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

FORM 10-K

(Mark One)

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

For the fiscal year ended: December 31, 2023

OR

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

For the transition period from to

Commission File Number: 0-24260

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

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

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

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

Title of Each Class	Trading Symbol	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	AMED	The NASDAQ Global Select Market

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

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or 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 every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☑ 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 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. ☑

If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. ☐

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to § 240.10D-1(b). ☐

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

The aggregate market value of the voting and non-voting common stock held by non-affiliates of the registrant, based on the last sale price as quoted by the NASDAQ Global Select Market on June 30, 2023 (the last business day of the registrant's most recently completed second fiscal quarter) was $2.6 billion. For purposes of this determination, shares beneficially owned by executive officers, directors and ten percent stockholders have been excluded, which does not constitute a determination that such persons are affiliates.

As of February 16, 2024, the registrant had 32,667,631 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement for its 2024 Annual Meeting of Stockholders (the "2024 Proxy Statement") are incorporated by reference into Part II – "Securities Authorized For Issuance Under Equity Compensation Plans" and Part III of this Form 10-K, or, in the event the registrant does not prepare and file such 2024 Proxy Statement, will be provided instead by an amendment to this report containing the applicable disclosures within 120 days after the end of the fiscal year covered by this report. With the exception of those portions which are specifically incorporated by reference in this report, any such Proxy Statement is not deemed to be filed or incorporated by reference as part of this report.

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SPECIAL CAUTION CONCERNING FORWARD-LOOKING STATEMENTS

When included in this Annual Report on Form 10-K, or in other documents that we file with the Securities and Exchange Commission ("SEC") or in statements made by or on behalf of the Company, words like "believes," "belief," "expects," "strategy," "plans," "anticipates," "intends," "projects," "estimates," "may," "might," "could," "would," "should" and similar expressions are intended to identify forward-looking statements as defined by the Private Securities Litigation Reform Act of 1995. These forward-looking statements involve a variety of risks and uncertainties that could cause actual results to differ materially from those described therein. These risks and uncertainties include, but are not limited to the following: disruption from the proposed merger with UnitedHealth Group with patient, payor, provider, referral source, supplier or management and employee relationships; the occurrence of any event, change or other circumstances that could give rise to the termination of the merger agreement with UnitedHealth Group or the inability to complete the proposed transaction on the anticipated terms and timetable; the risk that necessary regulatory approvals for the proposed merger with UnitedHealth Group are delayed, are not obtained or are obtained subject to conditions that are not anticipated; the failure of the conditions to the proposed merger to be satisfied; the costs related to the proposed transaction; the diversion of management time on merger-related issues; the risk that termination fees may be payable by the Company in the event that the merger agreement is terminated under certain circumstances; reputational risk related to the proposed merger; the risk of litigation or regulatory action related to the proposed merger; changes in Medicare and other medical payment levels; changes in payments and covered services by federal and state governments; future cost containment initiatives undertaken by third-party payors; changes in the episodic versus non-episodic mix of our payors, the case mix of our patients and payment methodologies; staffing shortages driven by the competitive labor market; our ability to attract and retain qualified personnel; competition in the healthcare industry; our ability to maintain or establish new patient referral sources; changes in or our failure to comply with existing federal and state laws or regulations or the inability to comply with new government regulations on a timely basis; changes in estimates and judgments associated with critical accounting policies; our ability to consistently provide high-quality care; our ability to keep our patients and employees safe; our access to financing; our ability to meet debt service requirements and comply with covenants in debt agreements; business disruptions due to natural or man-made disasters, climate change or acts of terrorism, widespread protests or civil unrest; our ability to open care centers, acquire additional care centers and integrate and operate these care centers effectively; our ability to realize the anticipated benefits of acquisitions, investments and joint ventures; our ability to integrate, manage and keep our information systems secure; the impact of inflation; and changes in laws or developments with respect to any litigation relating to the Company, including various other matters, many of which are beyond our control, and such other factors as discussed throughout Part I, Item 1A. "Risk Factors" of this Annual Report on Form 10-K.

Because forward-looking statements are inherently subject to risks and uncertainties, some of which cannot be predicted or quantified, you should not rely on any forward-looking statement as a prediction of future events. We expressly disclaim any obligation or undertaking, and we do not intend to release publicly any updates or changes in our expectations concerning the forward-looking statements or any changes in events, conditions or circumstances upon which any forward-looking statement may be based, except as may be required by law. For a discussion of some of the factors discussed above as well as additional factors, see Part I, Item 1A, "Risk Factors" and Part II, Item 7, "Critical Accounting Estimates" within "Management's Discussion and Analysis of Financial Condition and Results of Operations."

Unless otherwise provided, "Amedisys," "we," "us," "our," and "the Company" refer to Amedisys, Inc. and our consolidated subsidiaries, and when we refer to 2023, 2022 and 2021, we mean the twelve month period then ended December 31, unless otherwise provided.

A copy of this Annual Report on Form 10-K for the year ended December 31, 2023 as filed with the SEC, including all exhibits, is available on our internet website at http://www.amedisys.com on the "Investors" page under the "SEC Filings" link.

PART I

ITEM 1. BUSINESS

Overview

Amedisys, Inc. is a leading healthcare services company committed to helping our patients age in place by providing clinically excellent care and support in the home. Our operations involve serving patients across the United States through our three operating divisions: home health, hospice and high acuity care. We divested our personal care business on March 31, 2023. We deliver clinically distinct care that best suits our patients' needs, whether that is home-based recovery and rehabilitation after an operation or injury or care that empowers patients to manage a chronic disease through our home health division, hospice care at the end of life or delivering the essential elements of inpatient hospital, palliative and skilled nursing facility ("SNF") care to patients in their homes through our high acuity care division.

We are among the largest providers of home health and hospice care in the United States, with approximately 19,000 employees in 521 care centers in 37 states within the United States and the District of Columbia. Our employees deliver the highest quality care performing more than 10.6 million visits for more than 469,000 patients annually. Over 3,000 hospitals and 110,000 physicians nationwide have chosen us as a partner in post-acute care.

Due to the age demographics of our patient base, our services are primarily paid for by Medicare which has represented approximately 73% to 75% of our net service revenue over the last three years. We also remain focused on maintaining a profitable and strategically important managed care contract portfolio. We continuously work with our payors to structure innovative contracts which reward us for providing quality care to our patients.

Amedisys is headquartered in Baton Rouge, Louisiana, with an executive office in Nashville, Tennessee. Our common stock is currently traded on the NASDAQ Global Select Market under the trading symbol “AMED.” Founded and incorporated in Louisiana in 1982, Amedisys was reincorporated as a Delaware corporation prior to becoming a publicly traded company in August 1994.

Our strategy is to be the best choice for care wherever our patients call home. We accomplish this by providing clinically distinct care, being the employer of choice and delivering operational excellence and efficiency, which when combined, drive growth. Our mission is to provide best-in-class home health, hospice and high acuity care services allowing our patients to maintain a sense of independence, quality of life and dignity while delivering industry leading outcomes. We believe that our unwavering dedication to clinical quality and constant focus on both our patients and our employees differentiates us from our competitors.

Our Home Health Segment:

Our home health segment provides compassionate healthcare to help our patients recover from surgery or illness, live with chronic diseases and prevent avoidable hospital readmissions. Our home health footprint includes 346 care centers located in 34 states within the United States and the District of Columbia. Within these care centers, we deploy our care teams which include skilled nurses who are trained, licensed and certified to administer medications, care for wounds, monitor vital signs and provide a wide range of other nursing services; rehabilitation therapists who specialize in physical, speech and occupational therapy; and social workers and aides who assist our patients with completing important personal tasks.

We take an empowering approach to helping our patients and their families understand their medical conditions, how to manage them and how to maximize the quality of their lives while living with a chronic disease or other health condition. Our clinicians are trained to understand the whole patient – not just their medical diagnosis.

Our commitment to clinical distinction is most evident in our clinical quality measures such as the Quality of Patient Care and Patient Satisfaction star ratings. In the Centers for Medicare and Medicaid Services (“CMS”) reports for the April 2024 preview, the Quality of Patient Care star average across all Amedisys providers was 4.35 with 96% of our care centers rated at 4+ stars and 36 care centers rated at 5 stars. Our Patient Satisfaction star average for the January 2024 release was 3.61 (April 2024 preview data is not available for this metric). Our goal is to have all care centers achieve a 4.0 Quality of Patient Care star rating, and we have implemented targeted action plans to continue to improve the quality of care we deliver for our patients and further our culture of quality.

Our Hospice Segment:

Hospice care is designed to provide comfort and support for those who are dealing with a terminal illness. It is a benevolent form of care that promotes dignity and affirms quality of life for the patient, family members and other loved ones. Individuals with a terminal illness such as cancer, heart disease, pulmonary disease or Alzheimer's may be eligible for hospice care if they have a life expectancy of six months or less. Our hospice care teams include nurse practitioners and other skilled nurses, social workers, aides, bereavement counselors and chaplains.

Our focus is on building and retaining an exceptional team, delivering the highest quality care and service to our patients and their families and establishing Amedisys as the preferred and preeminent hospice provider in each community we serve. In order to realize these goals, we invest in tailored training and development for our employees which has led to our team's consistent achievement at or above the national average in family satisfaction results and quality scores, as well as the trust of the healthcare community.

Another element of our approach is our outreach strategy to more fully engage the entire community of eligible patients. These outreach efforts have built our hospice patient population to more accurately represent the causes of death in the communities we serve, with a specific focus on heart disease, lung disease and dementia in order to address the historical underrepresentation of non-cancer diagnoses. By working to accept every eligible patient who seeks end-of-life care, we fulfill our hospice mission and strengthen our standing in the community.

Our Personal Care Segment:

We divested our personal care business on March 31, 2023. Our personal care segment provided assistance with the essential activities of daily living. See Part II, Item 8, Note 5 – Mergers, Acquisitions and Dispositions for additional information.

Our High Acuity Care Segment:

The acquisition of Contessa Health ("Contessa") on August 1, 2021 established our high acuity care segment. Our high acuity care segment has the capability to deliver the essential elements of inpatient hospital, SNF care and palliative care to patients in their homes. In connection with the acquisition of Contessa, we obtained interests in a professional corporation that employs clinicians and several joint ventures with health system partners. Additionally, the acquisition provided the Company with an advanced claims analytic platform, network management and additional capabilities to enter into risk-based arrangements with managed care organizations.

Our joint venture partners in the high acuity care segment represent national and large regional healthcare systems, each of which view the ability to provide inpatient level care in patients' homes as critical to relieving capacity constraints within their facilities, providing care in a more cost-effective setting and keeping patients engaged with their health system brand by providing a superior patient experience. The patients who utilize our home-based recovery services typically have one or more chronic conditions that have historically required frequent emergency department visits and inpatient hospital stays. Our patient satisfaction scores for these home-based programs have consistently exceeded 85%, and we have successfully reduced hospital and skilled nursing readmission rates compared to historical baselines for these episodes of care.

We provide management services to the joint ventures which include the development and implementation of clinical protocols to ensure the safe and efficient delivery of services in the home and high quality outcomes; an internally-developed technology platform that provides medical documentation, analytics and claims processing capabilities; provider network development services to ensure that all care resources are available to meet patient needs; and expertise in developing and negotiating contracts with third-party health insurance payors to provide reimbursement for services under risk-based arrangements. Our expertise and capabilities in these areas deliver value to both the health system and the health insurance payor and give us the opportunity for future expansion within the healthcare continuum for chronically ill patients, including palliative care services, especially as the U.S. population ages and consumer preferences continue to shift to home-based care. Our joint venture partnership model with leading healthcare systems and our relationships with health plan insurers facilitate our ability to take and manage additional risk for this patient population in value-based arrangements.

Responding to the Changing Regulatory and Reimbursement Environment:

As the government continues to seek opportunities to refine payment models, we believe that our strategy of becoming a leader in providing a range of services across the at-home continuum positions us well for the future. Our ability to provide quality home health, hospice and high acuity care allows us to partner with health systems and managed care organizations to improve care coordination, reduce hospitalizations and lower costs.

Acquisitions:

On January 20, 2023, we acquired the regulatory assets of a home health provider in West Virginia.

Financial Information:

Financial information for our home health, hospice, personal care (divested on March 31, 2023) and high acuity care segments can be found in our consolidated financial statements included in this Annual Report on Form 10-K.

Amedisys and UnitedHealth Group Incorporated Merger

On June 26, 2023, Amedisys, UnitedHealth Group Incorporated, a Delaware corporation ("UnitedHealth Group"), and Aurora Holdings Merger Sub Inc., a Delaware corporation and a wholly owned subsidiary of UnitedHealth Group ("Merger Sub"), entered into an Agreement and Plan of Merger (the "Merger Agreement"), pursuant to which Merger Sub will merge with and into Amedisys (the "Merger") with Amedisys continuing as the surviving corporation and becoming a wholly owned subsidiary of UnitedHealth Group. See Part II, Item 8, Note 5 – Mergers, Acquisitions and Dispositions for additional information.

Human Capital

Our employees are critical to our vision to lead the future of healthcare in the home. Taking care of our people is our top priority. Our success is directly correlated with our ability to continue to attract, develop and retain the most qualified and passionate caregivers. Our work is not just a job but a calling. Our workforce strategy emanates from our core values of Service, Passion, Integrity, Respect, Innovation and Talent – SPIRIT. We know that by taking great care of our people, they can continue to provide industry leading patient care.

As of February 16, 2024, we employed approximately 19,000 people throughout the United States. We also utilize contract employees in the normal course of our business.

