite-lived assets subject to amortization such as non-compete agreements, customer relationships, and defensive assets, which are defined as trade names that are not actively used. Amortization of definite-lived intangible assets is calculated on a straight-line basis over the estimated useful lives of the related assets, ranging from four to 16 years. Amortization expense for the Company's definite-lived intangible assets for the years ended December 31, 2021, 2020, and 2019 was $1.5 million, $1.2 million, and $1.3 million, respectively. Amortization expense was recorded in general and administrative expenses.

Due to/from Governmental Entities

The Company's LTACHs are reimbursed for certain activities based on tentative rates. The amounts recorded in due to/from governmental entities on the Company's consolidated balance sheets relate to settled and open cost reports that are subject to the completion of audits and the issuance of final assessments. Final reimbursement is determined based on submission of annual cost reports and audits by the fiscal intermediary. Adjustments are accrued on an estimated basis in the period the related services were rendered and further adjusted as final settlements are determined. These adjustments are accounted for as changes in estimates. Additionally, reimbursements received in excess of hospice cap amounts are recorded in this account, if any.

Property, Building and Equipment

Property, building and equipment are recorded at cost. Property, building and equipment acquired in connection with business combinations are recorded at estimated fair value in accordance with the acquisition method of accounting in accordance with ASC 805. Expenditures that increase capacities or extend useful lives are capitalized to the appropriate property, building and equipment accounts. Costs and related accumulated depreciation associated with assets that are sold or retired are written off and any gain or losses are recorded in operating income. Routine repairs and maintenance costs are expensed as incurred.

Depreciation is computed using the straight-line method over the estimated useful lives of the individual assets. The estimated useful life of buildings is 39 years, while the estimated useful lives of transportation equipment, fixed equipment, office furniture, and computer equipment range from three to 15 years. The useful life for leasehold improvements is the shorter of the lease term or the expected life of the leasehold improvement.

In accordance with ASC 360, "Property, Plant, and Equipment", the Company evaluates its long-lived assets for possible impairment whenever events or changes in circumstances occur that indicate that the carrying amount of the asset may not be recoverable. There were no impairment charges recognized during the periods ended December 31, 2021, 2020, and 2019.

The following table describes the Company's components of property, building and equipment for the years ended December 31, 2021 and 2020 (amounts in thousands :

	2021	2020
Land	$ 7,339	$ 7,339
Building and leasehold improvements	105,431	40,766
Transportation equipment	19,898	19,821
Fixed equipment	365	365
Office furniture and medical equipment	116,732	104,557
Construction in progress	2,588	48,239
	252,353	221,087
Less accumulated depreciation	98,394	82,721
Property, building and equipment, net	$ 153,959	$ 138,366

Depreciation expense for the years ended December 31, 2021, 2020 and 2019 was $19.4 million, $20.0 million and $17.0 million, respectively, which was recorded in general and administrative expenses. In addition, during the years ended December 31, 2021 and 2020, the Company capitalized $1.0 million and $1.1 million, respectively, in interest costs related to the construction of its home office expansion project.

Noncontrolling Interest

The Company classifies noncontrolling interests of its joint ventures based upon a review of the legal provisions governing the redemption of such interests. In each of the Company's joint ventures, those provisions are embodied within the joint venture's operating agreement. For joint ventures with operating agreement provisions that establish an obligation for the Company to purchase the third party partners' noncontrolling interests other than as a result of events that lead to a

liquidation of the joint venture, such noncontrolling interests are classified as redeemable noncontrolling interests in temporary equity. For joint ventures with operating agreement provisions that establish an obligation that the Company purchase the third party partners' noncontrolling interests, but which obligation is triggered by events that lead to a liquidation of the joint venture, such noncontrolling interests are classified as nonredeemable noncontrolling interests in permanent equity. Additionally, for joint ventures with operating agreement provisions that do not establish an obligation for the Company to purchase the third party partners' noncontrolling interests (e.g., where the Company has the option, but not the obligation, to purchase the third party partners' noncontrolling interests), such noncontrolling interests are classified as nonredeemable noncontrolling interests in permanent equity.

The Company's equity joint ventures that are classified as redeemable noncontrolling interests are subject to operating agreement provisions that require the Company to purchase the noncontrolling partner's interest upon the occurrence of certain triggering events, which are defined as the bankruptcy of the partner or the partner's exclusion from the Medicare or Medicaid programs. These triggering events and the related repurchase provisions are specific to each redeemable equity joint venture, since the triggering of a repurchase obligation for any one redeemable noncontrolling interest in an equity joint venture does not necessarily impact any of the other redeemable noncontrolling interests in other equity joint ventures. Upon the occurrence of a triggering event requiring the purchase of a redeemable noncontrolling interest, the Company would be required to purchase the noncontrolling partner's interest based upon a valuation methodology set forth in the applicable joint venture agreement.

Redeemable noncontrolling interests and nonredeemable noncontrolling interests are initially recorded at their fair value as of the closing date of the transaction establishing the joint venture. Such fair values are determined using various accepted valuation methods, including the income approach, the market approach, the cost approach, and a combination of one or more of these approaches. A number of facts and circumstances concerning the operation of the joint venture are evaluated for each transaction, including (but not limited to) the ability to choose management, control over acquiring or liquidating assets, and control over the joint venture's strategy and direction, in order to determine the fair value of the noncontrolling interest.

Subsequent to the closing date of the transaction establishing the joint venture, recorded values for both redeemable and nonredeemable noncontrolling interests are adjusted at the end of each reporting period for (a) comprehensive income (loss) that is attributed to the noncontrolling interest, which is calculated by multiplying the noncontrolling interest percentage by the comprehensive income (loss) of the joint venture's operations during the reporting period, (b) dividends paid to the noncontrolling interest partner during the reporting period, and (c) any other transactions that increase or decrease the Company's ownership interest in the joint venture, as a result of which the Company retains its controlling interest. If the Company determines based upon its analysis as of the end of each reporting period in accordance with authoritative accounting guidance, that it is not probable that an event would occur to otherwise require the redemption of a redeemable noncontrolling interest (i.e., the date for such event is not set or such event is not certain to occur), then the Company does not adjust the recorded amount of such redeemable noncontrolling interest.

The carrying amount of each redeemable equity instrument presented in temporary equity as of December 31, 2021 is not less than the initial amount reported for each instrument. The activity of noncontrolling interest-redeemable for the twelve months ended December 31, 2021, 2020 and 2019 is summarized in the Company's statements of stockholders' equity.

Based upon the Company's evaluation of the redemption provisions concerning redeemable noncontrolling interests as of December 31, 2021, the Company determined in accordance with authoritative accounting guidance that it was not probable that an event otherwise requiring redemption of any redeemable noncontrolling interest would occur (i.e., the date for such event was not set or such event is not certain to occur). Therefore, none of the redeemable noncontrolling interests were identified as mandatorily redeemable interests at such times, and the Company did not record any values in respect of any mandatorily redeemable interests.

Stock-Based Compensation

The Company accounts for its stock-based awards in accordance with provisions of ASC 718, "Compensation - Stock Compensation" ("ASC 718"). The Company grants restricted stock or restricted stock units to employees and members of its Board of Directors as a form of compensation. In accordance with ASC 718, the expense for such awards is based on the grant date fair value of the award and is recognized on a straight-line basis over the requisite service period. See Note 7 to the Consolidated Financial Statements included in this Annual Report on Form 10-K for additional information.

Earnings Per Share

The following table sets forth shares used in the computation of basic and diluted per share information for the years ended December 31, 2021, 2020 and 2019:

	2021	2020	2019

Weighted average number of shares outstanding for basic per share calculation	31,195,305	31,092,417	30,932,607
Effect of dilutive potential shares:			
Nonvested restricted stock	201,353	273,348	277,217
Adjusted weighted average shares for diluted per share calculation	31,396,658	31,365,765	31,209,824
Antidilutive shares	117,238	1,155	157,608

Assets Held for Sale

As of December 31, 2020, the Company's assets held for sale was $1.9 million, which consisted of one hospice facility in Knoxville, Tennessee. The Company sold the property during the twelve months ended December 31, 2021 for $3.2 million. The gain on the sale of the property of $1.2 million was recorded in general and administrative expenses on our consolidated statements of income.

Investments

During the twelve months ended December 31, 2021, the Company invested $10.0 million and became a minority owner in a healthcare analytics company and invested $0.1 million in an investment fund focused on minority-owned businesses, which were recorded in other assets in our consolidated balance sheets. These investments were accounted for under the cost method of accounting as the Company does not have the ability to exercise significant influence in connection with its minority ownership positions.

Recently Adopted Accounting Pronouncements

In December 2019, the FASB issued ASU 2019-12, Simplifications to accounting for income taxes, which removes certain exceptions to the general principles of Topic 740 and adds guidance to reduce complexity in accounting for income taxes. The Company adopted the new guidance effective January 1, 2021. The adoption of the new guidance did not have a material impact to the Company.

In March 2020, the FASB issued ASU 2020-04, Facilitation of the Effects of Reference Rate Reform on Financial Reporting, which provides optional expedients and exceptions for applying U.S. GAAP to contracts, hedging relationships and other transactions affected by the transition away from reference rates expected to be discontinued to alternative reference rates. The pronouncement is effective immediately and may be applied prospectively to contract modifications made and hedging relationships entered into on or before December 31, 2022. The adoption of the new guidance did not have an effect on the Company's condensed consolidation financial statements.

3. Acquisitions, Divestitures, and Joint Venture Activities

2021 Acquisitions

On July 1, 2021, the Company purchased Heart n' Home Hospice for $50.1 million, which included seven wholly-owned hospice locations in Idaho and two wholly-owned hospice locations in Oregon. In addition, the Company purchased Casa de la Luz on July 1, 2021 for $48.0 million, which included two wholly-owned hospice and palliative care locations in Arizona.

On September 1, 2021, the Company purchased Heart of Hospice for $278.0 million, which included 24 wholly-owned hospice locations in Arkansas, Louisiana, Mississippi, Oklahoma, and South Carolina.

On November 1, 2021, the Company purchased Brookdale Health Care Services' agencies from the recently formed home health, hospice, and outpatient therapy venture between HCA Healthcare and Brookdale Senior Living, Inc. The wholly-owned purchased agencies included 23 home health locations, 11 hospice locations, and 13 main therapy agencies across 22 states. Total consideration for this acquisition was $197.0 million, of which $178.8 million was paid in cash, net of working capital adjustments.

In separate acquisitions, the Company acquired the majority-ownership of four home health agencies, three hospice, and one home and community-based agencies during the twelve months ended December 31, 2021 for an aggregate purchase price $17.8 million. The purchase prices were determined based on the Company's analysis of comparable acquisitions and the target market's potential future cash flows.

Goodwill generated from the acquisitions was recognized based on the expected contributions of each acquisition to the overall corporate strategy. The Company expects its portion of goodwill to be fully tax deductible. The acquisitions were accounted for under the acquisition method of accounting. Accordingly, the accompanying financial information includes the results of operations of the acquired entities from the date of acquisition.

Transaction costs associated with acquisitions are expensed as incurred. During the twelve months ended December 31, 2021, the Company incurred $9.1 million in acquisition-related transaction costs, which was recorded in the consolidated statements of income as general and administrative expenses.

The Company's net working capital adjustments for Heart of Hospice and Brookdale Health Care Services' agencies are being finalized and remain preliminary in accordance with the requirements of ASC Topic 805, Business Combinations. The final determination of the fair value of assets acquired and liabilities assumed will be completed in accordance with the applicable accounting guidance. The following table summarizes the amounts of the assets acquired and liabilities assumed at the acquisition dates, as well as their fair value at the acquisition dates and the noncontrolling interest acquired during the twelve months ended December 31, 2021 (amounts in thousands):

Consideration		
Cash	$	570,935
Net working capital		890
Fair value of total consideration transferred		
Recognized amounts of identifiable assets acquired and liabilities assumed		
Cash	$	1,352
Patient accounts receivable		14,299
Other receivables		209
Prepaid expenses		441
Other current assets		155
Property and equipment		2,614
Trade names		39,942
Certificates of need/licenses		40,221
Non-compete agreements		7,257
Operating lease right of use asset		9,494
Other assets		168
Accounts payable and other accrued liabilities		(10,378)
Salaries, wages, and benefits payable		(7,582)
Current operating lease payable		(3,600)
Amounts due to governmental entities		(4,364)
Current liabilities - deferred employer payroll tax		(1,692)
Operating lease payable		(5,897)
Total identifiable assets and liabilities	$	82,639
Noncontrolling interest		113
Goodwill, including noncontrolling interest of $78	$	489,299

Trade names, certificates of need and licenses are indefinite-lived assets and, therefore, not subject to amortization. Acquired trade names that are not being used actively are amortized over the estimated useful life on the straight line basis. Trade names are valued using the relief from royalty method, a form of the income approach. Certificates of need are valued using the replacement cost approach based on registration fees and opportunity costs. Licenses are valued based on the estimated direct costs associated with recreating the asset, including opportunity costs based on an income approach. In the case of states with a moratorium in place, the licenses are valued using the multi-period excess earnings method. Noncontrolling interest is recorded at fair value.

2021 Divestitures

During the twelve months ended December 31, 2021, the Company sold its controlling membership interests in a home health agency previously operated as an equity joint venture and sold its pharmacy location which was wholly-owned. The total consideration for these controlling interest sales was $1.5 million and resulted in a loss of $0.1 million, which was accounted for as a loss on the sale of entities and recorded in general and administrative expenses.

2021 Joint Venture Activities

During the twelve months ended December 31, 2021, the Company purchased additional controlling membership interests infour of our equity joint venture partnerships, whereby the agencies became wholly-owned subsidiaries of the Company. The total consideration for these additional controlling interest purchases was $2.1 million. The transactions were accounted for as equity transactions.

During the twelve months ended December 31, 2021, the Company sold noncontrolling membership interests intwo home health agencies. The total consideration of the sales of noncontrolling membership interest was $1.9 million. The transactions were accounted for as equity transactions.

2020 Acquisitions

The Company acquired the majority-ownership of 13 home health agencies, six hospice agencies, four home and community-based agencies, and one physician practice during the twelve months ended December 31, 2020. The total aggregate purchase price for these transactions was $42.1 million.

The Company funded three of these acquisitions in 2019 by paying cash consideration of $16.4 million.

During the twelve months ended December 31, 2020, the Company received $3.1 million from an equity joint venture partnership for the partner's noncontrolling interest for one of the Company's acquired home health and hospice agencies. In separate transactions, the Company received $3.9 million for consideration of two equity joint venture partnerships, whereby the Company acquired home health, hospice, and home and community-based agencies for $6.6 million and sold membership interests in these agencies for $4.4 million. The transactions for the sale of the membership interests were accounted for as an equity transaction.The total cash consideration includes adjustments for assets acquired and liabilities assumed. The allocation of the purchase price of these acquisitions were allocated to goodwill of $40.1 million, indefinite lived intangibles trade names of $4.8 million, certificates of need/licenses of $6.0 million, and other assets and assumed liabilities of $0.5 million. Acquired noncontrolling interest was $9.4 million.

2020 Joint Venture Activities

During the twelve months ended December 31, 2020, the Company purchased a portion of the noncontrolling membership interest intwo of our equity joint venture partnerships, which prior to the purchase was classified as a nonredeemable noncontrolling interest in permanent equity. As a result of the purchases, the Company retained its controlling financial interests in the joint venture partnerships and the noncontrolling interest of our partner will continue to be classified as a nonredeemable noncontrolling interest in permanent equity. Total consideration for these noncontrolling interest purchases was $24.3 million.

During the twelve months ended December 31, 2020, the Company sold minority ownership interests associated withseven home health agencies and one hospice agency. The total consideration for the sale of such ownership interests was $5.1 million, of which $4.9 million was paid in cash and $0.2 million was a contribution of a trade name. The transaction was accounted for as an equity transaction.

4. Goodwill and Other Intangibles, Net

The following table summarizes changes in goodwill and other intangibles assets by segment during the twelve months ended December 31, 2021 and 2020 (amounts in thousands):

	Home Health	Hospice	Home and community-based	Facility-based	HCI	Total
Goodwill						
Balance as of December 31, 2019	$ 867,924	$ 128,875	$ 166,629	$ 15,682	$ 40,862	$ 1,219,972
Acquisitions	12,025	21,025	134	88	—	33,272
Noncontrolling interest	4,695	2,122	10	—	—	6,827
Adjustments and disposals	(644)	(280)	—	—	—	(924)
Balance as of December 31, 2020	$ 884,000	$ 151,742	$ 166,773	$ 15,770	$ 40,862	$ 1,259,147
Acquisitions	84,377	404,590	254	—	—	489,221

Noncontrolling interest	78	—	—	—	—	78
Adjustments and disposals	(20)	—	—	—	—	(20)
Balance as of December 31, 2021	$ 968,435	$ 556,332	$ 167,027	$ 15,770	$ 40,862	$ 1,748,426
Intangibles Assets						
Balance as of December 31, 2019	$ 219,872	$ 40,590	$ 24,096	$ 5,317	$ 15,681	$ 305,556
Acquisitions	7,193	4,212	127	—	—	11,532
Amortization	(556)	(70)	(15)	(6)	(581)	(1,228)
Adjustments and disposals	(505)	—	—	—	—	(505)
Balance as of December 31, 2020	$ 226,004	$ 44,732	$ 24,208	$ 5,311	$ 15,100	$ 315,355
Acquisitions	13,734	73,026	46	614	—	87,420
Amortization	(480)	(418)	(9)	(6)	(581)	(1,494)
Adjustments and disposals	(1,279)	—	—	—	—	(1,279)
Balance as of December 31, 2021	$ 237,979	$ 117,340	$ 24,245	$ 5,919	$ 14,519	$ 400,002

The Company determined that there was no impairment for the goodwill of any reporting units as of December 31, 2021, 2020, and 2019 based on the Company's annual impairment testing.

During 2021, 2020, and 2019, the Company closed underperforming locations. Due to these closures, the Company recorded $0.02 million, $0.5 million, and $0.6 million of impairment of goodwill during the years ended December 31, 2021, 2020 and 2019. The amount of disposal of goodwill was determined using prices of comparable businesses in the market. This was recorded in impairment of intangibles and other on the Company's consolidated statements of income and disclosed in the changes in goodwill table in adjustments and disposals.

The Company performed an impairment analysis on its indefinite-lived intangible assets related to the Company's trade names, certificates of needs, and licenses and determined that it is not more likely than not that the fair values of the indefinite-lived intangible assets are less than its carrying amount as of November 30, 2021; however, the Company did record $0.9 million, $0.7 million, and $7.1 million, during the years ended December 31, 2021, 2020, and 2019. During the years ended December 31, 2021 and 2020, the impairments related to closures of underperforming locations. During the year ended December 31, 2019, the impairments related to the lifting of a moratoria of $6.1 million and closure of underperforming locations of $1.0 million. The Medicare license impairment was a result of CMS action to remove all federal moratoria with regard to Medicare provider enrollment in four states. The amounts of disposal of the Medicare licenses was its carrying value at the time of closure. This was recorded in impairment of intangibles and other on the Company's consolidated statements of income and disclosed in the changes in intangible assets table in adjustments and disposals.

During the twelve months ended December 31, 2021, the Company divested a certificate of need of $0.4 million, which was accounted for as a loss on the sale of an entity and recorded on the Company's consolidated statements of income in general and administrative expenses.

The following tables summarize the changes in intangible assets during the twelve months ended December 31, 2021 and 2020 (amounts in thousands):

	2021	2020
Indefinite-lived intangible assets:		
Trade names	$ 207,780	$ 168,700
Certificates of need/licenses	173,955	135,013
Net total	$ 381,735	$ 303,713
Definite-lived intangible assets:		
Trade names		
Gross carrying amount	$ 11,073	$ 10,212
Accumulated amortization	(9,606)	(9,480)

Net total	$ 1,467	$ 732
Non-compete agreements		
Gross carrying amount	$ 14,524	$ 7,267
Accumulated amortization	(7,172)	(6,387)
Net total	$ 7,352	$ 880
Customer relationships		
Gross carrying amount	$ 11,822	$ 11,822
Accumulated amortization	(2,374)	(1,792)
Net total	$ 9,448	$ 10,030
Total definite-lived intangible assets		
Gross carrying amount	$ 37,419	$ 29,301
Accumulated amortization	(19,152)	(17,659)
Net total	$ 18,267	$ 11,642
Total intangible assets:		
Gross carrying amount	$ 419,154	$ 333,014
Accumulated amortization	(19,152)	(17,659)
Net total	$ 400,002	$ 315,355

Remaining useful lives of trade names, customer relationships, and non-compete agreements were 7.8, 16.3 and 4.9 years, respectively at December 31, 2021. Similar amounts at December 31, 2020 were 8.8, 17.3 and 2.9 years, respectively.

Amortization expense for the Company's intangible assets was $1.5 million, $1.2 million, and $1.3 million for the years ended December 31, 2021, 2020 and 2019, which was recorded on the Company's consolidated statements of income in general and administrative expenses.

The estimated intangible asset amortization expense for each of the five years subsequent to December 31, 2021 is as follows (amounts in thousands):

Year	Amortization amount
2022	$ 3,696
2023	2,524
2024	2,098
2025	1,790
2026	1,578
Total	$ 11,686

5. Income Taxes

The Company accounts for income taxes using the asset and liability method. Under the asset and liability method, deferred taxes are determined based on differences between the financial reporting and tax bases of assets and liabilities and are measured using the enacted tax laws that will be in effect when the differences are expected to reverse.

Significant components of the Company’s deferred tax assets and liabilities as of December 31, 2021 and 2020 were as follows (amounts in thousands):

	2021	2020
Deferred tax assets:		
Allowance for uncollectible accounts	$ 8,394	$ 8,065
Accrued employee benefits	7,533	8,247
Stock compensation	2,735	2,373
Accrued self-insurance	6,626	6,596

Acquisition costs	2,631	1,635
Net operating loss carry forward	5,245	6,084
Intangible asset impairment	6	10
Lease payable	23,220	25,667
Government stimulus advance	21,591	19,114
Payroll tax	5,895	11,750
Other	312	285
Gross deferred tax assets	84,188	89,826
Less: valuation allowance	(3,121)	(3,876)
Net deferred tax assets	$ 81,067	$ 85,950
Deferred tax liabilities:		
Amortization of intangible assets	(100,339)	(85,826)
Tax depreciation in excess of book depreciation	(17,584)	(14,065)
Prepaid expenses	(1,733)	(1,538)
Non-accrual experience accounting method	(829)	(743)
Right of use asset	(22,781)	(25,202)
Other	(7,827)	(5,813)
Deferred tax liabilities	(151,093)	(133,187)
Net deferred tax liability	$ (70,026)	$ (47,237)

Based on the Company’s historical pattern of taxable income, the Company believes it will produce sufficient income in the future to realize its deferred income tax assets. Management provides a valuation allowance for any net deferred tax assets when it is more likely than not that a portion of such net deferred tax assets will not be recovered.

The components of the Company’s income tax expense from continuing operations, less noncontrolling interest, for the twelve months ended December 31, were as follows (amounts in thousands):

	2021	2020	2019
Current:			
Federal	$ 10,746	$ 37,253	$ 4,678
State	4,220	12,232	3,528
	14,966	49,485	8,206
Deferred:			
Federal	17,699	(10,800)	14,549
State	5,022	(2,642)	3,852
	22,721	(13,442)	18,401
Total income tax expense	$ 37,687	$ 36,043	$ 26,607

A reconciliation of the difference between the federal statutory tax rate and the Company's effective tax rate for income taxes for each of the twelve months ended December 31, were as follows:

	2021	2020	2019
Federal statutory tax rate	21.0 %	21.0 %	21.0 %
State income taxes, net of federal benefit	4.8	5.2	4.8
Nondeductible expenses	1.4	1.9	1.8
Uncertain tax position	0.1	1.5	(0.9)
Cares Act Enactment	—	(2.9)	—
Excess tax benefit	(1.5)	(1.7)	(2.5)

Credits and other	(1.2)	(0.6)	(2.5)%
Effective tax rate	24.6 %	24.4 %	21.7 %

The Company is subject to both federal tax and state income tax for jurisdictions within which it operates. Within these jurisdictions, the Company is open to examination for tax years ended after December 31, 2012.

As of December 31, 2021, the Company has gross U.S. operating loss carry forwards of $5.5 million that are available to reduce future taxable income. If not used to offset taxable income, a portion of these losses will expire between 2032 and 2034. Losses generated in years ending after December 31, 2017 have an unlimited carryforward under the Tax Cut and Jobs Act ("2017 Tax Act"). Due to U.S. limitations on acquired operating losses, a valuation allowance has been established on $1.6 million of these losses.

Gross state operating loss carryforwards totaling $82.3 million at December 31, 2021 are being carried forward in jurisdictions where the Company is permitted to use tax losses from prior periods to reduce future taxable income. If not used to offset future taxable income, these losses will expire between 2022 and 2041. Due to uncertainty regarding the Company's ability to use some of the carryforwards, a valuation allowance has been established on $49.1 million of state net operating loss carryforwards. Based on the Company's historical record of producing taxable income and expectations for the future, the Company has concluded that future operating income will be sufficient to give rise to taxable income sufficient to utilize the remaining state net operating loss carryforwards.

The effective tax rate for the twelve months ended December 31, 2021 benefited from $2.4 million of excess tax benefits associated with stock-based compensation arrangements. For the twelve months ended December 31, 2020, the effective tax rate benefited from $2.4 million of excess tax benefits associated with stock-based compensation arrangements and $2.2 million ($4.3 million and $2.1 million, as further described below) associated with increased tax benefits associated with the CARES Act.