Diversity and Inclusion:

We endeavor to create a culture of caregiving where our employees feel as cared for every day as our patients. Success means all team members feel a sense of belonging, support and empowerment to be their best selves personally and professionally. We have committed to giving our employees a voice and have instituted numerous formal listening programs including pulse surveys, focus groups and town halls to routinely gather feedback from our employees and address any concerns. Our commitment to diversity and inclusion is also broadly reflected across our policies and people practices. In 2023, creating a sense of belonging was a critical tactic as part of our People Strategy, and the metrics indicating how our people rated their sense of belonging were part of our management team scorecard. Additionally, we have four Employee Resource Groups ("ERGs") which foster connection and community within our workforce: (1) Global Black Community, (2) LGBTQIA+, (3) disAbilities and (4) Military/Veterans. We are also committed to having a diverse Board of Directors. Women currently comprise over half of the directors on our Board.

Talent Acquisition, Retention and Development:

We strive to hire, develop and retain top talent. The core of our care delivery model is dependent upon attracting clinicians, predominately nurses and therapists. We compete for talent by offering a great culture, an opportunity to provide the highest quality clinical care and competitive market-based compensation. Our compensation plans are designed to deliver a competitive base pay as well as attractive incentive opportunities, primarily for leadership positions, but also to reward quality care. We provide significant opportunities for development and continuing education as we know that career development is a key component of attracting and retaining top talent. We continually monitor and assess employee metrics on hiring, retention and terminations to gain a deep understanding of our workforce and drive continuous improvement.

The increased demand for clinicians has generated continuing pressure on the labor markets. Across the healthcare industry, the nurse workforce especially has become scarcer as demand for services outstrips supply. Clinicians have become harder to recruit and more costly to employ. Attracting the best people in healthcare and supporting our people with an unrivaled experience are key initiatives for the Company to ensure adequate clinical capacity for our patients.

Health and Safety:

The health and well-being of our employees is of utmost importance to us. We offer a comprehensive benefit package that provides employees and their families with access to a variety of innovative, flexible and convenient health and wellness programs that support their physical and mental health by providing tools and resources to help them improve or maintain their health status.

Payment for Our Services

Our revenues are derived in large part from governmental third-party payors. Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially increase or decrease the rate of program payments to us for our services. It is possible that future budget cuts in Medicare and Medicaid may be enacted by Congress and implemented by CMS. Therefore, we cannot assure you that payments from governmental or private payors will remain at levels comparable to present levels or will, in the future, be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to such programs. See Part II, Item 7, "Management's Discussion and Analysis of Financial Condition and Results of Operations: Overview – CMS Payment Updates" for additional information on the most recent regulations from CMS.

Home Health Medicare

The Medicare home health benefit is available both for patients who need home care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing, but intermittent, care.

As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services and receive treatment under a plan of care established and periodically reviewed by a physician.

Services under the Medicare home health benefit are bundled into 60-day episodes of care. An episode starts the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier. If a patient is still in treatment on the 60th day, a recertification assessment is undertaken to determine whether the patient needs additional care. If the patient's physician determines that further care is necessary, another episode begins on the 61st day (regardless of whether a billable visit is rendered on that day) and ends 60 days later.

Effective January 1, 2020, CMS implemented a revised case-mix adjustment methodology, the Patient-Driven Groupings Model ("PDGM"). PDGM uses a 30-day period of care rather than a 60-day episode of care as the unit of payment. Under PDGM, each 60-day episode includes two 30-day periods of care. The table below includes the base 30-day payment rates.

Period	Base 30-Day Payment
January 1, 2021 through December 31, 2021	$ 1,901
January 1, 2022 through December 31, 2022	$ 2,032
January 1, 2023 through December 31, 2023	$ 2,011
January 1, 2024 through December 31, 2024	$ 2,038

On November 1, 2023, CMS issued the Home Health Final Rule for Medicare home health providers for calendar year 2024. CMS estimates that the final rule will result in a 0.8% increase in payments to home health providers. This increase is the result of a 3.0% payment update (3.3% market basket adjustment less a 0.3% productivity adjustment) and an increase of 0.4% for the update to the fixed-dollar loss ratio used in determining outlier payments offset by a permanent adjustment of -2.6% based on the difference between assumed and actual behavior changes resulting from the implementation of PDGM. The -2.6% permanent adjustment was derived from a -2.890% adjustment which was only applied to the 30-day payment rate and not the low utilization payment adjustment. The -2.890% is only half of the total proposed adjustment. The remaining adjustment is to be considered in future rulemaking. Based on our analysis of the final rule, we expect our impact to be in line with the 0.8% increase.

In addition to permanent adjustments, CMS also has the discretion to make temporary adjustments through calendar year 2026; however, CMS has elected not to implement a temporary adjustment for calendar year 2024.

On July 5, 2023, the National Association for Home Care and Hospice ("NAHC"), the leading national home health trade association, filed suit against CMS in the United States District Court for the District of Columbia over the implementation of the payment cuts CMS made in the Calendar Year 2023 Home Health Final Rule effective January 1, 2023; that litigation remains pending.

PDGM uses timing, admission source, functional impairment levels and principal and other diagnoses to case-mix adjust payments. The case-mix adjusted payment for a 30-day period of care is subject to additional adjustments based on certain variables, including, but not limited to (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits provided was less than the established threshold, which ranges from two to six visits and varies for every case-mix group under PDGM; (c) a partial payment if a patient transferred to another provider or from another provider before completing the 30-day period of care; and (d) the applicable geographic wage index. Payments for routine and non-routine supplies are included in the 30-day payment rate.

As a Medicare provider, we are subject to periodic audits by the Medicare program, and that program has various rights and remedies against us if they assert that we have overcharged the program or failed to comply with program requirements. Home health providers are subject to pre- and post-payment reviews for compliance with Medicare coverage guidelines and medical necessity. Adjustments on this basis may include individual claims adjustments or overpayment determinations based on an extrapolated sample of claims. Medical necessity reviews evaluate whether services are clinically appropriate in terms of frequency, type, extent, site and duration. Technical billing and documentation reviews focus on documentation of services. Medicare and other payors may reject or deny claims for payment if the underlying documentation does not support the medical necessity of services or fails to establish satisfaction of a coverage rule, such as if a provider is unable to perform periodic therapy assessments required by coverage criteria or cannot provide appropriate billing documentation, acceptable physician authorizations or face-to-face documentation.

Medicare can reopen previously filed and reviewed claims and deny coverage of the services and require us to repay any overcharges, as well as make deductions from future amounts due to us. In the ordinary course of business, we appeal the Medicare and Medicaid programs' denial of claims that we believe are inappropriate in an effort to recover the denied claims.

Home Health Non-Medicare

Payments from non-Medicare payors are either a percentage of Medicare rates, per-visit rates or case rates depending upon the terms and conditions established with such payors. Reimbursements from our non-Medicare payors that are based on Medicare rates are paid in a similar manner and subject to the same adjustments as discussed above for Medicare; however, these rates can vary based upon negotiated terms which generally range from 90% to 100% of Medicare rates. Approximately 30% of our managed care contract volume affords us the opportunity to receive additional payments if we achieve certain quality or process metrics as defined in each contract (e.g. star ratings and acute-care hospitalization rates).

Hospice Medicare

The Medicare hospice benefit is available when a physician and specific clinical findings support a diagnosis of a terminal condition where the patient has a terminal diagnosis of six months or less. Hospice care is evaluated in benefit periods: two 90-day benefit periods followed by an unlimited number of 60-day benefit periods. Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Payments are made according to a fee schedule that has four different levels of care: routine home care, continuous home care, inpatient respite care and general inpatient care. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans, based on specific levels of care. Payments are adjusted by a wage index to reflect health care labor costs across the country and are established annually through federal legislation.

On July 28, 2023, CMS issued the final rule to update hospice payment rates and the wage index for fiscal year 2024, effective for services provided beginning October 1, 2023. CMS estimates hospices serving Medicare beneficiaries will see a 3.1% increase in payments. This increase is the result of a 3.3% market basket adjustment as required under the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act ("PPACA") less a 0.2% productivity adjustment. Additionally, CMS increased the aggregate cap amount by 3.1% to $33,494. Based on our analysis of the final rule, we expect our impact to be in line with the 3.1% increase.

Medicare payments include 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, Medicare also reimburses for 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.

Adjustments for eligibility and technical billing requirements may be made to Medicare revenue based on the same claims processing reviews described above for home health services when we find we are unable to obtain appropriate billing documentation, authorizations or face-to-face documentation and other reasons unrelated to credit risk.

Two caps limit the amount of payment that any individual hospice provider number can receive in a single year. Generally, each hospice care center has its own provider number; however, where we have created branch care centers to help our parent care centers serve a geographic location, the parent and branch have the same provider number.

- ***Inpatient Cap:*** The inpatient cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The daily Medicare payment rate for any inpatient days of service that exceed the cap is set at the routine home care rate, and the provider is required to reimburse Medicare for any amounts it receives in excess of the cap.
- ***Overall Payment Cap:*** The overall payment cap is an absolute dollar limit on the average annual payment per beneficiary a hospice agency can receive. This cap is calculated by the Medicare Administrative Contractor at the end of each hospice cap period to determine the maximum allowable payments per provider number.

We estimate our potential cap exposure using information available for both inpatient day limits as well as per beneficiary cap amounts. The total cap amount for each provider is calculated by multiplying the number of beneficiaries electing hospice care during the period by a statutory amount that is indexed for inflation.

Payment rates for hospice care, the hospice cap amount and the hospice wage index are updated annually according to Section 1814(i)(1)(C)(ii)(VII) of the Social Security Act ("SSA"), which requires CMS to use the inpatient hospital market basket, adjusted for multifactor productivity and other adjustments as specified in the SSA, to determine the hospice payment update percentage. The caps are subject to annual and retroactive adjustments, which can cause providers to be required to reimburse the Medicare program if such caps are exceeded. Our ability to stay within these caps depends on a number of factors, each determined on a provider number basis, including the average length of stay and mix in level of care.

Hospice Non-Medicare

Non-Medicare payors pay at rates that differ from established Medicare rates for hospice services, and are based on separate, negotiated agreements. We bill and are paid by these non-Medicare payors based on such negotiated agreements.

High Acuity Care

High acuity care payments are derived from health insurance plans and health system partners. Contracts with health insurance plans provide for fixed payment rates for a 30-day or 60-day episode of care indexed to assigned patient diagnoses in return for our obligation to assume risk for the coordination and payment of required medical services necessary to treat the medical condition for which the patient was diagnosed in a home-based setting. Contracts with health system partners provide for payments on a per diem basis at the contracted rate for each day during the remainder of an inpatient acute stay serviced at the patient's home.

The contracted payment rates with health insurance plans and health system partners are developed by our medical economics team using historical claims and inpatient admission data provided by the respective health insurance plan or health system partner. The data includes medical costs incurred outside of a patient’s historical inpatient stay that may be expected to continue under our program and an estimate of the cost of the medical services under our program which will replace the patient’s inpatient hospital stay. We mitigate the risk of excessive program medical costs by ensuring that we enroll eligible members into the plan, by effectuating clinically effective plans of care and by ensuring that all covered services are related to the condition for which the patient was admitted to the program. Additionally, we have purchased episodic stop-loss insurance for certain payor contracts.

Controls Over Our Business System Infrastructure

We establish and maintain processes and controls over coding, clinical operations, billing, patient recertifications and compliance to help monitor and promote adherence with Medicare requirements.

- ***Coding*** **–** Specified international classification of disease ("ICD") diagnosis codes are assigned to each of our patients based on their particular health conditions (such as diabetes, coronary artery disease or congestive heart failure). Because coding regulations are complex and are subject to frequent change, we maintain controls surrounding our coding process. To reduce the associated risk of coding failures, we provide annual update training to clinical managers, as needed training to care center directors and clinical managers and training during orientation for new employees to ensure accurate information is gathered and provided to our coding team. In addition, our electronic medical records system (Homecare Homebase) includes automated edits for home health and hospice based on pre-defined compliance metrics. For home health, we also provide monthly specialized coding education, obtain outside expert coding instruction and have certified coders review all patient outcome and assessment information sets (“OASIS”) and assign the appropriate ICD code.
- ***Clinical Operations*** **–** We provide education on coverage criteria and conditions of participation and utilize outside expert regulatory services if necessary. Regulatory requirements allow patients to be eligible for home health care benefits if through a face-to-face visit with a physician or a qualified non-physician practitioner, they are considered homebound and it is determined that skilled nursing, physical therapy or speech therapy services are required. These clinical services may include: educating the patient about their disease, assessment and observation of disease status, delivery of clinical skills such as wound care, administration of injections or intravenous medications, management and evaluation of a patient’s plan of care, physical therapy services to assist patients with functional limitations and speech therapy services for speech or swallowing disorders. Patients eligible for hospice care are terminally ill (with a life expectancy of six months or less if the illness runs its normal course). Our hospice program provides care and

support to our terminally ill patients with a six-month prognosis and their families through services including medical care, counseling, spiritual care, pre-bereavement and bereavement support, medication management and needed equipment and supplies for the terminal illness and all related conditions. Our high acuity care clinical protocols include utilization of the Milliman Clinical Guidelines ("MCG") criteria to ensure that patients are eligible for inpatient level care, in-person evaluations by hospital-based physicians to determine the patient's clinical eligibility for home-based inpatient care, social and behavioral assessments to determine safety of the patient's home setting and an informed consent requirement to ensure that the patient and caregivers are comfortable with the delivery of inpatient level care in the home.