In response to the COVID-19 pandemic, the CARES Act was signed into law in March 2020. The CARES Act lifts certain deduction limitations originally imposed by the 2017 Tax Act. Corporate taxpayers may carryback net operating losses ("NOLs") originating during 2018 through 2020 for up to five years, which was not previously allowed under the 2017 Tax Act. The CARES Act also eliminates the 80% of taxable income limitations by allowing corporate entities to fully utilize NOL carryforwards to offset taxable income in 2018, 2019, or 2020. Taxpayers may generally deduct interest up to the sum of 50% of adjusted taxable income plus business interest income (30% limit under the 2017 Tax Act) for tax years beginning January 1, 2019 and 2020. The CARES Act allows taxpayers with alternative minimum tax credits to claim a refund in 2020 for the entire amount of the credits instead of recovering the credits through refunds over a period of years, as originally enacted by the 2017 Tax Act. In addition, the CARES Act raises the corporate charitable deduction limit to 25% of taxable income and makes qualified improvement property generally eligible for 15-year cost-recovery and 100% bonus depreciation. The effective tax rate for the twelve months ended December 31, 2020 benefited from a $4.3 million impact from the enactment of the CARES Act. The benefit was primarily driven by NOL carryback provisions and rate differential between the affected years. There was no material impact to our net deferred tax assets as of December 31, 2020.

US GAAP prescribes a recognition threshold and measurement attribute for the accounting and financial statement disclosure of tax positions taken or expected to be taken in a tax return. The evaluation of a tax position is a two-step process. The first step requires the Company to determine whether it is more likely than not that a tax position will be sustained upon examination based on the technical merits of the position. The second step requires the Company to recognize in the financial statements each tax position that meets the more likely than not criteria, measured at the amount of benefit that has a greater than 50% likelihood of being realized. The Company's unrecognized tax benefits would affect the tax rate, if recognized. The Company includes the full amount of unrecognized tax benefits in noncurrent income taxes payable in the consolidated balance sheets. The Company anticipates it is reasonably possible an increase or decrease in the amount of unrecognized tax benefits could be made in the next twelve months; however, the Company does not presently anticipate that any increase or decrease in unrecognized tax benefits will be material to the consolidated financial statements. The impact of the CARES Act increased unrecognized tax benefits by $2.1 million, which also had an impact on the Company's effective tax rate for the twelve months ended December 31, 2020. The impact was primarily driven by the NOL carryback mentioned above to previously closed years. As of December 31, 2021 and 2020, the Company recognized $7.3 million and $6.2 million, respectively, in unrecognized tax benefits.

A reconciliation of the total amounts of unrecognized tax benefits follows:

	Unrecognized tax benefits
As of January 1, 2020	$ 3,867

Acquired unrecognized tax position		—
Increased (decreased) in unrecognized tax benefits as a result of:		
Tax positions taken in the current year		2,391
Lapse of statute of limitations		(55)
As of December 31, 2020	$	6,203
Increased (decreased) in unrecognized tax benefits as a result of:		
Tax positions taken in the current year		1,244
Lapse of statute of limitations		(127)
As of December 31, 2021	$	7,320

6. Debt

Credit Facility

On March 30, 2018, the Company entered into a Credit Agreement with JPMorgan Chase Bank, N.A., which was effective on April 2, 2018 (the "Credit Agreement"). The Credit Agreement provides a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $500.0 million, which includes an additional $200.0 million accordion expansion feature, and a letter of credit sub-limit equal to $50.0 million. The expiration date of the Credit Agreement was March 20, 2023. On August 3, 2021, the Company entered into an Amended and Restated Senior Credit Facility (the "2021 Amended Credit Agreement"), which amends and restates in its entirety the Credit Agreement. The 2021 Amended Credit Agreement provided a senior, secured revolving line of credit commitment with a maximum principal borrowing limit of $800.0 million, which included an additional $500.0 million accordion expansion, and a letter of credit sub-limit equal to $75.0 million. On December 31, 2021, the aggregate commitment was increased to a maximum borrowing limit of $1.0 billion, with an additional $300.0 million accordion expansion. The expiration date of the 2021 Amended Credit Agreement is August 3, 2026.

The Company's obligations under the 2021 Amended Credit Agreement are secured by substantially all of the assets of the Company and its wholly-owned subsidiaries (subject to customary exclusions), which assets include the Company's equity ownership of its wholly-owned subsidiaries and its equity ownership in joint venture entities. The Company's wholly-owned subsidiaries also guarantee the obligations of the Company under the 2021 Amended Credit Agreement.

Revolving loans under the 2021 Amended Credit Agreement bear interest at, as selected by the Company, either a (i) the prevailing London Interbank Offered Rate ("LIBOR") (with interest periods of one, three, or six months at the Company's option) plus a spread of 1.25% to 2.00% based on the Company's quarterly consolidated Leverage Ratio or (ii) the prevailing prime or base rate plus a spread of 0.25% to 1.00% based on the Company's quarterly consolidated Leverage Ratio. Swing line loans bear interest at the Base Rate. The Company is limited to 15 Eurodollar borrowings outstanding at any time. The Company is required to pay a commitment fee for the unused commitments at rates ranging from 0.15% to 0.30% per annum depending upon the Company's quarterly consolidated Leverage Ratio. The Base Rate at December 31, 2021 was 3.75% and the Eurodollar Rate was 1.63%. As of December 31, 2021, the effective interest rate on outstanding borrowings under the 2021 Amended Credit Agreement was 1.81%.

On March 5, 2021, the ICE Benchmark Administration, the administrator of LIBOR, announced its intention to cease the publication of LIBOR settings for 1-month, 3-month, 6-month, and 12-month LIBOR borrowings immediately on June 30, 2023. JPMorgan Chase Bank, N.A will transition our 2021 Amended Credit Agreement to an alternate rate to CME Term SOFR Reference Rate ("SOFR"), which is administered by CME Group Benchmark Administration Ltd ("CME"). Due to the differences observed between LIBOR rates and SOFR published rates, JPMorgan Chase Bank, N.A. will use a credit spread adjustment ("CSA") in order to minimize value transfer and leave the existing margin applicable to our 2021 Amended Credit Agreement. The CSA used by JPMorgan Chase Bank, N.A. is based on the average of the differences between LIBOR and SOFR over a 12-month period and will be added to SOFR.

As of December 31, 2021 the Company had $661.2 million drawn and letters of credit in the amount of $24.3 million outstanding under the credit facility. At December 31, 2020, the Company had $20.0 million drawn and letters of credit in the amount of $25.4 million outstanding under the credit facility.

Under the terms of the 2021 Amended Credit Agreement, the Company is required to maintain certain financial ratios and comply with certain financial covenants. The 2021 Amended Credit Agreement permits the Company to make certain restricted payments, such as purchasing shares of its stock, within certain parameters, provided the Company maintains

compliance with those financial ratios and covenants after giving effect to such restricted payments. The Company was in compliance with its debt covenants under the 2021 Amended Credit Agreement at December 31, 2021.

The scheduled principal payments on long-term debt for each of the five years subsequent to December 31, 2021 is as follows (amounts in thousands):

Year	Principal payment amount
2022	$ —
2023	—
2024	—
2025	—
2026	661
Total	$ 661

7. Stockholders' Equity

Equity Based Awards

The 2018 Incentive Plan is administered by the Compensation Committee of the Company's Board of Directors. The total number of shares of the Company's common stock originally reserved were 2,210,544 shares of our common stock and a total of1,746,779 shares are currently available for issuance. A variety of discretionary awards for employees, officers, directors, and consultants are authorized under the 2018 Incentive Plan, including incentive or non-qualified stock options and restricted stock, restricted stock units and performance-based awards. All awards must be evidenced by a written award certificate which will include the provisions specified by the Compensation Committee of the Board of Directors. The Compensation Committee determines the exercise price for stock options, which cannot be less than the fair market value of the Company's common stock as of the date of grant.

Share Based Compensation

Nonvested Stock

The Company issues stock-based compensation to employees in the form of nonvested stock, which is an award of common stock subject to certain restrictions. The awards, which the Company calls nonvested shares, generally vest over five years, conditioned on continued employment for the full incentive period. Compensation expense for the nonvested stock is recognized for the awards that are expected to vest. The expense is based on the fair value of the awards on the grant date recognized on a straight-line basis over the requisite service period, which generally relates to the vesting period. The Company estimates forfeitures at the time of grant and revises the estimate in subsequent periods if actual forfeitures differ to ensure that total compensation expense recognized is at least equal to the value of vested awards. The Company applies the same guidance to nonemployee share-based awards.

During 2021, employees and a consultant were granted 109,985 and 5,735, respectively, of nonvested shares of common stock. During 2020, employees and a consultant were granted 114,680 and 10,890, respectively. During 2019, 163,250 nonvested shares were granted to employees. All shares granted were granted pursuant to the 2018 Incentive Plan. The shares will vest over a period of five years, conditioned on continued employment and in accordance with the consulting agreement.

During 2021, 2020 and 2019, respectively, the Company granted 7,200, 9,900 and 17,880 nonvested shares of stock to the independent directors. The shares vest 100% on the one year anniversary date. During 2021, the Company granted 3,500 nonvested shares of common stock to the Company's Lead Director, which shares vest one-third at the date of grant and one-third on each of the first two anniversaries of the grant date. During 2020, one retired director was granted 775 nonvested shares of common stock, which vest 100% at the grant date. Shares granted to directors were pursuant to the Second Amended and Restated 2005 Non-Employee Directors Compensation Plan.

The fair value of nonvested shares is determined based on the closing trading price of the Company's shares on the grant date. The weighted average grant date fair values of nonvested shares granted during the years ended December 31, 2021, 2020 and 2019 were $186.08, $123.89 and $110.56, respectively.

The following table represents the share grants stock activity for the year ended December 31, 2021

	Nonvested stock	Options

	Number of Shares	Weighted average grant date fair value	Number of Shares	Weighted average grant date fair value
Share grants outstanding at December 31, 2020	469,631	$ 89.69	74,235	$ 42.07
Granted	126,420	186.08	—	—
Vested or exercised	(180,235)	186.86	—	—
Share grants outstanding at December 31, 2021	415,816	$ 122.40	74,235	$ 42.07

As of December 31 2021, there was $37.3 million of total unrecognized compensation cost related to nonvested shares granted. That cost is expected to be recognized over the weighted average period of 2.90 years. The total fair value of shares vested in the year ended 2021, 2020 and 2019 were $14.1 million, $12.2 million, and $9.4 million, respectively. The Company recorded $15.9 million, $14.3 million and $9.6 million in compensation expense related to non-vested stock grants in the years ended December 31, 2021, 2020 and 2019, respectively.

Aggregate intrinsic value for options represents the estimated value of the Company's common stock at the end of the period in excess of the weighted average exercise price multiplied by the number of options exercisable. The aggregate intrinsic value of options outstanding at December 31, 2021 was $7.4 million. The following table summarizes information about stock options outstanding and exercisable at December 31, 2021:

Range of Exercise Price	Shares	Wtd. Avg. Remaining Contractual Life	Wtd. Avg. Exercise Price
$0.00 - $30.00	15,737	2.05	$ 26.11
$30.01 - $40.00	20,609	4.18	$ 39.38
Over $40.00	37,889	5.16	$ 47.74
	74,235	4.00	$ 42.07

Employee Stock Purchase Plan

In 2006, the Company adopted the Employee Stock Purchase Plan allowing eligible employees to purchase the Company's common stock at 95% of the market price on the last day of each calendar quarter. There were 250,000 shares reserved for the plan.

On June 20, 2013, the Amended and Restated Employee Stock Purchase Plan was approved by the Company's stockholders. As a result of the amendment, the Employee Stock Purchase Plan was modified as follows:

- An additional 250,000 shares of common stock were authorized for issuance over the term of the Employee Stock Purchase Plan.
- The term of the Employee Stock Purchase Plan was extended from January 1, 2016 to January 1, 2023.

The following table represents the shares issued during 2021, 2020, and 2019, under the Employee Stock Purchase Plan:

	Number of Shares	Weighted Average Per Share Price
Shares available as of December 31, 2018	152,344	
Shares issued in 2019	19,895	$ 103.84
Shares issued in 2020	14,313	$ 152.10
Shares issued in 2021	13,792	$ 186.20
Shares available as of December 31, 2021	104,344	

Treasury Stock

In conjunction with the vesting of the nonvested shares of stock or exercise of options, recipients incur personal income tax obligations. The Company allows the recipients to turn in shares of common stock to satisfy those personal tax obligations. The Company redeemed 63,028, 78,767 and 107,461 shares of common stock related to these tax obligations during the years ended December 31, 2021, 2020 and 2019, respectively. Additionally, 1,556 shares were forfeited for terminated employees. Such shares are held in treasury stock and are available for reissuance by the Company.

Stock Repurchase

On December 6, 2021, the Company's Board of Directors approved a share repurchase program authorizing repurchases up to $150.0 million of the Company's common stock. The Company may purchase common stock in open market transactions, block or privately negotiated transactions, and may from time to time purchase shares pursuant to a trading plan in accordance with Rule 10b5-1 and Rule 10b-18 under the Exchange Act or by any combination of such methods, in each case subject to compliance with all SEC rules and other legal requirements. The number of shares to be purchased and the timing of the purchases are based on a variety of factors, including, but not limited to, the level of cash balances, credit availability, debt covenant restrictions, general business conditions, the market price of our stock and the availability of alternative investment opportunities. No time limit was set for completion of repurchases under the new authorization, and the program may be suspended or discontinued at any time.

The Company uses the cost method to account for the repurchase of common stock. During the twelve months ended December 31, 2021, the Company repurchased 634,869 shares from the open market under its Stock Repurchase plan at an aggregate cost of $83.7 million. The remaining dollar value of shares authorized to be purchased under the Stock Repurchase plan was $166.3 million at December 31, 2021.

8. Leases

The Company determines if a contract contains a lease at inception date. The Company's leases are operating leases, primarily for office and office equipment, that expire at various dates over the next five years. The facility based leases have renewal options for periods ranging from one to nine years. As it is not reasonably certain these renewal options will be exercised, the options were not considered in the lease term, and payments associated with the option years are excluded from lease payments.

Payments due under operating leases include fixed and variable payments. These variable payments for the Company's office leases can include operating expenses, utilities, property taxes, insurance, common area maintenance, and other facility-related expense. Additionally, any leases with terms less than one year were not recognized as operating lease right of use assets or payables for short term leases in accordance with the election of ‘package of practical expedient’ under ASU 2016-02.

The Company recognizes operating lease right of use assets and operating lease payable based on the present value of the future minimum lease payments at the lease commencement date. The Company's leases do not provide implicit rates. Therefore, the Company used an incremental borrowing rate based on the information available at the lease commencement date in determining the present value of future payments. As of December 31, 2021, the weighted-average remaining lease term was 3.85 years and weighted-average discount rate was 4.22%. As of December 31, 2020, the weighted-average remaining lease term was 4.15 years and weighted-average discount rate was 4.51%.

The following table summarizes the operating lease right of use assets and related lease payables in the consolidated balance sheets at December 31, 2021 and 2020 (amounts in thousands):

	December 31, 2021	December 31, 2020
Operating lease right of use asset	$ 113,399	$ 100,046
Current operating lease payable	$ 37,630	$ 32,676
Long-term operating lease payable	$ 78,688	$ 70,275

The components of lease costs for operating leases for the years ended December 31, 2021, 2020 and 2019 were as follows: (amounts in thousands):

	2021	2020	2019
Operating lease cost	$ 51,080	$ 47,288	$ 45,595
Short-term lease cost	3,480	4,273	3,243
Variable lease cost	4,013	4,187	3,879
Total lease costs	$ 58,573	$ 55,748	$ 52,717

Maturities of operating lease payables as of December 31, 2021 were as follows (amounts in thousands):

Year	Total
2022	$ 41,605
2023	32,035
2024	22,660
2025	15,485
Thereafter	14,057
Total future minimum lease payments	125,842
Less: Imputed interest	(9,524)
Total	$ 116,318

9. Employee Benefit Plan

Defined Contribution Plan

The Company sponsors a 401(k) plan for all eligible employees. The plan allows participants to contribute up to the IRS 402(g) limits each year, both on a pretax and after tax basis, which was $19,500 in 2021. The plan also allows discretionary Company contributions as determined by the Company's Board of Directors. Effective January 1, 2006, the Company implemented a discretionary match of up to two percent of participating employee contributions. The employer contribution will vest 25% in an employee's account for each year of service with the Company and 25% each additional year until it is fully vested in yearfour. Contribution expense to the Company was $12.6 million, $11.9 million and $12.2 million in the years ended December 31, 2021, 2020 and 2019, respectively.

10. Commitments and Contingencies

Contingencies

The Company provides services in a highly regulated industry and is a party to various proceedings and regulatory and other governmental and internal audits and investigations in the ordinary course of business (including audits by Zone Program Integrity Contractors ("ZPICs") and Recovery Audit Contractors ("RACs") and investigations resulting from the Company's obligation to self-report suspected violations of law). Management cannot predict the ultimate outcome of any regulatory, other governmental, and internal audits and investigations. While such audits and investigations are the subject of administrative appeals, the appeals process, even if successful, may take several years to resolve. The Department of Justice, CMS, or other federal and state enforcement and regulatory agencies may conduct additional investigations related to the Company's businesses. These audits and investigations have caused and could potentially continue to cause delays in collections and, recoupments from governmental payors. Currently, the Company has recorded $16.9 million in other assets, which are from government payors related to the disputed finding of pending ZPIC audits. Additionally, these audits may subject the Company to sanctions, damages, extrapolation of damage findings, additional recoupments, fines, and other penalties (some of which may not be covered by insurance), which may, either individually or in the aggregate, have a material adverse effect on the Company's business and financial condition.

We are involved in various legal proceedings arising in the ordinary course of business. Although the results of litigation cannot be predicted with certainty, we believe the outcome of pending litigation will not have a material adverse effect, after considering the effect of our insurance coverage, on our consolidated financial information.

Legal fees related to all legal matters are expensed as incurred.

Joint Venture Buy/Sell Provisions

Most of the Company's joint ventures include a buy/sell option that grants to the Company and its joint venture partners the right to require the other joint venture party to either purchase all of the exercising member's membership interests or sell to the exercising member all of the non-exercising member's membership interest, at the non-exercising member's option, within 30 days of the receipt of notice of the exercise of the buy/sell option. In some instances, the purchase price is based on a multiple of the historical or future earnings before income taxes and depreciation and amortization of the equity joint venture at the time the buy/sell option is exercised. In other instances, the buy/sell purchase price will be negotiated by the partners and subject to a fair market valuation process. The Company has not received notice from any joint venture partners of their intent to exercise the terms of the buy/sell agreement nor has the Company notified any joint venture partners of its intent to exercise the terms of the buy/sell agreement.

Compliance

The laws and regulations governing the Company's operations, along with the terms of participation in various government programs, regulate how the Company does business, the services offered and its interactions with patients and the public. These laws and regulations, and their interpretations, are subject to frequent change. Changes in existing laws or regulations, or their interpretations, or the enactment of new laws or regulations could materially and adversely affect the Company's operations and financial condition.

The Company is subject to various routine and non-routine governmental reviews, audits and investigations. In recent years, federal and state civil and criminal enforcement agencies have heightened and coordinated their oversight efforts related to the health care industry, including referral practices, cost reporting, billing practices, joint ventures and other financial relationships among health care providers. Violation of the laws governing the Company's operations, or changes in the interpretation of those laws, could result in the imposition of fines, civil or criminal penalties, and/or termination of the Company's rights to participate in federal and state-sponsored programs and suspension or revocation of the Company's licenses. The Company believes that it is in material compliance with all applicable laws and regulations.

11. Segment Information

The Company's reporting segments include (1) home health services, (2) hospice services, (3) home and community-based services, (4) facility-based services and (5) healthcare innovations ("HCI"). The accounting policies of the segments are the same as those described in the summary of significant accounting policies, as described in Note 2 to the Consolidated Financial Statements included in this Annual Report on Form 10-K.

Reportable segments have been identified based upon how management has organized the business by services provided to customers and how the chief operating decision maker manages the business and allocates resources, consistent with the criteria in ASC 280, Segment Reporting.

The following tables summarize the Company's segment information for the twelve months ended December 31, 2021, 2020 and 2019 (amounts in thousands):

	Year Ended December 31, 2021					
	Home Health	Hospice	Home and Community-Based	Facility-Based	HCI	Total
Net service revenue	$ 1,551,542	$ 311,218	$ 189,561	$ 132,098	$ 35,203	$ 2,219,622
Cost of service revenue (excluding depreciation and amortization)	901,685	194,895	137,852	89,270	12,907	1,336,609
General and administrative expenses	501,132	89,693	46,724	45,304	13,582	696,435
Impairment of intangibles and other	937	—	—	—	—	937
Operating income (loss)	147,788	26,630	4,985	(2,476)	8,714	185,641
Interest expense	(3,103)	(529)	(413)	(208)	(85)	(4,338)
Income (loss) before income taxes and noncontrolling interests	144,685	26,101	4,572	(2,684)	8,629	181,303
Income tax expense (benefit)	30,089	5,344	1,069	(919)	2,104	37,687
Net income (loss)	114,596	20,757	3,503	(1,765)	6,525	143,616
Less net income (loss) attributable to noncontrolling interests	22,060	4,297	467	1,105	(41)	27,888
Net income (loss) attributable to LHC Group, Inc.'s common stockholders	$ 92,536	$ 16,460	$ 3,036	$ (2,870)	$ 6,566	$ 115,728
Total assets	$ 1,719,403	$ 786,671	$ 239,314	$ 85,005	$ 65,228	$ 2,895,621

	Year Ended December 31, 2020					
	Home Health	Hospice	Home and Community-Based	Facility-Based	HCI	Total
Net service revenue	$ 1,463,779	$ 243,806	$ 194,584	$ 128,578	$ 32,457	$ 2,063,204

Cost of service revenue (excluding depreciation and amortization)	848,663	150,675	150,378	85,827	14,860	1,250,403
General and administrative expenses	464,568	66,454	45,443	43,435	12,947	632,847
Impairment of intangibles and other	1,249	600	—	—	—	1,849
Operating income (loss)	149,299	26,077	(1,237)	(684)	4,650	178,105
Interest expense	(2,856)	(469)	(390)	(297)	(117)	(4,129)
Income (loss) before income taxes and noncontrolling interests	146,443	25,608	(1,627)	(981)	4,533	173,976
Income tax expense (benefit)	30,435	4,925	(357)	(185)	1,225	36,043
Net income (loss)	116,008	20,683	(1,270)	(796)	3,308	137,933
Less net income (loss) attributable to noncontrolling interests	20,525	4,822	(171)	1,193	(32)	26,337
Net income (loss) attributable to LHC Group, Inc.'s common stockholders	$ 95,483	$ 15,861	$ (1,099)	$ (1,989)	$ 3,340	$ 111,596
Total assets	$ 1,741,044	$ 301,475	$ 263,708	$ 103,401	$ 73,726	$ 2,483,354

	Year Ended December 31, 2019					
	Home Health	Hospice	Home and Community-Based	Facility-Based	HCI	Total
Net service revenue	$ 1,503,393	$ 226,922	$ 208,455	$ 111,809	$ 29,662	$ 2,080,241
Cost of service revenue (excluding depreciation and amortization)	939,035	140,177	157,817	73,274	14,584	1,324,887
General and administrative expenses	437,276	61,190	44,025	38,358	15,157	596,006
Impairment of intangibles and other	7,443	291	—	—	—	7,734
Operating income (loss)	119,639	25,264	6,613	177	(79)	151,614
Interest expense	(7,762)	(1,269)	(1,112)	(678)	(334)	(11,155)
Income (loss) before income taxes and noncontrolling interests	111,877	23,995	5,501	(501)	(413)	140,459
Income tax expense (benefit)	21,147	4,353	1,394	(204)	(83)	26,607
Net income (loss)	90,730	19,642	4,107	(297)	(330)	113,852
Less net income (loss) attributable to noncontrolling interests	14,651	3,979	(906)	435	(33)	18,126
Net income (loss) attributable to LHC Group, Inc.'s common stockholders	$ 76,079	$ 15,663	$ 5,013	$ (732)	$ (297)	$ 95,726
Total assets	$ 1,486,012	$ 244,105	$ 249,524	$ 91,337	$ 69,317	$ 2,140,295

12. Fair Value of Financial Instruments

The carrying amounts of the Company's cash, receivables, accounts payable, accrued liabilities, and operating lease right of use assets and liabilities approximate their fair values because of their short maturity. The estimated fair value of intangible assets acquired was calculated using level 3 inputs based on the present value of anticipated future benefits. For the year ended December 31, 2021, the carrying value of the Company's long-term debt approximates fair value as the interest rates approximates current rates.

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.

LHC GROUP, INC.

February 24, 2022

/s/ KEITH G. MYERS

Keith G. Myers
Chief Executive Officer

POWER OF ATTORNEY

KNOW ALL MEN BY THESE PRESENTS, that each person whose signature appears below constitutes and appoints Keith G. Myers and Dale G. Mackel and either of them (with full power in each to act alone) as true and lawful attorneys-in-fact with full power of substitution, for him and in his name, place and stead, in any and all capacities, to sign any and all amendments to this Annual Report on Form 10-K and to file the same, with all exhibits thereto and other documents in connection therewith, with the Securities and Exchange Commission, hereby ratifying and confirming all that said attorneys-in-fact, or their substitute or substitutes, may lawfully do or cause to be done by virtue hereof.