- ***Billing*** **–** We maintain controls over our billing processes to help promote accurate and complete billing. Processes and controls have been implemented to ensure that prior to the submission of any bills, the visit/occurrence was completed, documented sufficiently by an appropriate clinician and/or provider, and that the billed claim complies with all regulatory and payor requirements. Examples of process monitoring controls include conducting annual billing compliance testing, user access reviews for billing systems and use of automated daily billing operational indicators. We take prompt corrective action with employees who knowingly fail to follow our billing policies and procedures.
- ***Patient Recertification*** **–** In order to be recertified for an additional home health episode of care, a patient must continue to meet qualifying criteria and have a continuing medical need that requires the skills of a nurse or therapist. Changes in the patient’s condition may require changes to the patient’s medical regimen or modified care protocols within the episode of care. The patient’s progress towards established goals is evaluated prior to recertification. As with the initial episode of care, a recertification requires orders from the patient’s physician. Before any employee recommends recertification to a physician, we conduct a care center level, multidisciplinary care team conference. Specific tools are used to ensure that the patient continues to meet coverage criteria prior to recertifying. Hospice recertification for additional benefit periods of care requires continued demonstration of a terminal prognosis as determined by the hospice physician in collaboration with the attending physician and the interdisciplinary care team.
- ***Compliance*** **–** We develop, implement and maintain ethics and compliance programs as a component of the centralized corporate services provided to our home health, hospice and high acuity-care service lines. Our ethics and compliance program includes a Code of Conduct for our employees, officers, directors, contractors and affiliates and a disclosure program for reporting regulatory or ethical concerns to our compliance team through a confidential hotline, which is augmented by exit surveys of departing employees. We promote a culture of compliance within our company through educational presentations, newsletters and persistent messaging from our senior leadership to our employees stressing the importance of strict compliance with legal requirements and company policies and procedures. Additionally, we have mandatory compliance training and testing for all new employees upon hire and annually for all staff thereafter. We also maintain a robust compliance audit program focusing on key risk areas.

Our Regulatory Environment

We are highly regulated by federal, state and local authorities. The healthcare industry is subject to numerous laws, regulations and rules including, among others, those related to government healthcare participation requirements, licensure and accreditations, reimbursement for patient services, health information privacy and security and Medicare and Medicaid fraud and abuse prohibitions (including, but not limited to, federal statutes and regulations prohibiting kickbacks and other illegal inducements to potential referral sources, self-referrals by physicians and false claims submitted to federal health care programs). Regulations and policies frequently change, and we monitor changes through our internal government affairs department, as well as multiple trade and governmental publications and associations.

Our home health and hospice subsidiaries are certified by CMS and therefore are subject to the rules and regulations of the Medicare system. Additionally, all of our business lines are subject to federal, state and local laws and regulations dealing with issues such as occupational safety, employment, medical leave, insurance, civil rights, discrimination, building codes, data privacy, data security and recordkeeping. We have set forth below a discussion of the regulations that we believe most significantly affect our businesses.

Licensure, Certificates of Need ("CON"), Permits of Approval ("POA") and Facility Need Review ("FNR")

Home health and hospice care centers operate under licenses granted by the health authorities of their respective states. Some states require health care providers (including hospice and home health agencies) to obtain prior state approval for the purchase, construction or expansion of health care locations, capital expenditures exceeding a prescribed amount or changes in services. Additionally, certain states, including a number in which we operate, carefully restrict new entrants into the market based on demographic and/or demonstrative usage of additional providers. These states limit the entry of new providers or services and the expansion of existing providers or services in their markets through a CON, POA or FNR process, which is periodically evaluated and updated as required by applicable state law. For those states that require a CON, POA or FNR, the provider must complete a separate application process establishing a location and must receive required approvals.

To the extent a CON, POA, FNR or other similar approvals are required to expand our operations, our expansion could be adversely affected by the inability to obtain the necessary approvals, changes in the standards applicable to those approvals and possible delays and expenses associated with obtaining those approvals. In some instances, other providers in the market may file opposition to a CON, POA or FNR application, and this could further delay an approval.

In every state where required, our care centers possess a license and/or a CON, POA or FNR issued by the state health authority that determines the local service area for the home health or hospice care centers. Currently, state health authorities in 19 states and the District of Columbia require a CON or, in the State of Arkansas, a POA, in order to establish and operate a home health care center, and state health authorities in 15 states and the District of Columbia require a CON or, in the State of Louisiana, a FNR, to operate a hospice care center.

We operate 233 home health care centers and 55 hospice care centers in the following CON/POA/FNR states as listed below.

State	Home Health	Hospice
Alabama	29	10
Arkansas (POA)	7	—
Florida	—	7
Georgia	56	—
Kentucky	17	—
Louisiana (FNR)	—	5
Maryland	9	3
Mississippi	8	—
New Jersey	2	—
New York	6	—
North Carolina	13	7
Rhode Island	1	2
South Carolina	26	—
Tennessee	45	15
Washington	2	—
West Virginia	11	6
Washington, DC	1	—
Total Care Centers in CON/POA/FNR States	233	55

Medicare Participation: Licensing, Certification and Accreditation

Our care centers must comply with regulations promulgated by the United States Department of Health and Human Services ("HHS") and CMS in order to participate in the Medicare program and receive Medicare payments. Sections 1861(o) and 1891 of the SSA, 42 CFR 484.1 *et seq*., establish the conditions that a home health agency ("HHA") must meet in order to participate in the Medicare program. Section 1861(dd) of the SSA, 42 CFR 418.1, *et seq*., establishes the conditions that a hospice provider must meet in order to participate in the Medicare program. Among other things, these regulations, applicable to HHAs and hospices, respectively, known as conditions of participation and/or conditions of payment (“COPs”), relate to the type of facility, its personnel and its standards of medical care, as well as its compliance with federal, state and local laws and regulations. Additional COPs applicable to HHAs focus on the safe delivery of quality care provided to patients and the impact

of that care on patient outcomes through the protection and promotion of patients' rights, care planning, delivery and coordination of services and streamlining of regulatory requirements.

CMS has adopted alternative sanction enforcement options which allow CMS (i) to impose temporary management, direct plans of correction or direct training and (ii) to impose payment suspensions and civil monetary penalties in each case on providers out of compliance with the COPs. CMS engages or has engaged a number of third-party contractors, including Recovery Audit Contractors (“RACs”), Program Safeguard Contractors (“PSCs”), Zone Program Integrity Contractors (“ZPICs”), Uniform Program Integrity Contractors ("UPICs"), Medicaid Integrity Contractors (“MICs”) and Supplemental Medical Review Contractors (“SMRCs”), 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. In addition to identifying overpayments, audit contractors can refer suspected violations of law to government enforcement authorities.

All providers are subject to compliance with various federal, state and local statutes and regulations in the United States and receive periodic inspection by state licensing agencies to review standards of medical care, equipment and safety. We have dedicated internal resources and utilize external parties when necessary to monitor and ensure compliance with the various applicable federal, state and local laws, rules and regulations, as well as requirements of applicable accrediting organizations.

If we fail to comply with applicable laws and regulations, we could be subjected to liabilities, including criminal penalties, civil penalties (including the loss of our licenses to operate one or more of our businesses) and/or exclusion of a facility from participation in the Medicare, Medicaid and other federal and state health care programs. If any of our facilities were to lose its accreditation or otherwise lose its certification under the Medicare and Medicaid programs, the facility would be unable to receive reimbursement from the Medicare and Medicaid programs and other payors until it gains recertification or accreditation. We believe our facilities are in substantial compliance with current applicable federal, state, local and independent review body regulations and standards. The requirements for licensure, certification and accreditation are subject to change and, in order to remain qualified, it may become necessary for us to make changes in our facilities, equipment, personnel and services in the future, which could have a material adverse impact on our operations.

Federal and State Anti-Fraud and Abuse Laws and Regulations

As a provider under the Medicare and Medicaid programs, we are subject to various anti-fraud and abuse laws, including the federal Anti-Kickback Statute, the Stark or Physician Self-Referral Law, the False Claims Act, Civil Monetary Penalties Law and various state anti-fraud and abuse laws. These laws govern any health care plans or programs that are funded by the United States government (other than certain federal employee health insurance benefits/programs), as well as certain state health care programs that receive federal funds, such as Medicaid. Our compliance and ethics program is designed to ensure Amedisys meets all applicable federal and state laws and regulations as well as industry standards.

Federal Anti-Kickback Statute ("AKS")

Subject to certain exceptions, the federal AKS prohibits any offer, payment, solicitation or receipt of any form of remuneration to induce or reward the referral of business payable under a government health care program or in return for the purchase, lease, order, arranging for, or recommendation of items or services covered under a government health care program. The law also forbids the offer or transfer of anything of value, including certain waivers of co-payment obligations and deductible amounts, to a beneficiary of Medicare or Medicaid that is likely to influence the beneficiary’s selection of health care providers, again, subject to certain safe harbor exceptions. Violations of the federal AKS can trigger the False Claims Act and Civil Monetary Penalties Law, potentially resulting in civil fines up to $27,018 for each violation, penalties of up to $120,816 (last updated 2023) plus three times the amount of the improper remuneration, imprisonment and potentially, exclusion from furnishing services under any government health care program. There are also criminal penalties under the AKS, and providers found to be in violation of the federal AKS can be excluded from participation in federal health care programs.

Stark or Physician Self-Referral Law

The Stark Law, also known as the Physician Self-Referral Law, prohibits physicians from referring Medicare and Medicaid patients to entities for the provision of designated health services with which they or any of their immediate family members have a direct or indirect financial relationship, unless an exception to the law's prohibition is met. Sanctions for violating the Stark Law include penalties of up to $29,899 for each violation and up to $199,338 (last updated 2023) for schemes to circumvent the Stark Law restrictions. There are a number of exceptions to the self-referral prohibition, including employment contracts and leases, that may be used so long as the arrangement adheres to certain enumerated requirements. Violations of the Stark Law may also result in payment denials, False Claims Act scrutiny, additional civil monetary penalties and federal program exclusion.

The False Claims Act

The federal False Claims Act ("FCA") prohibits false claims or requests for payment for health care services. Under the FCA, the government may penalize any person who knowingly submits, or participates in submitting, claims for payment to the Federal Government which are false or fraudulent, or which contain false or misleading information. Any person who knowingly makes or uses a false record or statement to avoid paying the Federal Government, or knowingly conceals or avoids an obligation to pay money to the Federal Government, may also be subject to fines under the FCA. Under the FCA, the term “person” means an individual, company or corporation. The term "knowingly" means the person (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information.

The Federal Government has used the FCA to prosecute Medicare and other governmental program fraud in areas such as violations of the federal Anti-Kickback Statute or the Stark Law, coding errors, billing for services not provided and submitting false cost reports. The FCA has also been used to prosecute people or entities that bill services at a higher reimbursement rate than is allowed and that bill for care that is not medically necessary. In addition to government enforcement, the FCA authorizes private citizens to bring qui tam or “whistleblower” lawsuits, greatly extending the practical reach of the FCA. The per-claim maximum penalty is $27,018 (last updated 2023).

The Fraud Enforcement and Recovery Act of 2009 (“FERA”) amended the FCA with the intent of enhancing the powers of government enforcement authorities and whistleblowers to bring FCA cases. In particular, FERA attempts to clarify that liability may be established not only for false claims submitted directly to the government, but also for claims submitted to government contractors and grantees. FERA also seeks to clarify that liability exists for attempts to avoid repayment of overpayments, including improper retention of federal funds. FERA also included amendments to FCA procedures, expanding the government’s ability to use the Civil Investigative Demand process to investigate defendants, and permitting government complaints and intervention to relate back to the filing of the whistleblower’s original complaint. FERA is likely to increase both the volume and liability exposure of FCA cases brought against health care providers.

In the Patient Protection and Affordable Care Act (enacted in 2010), Congress enacted requirements related to identifying and returning overpayments made under Medicare and Medicaid. CMS finalized regulations regarding this so-called “60-day rule,” which requires providers to report and return Medicare and Medicaid overpayments within 60 days of identifying the overpayment. A provider who retains identified overpayments beyond 60 days may be liable under the FCA. “Identification” occurs when a person “has, or should have through the exercise of reasonable diligence,” identified and quantified the amount of an overpayment. The final rule also established a six-year lookback period, meaning overpayments must be reported and returned if a person identifies the overpayment within six years of the date the overpayment was received. Providers must report and return overpayments even if they did not cause the overpayment.

In addition to the FCA, the Federal Government may use several criminal statutes to prosecute the submission of false or fraudulent claims for payment to the Federal Government. Many states have similar false claims statutes that impose liability for the types of acts prohibited by the False Claims Act. As part of the Deficit Reduction Act of 2005 (the “DRA”), Congress provides states an incentive to adopt state false claims acts consistent with the federal FCA. Additionally, the DRA requires providers who receive $5 million or more annually from Medicaid to include information on federal and state false claims acts, whistleblower protections and the providers’ own policies on detecting and preventing fraud in their written employee policies.

Civil Monetary Penalties Law

HHS may impose civil monetary penalties ("CMP") for a variety of civil offenses related to federal health care programs. They may be imposed upon any person or entity who presents, or causes to be presented, certain ineligible claims for medical items or services, for providing improper inducements to beneficiaries to obtain services, for payments to limit services to patients and for offenses related to relationships with excluded individuals, among other things.

Maximum CMP amounts increased in 2023. For example, the penalty for knowing and willful solicitation, receipt, offer or payment of remuneration for referring an individual for a service or for purchasing, leasing or ordering an item to be paid for by a federal health care program increased from $112,131 to $120,816, and the CMP for beneficiary inducement increased from $22,427 to $24,164 per occurrence.

State Laws

In addition to federal laws, some states in which we operate generally have laws that prohibit kickbacks in exchange for referrals, certain direct or indirect payments or fee-splitting arrangements between health care providers, improper physician referrals, beneficiary inducements and false or improperly billed claims. The available guidance and enforcement activity associated with such state laws vary considerably but, in some cases, may be stricter than federal law.

Federal and State Privacy and Security Laws

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to comply with standards for the exchange of health information within our company and with third parties, such as payors, business associates and patients. These include standards for common health care transactions, such as claims information, plan eligibility and payment information, standards for the use of electronic signatures and unique identifiers for providers, employers, health plans and individuals as well as standards for privacy, security and breach notification and enforcement.

The HIPAA transaction regulations establish form, format and data content requirements for most electronic health care transactions, such as health care claims that are submitted electronically. The HIPAA privacy regulations establish comprehensive requirements relating to the use and disclosure of protected health information. The HIPAA security regulations establish minimum standards for the protection of protected health information that is stored or transmitted electronically. The HIPAA breach notification regulations establish the applicable requirements for notifying individuals, HHS and the media in the event of a data breach affecting protected health information. Violations of the privacy, security and breach notification regulations are punishable by civil and criminal penalties and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance.

Currently, civil monetary penalties for HIPAA violations can range from $137 per violation to a maximum fine of $2.067 million for multiple violations of the same provision during a calendar year. To date, the largest penalty imposed by HHS following a data breach is $16 million. State attorneys general may also bring civil enforcement actions under HIPAA, and attorneys general are actively engaged in enforcement. These penalties could be in addition to other penalties assessed by a state for a breach which would be considered reportable under a particular state’s data breach notification laws.

Changes to HIPAA have stimulated increased enforcement activity and enhanced the potential that health care providers will be subject to financial penalties for violations of HIPAA. In addition, the Secretary of HHS is required to perform periodic audits to ensure covered entities (and their business associates, as that term is defined under HIPAA) comply with the applicable HIPAA requirements, increasing the likelihood that a HIPAA violation will result in an enforcement action.

In addition to the federal HIPAA regulations, most states also have laws that protect the confidentiality of health information and other personally identifiable information, and these laws may be broader in scope with respect to protected health information and other personal information than HIPAA. Some of these laws grant individuals rights with respect to personal information. We may be required to expend significant resources to comply with these laws. Further, all 50 states, the U.S. territories and the District of Columbia have adopted data breach notification laws that impose, in varying degrees, an obligation to notify affected persons and/or state regulators in the event of a data breach or compromise, including when their personal information has or may have been accessed by an unauthorized person. Some state breach notification laws may also impose physical and electronic security requirements regarding the safeguarding of personal information, such as social security numbers and bank and credit card account numbers. Violation of state privacy, security and breach notification laws can trigger significant monetary penalties. In addition, certain states’ privacy, security and data breach laws, including, for example, the California Consumer Privacy Act, as amended by the California Privacy Rights Act, include private rights of action that may expose us to private litigation regarding our privacy practices and significant damages awards or settlements in civil litigation.

U.S. Food and Drug Administration ("FDA") Regulation

The FDA regulates medical device user facilities, which include home health care providers. FDA regulations require user facilities to report patient deaths and serious injuries to the FDA and/or the manufacturer of a device used by the facility if the device may have caused or contributed to the death or serious injury of any patient. FDA regulations also require user facilities to maintain files related to adverse events and to establish and implement appropriate procedures to ensure compliance with the above reporting and recordkeeping requirements. User facilities are subject to FDA inspection, and noncompliance with applicable requirements may result in warning letters or sanctions including civil monetary penalties, injunction, product seizure, criminal fines and/or imprisonment.

The Improving Medicare Post-Acute Care Transformation Act

In October 2014, the Improving Medicare Post-Acute Care Transformation Act (“IMPACT Act”) was signed into law requiring the reporting of standardized patient assessment data for quality improvement, payment and discharge planning purposes across the spectrum of post-acute care providers (“PACs”), including skilled nursing facilities and home health agencies. The IMPACT Act requires PACs to report: (1) standardized patient assessment data at admission and discharge; (2) quality measures, including functional status, skin integrity, medication reconciliation, incidence of major falls and patient preference regarding treatment and discharge; and (3) resource use measures, including Medicare spending per beneficiary, discharge to community and hospitalization rates of potentially preventable readmissions. Failure to report such data when required would subject a facility to a two percent reduction in market basket prices then in effect.

The IMPACT Act further requires HHS and the Medicare Payment Advisory Commission (“MedPAC”), a commission chartered by Congress to advise it on Medicare payment issues, to study alternative PAC payment models, including payment based upon individual patient characteristics and not care setting, with corresponding Congressional reports required based on such analysis. The IMPACT Act also includes provisions impacting Medicare-certified hospices, including: (1) increasing survey frequency for Medicare-certified hospices to once every 36 months; (2) imposing a medical review process for facilities with a high percentage of stays in excess of 180 days; and (3) updating the annual aggregate Medicare payment cap.

Review Choice Demonstration for Home Health Services ("RCD")

CMS' RCD gives HHAs in the demonstration states three options in the initial selection period: pre-claim review of all claims, post-payment review of all claims or minimal post-payment review with a 25% payment reduction for all home health services. Under the pre-claim review and post-payment review options, provider claims are reviewed for every episode of care until the appropriate claim approval rate (90% based on a minimum of ten pre-claim requests or claims submitted) is reached. Further, once the appropriate claim approval rate is reached and maintained for six months, a provider can elect to opt out of pre-claim review or post-payment review of all claims and choose selective post-payment review, a spot check of a statistically valid random sample of claims determined by the Medicare Administrative Contractor ("MAC") to ensure continued compliance. Amedisys has elected the pre-claim review option. The demonstration initially applied to HHA providers in Florida, Illinois, North Carolina, Ohio and Texas, with the option to expand after five years to other states in the Medicare Administrative Contractor Jurisdiction M (Palmetto). CMS added Oklahoma to the demonstration effective December 31, 2023.

Targeted Probe and Educate Program ("TPE")

CMS' TPE program is designed to help reduce provider claim denials and educate providers on appropriate billing practices. Under the TPE program, MACs use data analysis to identify providers who have high claim error rates, unusual billing practices or provide services that have high national error rates. If a provider is selected for a TPE review by a MAC, the initial volume of claims reviewed is limited to 20 to 40 claims. If the provider is deemed compliant, it will not be reviewed on the particular topic for that review for one year; however, if errors are identified, the provider has 45 days to make changes and improvements. If a provider cannot correct the errors after the 45-day period, it will be referred to one-on-one education sessions. The TPE process can include up to three rounds of claims review, if necessary, with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action which may include 100% prepay review, extrapolation, referral to a Recovery Auditor and/or referral for revocation from the Medicare program.

Home Health Value-Based Purchasing

On January 1, 2016, CMS implemented Home Health Value-Based Purchasing ("HHVBP"). The HHVBP model was designed to give Medicare-certified home health agencies incentives or penalties in order to provide higher quality and more efficient care. In November 2021, CMS issued the Calendar Year 2022 Home Health Final Rule for Medicare home health providers

which provided for the expansion of the HHVBP model to all 50 states beginning January 1, 2023 with calendar year 2023 being the first performance year and calendar year 2025 being the first payment year with a proposed maximum payment adjustment, up or down, of 5%.

HHAs receive adjustments to their Medicare fee-for-service payments based on their performance against a set of quality measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year). Cohorts are determined based on each HHA's unique beneficiary count in the prior calendar year. HHAs are assigned to either a nationwide larger-volume cohort or a nationwide smaller-volume cohort in order to group HHAs that are of similar size and are more likely to receive scores on the same set of measures for purposes of setting benchmarks and achievement thresholds and determining payment adjustments.

Home Health Payment Reform

On February 9, 2018, Congress passed the Bipartisan Budget Act of 2018 ("BBA of 2018"), which provided for a targeted extension of the home health rural add-on payment, a reduction of the 2020 market basket update, modification of eligibility documentation requirements and reform to the Home Health Prospective Payment System ("HHPPS"). The HHPPS reform included the following parameters: for home health units of service beginning on January 1, 2020, a 30-day payment system was to be applied; the transition to the 30-day payment system was to be budget neutral; and CMS was to conduct at least one Technical Expert Panel during 2018, prior to any notice and comment rulemaking process, related to the design of any new case-mix adjustment model.

The Calendar Year 2019 Home Health Final Rule updated the Medicare HHPPS and finalized the implementation of an alternative case-mix adjustment methodology, PDGM, which became effective on January 1, 2020. PDGM adjusted payments to home health agencies based on patient characteristics for 30-day periods of care. While the payment changes were to be implemented in a budget neutral manner to the industry, the ultimate impact varied by provider based on factors including patient mix and admission source. Additionally, CMS made assumptions about behavior changes that were expected to occur as a result of the transition to PDGM. The behavior change assumptions were finalized in the Calendar Year 2020 Home Health Final Rule released on October 31, 2019 and resulted in a 4.36% reduction to reimbursement. The behavior changes were related to coding practices, low utilization payment adjustment ("LUPA") management and co-morbidities. CMS is required by law to analyze data for calendar years 2020-2026, retrospectively, to determine the impact of the difference between assumed and actual behavior changes and to make any such payment changes as are necessary to offset or supplement the adjustments based on anticipated behavior.

On October 31, 2022, CMS issued the Home Health Final Rule for Medicare home health providers for calendar year 2023, which finalized a methodology for analyzing differences between assumed and actual behavior changes and determined that a permanent adjustment was needed. The 2023 Final Rule included a -3.5% permanent reduction to reimbursement based on the difference between assumed and actual behavior changes resulting from the implementation of PDGM. The -3.5% permanent adjustment was derived from a -3.925% adjustment which was only applied to the 30-day payment rate and not the low utilization payment adjustment. The -3.925% was only half of the total proposed adjustment. The remaining adjustment was to be considered in future rulemaking.

On July 5, 2023, the National Association for Home Care and Hospice ("NAHC"), the leading national home health trade association, filed suit against CMS in the United States District Court for the District of Columbia over the implementation of the payment cuts in the Calendar Year 2023 Home Health Final Rule effective January 1, 2023; that litigation remains pending.

On November 1, 2023, CMS issued the Home Health Final Rule for Medicare home health providers for calendar year 2024. CMS estimates that the final rule will result in an 0.8% increase in payments to home health providers. This increase is the result of a 3.0% payment update (3.3% market basket adjustment less a 0.3% productivity adjustment) and an increase of 0.4% for the update to the fixed-dollar loss ratio used in determining outlier payments offset by a permanent adjustment of -2.6% based on the difference between assumed and actual behavior changes resulting from the implementation of PDGM. Similar to the 2023 permanent adjustment, the -2.6% permanent adjustment was derived from a -2.890% adjustment which was only applied to the 30-day payment rate and not the low utilization payment adjustment. The -2.890% was only half of the total proposed adjustment. The remaining adjustment is to be considered in future rulemaking. Based on our analysis of the final rule, we expect our impact to be in line with the 0.8% increase.

In addition to permanent adjustments, CMS also has the discretion to make temporary adjustments through calendar year 2026; however, CMS has elected not to implement a temporary adjustment for calendar year 2024.

Environmental and Climate Change Matters

We are committed to transparency around our environmental footprint and climate-related risks and opportunities. We have adopted an integrated approach to address the impacts of climate change on our business, with cross-disciplinary teams responsible for managing climate-related activities, initiatives and policies. Strategies and progress toward our goals are reviewed with senior leadership and the Nominating and Corporate Governance Committee of our Board of Directors. Additional information about our environmental and climate activities can be found in our annual Environmental, Social and Governance Report, which is available on our website. Reference to our website does not constitute incorporation by reference of the information contained on the website and should not be considered part of this document. For more information regarding climate change and its possible adverse impact on us, see "Item 1A. Risk Factors — Risks Related to Our Operations — Our operations could be impacted by war, terrorism, natural or man-made disasters and climate change" in this Annual Report on Form 10-K.

Our Competitors

There are few barriers to entry in the home health and hospice jurisdictions that do not require a CON, POA or FNR. Our primary competition in these jurisdictions comes from local privately and publicly-owned and hospital-owned health care providers. We compete based on the quality of services, the availability of personnel, expertise of visiting staff and, in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations that finance acquisitions and capital expenditures on a tax-exempt basis or receive charitable contributions that are unavailable to us.

Available Information

Our company website address is www.amedisys.com. We use our website as a channel of distribution for important company information. Important information, including press releases, analyst presentations and financial information regarding our company, is routinely posted on and accessible on the Investor Relations subpage of our website, which is accessible by clicking on the tab labeled "Investors" on our website home page. Visitors to our website can also register to receive automatic e-mail and other notifications alerting them when new information is made available on the Investor Relations subpage of our website. In addition, we make available on the Investor Relations subpage of our website (under the link "SEC Filings"), free of charge, our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, ownership reports on Forms 3, 4 and 5 and any amendments to those reports as soon as reasonably practicable after we electronically file or furnish such reports with the Securities and Exchange Commission ("SEC"). Further, copies of our Certificate of Incorporation and Bylaws, our Code of Ethical Business Conduct, our Corporate Governance Guidelines and the charters for the Audit, Compensation, Quality of Care, Compliance and Ethics and Nominating and Corporate Governance Committees of our Board are also available on the Investor Relations subpage of our website (under the link "Governance"). Reference to our website does not constitute incorporation by reference of the information contained on the website and should not be considered part of this document.

Our electronically filed reports can also be obtained on the SEC's internet site at http://www.sec.gov.

ITEM 1A. RISK FACTORS

The risks described below, and risks described elsewhere in this Form 10-K, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows and the actual outcome of matters as to which forward-looking statements are made in this Form 10-K. The risk factors described below and elsewhere in this Form 10-K are not the only risks faced by Amedisys. Our business and consolidated financial condition, results of operations and cash flows may also be materially adversely affected by factors that are not currently known to us, by factors that we currently consider immaterial or by factors that are not specific to us, such as general economic conditions.

If any of the following risks are actually realized, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected. In that case, the trading price of our common stock could decline.

You should refer to the explanation of the qualifications and limitations on forward-looking statements under "Special Caution Concerning Forward-Looking Statements." All forward-looking statements made by us are qualified by the risk factors described below.