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

Signature	Title	Date
/s/ KEITH G. MYERS **Keith G. Myers**	Chief Executive Officer and Chairman of the Board of Directors	February 24, 2022
/s/ DALE G. MACKEL **Dale G. Mackel**	Chief Financial Officer, Principal Accounting Officer	February 24, 2022
/s/ KIMBERLY S. SEYMOUR **Kimberly S. Seymour**	Senior Vice President of Accounting, Chief Accounting Officer	February 24, 2022
/s/ MONICA F. AZARE **Monica F. Azare**	Director	February 24, 2022
/s/ TERI G. FONTENOT **Teri G. Fontenot**	Director	February 24, 2022
/s/ JONATHAN D. GOLDBERG **Jonathan D. Goldberg**	Director	February 24, 2022
/s/ CLIFFORD S. HOLTZ **Clifford S. Holtz**	Director	February 24, 2022
/s/ JOHN L. INDEST **John L. Indest**	Director	February 24, 2022
/s/ RONALD T. NIXON **Ronald T. Nixon**	Director	February 24, 2022
/s/ W. EARL REED, III **W. Earl Reed, III**	Director	February 24, 2022
/s/ BRENT TURNER **Brent Turner**	Director	February 24, 2022

EXHIBIT INDEX

Exhibit Number	Description of Exhibits
2.1	Agreement and Plan of Merger, dated as of November 15, 2017, by and among LHC Group, Inc., Hammer Merger Sub, Inc., and Almost Family, Inc. (incorporated by reference to Exhibit 2.1 to LHC Group's Form 8-K filed on November 16, 2017).
3.1	Amended and Restated Certificate of Incorporation of LHC Group, Inc. (previously filed as Exhibit 3.3 to LHC Group's Form S-4/A (File No. 333-222209) filed on February 5, 2018).
3.2	Bylaws of LHC Group, Inc., as amended on December 3, 2007 (previously filed as Exhibit 3.2 to LHC Group's Form 10-Q for the quarterly period ended March 31, 2008, filed on May 9, 2008).
4.1	Specimen Stock Certificate of LHC Group's Common Stock, par value $0.01 per share (previously filed as Exhibit 4.1 to LHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
4.2	Description of Securities Registered Pursuant to Section 12 of the Exchange Act.
10.1+	LHC 2003 Key Employee Equity Participation Plan (previously filed as Exhibit 10.3 to LHC Group's Form S-1 (File No. 333-120792) filed on November 26, 2004).
10.2+	LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan (previously filed as Exhibit 10.4 to LHC Group's Form 10-K for the year ended December 31, 2014, filed on March 11, 2015).
10.3+	Amendment to LHC Group, Inc. Second Amended and Restated 2005 Non-Employee Directors Compensation Plan, effective January 20, 2015. (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q filed on May 7, 2015).
10.4+	LHC Group, Inc. 2005 Long-Term Incentive Plan (previously filed as Exhibit 10.4 toLHC Group's Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.5+	LHC Group, Inc. 2010 Long-Term Incentive Plan (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q for the quarterly period ended June 30, 2010, filed on August 6, 2010).
10.6+	LHC Group, Inc. 2018 Incentive Plan (previously filed as Appendix A of the Company's Definitive Proxy Statement on Schedule 14A filed on April 27, 2018).
10.7+	Form of Indemnity Agreement between LHC Group and directors and certain officers (previously filed as Exhibit 10.10 toLHC Group's the Form S-1/A (File No. 333-120792) filed on February 14, 2005).
10.8+	LHC Group, Inc. 2006 Employee Stock Purchase Plan (previously filed as Exhibit 99.2 to LHC Group's Form 8-K filed on June 16, 2006).
10.9+	Amended and Restated Senior Secured Credit Facility, dated August 3, 2021, among LHC Group, Inc., the Lenders Party Thereto, and JPMorgan Chase Bank, N.A. as Administrative Agent (previously filed as Exhibit 10.1 to LHC Group's Form 8-K filed on August 3, 2021).

10.10+	Amended and Restated Employment Agreement between Keith G. Myers and LHC Group, Inc. dated April 1, 2017 (previously filed as Exhibit 10.1 to LHC Group's Form 8-K filed April 5, 2017).
10.11+	Amended and Restated Employment Agreement between Joshua L. Proffitt and LHC Group, Inc. dated October 7, 2019 (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q filed November 7, 2019).
10.12+	Amended and Restated Employment Agreement between Bruce D. Greenstein and LHC Group, Inc. dated July 1, 2021 (previously filed as Exhibit 10.1 to LHC Group's Form 10-Q filed August 5, 2021).
10.13+	Employment Agreement between Nicholas Gachassin, III and LHC Group, Inc. dated January 2, 2019 (previously filed as Exhibit 10.12 to LHC Group's Form 10-K filed February 28, 2019).
10.14+	Employment Agreement between Dale Mackel and LHC Group, Inc. dated November 2, 2020 (previously filed as Exhibit 10.12 to LHC Group's Form 10-K filed February 26, 2021).
21.1	Subsidiaries of the Registrant.
23.1	Consent of KPMG LLP.
31.1	Certification of Keith G. Myers, Chief Executive Officer pursuant to Rule 13a- 14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
31.2	Certification of Dale Mackel, Chief Financial Officer pursuant to Rule 13a- 14(a)/15d-14(a), as adopted pursuant to Section 302 of the Sarbanes-Oxley Act of 2002.
32.1*	Certification of the Chief Executive Officer and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.INS	XBRL Instance Document
101.SCH	XBRL Schema Document
101.CAL	XBRL Calculation Linkbase Document
101.DEF	XBRL Definition Linkbase Document
101.LAB	XBRL Label Linkbase Document
101.PRE	XBRL Presentation Linkbase Document

Attached as Exhibit 101 to this report are documents formatted in XBRL (Extensible Business Reporting Language). Users of this data are advised pursuant to Rule 406T of Regulation S-T that the interactive data file is deemed not filed or part of a registration statement or prospectus for purposes of section 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise not subject to liability under these sections. The financial information contained in the XBRL-related documents is “unaudited” or “unreviewed.”

+ Indicates a management contract or compensatory plan.

* This exhibit is furnished to the SEC as an accompanying document and is not deemed to be "filed" for purposes of Section 18 of the Securities Exchange Act of 1934 or otherwise subject to the liabilities of that Section, and the document will not be deemed incorporated by reference into any filing under the Securities Act of 1933.

Exhibit 21.1

LHC GROUP, INC. SUBSIDIARIES

Company	Domestic State
Able Home Health, Inc.	Alabama
Advanced Care House Calls of Alabama, LLC	Alabama
Alabama Health Care Group, LLC	Alabama
Athens-Limestone HomeCare, LLC	Alabama
Baptist Home Health, LLC	Alabama
Camden HomeCare, LLC	Alabama
Centre Home Care, LLC	Alabama
Clay County Hospital Home Care, LLC	Alabama
Coosa Valley HomeCare, LLLC	Alabama
East Alabama Medical Center HomeCare, LLC	Alabama
Fayette Medical Center HomeCare, LLC	Alabama
Fort Payne Home Care, LLC	Alabama
Gulf Homecare, Inc.	Alabama
HGA HomeCare, LLC	Alabama
Infirmary Home Health Agency, Inc.	Alabama
LHCG CXXVIII, LLC	Alabama
LHCG LI, LLC	Alabama
LHCG LXIV, LLC	Alabama
LHCG LXXIX, LLC	Alabama
LHCG LXXXIV, LLC	Alabama
LHCG XXII, LLC	Alabama
LHCG XXIX, LLC	Alabama
LHCG XXXIV, LLC	Alabama
LHCG CCVI, LLC	Alabama
Marion Regional HomeCare, LLC	Alabama
Medical Centers HomeCare, LLC	Alabama
Mizell Memorial Hospital HomeCare, LLC	Alabama
Princeton Home Health, LLC	Alabama
Southeast Alabama HomeCare, LLC	Alabama
SunCrest Home Health of AL, Inc.	Alabama
Thomas Home Health, LLC	Alabama
Advanced Care House Calls of Arizona, LLC	Arizona
Arizona Health Care Group, LLC	Arizona
Arizona In-Home Healthcare Partnership-I, LLC	Arizona
Arizona In-Home Healthcare Partnership-II, LLC	Arizona
Arizona In-Home Healthcare Partnership-III, LLC	Arizona
Arizona In-Home Partner-I, LLC	Arizona
Arizona In-Home Partner-II, LLC	Arizona
Arizona In-Home Partner-III, LLC	Arizona
LHCG LVI, LLC	Arizona
LHCG LXXVII, LLC	Arizona
LHCG CLXXI, LLC	Arizona
LHCGCLXXII, LLC	Arizona
LHCG CLXXII, LLC	Arizona
LHCG CXCVI, LLC	Arizona
Western Arizona Regional Home Health and Hospice, LLC	Arizona
AHCG Management, LLC	Arkansas

Arkansas Extended Care, LLC	Arkansas
Arkansas Health Care Group, LLC	Arkansas
Arkansas Healthcare Partners, LLC	Arkansas
Arkansas Home Health Providers-III, LLC	Arkansas
Arkansas Home Health Providers-IV, LLC	Arkansas
Arkansas Home Hospice, LLC	Arkansas
Arkansas HomeCare of Forrest City, LLC	Arkansas
Arkansas HomeCare of Fulton, LLC	Arkansas
Arkansas HomeCare of Hot Springs, LLC	Arkansas
Arkansas In-Home Healthcare Partnership-I, LLC	Arkansas
Arkansas In-Home Healthcare Partnership-II, LLC	Arkansas
Arkansas In-Home Partner-I, LLC	Arkansas
Arkansas In-Home Partner-II, LLC	Arkansas
Arkansas Nursing Providers, LLC	Arkansas
Arkansas Physical Therapy Services of Conway, LLC	Arkansas
CMC Home Health and Hospice, LLC	Arkansas
Dallas County Medical Center HomeCare, LLC	Arkansas
East Arkansas Health Holdings, LLC	Arkansas
Elite Physical Therapy Services, LLC	Arkansas
Eureka Springs Hospital HomeCare, LLC	Arkansas
Eureka Springs Hospital Hospice, LLC	Arkansas
Fort Smith HMA Home Health, LLC	Arkansas
Hospice of Central Arkansas, LLC	Arkansas
Jefferson Regional HomeCare, LLC	Arkansas
LHCG CII, LLC	Arkansas
LHCG CIV, LLC	Arkansas
LHCG CV, LLC	Arkansas
LHCG CXIX, LLC	Arkansas
LHCG CXVIII, LLC	Arkansas
LHCG CXXV, LLC	Arkansas
LHCG CXXXX, LLC	Arkansas
LHCG CXXXXI, LLC	Arkansas
LHCG CXXXXII, LLC	Arkansas
LHCG LXVIII, LLC	Arkansas
LHCG LXXXIII, LLC	Arkansas
LHCG LXXXV, LLC	Arkansas
LHCG LXXXVI, LLC	Arkansas
LHCG XLII, LLC	Arkansas
Mena Medical Center Home Health, LLC	Arkansas
Mena Medical Center Hospice, LLC	Arkansas
Midwest Hospice, LLC	Arkansas
Northeast Arkansas Partnership, LLC	Arkansas
Patient’s Choice Hospice, LLC	Arkansas
Southwest Arkansas HomeCare, LLC	Arkansas
Alaska Health Care Group, LLC	Alaska
Advanced Care House Calls of California, LLC	California
California Health Care Group, LLC	California
LHCG XXXVIII, LLC	California
Advanced Care House Calls of Colorado, LLC	Colorado
Colorado Health Care Group, LLC	Colorado
Colorado In-Home Healthcare Partnership-I, LLC	Colorado
Colorado In-Home Partner-I, LLC	Colorado
LHCG LVII, LLC	Colorado
LHCG CLXIII, LLC	Colorado
Advanced Care House Calls of Connecticut, LLC	Connecticut
Connecticut Home Health Care, Inc.	Connecticut

Patient Care Connecticut, LLC	Connecticut
Patient Care HHA, LLC	Connecticut
Patient's Choice Homecare, LLC	Connecticut
Priority Care, Inc.	Connecticut
Adult Day Care of America, Inc.	Delaware
AF-CH-HH, LLC	Delaware
AFAM Holding Co, LLC	Delaware
AFAM Holding Co II, LLC	Delaware
AFAM Sub I, LLC	Delaware
Almost Family, Inc.	Delaware
Altus Hospice of Georgia, LLC	Delaware
Augusta Home Care Services, LLC	Delaware
Berwick Home Care Services, LLC	Delaware
Birmingham Home Care Services, LLC	Delaware
Blue Island Home Care Services, LLC	Delaware
Brookdale Hospice of Philadelphia, LLC	Delaware
Cambridge Home Health Care Holdings, Inc.	Delaware
Clarksville Home Care Services, LLC	Delaware
Cleveland Home Care Services, LLC	Delaware
Compassionate Hospice of Georgia, Inc.	Delaware
Crossroads Home Care Services, LLC	Delaware
Deming Home Care Services, LLC	Delaware
El Dorado Home Care Services, LLC	Delaware
Emporia Home Care Services, LLC	Delaware
Florence Home Care Services, LLC	Delaware
Franklin Home Care Services, LLC	Delaware
Fulton Home Care Services, LLC	Delaware
Gadsden Home Care Services, LLC	Delaware
Galesburg Home Care, LLC	Delaware
Granite City Home Care Services, LLC	Delaware
Halcyon Healthcare, LLC	Delaware
Hattiesburg Home Care Services, LLC	Delaware
Helena Home Care Services, LLC	Delaware
Health at Home - Seattle Metro, LLC	Delaware
Health at Home - Sonoma, LLC	Delaware
Health at Home Holdings, LLC	Delaware
Health at Home Holdings - Alabama, LLC	Delaware
Health at Home Holdings - Albuquerque, LLC	Delaware
Health at Home Holdings - Arizona, LLC	Delaware
Health at Home Holdings - Boston, LLC	Delaware
Health at Home Holdings - Charlotte, LLC	Delaware
Health at Home Holdings - Chicago, LLC	Delaware
Health at Home Holdings - Detroit, LLC	Delaware
Health at Home Holdings - Durham, LLC	Delaware
Health at Home Holdings - Edmond, LLC	Delaware
Health at Home Holdings - High Point LLC	Delaware
Health at Home Holdings - Indianapolis, LLC	Delaware
Health at Home Holdings - Ohio, LLC	Delaware
Health at Home Holdings - Philadelphia, LLC	Delaware
Health at Home Holdings - Portland, LLC	Delaware
Health at Home Holdings - Seattle Metro, LLC	Delaware
Health at Home Holdings - Sonoma, LLC	Delaware
Health at Home Holdings - St. Louis, LLC	Delaware
Health at Home Holdings - Tulsa, LLC	Delaware
Health at Home Hospice - Chicago, LLC	Delaware
Health at Home Hospice - Cleveland, LLC	Delaware

Health at Home Hospice - Columbus, LLC	Delaware
Health at Home Hospice - Davton, LLC	Delaware
Health at Home Hospice - Detroit, LLC	Delaware
Health at Home Hospice - Indianapolis, LLC	Delaware
Health at Home Hospice - Minnestoa, LLC	Delaware
Health at Home Hospice - Phoenix, LLC	Delaware
Health at Home Hospice - Portland, LLC	Delaware
Health at Home Hospice - Sacromento, LLC	Delaware
Health at Home Hospice - Atlanta, LLC	Delaware
Health of Home Hospice - Knoxville, LLC	Delaware
Health of Home Hospice - New Jersey, LLC	Delaware
Health of Home Hospice - Greenville, LLC	Delaware
Ingenios Health Co	Delaware
Ingenios Health Holdings, Inc.	Delaware
In-Home Healthcare Partnership, LLC	Delaware
Innovative Senior Care Home Health of Alabama, LLC	Delaware
Innovative Senior Care Home Health of Albuquerque, LLC	Delaware
Innovative Senior Care Home Health of Boston, LLC	Delaware
Innovative Senior Care Home Health of Charlotte, LLC	Delaware
Innovative Senior Care Home Health of Chicago, LLC	Delaware
Innovative Senior Care Home Health of Detroit, LLC	Delaware
Innovative Senior Care Home Health of Durham, LLC	Delaware
Innovative Senior Care Home Health of Edmond, LLC	Delaware
Innovative Senior Care Home Health of Hartford, LLC	Delaware
Innovative Senior Care Home Health of High Point, LLC	Delaware
Innovative Senior Care Home Health of Indianapolis, LLC	Delaware
Innovative Senior Care Home Health of Minneapolis, LLC	Delaware
Innovative Senior Care Home Health of Ohio, LLC	Delaware
Innovative Senior Care Home Health of Philadelphia, LLC	Delaware
Innovative Senior Care Home Health of Portland, LLC	Delaware
Innovative Senior Care Home Health of Rhode Island, LLC	Delaware
Innovative Senior Care Home Health of St. Louis, LLC	Delaware
Innovative Senior Care Home Health of Tulsa, LLC	Delaware
ISCHH of Minneapolis Holdings, LLC	Delaware
Jackson Home Care Services, LLC	Delaware
Jourdanton Home Care Services, LLC	Delaware
Knoxville Home Care Services, LLC	Delaware
Lakeland Home Care Services, LLC	Delaware
Lancaster Home Care Services, LLC	Delaware
La Porte Home Care Services, LLC	Delaware
LHC Group, Inc.	Delaware
LHC Group Recruiting & Training Center, LLC	Delaware
LHCG Partner, LLC	Delaware
LHCG New York Holding, LLC	Delaware
Louisa Home Care Holdings, LLC	Delaware
Louisa Home Care Services, LLC	Delaware
Mooresville Home Care Services, LLC	Delaware
Northampton Home Care, LLC	Delaware
Nurse on Call of Arizona, LLC	Delaware
Oklahoma City Home Care Services, LLC	Delaware
OMNI Home Health Holdings, Inc.	Delaware
OMNI Home Health Services, LLC	Delaware
Patient Care New Jersey, Inc.	Delaware
Patient Care Pennsylvania, Inc.	Delaware
Patient Care, Inc.	Delaware
Petersburg Home Care Services, LLC	Delaware
Pottstown Home Care Services, LLC	Delaware

Red Bud Home Care Services, LLC	Delaware
River West Home Care, LLC	Delaware
Scranton Quincy Home Care Services, LLC	Delaware
Sharon Home Care Services, LLC	Delaware
Shelbyville Home Care Services, LLC	Delaware
SJ Home Care, LLC	Delaware
Spokane Home Care Services, LLC	Delaware
Springdale Home Care Services, LLC	Delaware
Tomball Texas Home Care Services, LLC	Delaware
Tucson Home Care Services, LLC	Delaware
Valparaiso Home Care Services, LLC	Delaware
Venice Home Care Services, LLC	Delaware
Victoria Texas Home Care Services, LLC	Delaware
Waukegan Hospice, LLC	Delaware
Weatherford Home Care Services, LLC	Delaware
West Grove Home Care, LLC	Delaware
Wilkes-Barre Home Care Services, LLC	Delaware
Woodward Home Care Services, LLC	Delaware
York Home Care Services, LLC	Delaware
Youngstown Home Care Services, LLC	Delaware
LHCG CXXXXV, LLC	District of Columbia
Washington D.C. Health Care Group, LLC	District of Columbia
Advanced Care House Calls of Florida, LLC	Florida
Almost Family ACO Services of South Florida, LLC	Florida
Almost Family PC of Ft. Lauderdale, LLC	Florida
Almost Family PC of SW Florida, LLC	Florida
Almost Family PC of West Palm, LLC	Florida
Bayfront HMA Home Health, LLC	Florida
BGR Acquisition, LLC	Florida
Brevard HMA Home Health, LLC	Florida
Brevard HMA Hospice, LLC	Florida
Caretenders of Jacksonville, LLC	Florida
Caretenders Visiting Services of District 6, LLC	Florida
Caretenders Visiting Services of District 7, LLC	Florida
Caretenders Visiting Services of Gainesville, LLC	Florida
Caretenders Visiting Services of Hernando County, LLC	Florida
Caretenders Visiting Services of Ocala, LLC	Florida
Caretenders Visiting Services of Pinellas County, LLC	Florida
Caretenders Visiting Services of St. Augustine, LLC	Florida
Central Florida Partnership, LLC	Florida
Florida Physical Therapy Services of Fort Myers, LLC	Florida
Florida Physical Therapy Services of Gainesville, LLC	Florida
Florida Physical Therapy Services of Pensacola, LLC	Florida
Florida Physical Therapy Services of Miramar, LLC	Florida
Florida Physical Therapy Services of Panama City, LLC	Florida
Home Health Agency - Central Pennsylvania, LLC	Florida
Home Health Agency - Collier, LLC	Florida
Home Health Agency - Hillsborough, LLC	Florida
Home Health Agency - Indiana, LLC	Florida
Home Health Agency - Pennsylvania, LLC	Florida
Home Health Agency - Philadelphia, LLC	Florida
Home Health Agency - Pinellas, LLC	Florida
Key West HHA, LLC	Florida
Key West PD, LLC	Florida

LHC Health Care Group of Florida, LLC	Florida
LHCG LXXXII, LLC	Florida
LHCG XIX, LLC	Florida
LHCG CLIII, LLC	Florida
LHCG CLIV, LLC	Florida
LHCG CLV, LLC	Florida
LHCG CLVI, LLC	Florida
LHCG CLVII, LLC	Florida
LHCG CLX, LLC	Florida
LHCG CCX, LLC	Florida
Lifeline Home Health Care of Lady Lake, LLC	Florida
Lifeline Home Health Care of Lakeland, LLC	Florida
Lifeline Home Health Care of Marathon, LLC	Florida
Lifeline Home Health Care of Port Charlotte, LLC	Florida
Mederi Caretenders VS of Broward, LLC	Florida
Mederi Caretenders VS of SE FL, LLC	Florida
Mederi Caretenders VS of SW FL, LLC	Florida
Mederi Caretenders VS of Tampa, LLC	Florida
Merderi Private Care, LLC	Florida
Munroe Regional HomeCare, LLC	Florida
North Okaloosa Home Health, LLC	Florida
OMNI Health Management, LLC	Florida
OMNI Home Health - District 1, LLC	Florida
OMNI Home Health - District 2, LLC	Florida
OMNI Home Health – District 4, LLC	Florida
OMNI Home Health - Hernando, LLC	Florida
OMNI Home Health - Jacksonville, LLC	Florida
SunCrest Home Health of Tampa, LLC	Florida
SWF Home Care Services, LLC	Florida
Advanced Care House Calls of Georgia, LLC	Georgia
Compassionate Healthcare Management Group, Inc.	Georgia
Eastern Georgia Partnership, LLC	Georgia
Floyd HomeCare, LLC	Georgia
Georgia Health Care Group, LLC	Georgia
Georgia HomeCare of Harris, LLC	Georgia
Grace Hospice, LLC	Georgia
LHCG CXXIII, LLC	Georgia
LHCG LXXIV, LLC	Georgia
LHCG LXXV, LLC	Georgia
LHCG XL, LLC	Georgia
LHCG CLXI, LLC	Georgia
LHCG CLXIV, LLC	Georgia
LHCG CLXV, LLC	Georgia
Northwest Georgia Home Health, LLC	Georgia
SunCrest Healthcare, Inc.	Georgia
Suncrest Home Health-Southside, LLC	Georgia
SunCrest Home Health of Georgia, Inc.	Georgia
SunCrest Home Health of South GA, Inc.	Georgia
Advanced Care House Calls of Idaho, LLC	Idaho
Heart /n Home Hospice and Palliative Care, LLC	Idaho
Idaho Health Care Group, LLC	Idaho
Idaho In-Home Healthcare Partnership-I, LLC	Idaho
Idaho In-Home Partner-I, LLC	Idaho
Kambros, LLC	Idaho
LHCG XVII, LLC	Idaho
LHCG XXI, LLC	Idaho
Advanced Care House Calls of Illinois, LLC	Illinois

Caretenders Visiting Services of Southern Illinois, LLC	Illinois
Illinois Health Care Group, LLC	Illinois
Illinois Home Care Holdings, LLC	Illinois
Illinois Home Health Care, LLC	Illinois
Illinois LIV, LLC	Illinois
LHCG XXXVII, LLC	Illinois
IN HomeCare Network Central, LLC	Indiana
IN HomeCare Network North, LLC	Indiana
Indiana Health Care Group, LLC	Indiana
LHCG CXCVII, LLC	Indiana
NP Services of IN, LLC	Indiana
ACHC ACO, LLC	Kentucky
ACO Clinical Partners, LLC	Kentucky
Advanced Care House Calls of Kentucky, LLC	Kentucky
Advanced Clinical Partners, LLC	Kentucky
AFAM Acquisition, LLC	Kentucky
Almost Family ACO Services of Kentucky, LLC	Kentucky
Almost Family PC of Kentucky, LLC	Kentucky
Apex Clinical Partners, LLC	Kentucky
Bluegrass Accountable Care, LLC	Kentucky
Caretenders of Cleveland, Inc.	Kentucky
Caretenders of Columbus, Inc.	Kentucky
Caretenders Visiting Services Employment Company, Inc.	Kentucky
Caretenders Visiting Services of Kentuckiana, LLC	Kentucky
Caretenders Visiting Services of Orlando, LLC	Kentucky
Caretenders VS of Central KY, LLC	Kentucky
Caretenders VS of Lincoln Trail, LLC	Kentucky
Caretenders VS of Louisville, LLC	Kentucky
Caretenders VS of Western KY, LLC	Kentucky
Home Health of Jefferson Co, LLC	Kentucky
Imperium Health Management, LLC	Kentucky
Kentuckiana Clinical Partners, LLC	Kentucky
Kentucky Accountable Care, LLC	Kentucky
Kentucky Clinical Partners, LLC	Kentucky
Kentucky Health Care Group, LLC	Kentucky
Kentucky Home Health Care, LLC	Kentucky
Kentucky HomeCare of Henderson, LLC	Kentucky
Kentucky In-Home Healthcare Partnership-I, LLC	Kentucky
Kentucky In-Home Healthcare Partnership-II, LLC	Kentucky
Kentucky In-Home Partner-I, LLC	Kentucky
Kentucky In-Home Partner-II, LLC	Kentucky
Kentucky LV, LLC	Kentucky
LHC HomeCare-Lifeline, LLC	Kentucky
LHCG LXX, LLC	Kentucky
LHCG LXXI, LLC	Kentucky
LHCG XLVI, LLC	Kentucky
LHCG XXIII, LLC	Kentucky
Lifeline Home Health Care of Bowling Green, LLC	Kentucky
Lifeline Home Health Care of Fulton, LLC	Kentucky
Lifeline Home Health Care of Hopkinsville, LLC	Kentucky
Lifeline Home Health Care of Lexington, LLC	Kentucky
Lifeline Home Health Care of Russellville, LLC	Kentucky
Lifeline Home Health Care of Somerset, LLC	Kentucky
Lifeline HomeCare of Salem, LLC	Kentucky
Lifeline Private Duty Services of Kentucky, LLC	Kentucky
Lifeline Rockcastle Home Health, LLC	Kentucky