Risk Factor Summary

The following is a summary of the principal risks that could adversely affect our business, operations and financial results:

- The proposed Merger is subject to the satisfaction of certain closing conditions, including government consents and approvals, some or all of which may not be satisfied or completed within the expected timeframe, if at all.
- We may not complete the proposed Merger within the time frame we anticipate or at all, which could have an adverse effect on our business, financial results and/or operations.
- We will be subject to various uncertainties while the Merger is pending that may cause disruption and may make it more difficult to maintain relationships with employees, customers and other third-party business partners.
- In certain instances, the Merger Agreement requires us to pay a termination fee to UnitedHealth Group, which could affect the decisions of a third-party considering making an alternative acquisition proposal.
- We have incurred, and will continue to incur, direct and indirect costs as a result of the Merger.
- Litigation challenging the Merger Agreement may prevent the Merger from being consummated within the expected timeframe or at all.
- Federal and state changes to reimbursement and other aspects of Medicare and Medicaid could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.
- Future cost containment initiatives undertaken by private third-party payors may limit our future revenue and profitability.
- Possible changes in the case mix of patients, as well as payor mix and payment methodologies, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.
- Our failure to negotiate favorable managed care contracts, 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.
- Quality reporting requirements may negatively impact Medicare reimbursement.
- Value-based purchasing may negatively impact Medicare reimbursement.
- Any economic downturn, deepening of an economic downturn, continued deficit spending by the Federal Government or state budget pressures may result in a reduction in payments and covered services.
- A shortage of qualified nursing staff and other clinicians, such as therapists and nurse practitioners, could materially impact our ability to attract, train and retain qualified personnel and could increase operating costs.
- We may be more vulnerable to the effects of a public health emergency than other businesses due to the nature of our patient population and the physical proximity required by our operations, which could harm our business disproportionately to other businesses.
- Because we are limited in our ability to control rates received for our services, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services.

- If we are unable to consistently provide high quality of care, our business will be adversely impacted.
- If we are unable to maintain relationships with existing patient referral sources, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.
- Our industry is highly competitive, with few barriers to entry in certain states.
- The success of our high acuity care segment depends on our ability to enter into capitation and other forms of risk-based contracts with managed care health plans. If we are unsuccessful in obtaining these contracts or if we are unsuccessful in managing costs associated with risk-based contracts, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.
- Our business depends on our information systems. A cyber-attack, security breach or our inability to effectively integrate, manage and keep our information systems secure and operational could disrupt our operations.
- Our insurance liability coverage may not be sufficient for our business needs.
- We may be subject to substantial malpractice or other similar claims.
- If we are unable to maintain our corporate reputation, our business may suffer.
- A write off of a significant amount of intangible assets or long-lived assets could have a material adverse effect on our consolidated financial condition and results of operations.
- Our operations could be impacted by war, terrorism, natural or man-made disasters and climate change.
- Inflation in the economy could negatively impact our business and results of operations.
- Our growth strategy depends on our ability to acquire additional care centers and integrate and operate these care centers effectively, make investments and enter into joint ventures and other strategic relationships. If our growth strategy is unsuccessful or we are not able to successfully integrate newly acquired care centers into our existing operations, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.
- The indemnification provisions of acquisition agreements by which we have acquired companies may not fully protect us, and as a result, we may face unexpected liabilities.
- State efforts to regulate the establishment or expansion of health care providers could impair our ability to expand our operations.
- Federal regulation may impair our ability to consummate acquisitions or open new care centers.
- Divestitures or other dispositions could negatively impact our business, and contingent liabilities from businesses that we have sold could adversely affect our business and consolidated financial condition, results of operations and cash flows.
- We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.
- We face periodic and routine 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.
- If a care center fails to comply with the conditions of participation in the Medicare program, that care center could be subjected to sanctions or terminated from the Medicare program.
- We are subject to federal and state laws that govern our financial relationships with physicians and other health care providers, including potential or current referral sources.
- The No Surprises Act and similar price transparency initiatives could impact our relationships with patients and insurers.
- Delays in payment may cause liquidity problems.
- Changes in units of payment for home health agencies could reduce our Medicare home health reimbursement levels.

- The volatility and disruption of the capital and credit markets and adverse changes in the United States and global economies could impact our ability to access both available and affordable financing, and without such financing, we may be unable to achieve our objectives for strategic acquisitions and internal growth.
- Our indebtedness could impact our financial condition and impair our ability to fulfill other obligations.
- The agreements governing our indebtedness contain various covenants that limit our discretion in the operation of our business, and our failure to satisfy requirements in these agreements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.
- The price of our common stock has been and may continue to be volatile, which could lead to securities litigation brought against us or cause investors to lose the value of their investment.
- Our Board of Directors may use anti-takeover provisions or issue stock to discourage a change of control.
- Our Bylaws designate the Court of Chancery of the State of Delaware or, if the Court of Chancery does not have jurisdiction, the federal court for the District of Delaware, as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could discourage lawsuits against us and our directors, officers, employees and stockholders.

Risks Related to the Proposed Merger with UnitedHealth Group Incorporated ("UnitedHealth Group")

The proposed Merger is subject to the satisfaction of certain closing conditions, including government consents and approvals, some or all of which may not be satisfied or completed within the expected timeframe, if at all.

Completion of the Merger is subject to a number of closing conditions, including obtaining the approval of our stockholders, which approval was obtained on September 8, 2023, the expiration or termination of the applicable waiting period (and any extension thereof) under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, the receipt of the required state regulatory approvals, the absence of any law or order that has the effect of enjoining or otherwise prohibiting the completion of the Merger, and the expiration or termination of the waiting period (and any extension thereof) applicable to the consummation of the transactions contemplated by the Merger Agreement under all applicable antitrust laws without the imposition by any governmental entity of any term, condition, obligation, requirement, limitation, prohibition, remedy, sanction or other action that has resulted in or would reasonably be expected to result in a Burdensome Condition (as defined in the Merger Agreement). We can provide no assurance that all required consents and approvals will be obtained or that all closing conditions will otherwise be satisfied (or waived, if applicable), and, even if all required consents and approvals can be obtained and all closing conditions are satisfied (or waived, if applicable), we can provide no assurance as to the terms, conditions and timing of such consents and approvals or the timing of the completion of the Merger. Many of the conditions to completion of the Merger are not within our control, and we cannot predict when or if these conditions will be satisfied (or waived, if applicable). Any adverse consequence of the pending Merger could be exacerbated by any delays in completion of the Merger or termination of the Merger Agreement.

Each party’s obligation to consummate the Merger is also subject to the accuracy of the representations and warranties of the other party (subject to certain exceptions) and performance by each party of its respective obligations under the Merger Agreement, including an agreement by us to use our reasonable best efforts to carry on our business in all material respects in the ordinary course, consistent with past practice, and to preserve our business organization and relationships with customers, suppliers, licensors, licensees and other third parties, and to comply with certain operating covenants. In addition, the Merger Agreement may be terminated under certain specified circumstances, including, but not limited to, (1) if our board of directors makes an Amedisys Recommendation Change (as defined in the Merger Agreement) or (2) by our board of directors in order for us to enter into a definitive agreement for an alternative transaction with a third-party with respect to an unsolicited Amedisys Superior Proposal (as defined in the Merger Agreement). As a result, we cannot assure you that the Merger will be completed, even though our stockholders approved the Merger, or that, if completed, it will be exactly on the terms set forth in the Merger Agreement or within the expected time frame.

We may not complete the proposed Merger within the time frame we anticipate or at all, which could have an adverse effect on our business, financial results and/or operations.

The proposed Merger may not be completed within the expected timeframe, or at all, as a result of various factors and conditions, some of which may be beyond our control. If the Merger is not completed for any reason, our stockholders will not receive any payment for their shares of our common stock in connection with the Merger. Instead, we will remain a public company, our common stock will continue to be listed and traded on The Nasdaq Global Select Market and registered under the

Exchange Act, and we will be required to continue to file periodic reports with the SEC. Moreover, our ongoing business may be materially adversely affected, and we would be subject to a number of risks, including the following:

- we may experience negative reactions from the financial markets, including negative impacts on our stock price, and it is uncertain when, if ever, the price of our shares would return to the prices at which our shares currently trade;
- we may experience negative publicity, which could have an adverse effect on our ongoing operations including, but not limited to, retaining and attracting employees, customers, partners, suppliers and others with whom we do business;
- we will still be required to pay certain significant costs relating to the Merger, such as legal, accounting, financial advisory, printing and other professional services fees, which may relate to activities that we would not have undertaken other than in connection with the Merger;
- we may be required to pay a termination fee to UnitedHealth Group of $125,000,000, as required under the Merger Agreement under certain circumstances;
- we may be required to reimburse UnitedHealth Group for the $106,000,000 termination fee payment that UnitedHealth Group, on our behalf, paid to Option Care Health Inc. ("OPCH") in connection with the termination of the Agreement and Plan of Merger (the "OPCH Merger Agreement"), dated as of May 3, 2023, by and among Amedisys, OPCH and Uintah Merger Sub, Inc. ("OPCH Merger Sub") under certain circumstances;
- while the Merger Agreement is in effect, we are subject to restrictions on our business activities, including, among other things, restrictions on our ability to engage in certain kinds of material transactions that would reasonably be expected to materially delay or prevent the consummation of the transaction contemplated by the Merger Agreement, which could prevent us from pursuing strategic business opportunities, taking actions with respect to our business that we may consider advantageous and responding effectively and/or timely to competitive pressures and industry developments, and may, as a result, materially adversely affect our business, results of operations and financial condition;
- matters relating to the Merger require substantial commitments of time and resources by our management, which could result in the distraction of management from ongoing business operations and pursuing other opportunities that could have been beneficial to us; and
- we may commit significant time and resources to defending against litigation related to the Merger.

If the Merger is not consummated, the risks described above may materialize, and they may have a material adverse effect on our business operations, financial results and stock price, particularly to the extent that the current market price of our common stock reflects an assumption that the Merger will be completed.

We will be subject to various uncertainties while the Merger is pending that may cause disruption and may make it more difficult to maintain relationships with employees, customers and other third-party business partners.

Our efforts to complete the Merger could cause substantial disruptions in, and create uncertainty surrounding, our business, which may materially adversely affect our results of operations and our business. Uncertainty as to whether the Merger will be completed may affect our ability to recruit prospective employees or to retain and motivate existing employees. Employee retention may be particularly challenging while the Merger is pending because employees may experience uncertainty about their roles following the Merger. As mentioned above, a substantial amount of our management's and employees' attention is being directed toward the completion of the Merger and thus is being diverted from our day-to-day operations. Uncertainty as to our future could adversely affect our business and our relationship with customers and potential customers. For example, customers, suppliers and other third parties may defer decisions concerning working with us or seek to change existing business relationships with us. Changes to or termination of existing business relationships could adversely affect our revenue, earnings and financial condition, as well as the market price of our common stock. The adverse effects of the pendency of the Merger could be exacerbated by any delays in completion of the Merger or termination of the Merger Agreement.

In certain instances, the Merger Agreement requires us to pay a termination fee to UnitedHealth Group, which could affect the decisions of a third-party considering making an alternative acquisition proposal.

Under the terms of the Merger Agreement, we may be required to pay UnitedHealth Group a termination fee of $125,000,000 under specified conditions, including in the event the Merger Agreement is terminated due to a recommendation change by our board of directors, the termination of the Merger Agreement by our board of directors in order for us to enter into a definitive agreement with a third-party for an alternative transaction with respect to an unsolicited Amedisys Superior Proposal or under certain circumstances where a proposal for an alternative transaction has been made to us and, within 12 months following

termination, we enter into a definitive agreement providing for an alternative transaction or consummate an alternative transaction. Further, under specified circumstances, we may be required to reimburse UnitedHealth Group for the $106,000,000 termination fee payment that UnitedHealth Group, on our behalf, paid to OPCH in connection with the termination of the OPCH Merger Agreement. These payments could affect the structure, pricing and terms proposed by a third-party seeking to acquire or merge with us and could discourage a third-party from making a competing acquisition proposal, including a proposal that would be more favorable to our stockholders than the Merger.

We have incurred, and will continue to incur, direct and indirect costs as a result of the Merger.

We have incurred, and will continue to incur, significant costs and expenses, including regulatory costs, fees for professional services and other transaction costs in connection with the Merger, for which we will have received little or no benefit if the Merger is not completed. There are a number of factors beyond our control that could affect the total amount or the timing of these costs and expenses. Many of these fees and costs will be payable by us even if the Merger is not completed and may relate to activities that we would not have undertaken other than to complete the Merger.

Litigation challenging the Merger Agreement may prevent the Merger from being consummated within the expected timeframe or at all.

Following the announcement of the Merger and the filing of the Definitive Proxy Statement, purported stockholders filed complaints and sent Amedisys demand letters alleging that the Definitive Proxy Statement omitted material information that rendered it misleading or incomplete in violation of federal securities laws and that the Amedisys Board breached their fiduciary duties. Certain of the complaints have sought, among other things, an injunction enjoining the consummation of the Merger unless and until certain additional information is disclosed to Amedisys stockholders, rescissory damages, an accounting to the plaintiff for all damages suffered as a result of Amedisys' and Amedisys' Board's alleged wrongdoing, costs of the action including plaintiffs' attorneys' fees and experts' fees, and other relief the court may deem just and proper. Amedisys also received a demand from a purported stockholder in connection with the Definitive Proxy Statement seeking to inspect certain Amedisys corporate books and records under Section 220 of the Delaware General Corporation Law. See the Company's Current Report on Form 8-K dated September 1, 2023 for additional information. Amedisys believes that the allegations in the complaints, demand letters and Section 220 demand letters lack merit and that Amedisys' disclosures have at all times complied with the applicable laws.