NP Services of KY, LLC	Kentucky
Physicians Accountable Care, LLC	Kentucky
Physicians Accountable Care of Kentucky, LLC	Kentucky
Trigg County Home Health, LLC	Kentucky
Twin Lakes Home Health Agency, LLC	Kentucky
AAA Home Health, Inc.	Louisiana
Acadian Home Health Care Services, LLC	Louisiana
Acadian HomeCare of New Iberia, LLC	Louisiana
Acadian HomeCare, LLC	Louisiana
Acadian Physical Therapy Services, LLC	Louisiana
Baton Rouge HomeCare, LLC	Louisiana
Beauregard Memorial Hospital HomeCare, LLC	Louisiana
Egan Health Care Corporation	Louisiana
Egan Healthcare of Northshore, Inc	Louisiana
Egan Healthcare of Plaquemines, Inc	Louisiana
Egan Hospice Services of Northshore, LLC	Louisiana
Feliciana Physical Therapy Services, LLC	Louisiana
Hood Home Health Service, LLC	Louisiana
LHC Group Employee Hardship Relief Fund	Louisiana
LHC Group Health Clinic, LLC	Louisiana
LHC Group Pharmaceutical Services II, LLC	Louisiana
LHC Group Pharmaceutical Services III, LLC	Louisiana
LHC Group Pharmaceutical Services, LLC	Louisiana
LHC Physician Services, LLC	Louisiana
LHC Real Estate I, LLC	Louisiana
LHC Real Estate II, LLC	Louisiana
LHCG CIX, LLC.	Louisiana
LHCG CVI, LLC	Louisiana
LHCG CVII, LLC	Louisiana
LHCG CVIII, LLC	Louisiana
LHCG CX, LLC	Louisiana
LHCG CXX, LLC	Louisiana
LHCG CXXVI, LLC	Louisiana
LHCG LXVII, LLC	Louisiana
LHCG LXXII, LLC	Louisiana
LHCG LXXVI, LLC	Louisiana
LHCG LXXVIII, LLC	Louisiana
LHCG V, LLC	Louisiana
LHCG VI, LLC	Louisiana
LHCG VIII, LLC	Louisiana
LHCG X, LLC	Louisiana
LHCG XII, LLC	Louisiana
LHCG XIII, LLC	Louisiana
LHCG XIV, LLC	Louisiana
LHCG XLIII, LLC	Louisiana
LHCG XLIV, LLC	Louisiana
LHCG XV, LLC	Louisiana
LHCG XVI, LLC	Louisiana
LLC-I, LLC	Louisiana
LLC-II, LLC	Louisiana
LHCG CLXIX, LLC	Louisiana
LHCG CCV, LLC	Louisiana
LHCG CCXIII, LLC	Louisiana
LHCG CCIII, LLC	Louisiana
Louisiana Extended Care Hospital of Kenner, LLC	Louisiana
Louisiana Health Care Group, LLC	Louisiana
Louisiana Home Health of Feliciana, LLC	Louisiana

Louisiana Home Health of Hammond, LLC	Louisiana
Louisiana Home Health of Houma, LLC	Louisiana
Louisiana HomeCare of Delhi, LLC	Louisiana
Louisiana HomeCare of Kenner, LLC	Louisiana
Louisiana HomeCare of Lutcher, LLC	Louisiana
Louisiana HomeCare of Minden, LLC	Louisiana
Louisiana HomeCare of Miss-Lou, LLC	Louisiana
Louisiana HomeCare of Monroe, LLC	Louisiana
Louisiana HomeCare of North Louisiana, LLC	Louisiana
Louisiana HomeCare of Northwest Louisiana, LLC	Louisiana
Louisiana HomeCare of Plaquemine, LLC	Louisiana
Louisiana HomeCare of Raceland, LLC	Louisiana
Louisiana HomeCare of Slidell, LLC	Louisiana
Louisiana Hospice and Palliative Care, LLC	Louisiana
Louisiana Hospice Group, LLC	Louisiana
Louisiana In-Home Healthcare Partnership - I, LLC	Louisiana
Louisiana In-Home Partner - I, LLC	Louisiana
Louisiana Physical Therapy Services of Bossier City, LLC	Louisiana
Louisiana Physical Therapy Services of Harahan, LLC	Louisiana
Louisiana Physical Therapy Services of Lafayette, LLC	Louisiana
Louisiana Physical Therapy, LLC	Louisiana
Northshore Extended Care Hospital, LLC	Louisiana
Oak Shadows of Jennings, LLC	Louisiana
Palmetto Express, LLC	Louisiana
Patient’s Choice Hospice and Palliative Care of Louisiana, LLC	Louisiana
Primary Care at Home of Louisiana II, LLC	Louisiana
Primary Care at Home of Louisiana III, LLC	Louisiana
Primary Care at Home of Louisiana IV, LLC	Louisiana
Primary Care at Home of Louisiana, LLC	Louisiana
Richardson Medical Center HomeCare, LLC	Louisiana
Southeast Louisiana HomeCare, LLC	Louisiana
Specialty Extended Care Hospital of Monroe, LLC	Louisiana
St. James HomeCare, LLC	Louisiana
St. Landry Family Healthcare, LLC	Louisiana
Texas Health Care Group Holdings, LLC	Louisiana
The Hospice Promise Foundation	Louisiana
Tri-Parish Community HomeCare, LLC	Louisiana
Vital Hospice, Inc.	Louisiana
Advanced Care House Calls of Maryland, LLC	Maryland
FirstCall Health Services, Inc.	Maryland
HomeCall, Inc.	Maryland
LHCG CL, LLC	Maryland
LHCG CXLIX, LLC	Maryland
LHCG LXXXI, LLC	Maryland
Maryland Health Care Group, LLC	Maryland
Marlyland Physical Therapy Services of Frederick, LLC	Maryland
Primary Care at Home of Maryland, LLC	Maryland
Advanced Care House Calls of Massachusetts, LLC	Massachusetts
Caretenders VS of Boston, LLC	Massachusetts
LHCG LVIII, LLC	Massachusetts
Long Term Solutions, Inc.	Massachusetts
Massachusetts Health Care Group, LLC	Massachusetts
Advanced Care House Calls of Michigan, LLC	Michigan
LHC Home Health Care Group of Michigan, LLC	Michigan
Michigan In-Home Healthcare Partnership-I, LLC	Michigan
Michigan In-Home Healthcare Partnership-II, LLC	Michigan
Michigan In-Home Healthcare Partnership-III, LLC	Michigan

Michigan In-Home Healthcare Partnership-IV, LLC	Michigan
Michigan In-Home Partner-I, LLC	Michigan
Michigan In-Home Partner-II, LLC	Michigan
Michigan In-Home Partner-III, LLC	Michigan
Michigan In-Home Partner-IV, LLC	Michigan
LHCG XLVIII, LLC	Minnesota
Minnesota Health Care Group, LLC	Minnesota
Able Home Health, Inc.	Mississippi
Advanced Care House Calls of Mississippi, LLC	Mississippi
Community Hospice, LLC	Mississippi
Cornerstone Palliative and Hospice, LLC	Mississippi
Covenant Palliative and Hospice, LLC	Mississippi
Leaf River Health Care, LLC	Mississippi
LHCG C, LLC	Mississippi
LHCG XCIX, LLC	Mississippi
LHCG XCVIII, LLC	Mississippi
LHCG XXVI, LLC	Mississippi
Mississippi Health Care Group, LLC	Mississippi
Mississippi HomeCare of Jackson II, LLC	Mississippi
Mississippi HomeCare, LLC	Mississippi
Mississippi Physical Therapy Services of Biloxi, LLC	Mississippi
Picayune HomeCare, LLC	Mississippi
South Mississippi Home Health, Inc.	Mississippi
South Mississippi Home Health, Inc. - Region I	Mississippi
South Mississippi Home Health, Inc. - Region II	Mississippi
South Mississippi Home Health, Inc. - Region III	Mississippi
Access Hospice, LLC	Missouri
Caretenders Visiting Services of St. Louis, LLC	Missouri
Kirksville Home Care Services, LLC	Missouri
LHCG CXLVI, LLC	Missouri
LHCG CXLVII, LLC	Missouri
LHCG CXLVIII, LLC	Missouri
LHCG CXXXXIII, LLC	Missouri
LHCG LXIX, LLC	Missouri
LHCG LXV, LLC	Missouri
LHCG XXV, LLC	Missouri
Missouri Health Care Group, LLC	Missouri
Southwest Missouri HomeCare, LLC	Missouri
SunCrest Home Health of MO, Inc.	Missouri
Nebraska Health Care Group, LLC	Nebraska
Advanced Care House Calls of Nevada, LLC	Nevada
Assured Capital Partners, Inc.	Nevada
LHCG CXXXIX, LLC	Nevada
LHCG CXXXVIII, LLC	Nevada
LHCG CXXXXIV, LLC	Nevada
LHCG XXXIX, LLC	Nevada
LHCG CLII, LLC	Nevada
Nevada Health Care Group, LLC.	Nevada
Advanced Care House Calls of New Hampshire, LLC	New Hampshire
New Hampshire Health Care Group, LLC	New Hampshire
New Hampshire Physical Therapy Services of Hanover, LLC	New Hampshire
LHCG CXLIV, LLC	New Jersey
LHCG CXLV, LLC	New Jersey
Patient Care Medical Services, Inc.	New Jersey
Patient Care of Hudson County, LLC	New Jersey
Advanced Care House Calls of New Mexico, LLC	New Mexico
Advanced Care House Calls of New York, LLC	New York

BHC Services, Inc.	New York
BRACOR, Inc.	New York
LHCG New York Holdings, LLC	New York
Litson Certified Care, Inc.	New York
Litson Health Care, Inc.	New York
National Health Industries, Inc.	New York
Western Region Health Corporation	New York
Willcare, Inc.	New York
Cape Fear Valley HomeCare and Hospice, LLC	North Carolina
LHCG CXXXXVI, LLC	North Carolina
LHCG L, LLC	North Carolina
LHCG CLXXIX, LLC	North Carolina
North Carolina Health Care Group, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-I, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-II, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-III, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-IV, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-IX, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-V, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-VI, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-VII, LLC	North Carolina
North Carolina In-Home Healthcare Partnership-VIII, LLC	North Carolina
North Carolina In-Home Partner-I, LLC	North Carolina
North Carolina In-Home Partner-II, LLC	North Carolina
North Carolina In-Home Partner-III, LLC	North Carolina
North Carolina In-Home Partner-IV, LLC	North Carolina
North Carolina In-Home Partner-IX, LLC	North Carolina
North Carolina In-Home Partner-V, LLC	North Carolina
North Carolina In-Home Partner-VI, LLC	North Carolina
North Carolina In-Home Partner-VII, LLC	North Carolina
North Carolina In-Home Partner-VIII, LLC	North Carolina
NP Services of NC, LLC	North Carolina
Advance Geriatric Education and Consulting, LLC	Ohio
Assisted Care by Black Stone of Central Ohio, LLC	Ohio
Assisted Care by Black Stone of Cincinnati, LLC	Ohio
Assisted Care by Black Stone of Dayton, LLC	Ohio
Assisted Care by Black Stone of Northwest Ohio, LLC	Ohio
Assisted Care by Black Stone of Toledo, LLC	Ohio
Black Stone of Central Ohio, LLC	Ohio
Black Stone of Cincinnati, LLC	Ohio
Black Stone of Dayton, LLC	Ohio
Black Stone of Northeast Ohio, LLC	Ohio
Black Stone of Northwest Ohio, LLC	Ohio
Black Stone Operations, LLC	Ohio
Blackstone Group, LLC	Ohio
Blackstone Health Care, LLC	Ohio
Cambridge Home Health Care, Inc.	Ohio
Cambridge Home Health Care, Inc. / Private	Ohio
Cambridge Personal Care, LLC	Ohio
Care Advisors by Black Stone, LLC	Ohio
Caretenders VNA of Ohio, LLC	Ohio
Caretenders VS of Ohio, LLC	Ohio
Caretenders VS of SE Ohio, LLC	Ohio
Home Health Care by Black Stone of Central Ohio, LLC	Ohio