Nevertheless, lawsuits may continue to be filed against us, our Board of Directors or other parties to the Merger Agreement, challenging the Merger or making other claims in connection therewith. Such lawsuits may be brought by our purported stockholders and may seek, among other things, to enjoin consummation of the Merger. One of the conditions to the consummation of the Merger is the absence of any order or law that has the effect of enjoining or otherwise prohibiting the consummation of the Merger. As such, if the plaintiffs in such lawsuits are successful in obtaining an injunction prohibiting the defendants from completing the Merger on the agreed upon terms, then such injunction may prevent the Merger from becoming effective, or from becoming effective within the expected timeframe.

Risks Related to Reimbursement

Federal and state changes to reimbursement and other aspects of Medicare and Medicaid could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our net service revenue is primarily derived from Medicare, which accounted for 73%, 74% and 75% of our consolidated net service revenue during 2023, 2022 and 2021, respectively. Payments received from Medicare are subject to changes made through federal legislation. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. These changes, as further detailed in Part I, Item 1, “Business: Payment for Our Services,” can include changes to base payments and adjustments for home health services, changes to cap limits and per diem rates for hospice services and changes to Medicare eligibility and documentation requirements or changes designed to restrict utilization. Any such changes, including retroactive adjustments, adopted in the future by CMS could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Section 6407 of the Affordable Care Act, as implemented by 42 CFR § 424.22, added Medicare requirements for face-to-face encounters to support claims for home health services. The requirements for face-to-face encounters continue to be one of the most complex issues in the industry and can be the source of claims denials if not fulfilled. Section 6407(d) of the Affordable Care Act also provided that the requirements for face-to-face encounters in the provisions described above shall apply in the case of physicians making certifications for home health services under title XIX of the Act (Medicaid) in the same manner and to the same extent as such requirements apply under title XVIII (Medicare).

There are 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 centers. The U.S. federal budget is subject to change, and the Medicare program is frequently mentioned as a target for spending cuts. Within the Medicare program, the hospice benefit is often specifically targeted for cuts. The full impact on our business of any future cuts in Medicare or other programs is uncertain. Though we cannot predict what, if any, reform proposals will be adopted, health care reform and legislation may have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows through decreasing payments made for our services.

We could also be affected adversely by the continuing efforts of governmental payors to contain health care costs. We cannot assure you that reimbursement payments under governmental payor programs, including Medicare supplemental insurance policies, 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.

Future cost containment initiatives undertaken by private third-party payors may limit our future revenue and profitability.

Our non-Medicare revenue and profitability are affected by continuing efforts of third-party payors to maintain or reduce costs of health care by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. There can be no assurance that third-party payors will make timely payments for our services, and there is no assurance that we will continue to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare sources of revenue. Any changes in payment levels from current or future third-party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Possible changes in the case mix of patients, as well as payor mix and payment methodologies, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our revenue is determined by a number of factors, including our mix of patients and the rates of payment among payors. Changes in the case mix of our patients, payment methodologies or the payor mix among Medicare, Medicaid and private payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our failure to negotiate favorable managed care contracts, 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. We strive to put in place favorable contracts with managed care payors; however, we may not be successful in these efforts. Additionally, there is a risk that the favorable managed care contracts that we put in place may be terminated. Managed care contracts typically permit the payor to terminate the contract without cause, on very short notice, typically 60 days, which can provide payors leverage to reduce volume or obtain favorable pricing. Our failure to negotiate and put in place favorable managed care contracts, or our failure to maintain in place favorable managed care contracts, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Quality reporting requirements may negatively impact Medicare reimbursement.

Hospice quality reporting was mandated by the Patient Protection and Affordable Health Care Act and the Health Care and Education Reconciliation Act ("PPACA"), which directs the Secretary to establish quality reporting requirements for hospice programs. Failure to submit required quality data will result in a specified reduction to the market basket percentage increase for that fiscal year. This quality reporting program is currently “pay-for-reporting,” meaning it is the act of submitting data that determines compliance with program requirements.

On July 28, 2023, CMS issued a final rule (CMS-1787-F) which updated Medicare hospice payments and the aggregate cap amount for fiscal year 2024 (the "FY 2024 Hospice Final Rule") in accordance with existing statutory and regulatory requirements. The FY 2024 Hospice Final Rule also finalized the codification of the Hospice Quality Reporting Program ("HQRP") data submission threshold policy adopted in the fiscal year ("FY") 2016 Hospice Final Rule at §418. Section 1814(i)(5)(A)(i) of the Act was amended to change the payment reduction for failing to meet hospice quality reporting requirements from 2 to 4 percentage points. Therefore, beginning in FY 2024 and for each subsequent year, hospices that fail to meet quality reporting requirements will receive a 4 percentage point reduction to the annual hospice payment update percentage increase for the year. The FY 2024 rate for hospices that do not submit the required quality data would be updated to -0.9%, which is the FY 2024 hospice payment update percentage of 3.1% minus 4 percentage points.

Section 1895(b)(3)(B)(v) of the Social Security Act requires the submission of quality data by home health agencies. Failure to submit quality data will result in a 2% reduction in the home health agency's annual home health payment update percentage. This pay-for-reporting requirement was implemented on January 1, 2007. In the Calendar Year 2015 Home Health Final Rule, CMS defined a more explicit “Pay-for-Reporting Performance Requirement” by which provider compliance with quality reporting requirements can be measured. In the Calendar Year 2016 Home Health Final Rule, CMS required home health agencies to report prescribed quality assessment data for a minimum of 90% of all patients.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the “IMPACT Act”) requires the submission of standardized data by home health agencies and other providers. Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use and other measures. Failure to report data as required will subject providers to a 2% reduction in market basket prices then in effect.

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, we, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements.

Value-based purchasing may negatively impact Medicare reimbursement.

Both government and private payors are increasingly looking to value-based purchasing to contain costs. Value-based purchasing focuses on quality of outcomes and efficiency of care, rather than quantity of care. The first performance year of the expanded value-based purchasing model began on January 1, 2023, and the model has been expanded to all 50 states. Under the expanded model, home health agencies receive adjustments to their Medicare fee-for-service payments based on their performance against a set of quality measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year (payment year). CMS may also create a similar plan for hospices in the future. Government and private payors’ implementation of value-based purchasing requirements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. The Calendar Year 2024 Home Health Final Rule noted that agencies certified in the value-based purchasing model before January 1, 2022 will have a reduction or an increase to their Medicare payments by up to 5% based on their performance on specified quality measures, beginning in CY 2025.

Any economic downturn, deepening of an economic downturn, continued deficit spending by the Federal Government or state budget pressures may result in a reduction in payments and covered services.

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. As an example, the failure of the 2011 Joint Select Committee to meet its Deficit Reduction goal resulted in a reduction in Medicare home health and hospice payments of 2% beginning April 1, 2013 ("sequestration" - suspended from May 1, 2020 through March 31, 2022; reinstated at 1% for the period April 1, 2022 through June 30, 2022 and at 2% thereafter).

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.

In addition, sustained unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates and could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to our Operations

A shortage of qualified nursing staff and other clinicians, such as therapists and nurse practitioners, could materially impact our ability to attract, train and retain qualified personnel and could increase operating costs.

We compete for qualified personnel with other healthcare providers. Our ability to attract and retain clinicians depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. In addition, there are shortages of qualified health care personnel in some of our markets. As a result, we may face higher costs of attracting clinicians and providing them with more attractive benefit packages than we originally anticipated, or we may have to utilize contract clinicians, both of which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. 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. In some circumstances, we may have to hire contract clinicians to fulfill staffing needs, which could increase the risk of an adverse patient event. Generally, if we are unable to attract and retain clinicians, the quality of our services may decline, and we could lose patients and referral sources, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We may be more vulnerable to the effects of a public health emergency than other businesses due to the nature of our patient population and the physical proximity required by our operations, which could harm our business disproportionately to other businesses.

The majority of our patients are older individuals and/or individuals with complex medical challenges or multiple ongoing diseases, many of whom may be more vulnerable than the general public during a pandemic or in a public health emergency. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable individuals. Our employees could also have difficulty attending to our patients if a program of social distancing or quarantine is instituted in response to a public health emergency. In addition, we may expand existing internal policies in a manner that may have a similar effect. If the virus that causes COVID-19 and its potentially more contagious variants cause an additional resurgence of infections of COVID-19, if new variants that are resistant to government approved COVID-19 vaccinations continue to emerge, or if an influenza or other pandemic were to occur, we could suffer significant losses to our patient population or a reduction in the availability of our employees and caregivers, and we could be required to hire replacements for affected workers at an inflated cost. Accordingly, public health emergencies could have a disproportionate material adverse effect on our financial condition, results of operations and cash flows.

Because we are limited in our ability to control rates received for our services, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services.

As Medicare is our primary payor and rates are established through federal legislation, we have to manage our costs of providing care to achieve a desired level of profitability. Additionally, non-Medicare rates are difficult for us to negotiate as such payors are under pressure to reduce their own costs. As a result, we manage our costs in order to achieve a desired level of profitability, including, but not limited to, centralization of various processes, the use of technology and management of the number of employees utilized. If we are not able to continue to streamline our processes and reduce our costs, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

If we are unable to consistently provide high quality of care, our business will be adversely impacted.

Providing quality patient care is the cornerstone of our business. We believe that hospitals, physicians and other referral sources refer patients to us in large part because of our reputation for delivering quality care. Clinical quality has become increasingly important within our industry. Medicare imposes a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this regulation provides a competitive advantage to home health providers who can differentiate themselves based upon quality, particularly by achieving low patient acute care hospitalization readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. We are focused intently upon improving our patient outcomes, particularly our patient acute care hospitalization readmission rates. If we should fail to attain our goals regarding acute care hospitalization readmission rates and other quality metrics, we expect our ability to generate referrals would be adversely impacted, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

Additionally, Medicare has established consumer-facing websites, Home Health Compare and Hospice Compare, that present data regarding our performance on certain quality measures compared to state and national averages. Failure to achieve or exceed these averages may negatively affect our rates of reimbursement and our ability to generate referrals, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

If we are unable to maintain relationships with existing patient referral sources, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our success depends on referrals from physicians, hospitals and other sources in the communities we serve and on our ability to maintain good relationships with existing referral sources. Our referral sources are not (and cannot be) contractually obligated to refer patients to us and may refer their patients to other providers. Our growth and profitability depend, in part, on our ability to establish and maintain close working relationships with these patient referral sources and to increase awareness and acceptance of the benefits of home health and hospice care by our referral sources and their patients. Our loss of, or failure to maintain, existing relationships or our failure to develop new referral relationships could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our industry is highly competitive, with few barriers to entry in certain states.

There are few barriers to entry in home health and hospice markets that do not require a CON, POA or FNR. Our primary competition comes from local privately-owned, publicly-owned and hospital-owned health care providers. We compete based on the availability of personnel, the quality of services, expertise of visiting staff and, in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations and tax-supported governmental agencies that finance acquisitions and capital expenditures on a tax-exempt or tax-favorable basis or receive charitable contributions that are unavailable to us. Increased competition in the future may limit our ability to maintain or increase our market share.

Further, the introduction of new and enhanced service offerings by others, in combination with industry consolidation and the development of strategic relationships by our competitors (including mergers of competitors with each other and with insurers) could cause a decline in revenue or loss of market acceptance of our services or make our services less attractive.

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. 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 terminate us as a provider and/or engage our competitors as a preferred or exclusive provider. 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 CON, POA or FNR 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 CONs, POAs or FNRs, we could face increased competition in these states. There can be no assurances that other states will not seek to eliminate or limit their existing CON, POA or FNR programs, which could lead to increased competition in these states. Further, we cannot assure you that we will 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.

The success of our high acuity care segment depends on our ability to enter into capitation and other forms of risk-based contracts with managed care health plans. If we are unsuccessful in obtaining these contracts or if we are unsuccessful in managing costs associated with risk-based contracts, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our acquisition of Contessa not only established the foundation for our high acuity care segment, but it also added key infrastructure to enable us to more quickly and effectively enter into risk-based contracts with managed care health plans. Should our high acuity care joint venture partnerships not deliver sufficient perceived value to managed care health plans, those health plans may limit or forego opportunities to partner with us in expanded risk-based contracts. Additionally, assuming risk from managed care health plans requires that the appropriate clinical and operating protocols be in place to actuarially assess eligible members and determine historical baseline healthcare expenditures, enroll eligible members into the program, effectuate a clinically effective plan of care to treat those patients primarily in a home-based setting and coordinate care throughout various phases of the member's treatment including proactive primary care and palliative care services. Should we be ineffective in identifying and enrolling members into the program or should the clinical treatment plans we implement for

enrolled members not result in reduced healthcare costs during the period in which those members are enrolled, we could incur significant additional costs under these contracts that exceed the revenues we receive. These negative outcomes could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our business depends on our information systems. A cyber-attack, security breach or our inability to effectively integrate, manage and keep our information systems secure and operational could disrupt our operations.

As a healthcare provider, we face increased legal and regulatory compliance risk in the event of a cyber-attack. Healthcare providers and health insurance plans must comply with the HIPAA regulations regarding the privacy and security of protected health information. The HIPAA regulations impose significant requirements on providers with regard to how such protected health information may be used and disclosed. Further, the regulations include extensive and complex requirements for providers to establish reasonable and appropriate administrative, technical and physical safeguards to ensure the confidentiality, integrity and availability of protected health information. Even when providers establish reasonable and appropriate administrative, technical and physical safeguards, it is difficult to fully protect information systems from a breach or security incident. In the event the provider experiences a "breach" and protected health information is compromised, providers are obligated under HIPAA to notify individuals, the government, and in the event the breach involves 500 or more individuals, the media. HIPAA directs the Secretary of HHS to provide for periodic audits to ensure covered entities (and their business associates, as that term is defined under HIPAA) comply with the applicable HIPAA requirements. Entities within the U.S. that are found to be in violation of HIPAA may be subject to significant civil, criminal and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance.

In addition to federal regulators, state attorneys general are also enforcing proactive security protocols and reporting requirements relating to information security breaches. All 50 states and the U.S. territories have breach notification laws; some of these laws also include proactive data security requirements. In addition to state laws regarding confidentiality of medical information, several states expanded state privacy laws regarding personal information which is more broadly defined than medical information.

Our networks, systems and devices store sensitive information, including intellectual property, proprietary business information and personal information of our patients, partners and employees. We have installed a number of protective technology systems and devices on our network, systems and point of care tablets in an attempt to prevent unauthorized access to information created, received, transmitted and maintained by us. However, healthcare companies are routinely targeted by threat actors, and no level of security can guarantee that cybersecurity incidents will not occur. In the event of a sophisticated ransomware attack, malware, viruses, phishing or social engineering, our technology may fail to adequately secure the protected health information and personal information we create, receive, transmit and maintain in our databases. In such circumstances, we may be held liable to our patients and regulators, which could result in fines, litigation or adverse publicity that could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Even if we are not held liable, any resulting negative publicity could harm our business and distract the attention of management.

Our business depends on effective, secure and operational information systems that include systems provided by or hosted by external contractors, partners and other service providers. For example, our care centers depend upon our information systems and software for patient care, accounting, billing, collections, risk management, quality assurance, human resources, payroll and other information considered to be sensitive and/or confidential, including protected health information. These third-party vendors or "business associates", in the event the vendor creates, receives, transmits or maintains protected health information on our behalf, are required to comply with substantially the same HIPAA requirements as the healthcare provider. This is accomplished through the use of "Business Associate Agreements" with vendors. However, third- and fourth-party security incidents and supply-chain cyber attacks have been increasingly common, and there is no way for an organization to ensure that such incidents and attacks do not occur. The occurrence of any information system failure, breach or security incident, or a vendor's breach of the Business Associate Agreement could result in interruptions, delays, breaches of protected health information and personal information, loss or corruption of data and cessations or interruptions in the availability of these systems and the information they create, receive, transmit or maintain. Any of these events or circumstances, among others, could have an adverse effect on our business and consolidated financial condition, results of operations and cash flows, and they could harm our business reputation.

In general, all information systems, including those we host or have hosted by third parties, are vulnerable to damage or interruption from fire, flood, power loss, telecommunications failure, human error, malicious acts, break-ins and other intentional or unintentional events. Our business is also at risk from and may be materially impacted and/or disrupted by information security incidents, such as ransomware, malware, viruses, phishing, social engineering and other security events. Such incidents can range from individual attempts to gain unauthorized access to information technology systems to more sophisticated security threats. These events can also result from internal compromises, such as human error or a rogue employee

or contractor, and can occur on our systems or on the systems of our partners and subcontractors. Additionally, our current information systems are subject to other non-environmental risks, including technological obsolescence, in some instances, which may create increased security and/or operational risk.

Problems with, or the failure of, our technology and systems or any system upgrades or programming changes associated with such technology and systems could have a material adverse effect on our operations, patient care, data capture and integrity, medical documentation, billing, collections, assessment of internal controls and management and reporting capabilities. If we experience a reduction in the performance, reliability or availability of our information systems, our operations and ability to produce timely and accurate reports could be materially adversely affected.

Our information systems and applications also require continual maintenance, upgrading and enhancement to meet our operational and security needs. Our acquisition activity requires transitions and integration of various information systems. We regularly upgrade and expand our information systems' capabilities. If we experience difficulties with the transition and integration of information systems or are unable to implement, maintain or expand our systems properly, we could suffer from, among other things, operational disruptions, regulatory investigations or audits and increases in administrative expenses.

As cyber threats continue to evolve, we may be required to expend significant capital and other resources to protect against the threat of security breaches or to mitigate and alleviate problems caused by security incidents, including unauthorized access to protected health information and personal information stored in our information systems and the introduction of computer viruses or other malicious software programs to our systems. If we don't expend capital and other resources to continually enhance our security systems, our security measures may be inadequate to prevent security breaches, and our business operations and reputation could be materially adversely affected by federal and state fines and penalties, legal claims or proceedings, cancellation of contracts and loss of patients if security breaches are not prevented. The healthcare industry is currently a target for cyber criminals and is therefore experiencing increased scrutiny from federal and state regulators with respect to compliance with regulations designed to safeguard protected health information and mitigate cyber-attacks. There are significant costs associated with a breach, including investigation costs, remediation and mitigation costs, notification costs, attorney fees, litigation and the potential for reputational harm and lost revenues due to a loss in confidence in the provider. We cannot predict the costs to comply with these laws or the costs associated with a potential breach of protected health information, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows, and our business reputation.

If we are subject to cyber-attacks or security breaches in the future, this could result in harm to patients; business interruptions and delays; the loss, misappropriation, corruption or unauthorized access of data; litigation and potential liability under privacy, security and consumer protection laws or other applicable laws; reputational damage and federal and state governmental inquiries. Any such problems or failures and the costs incurred in correcting any such problems or failures could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, to the extent our external information technology contractors or other service providers have their own cyber-attack, security event or information technology failure, become insolvent or fail to support the software or systems we have licensed from them, our operations could be materially adversely affected. A failure to restore our information systems after the occurrence of any of these events could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Because of the protected health information we store and transmit, loss of electronically stored information for any reason could expose us to risk of regulatory action and litigation and possible liability and loss.

We believe we have all the necessary licenses from third parties to use technology and software that we do not own. A third-party could, however, allege that we are infringing its rights, which may deter our ability to obtain licenses on commercially reasonable terms from the third-party, if at all, or cause the third-party to commence litigation against us. In addition, we may find it necessary to initiate litigation to protect our trade secrets, to enforce our intellectual property rights and to determine the scope and validity of any proprietary rights of others. Any such litigation, or the failure to obtain any necessary licenses or other rights, could materially and adversely affect our business.

Our insurance liability coverage may not be sufficient for our business needs.

As a result of operating in the home health industry, our business entails an inherent risk of claims, losses and potential lawsuits alleging incidents involving our employees that may occur in a patient's home. We maintain professional liability insurance to provide coverage to us and our subsidiaries against these risks. However, we cannot assure you claims will not be made in the future in excess of the limits of our insurance, nor can we assure you that any such claims, if successful and in excess of such limits, will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. In some states, state law may prohibit or limit insurance coverage for the risk of punitive damages arising from professional liability and general liability claims and/or litigation. As a result, we may be liable for punitive damage awards in these states that either are not covered or are in excess of our insurance policy limits. Our insurance coverage also includes fire,

property damage, cyber security and general liability with varying limits. We cannot assure you that the insurance we maintain will satisfy claims made against us or that insurance coverage will continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms. Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business.

We may be subject to substantial malpractice or other similar claims.

As of February 16, 2024, we have approximately 19,000 employees (11,600 home health, 6,000 hospice, 200 high acuity care and 1,000 corporate employees). In addition, we employ direct care workers on a contractual basis to support our existing workforce. Due to the nature of our business, we, through our employees and caregivers who provide services on our behalf, may be the subject of medical malpractice claims. A court could find these individuals should be considered our agents, and, as a result, we could be held liable for their acts or omissions. 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. While we maintain malpractice liability coverage that we believe is appropriate given the nature and breadth of our operations, any claims against us in excess of insurance limits, or multiple claims requiring us to pay deductibles, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

If we are unable to maintain our corporate reputation, our business may suffer.

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with Medicare requirements and the other laws to which we are subject. Adverse publicity surrounding any aspect of our business, including the death or disability of any of our patients due to our failure to provide proper care, or due to any failure on our part to comply with Medicare requirements, HIPAA requirements or other laws to which we are subject, could negatively affect our Company's overall reputation and the willingness of referral sources to refer patients to us. Further, the poor performance, reputation or negative conduct of competitors may have spillover effects that adversely affect the industry and our brand.

A write off of a significant amount of intangible assets or long-lived assets could have a material adverse effect on our consolidated financial condition and results of operations.

A significant and sustained decline in our stock price and market capitalization, a significant decline in our expected future cash flows, a significant adverse change in the business climate or slower growth rates could result in the need to perform an impairment analysis under Accounting Standards Codification ("ASC") Topic 350 "*Intangibles – Goodwill and Other*" in future periods in addition to our annual impairment test. If we were to conclude that a write down of goodwill is necessary, then we would record the appropriate charge, which could result in material charges that are adverse to our consolidated financial condition and results of operations. See Part II, Item 8, Note 6 – Goodwill and Other Intangible Assets, Net to our consolidated financial statements for additional information.

Because we have grown in part through acquisitions, goodwill and other acquired intangible assets represent a substantial portion of our assets. Goodwill was $1.2 billion as of December 31, 2023, and if we make additional acquisitions, it is likely that we will record additional goodwill and intangible assets in our consolidated financial statements. We also have long-lived assets consisting of property and equipment, operating lease right of use assets and other identifiable intangible assets of $233.5 million as of December 31, 2023, which we review on a periodic basis as well as when events or circumstances indicate that the carrying amount of an asset may not be recoverable. If a determination that a significant impairment in value of our unamortized intangible assets or long-lived assets occurs, such determination could require us to write off a substantial portion of our assets. A write off of these assets could have a material adverse effect on our consolidated financial condition and results of operations.

Our operations could be impacted by war, terrorism, natural or man-made disasters and climate change.

The Company's business may be adversely affected by instability, disruption or destruction in a geographic region in which it operates, regardless of cause, including war, terrorism, riot, civil insurrection or social unrest, climate change, natural or man-made disasters and extreme weather conditions, such as hurricanes, tornadoes, wildfires, earthquakes, floods and severe snow storms. Any such event in the markets in which we operate could not only impact the day-to-day operations of our care centers but could also disrupt our relationships with patients, employees and referral sources located in the affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. In addition, any episode of care that is not completed due to such an event will generally result in lower revenue for the episode. Our corporate office and a number of our care centers are located in the southeastern United States and the Gulf Coast Region, increasing our exposure to hurricanes and flooding. Moreover, global climate change could increase the intensity of individual hurricanes or the number of hurricanes that occur each year. Even if our facilities are not directly damaged, we may experience considerable disruptions in our operations due to property damage or electrical outages experienced in storm-affected areas by

our care givers, payors, vendors and others. Additionally, long-term adverse weather conditions, whether caused by global climate change or otherwise, could cause an outmigration of people from the communities where our care centers are located. If any of the circumstances described above occur, there could be a harmful effect on our business and our results of operations could be adversely affected.

Further, the current Russia-Ukraine conflict has created extreme volatility in the global financial markets and is expected to have further global economic consequences, including disruptions of the global supply chain and energy markets. Any such volatility or disruptions or similar disruptions caused by the Israel-Hamas War may have adverse consequences on us or the third parties on whom we rely. If the equity and credit markets deteriorate, including as a result of political unrest or war, it may make any necessary debt or equity financing more difficult to obtain in a timely manner or on favorable terms, more costly or more dilutive. Our business, financial condition and results of operations may be materially and adversely affected by any negative impact on the global economy resulting from the conflict in Ukraine, the Middle East or any other geopolitical tensions.

Inflation in the economy could negatively impact our business and results of operations.

Recently, inflation has increased throughout the United States economy. Our operations have been materially impacted by the recent inflationary environment as we have experienced higher labor costs and increases in supply costs, fuel costs and mileage reimbursements. Additionally, cost increases may outpace our expectations, causing us to use our cash and other liquid assets faster than forecasted. If we are unable to successfully manage the effects of inflation, our business, operating results, cash flows and financial condition may be adversely affected.

Risks Related to our Growth Strategies

Our growth strategy depends on our ability to acquire additional care centers and integrate and operate these care centers effectively, make investments and enter into joint ventures and other strategic relationships. If our growth strategy is unsuccessful or we are not able to successfully integrate newly acquired care centers into our existing operations, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We may not be able to fully integrate the operations of our acquired businesses with our current business structure in an efficient and cost-effective manner. Acquisitions, investments, joint ventures or strategic relationships involve significant risks and uncertainties, including:

- Difficulties in recouping partial episode payments and other types of misdirected payments for services from the previous owners in an acquisition;
- Difficulties integrating acquired personnel and business practices into our business;
- The potential loss of key employees, referral sources or patients of acquired care centers;
- The delay in payments associated with change in ownership, control and the internal processes of the Medicare Administrative Contractors;
- The assumption of liabilities and exposure to unforeseen liabilities of acquired care centers;
- The incurrence or assumption of significant debt, which could also cause a deterioration of our credit ratings, result in increased borrowing costs and interest expense and diminish our future access to the capital markets;
- Diverging interests from those of our joint venture partners or other strategic partners - we may not be able to direct the management and operations of the joint venture or other strategic relationship in the manner we believe is most appropriate, exposing us to additional risk;
- Variability in operating results which could cause our financial results to differ from our own expectations or the investment community’s expectations in any given period, or over the long-term; and
- Pre-closing and post-closing earnings charges which could adversely impact operating results in any given period.

As a result of our acquisitions and investments, we have recorded significant goodwill and other assets on our balance sheet. If we are not able to realize the value of these assets, or if the fair value of our investments declines, we may be required to record impairment charges which could have a material adverse effect on our consolidated financial condition and results of operations.

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, improve the reputation of the acquired business in the community and control costs. As we expand our markets, our growth could strain our resources, including our management,

information and accounting systems, regulatory compliance, logistics and other internal controls. The failure to accomplish any of these objectives, to effectively integrate any of these businesses or to maintain a sufficient level of resources to match our growth could have material adverse effects on our business and consolidated financial condition, results of operations and cash flows.

The indemnification provisions of acquisition agreements by which we have acquired companies may not fully protect us, and as a result, we may face unexpected liabilities.