Home Health Care by Black Stone of Cincinnati, LLC	Ohio
Home Health Care by Black Stone of Dayton, LLC	Ohio
Home Health Care by Black Stone of Northwest Ohio, LLC	Ohio
LHCG XCI, LLC	Ohio
LHCG XCII, LLC	Ohio
LHCG CCVII, LLC	Ohio
LHCG CCVIII, LLC	Ohio
MJ Nursing at Blackstone, LLC	Ohio
NP Services of OH, LLC	Ohio
Ohio Health Care Group, LLC	Ohio
Ohio HomeCare, LLC	Ohio
Ohio In-Home Healthcare Partnership-I, LLC	Ohio
Ohio In-Home Partnership-I, LLC	Ohio
Ohio Physical Therapy Services of Xenia, LLC	Ohio
Ohio Physical Therapy Services of Mayfield Heights, LLC	Ohio
Ohio Physical Therapy Services of Richmond Heights, LLC	Ohio
S&B Health Care, LLC	Ohio
Clinton Home Health & Hospice, LLC	Oklahoma
LHCG CLXX, LLC	Oklahoma
Mayes County HMA Home Health, LLC	Oklahoma
OHHP, LLC	Oklahoma
Oklahoma Health Care Group, LLC	Oklahoma
Ponca City Home Care Services, LLC	Oklahoma
Summit Properties - Muskogee, LLC	Oklahoma
LHCG LXXIII, LLC	Oregon
Oregon Health Care Group, LLC	Oregon
Salem HomeCare, LLC	Oregon
Three Rivers HomeCare, LLC	Oregon
Keystone Healthcare Partnership, LLC	Pennsylvania
LHCG CXL, LLC	Pennsylvania
LHCG CXLI, LLC	Pennsylvania
LHCG CXLII, LLC	Pennsylvania
LHCG CXLIII, LLC	Pennsylvania
LHCG XXVII, LLC	Pennsylvania
Patient Care Pennsylvania II, LLC	Pennsylvania
Pennsylvania Health Care Group Holdings, LLC	Pennsylvania
Pennsylvania In-Home Healthcare Partnership-I, LLC	Pennsylvania
Pennsylvania In-Home Healthcare Partnership-II, LLC	Pennsylvania
Pennsylvania In-Home Healthcare Partnership-III, LLC	Pennsylvania
Pennsylvania In-Home Partner-I, LLC	Pennsylvania
Pennsylvania In-Home Partner-II, LLC	Pennsylvania
Pennsylvania In-Home Partner-III, LLC	Pennsylvania
Advanced Care House Calls of Rhode Island, LLC	Rhode Island
LHCG LIX, LLC	Rhode Island
LHCG CCXIV, LLC	Rhode Island
Rhode Island Health Care Group, LLC	Rhode Island
Advanced Care House Calls of South Carolina, LLC	South Carolina
Halcyon Hospice of Aiken, LLC	South Carolina
Heart of Hospice, LLC	South Carolina
LHCG XLI, LLC	South Carolina
LHCG CLXVI, LLC	South Carolina
Palliative Care at Heart, LLC	South Carolina
South Carolina Health Care Group, LLC	South Carolina
South Carolina In-Home Healthcare Partnership-I, LLC	South Carolina
South Caroline In-Home Partner-I, LLC	South Carolina

Advanced Care House Calls of Tennessee, LLC	Tennessee
Almost Family ACO Services of Tennessee, LLC	Tennessee
Cedar Creek Home Health Care Agency, LLC	Tennessee
Elk Valley Health Services, LLC	Tennessee
Elk Valley Home Health Care Agency, LLC	Tennessee
Elk Valley Professional Affiliates, Inc.	Tennessee
Gericare, LLC	Tennessee
HMC Home Health, LLC	Tennessee
LHC HomeCare of Tennessee, LLC	Tennessee
LHCG CXXXII, LLC	Tennessee
LHCG CXXXIII, LLC	Tennessee
LHCG CXXXIV, LLC	Tennessee
LHCG CXXXV, LLC	Tennessee
LHCG CXXXVI, LLC	Tennessee
LHCG LXII, LLC	Tennessee
LHCG LXXXVIII, LLC	Tennessee
LHCG XCIII, LLC	Tennessee
LHCG XCIV, LLC	Tennessee
LHCG XCV, LLC	Tennessee
LHCG XCVI, LLC	Tennessee
LHCG XCVII, LLC	Tennessee
LHCG CLXII, LLC	Tennessee
Lifeline Home Health Care of Springfield, LLC	Tennessee
Lifeline Home Health Care of Union City, LLC	Tennessee
Lifeline of West Tennessee, LLC	Tennessee
Medical Center Home Health, LLC	Tennessee
Morristown-Hamblen HomeCare & Hospice, LLC	Tennessee
Primary Care at Home of Tennessee, LLC	Tennessee
SunCrest Companion Services, LLC	Tennessee
SunCrest Healthcare of East Tennessee, LLC	Tennessee
SunCrest Healthcare of Middle TN, LLC	Tennessee
SunCrest Healthcare of West Tennessee, LLC	Tennessee
SunCrest Home Health of Claiborne County, Inc.	Tennessee
SunCrest Home Health of Manchester, Inc.	Tennessee
SunCrest Home Health of Nashville, Inc.	Tennessee
SunCrest LBL Holdings, Inc.	Tennessee
SunCrest Outpatient Rehab Services of TN, LLC	Tennessee
SunCrest Outpatient Rehab Services, LLC	Tennessee
SunCrest Telehealth Services, Inc.	Tennessee
Tennessee Health Care Group, LLC	Tennessee
Tennessee In-Home Healthcare Partnership-I, LLC	Tennessee
Tennessee In-Home Healthcare Partnership-II, LLC	Tennessee
Tennessee In-Home Healthcare Partnership-III, LLC	Tennessee
Tennessee In-Home Healthcare Partnership-IV, LLC	Tennessee
Tennessee In-Home Partner-I, LLC	Tennessee
Tennessee In-Home Partner-II, LLC	Tennessee
Tennessee In-Home Partner-III, LLC	Tennessee
Tennessee In-Home Partner-IV, LLC	Tennessee
Tennessee Nursing Services of Morristown, Inc.	Tennessee
Tennessee Physical Therapy Services of Kingsport, LLC	Tennessee
Tennessee Physical Therapy Services of Knoxville, LLC	Tennessee
Tennessee Physical Therapy Services of Mt. Juliet, LLC	Tennessee
Tennessee Physical Therapy Services of Memphis, LLC	Tennessee
University of TN Medical Center Home Care Services, LLC	Tennessee
West Tennessee HomeCare, LLC	Tennessee
Woods Home Health, LLC	Tennessee
GSHS Home Health, LP.	Texas

Home Care Connections, Inc.	Texas
In-Home Healthcare Partnership-I, LLC	Texas
In-Home Partner of Texas-I, LLC	Texas
LHCG CXI, LLC	Texas
LHCG CXII, LLC	Texas
LHCG CXIII, LLC	Texas
LHCG CXIV, LLC	Texas
LHCG CXV, LLC	Texas
LHCG CXVI, LLC	Texas
LHCG CXVII, LLC	Texas
LHCG CXXI, LLC	Texas
LHCG CXXII, LLC	Texas
LHCG CXXIV, LLC	Texas
LHCG CXXX, LLC	Texas
LHCG CXXXI, LLC	Texas
LHCG CXXXVII, LLC	Texas
LHCG Partner II, LLC	Texas
LHCG XXXIII, LLC	Texas
LHCG CLI, LLC	Texas
LHCG CXCIV, LLC	Texas
Marshall HomeCare, LLC	Texas
Red River HomeCare, LLC	Texas
Rivercrest Home Health Care, Inc.	Texas
Southwet Post-Acute Care Partnership, LLC	Texas
Texas Health Care Group of Texarkana, LLC	Texas
Texas Health Care Group of The Golden Triangle, LLC	Texas
Texas Health Care Group, LLC	Texas
Texas Physical Therapy Services of Baytown, LLC	Texas
Wichita Falls Texas Home Care, LLC	Texas
LHCG LX, LLC	Utah
Utah Health Care Group, LLC	Utah
Advanced Care House Calls Virginia, LLC	Virginia
LHCG CXXVII, LLC	Virginia
LHCG LXXX, LLC	Virginia
LHCG CXCVIII, LLC	Virginia
LHCG CXCIX, LLC	Virginia
LHCG CCI, LLC	Virginia
LHCG CCIV, LLC	Virginia
Virginia Health Care Group, LLC	Virginia
Virginia HomeCare, LLC	Virginia
Virginia In-Home Healthcare Partnership-I, LLC	Virginia
Virginia In-Home Healthcare Partnership-II, LLC	Virginia
Virginia In-Home Healthcare Partnership-III, LLC	Virginia
Virginia In-Home Healthcare Partnership-IV, LLC	Virginia
Virginia In-Home Healthcare Partnership-IX, LLC	Virginia
Virginia In-Home Healthcare Partnership-V, LLC	Virginia
Virginia In-Home Healthcare Partnership-VI, LLC	Virginia
Virginia In-Home Healthcare Partnership-VII, LLC	Virginia
Virginia In-Home Healthcare Partnership-VIII, LLC	Virginia
Virginia In-Home Healthcare Partnership-X, LLC	Virginia
Virginia In-Home Healthcare Partnership-XI, LLC	Virginia
Virginia In-Home Healthcare Partnership-XII, LLC	Virginia
Virginia In-Home Partner-I, LLC	Virginia
Virginia In-Home Partner-II, LLC	Virginia
Virginia In-Home Partner-III, LLC	Virginia
Virginia In-Home Partner-IV, LLC	Virginia
Virginia In-Home Partner-IX, LLC	Virginia

Virginia In-Home Partner-V, LLC	Virginia
Virginia In-Home Partner-VI, LLC	Virginia
Virginia In-Home Partner-VII, LLC	Virginia
Virginia In-Home Partner-VIII, LLC	Virginia
Virginia In-Home Partner-X, LLC	Virginia
Virginia In-Home Partner-XI, LLC	Virginia
Virginia In-Home Partner-XII, LLC	Virginia
Advanced Care House Calls of Washington, LLC	Washington
LHCG LXIII, LLC	Washington
Northeast Washington Home Health, Inc.	Washington
Northwest Healthcare Alliance, Inc.	Washington
Washington Health Care Group, LLC	Washington
Washington HomeCare and Hospice of Central Basin, LLC	Washington
Boone Memorial HomeCare, LLC	West Virginia
Grant Memorial HomeCare and Hospice, LLC	West Virginia
Home Care Plus, Inc.	West Virginia
Housecalls Home Health & Hospice, LLC	West Virginia
Jackson County Home Health, LLC	West Virginia
LHC HomeCare of West Virginia, LLC	West Virginia
LHC Physician Services of West Virginia, LLC	West Virginia
LHCG LII, LLC	West Virginia
LHCG LXXXIX, LLC	West Virginia
LHCG LXXXVII, LLC	West Virginia
LHCG XC, LLC	West Virginia
Mountaineer HomeCare, LLC	West Virginia
Preston Memorial HomeCare, LLC	West Virginia
Primary Care at Home of West Virginia, LLC	West Virginia
Princeton Community HomeCare, LLC	West Virginia
Roane HomeCare, LLC	West Virginia
St. Mary’s Medical Center Home Health Services, LLC	West Virginia
West Virginia Health Care Group, LLC	West Virginia
West Virginia HomeCare, LLC	West Virginia
West Virginia Physical Therapy Services of Charleston, LLC	West Virginia
Wetzel County HomeCare, LLC	West Virginia
Advanced Care House Calls of Wisconsin, LLC	Wisconsin
Almost Family Personal Care, LLC	Wisconsin
HHA of Wisconsin, LLC	Wisconsin
LHCG XLVII, LLC	Wisconsin
Wisconsin Health Care Group, LLC	Wisconsin

Exhibit 23.1

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the registration statements (No. 333-225718 and 333-224140) on Form S-8 and (No. 333-256364) on Form S-3 of our report dated February 24, 2022, with respect to the consolidated financial statements of LHC Group, Inc. and the effectiveness of internal control over financial reporting.

Baton Rouge, Louisiana
February 24, 2022

Exhibit 31.1

CERTIFICATION PURSUANT TO RULE 13a-14(a)/15d-14(a),
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Keith G. Myers, certify that:

1. I have reviewed this Annual Report on Form 10-K of LHC Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2022

/s/ Keith G. Myers

Keith G. Myers
Chief Executive Officer (Principal executive officer)

Exhibit 31.2

CERTIFICATION PURSUANT TO RULE 13a-14(a)/15d-14(a),
AS ADOPTED PURSUANT TO
SECTION 302 OF THE SARBANES-OXLEY ACT OF 2002

I, Dale G. Mackel, certify that:

1. I have reviewed this Annual Report on Form 10-K of LHC Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: February 24, 2022

/s/ Dale G. Mackel

Dale G. Mackel
Chief Financial Officer
(Principal financial officer)

Exhibit 32.1

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Annual Report of LHC Group, Inc. (the "Company") on Form 10-K for the year ended December 31, 2021 as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Keith G. Myers, Chief Executive Officer of the Company, and Dale G. Mackel, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

1. The Report fully complies with the requirements of section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2. The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: February 24, 2022

/s/ Keith G. Myers

Keith G. Myers
Chief Executive Officer
(Principal executive officer)

/s/ Dale G. Mackel

Dale G. Mackel
Chief Financial Officer
(Principal financial officer)