Certain of the acquisition agreements by which we have acquired companies require the former owners to indemnify us against certain liabilities related to the operation of the acquired company before we acquired it. In most of these agreements, however, the liability of the former owners is limited, and certain former owners may be unable to meet their indemnification responsibilities. We cannot assure you that these indemnification provisions will protect us fully or at all, and as a result, we may face unexpected liabilities that could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

State efforts to regulate the establishment or expansion of health care providers could impair our ability to expand our operations.

Some states require health care providers (including skilled nursing facilities, hospice care centers, home health care centers and assisted living facilities) to obtain prior approval, known as a CON, POA or FNR, in order to commence operations (see Part I, Item 1, "Our Regulatory Environment" for additional information on CONs, POAs and FNRs). If we are not able to obtain such approvals, our ability to expand our operations could be impaired, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

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

Changes in federal laws or regulations may materially adversely impact our ability to acquire care centers or open new start-up care centers. For example, the Social Security Act provides the Secretary with the authority to impose temporary moratoria on the enrollment of new Medicare providers, if deemed necessary to combat fraud, waste or abuse under government programs. While there are no active Medicare moratoria, there can be no assurance that CMS will not adopt a moratorium on new providers in the future. Additionally, in 2010, CMS implemented and amended a regulation known as the "36 Month Rule" that is applicable to home health and hospice care center acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health and hospice care centers, those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition, from assuming the Medicare billing privileges of the acquired care center. The 36 Month Rule may restrict bona fide transactions and potentially block new investments in home health and hospice agencies. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material detrimental impact on our acquisition strategy. Further, some states have enacted laws requiring merging parties in healthcare-related transactions to notify state agencies and observe waiting periods (e.g., from 30 days to, in some cases, months) prior to closing.

Divestitures or other dispositions could negatively impact our business, and contingent liabilities from businesses that we have sold could adversely affect our business and consolidated financial condition, results of operations and cash flows.

We continually assess the strategic fit of our existing businesses and may divest, spin-off or otherwise dispose of businesses that are deemed not to fit with our strategic plan or are not achieving the desired return on investment. These transactions pose risks and challenges that could negatively impact our business and results of operations. For example, when we decide to sell or otherwise dispose of a business or assets, we may be unable to do so on satisfactory terms within our anticipated timeframe or at all, and even after reaching a definitive agreement to sell or dispose a business, the sale is typically subject to satisfaction of pre-closing conditions which may not become satisfied. In addition, divestitures or other dispositions may dilute our earnings per share, have other adverse tax, financial and accounting impacts and distract management, and disputes may arise with buyers. In addition, we may retain responsibility for and/or agree to indemnify buyers against some known and unknown contingent liabilities related to certain businesses or assets we sell or dispose. Any of these conditions or liabilities may negatively impact our results of operations and cash flows.

Risks Related to Laws and Government Regulations

We are subject to extensive government regulation. Any changes to the laws and regulations governing our business, or to the interpretation and enforcement of those laws or regulations, could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Our industry is subject to extensive federal and state laws and regulations. See Part I, Item 1, "Our Regulatory Environment" for additional information on such laws and regulations. Federal and state laws and regulations impact how we conduct our

business, the services we offer and our interactions with patients, our employees and the public and impose certain requirements on us related to:

- licensure and certification;
- adequacy and quality of health care services;
- qualifications of health care and support personnel;
- quality and safety of medical equipment;
- confidentiality, maintenance and security associated with medical records and claims processing;
- relationships with physicians and other referral sources;
- operating policies and procedures;
- emergency preparedness risk assessments and policies and procedures;
- policies and procedures regarding employee relations;
- addition of facilities and services;
- billing for services;
- utilization of services;
- documentation required for billing and patient care; and
- reporting and maintaining records regarding adverse events.

These laws and regulations, and their interpretations, are subject to change. Changes in existing laws and regulations, or their interpretations, or the enactment of new laws or regulations could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows by:

- increasing our administrative and other costs;
- increasing or decreasing mandated services;
- causing us to abandon business opportunities we might have otherwise pursued;
- decreasing utilization of services;
- forcing us to restructure our relationships with referral sources and providers; or
- requiring us to implement additional or different programs and systems.

Additionally, we are subject to various routine and non-routine reviews, audits and investigations by the Medicare and Medicaid programs and other federal and state governmental agencies, which have various rights and remedies against us if they establish that we have overcharged the programs or failed to comply with program requirements. We are also subject to potential lawsuits under the federal False Claims Act and other federal and state whistleblower statutes designed to combat fraud and abuse in our industry. Violation of the laws governing our operations or changes in interpretations of those laws could result in the imposition of fines, civil or criminal penalties, the termination of our rights to participate in federal and state-sponsored programs and/or the suspension or revocation of our licenses. If we become subject to material fines or if other sanctions or other corrective actions are imposed on us, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

We face periodic and routine 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.

As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. We also are subject to audits under various federal and state government programs in which third-party firms engaged by CMS, including Recovery Audit Contractors (“RACs”), Zone Program Integrity Contractors (“ZPICs”), Uniform Program Integrity Contractors ("UPICs"), Program Safeguard Contractors (“PSCs”), Medicaid Integrity Contractors (“MICs”), Supplemental Medical Review Contractors (“SMRCs”) and the Office of the Inspector General ("OIG"), conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare program. Additionally, private pay sources reserve the right to conduct audits. If billing errors are identified in the sample of reviewed claims, the billing error can be

extrapolated to all claims filed which could result in a larger overpayment than originally identified in the sample of reviewed claims. 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 a care center fails to comply with the conditions of participation in the Medicare program, that care center could be subjected to sanctions or terminated from the Medicare program.

Each of our care centers must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a care center, we may receive a notice of deficiency from the applicable state surveyor. If that care center then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program or subjected to alternative sanctions. CMS may impose temporary management, direct a plan of correction, direct training or impose payment suspensions and civil monetary penalties, in each case, upon providers who fail to comply with the conditions of participation. Termination of one or more of our care centers from the Medicare program for failure to satisfy the program's conditions of participation or the imposition of alternative sanctions could disrupt operations, require significant attention by management or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations and cash flows.

We are subject to federal and state laws that govern our financial relationships with physicians and other health care providers, including potential or current referral sources.

As stated in Part I, Item 1, "Our Regulatory Environment" of this document pertaining to *Federal and State Anti-Fraud and Abuse Laws and Regulations*, we are required to comply with various federal anti-fraud and abuse laws, including the federal Anti-Kickback Statute, the Stark or Physician Self-Referral Law, the False Claims Act and Civil Monetary Penalties Law, as well as state laws and regulations.

Although we believe we have structured our relationships with physicians and other actual or potential referral sources to comply with these laws where applicable, the laws are complex, and the Stark Law contains a number of strict liability provisions under which no intent to violate the law is required for a violation to be found. It is possible that courts or regulatory agencies may interpret state and federal anti-kickback laws and/or the Stark Law and similar state laws regulating relationships between health care providers and physicians in ways that will adversely implicate our practices or that isolated instances of noncompliance may occur. Violations of federal or state anti-kickback laws or the Stark Law could lead to criminal or civil fines or other sanctions, including repayment of federal health care program payments related to these arrangements, denials of government program reimbursement or even exclusion from participation in governmental health care programs, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. It is possible that a claim that results from a kickback or is made in violation of the Stark Law also may render it false or fraudulent, creating further potential liability under the federal False Claims Act, discussed above.

The No Surprises Act and similar price transparency initiatives could impact our relationships with patients and insurers.

Effective January 1, 2022, the No Surprises Act, enacted as part of the Consolidated Appropriations Act, 2021, creates price transparency requirements, including (i) requiring providers to send to patients or their health plan a good faith estimate of the expected charges and diagnostic codes prior to furnishing scheduled items or services and (ii) prohibiting providers from charging patients an amount beyond the in-network cost sharing amount for services rendered by out-of network providers, subject to limited exceptions. Price transparency initiatives such as the No Surprises Act may impact our ability to obtain or maintain favorable contract terms and may impact our competitive position and our relationships with patients and insurers.

Risks Related to Liquidity

Delays in payment may cause liquidity problems.

Our business is characterized by delays from the time we provide services to the time we receive payment for these services. 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 delays in obtaining documentation support such as physician orders, system problems, Medicare 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.

On May 29, 2018, CMS issued a notice indicating its intention to re-launch a home health agency pre-claim review demonstration project. Now called the Review Choice Demonstration for Home Health Services ("RCD") and fully implemented in six states (Florida, Illinois, North Carolina, Ohio, Texas and Oklahoma), RCD gives home health agencies three initial options: pre-claim review of all claims, post-payment review of all claims or minimal post-payment review with a 25% payment reduction for all home health services. Reduced review options are available for home health agencies that demonstrate compliance.

CMS has also implemented the Targeted Probe and Educate ("TPE") program for home health and hospice providers to help reduce provider claim denials and educate providers on appropriate billing practices. Under the TPE program, Medicare Administrative Contractors ("MACs") use data analysis to identify providers who have high claim error rates, unusual billing practices or provide services that have high national error rates. If a provider is selected for a TPE review by a MAC, the initial volume of claims reviewed is limited to 20 to 40 claims and can include up to three rounds of claims review, if necessary, with corresponding provider education and a subsequent period to allow for improvement. If results do not improve sufficiently after three rounds, the MAC may refer the provider to CMS for further action which may include 100% prepay review, extrapolation, referral to a Recovery Auditor and/or referral for revocation from the Medicare program. Providers will not be under TPE review and RCD at the same time. Providers currently on TPE review will be removed prior to CMS implementing RCD in that particular state.

Compliance with the RCD and TPE processes has resulted in increased administrative costs and delays in reimbursement for services in the states subject to RCD and TPE review. These delays could materially adversely affect our working capital.

Additionally, our hospice operations may experience payment delays when attempting to collect funds from state Medicaid programs in certain instances. Delays in receiving payments from these programs may also materially adversely affect our working capital.

Changes in units of payment for home health agencies could reduce our Medicare home health reimbursement levels.

Effective January 1, 2020, CMS implemented a revised case-mix adjustment methodology, the Patient-Driven Groupings Model ("PDGM"). Although this payment change was to be implemented in an overall budget neutral manner, the ultimate impact varied by provider based on factors including patient mix and admission source. Additionally, CMS made assumptions about behavior changes which resulted in a 4.36% reduction to reimbursement. Accordingly, the adoption of PDGM had a negative impact on our Medicare revenue per episode in 2020. Additionally, in the Calendar Year 2023 and 2024 Home Health Final Rules, CMS finalized permanent reductions in reimbursement totaling -3.5% and -2.6%, respectively, based on the difference between assumed and actual behavioral changes resulting from the implementation of PDGM. The permanent adjustments were only half of the behavioral adjustments initially proposed. CMS had concerns about implementing the full adjustments given the impact such a large decrease would have on providers. CMS will consider the remaining adjustments in future rulemaking. In addition to the permanent adjustments, CMS also has the discretion to make temporary adjustments through Calendar Year 2026. Payment updates could continue to negatively impact our rates of reimbursement in future years and have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. See Part I, Item 1, “Our Regulatory Environment – Home Health Payment Reform” for additional information.

The volatility and disruption of the capital and credit markets and adverse changes in the United States and global economies could impact our ability to access both available and affordable financing, and without such financing, we may be unable to achieve our objectives for strategic acquisitions and internal growth.

While we intend to finance strategic acquisitions and internal growth with cash flows from operations and borrowings under our revolving credit facility, we may require sources of capital in addition to those presently available to us. Uncertainty in the capital and credit markets may impact our ability to access capital on terms acceptable to us (i.e. at attractive/affordable rates) or at all, and this may result in our inability to achieve present objectives for strategic acquisitions and internal growth. Further, in the event we need additional funds and are unable to raise the necessary funds on acceptable terms, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

Our indebtedness could impact our financial condition and impair our ability to fulfill other obligations.

As of December 31, 2023, we had total outstanding indebtedness, excluding finance leases, of approximately $371.9 million. Our level of indebtedness could have a material adverse effect on our business and consolidated financial position, results of operations and cash flows and could impair our ability to fulfill other obligations in several ways, including:

- it could require us to dedicate a portion of our cash flow from operations to payments on our indebtedness, which could reduce the availability of cash flow to fund acquisitions, start-ups, working capital, capital expenditures and other general corporate purposes;
- it could limit our ability to borrow money or sell stock for working capital, capital expenditures, debt service requirements and other purposes;
- it could limit our flexibility in planning for, and reacting to, changes in our industry or business;
- it could make us more vulnerable to unfavorable economic or business conditions; and
- it could limit our ability to make acquisitions or take advantage of other business opportunities.

In the event we incur additional indebtedness, the risks described above could increase.

The agreements governing our indebtedness contain various covenants that limit our discretion in the operation of our business, and our failure to satisfy requirements in these agreements could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

The agreements governing our indebtedness (the "Debt Agreements") contain certain obligations, including restrictive covenants that require us to comply with or maintain certain financial covenants and ratios and restrict our ability to:

- incur additional debt;
- redeem or repurchase stock, pay dividends or make other distributions;
- make certain investments;
- create liens;
- enter into transactions with affiliates;
- make acquisitions;
- enter into joint ventures;
- merge or consolidate;
- invest in foreign subsidiaries;
- amend acquisition documents;
- enter into certain swap agreements;
- make certain restricted payments;
- transfer, sell or leaseback assets; and
- make fundamental changes in our corporate existence and principal business.

Our Debt Agreements also limit our ability to reinvest the net cash proceeds from asset sales or subordinated debt issuances in certain circumstances. For example, in the event we or any of our subsidiaries receive more than $5 million in net cash proceeds from an asset sale, disposition or involuntary disposition, our Debt Agreements require us to prepay our term loan facility and revolving credit facility with all of such net cash proceeds, unless we elect to reinvest the net cash proceeds in fixed or capital assets related to our business.

In addition, events beyond our control could affect our ability to comply with the Debt Agreements. Any failure by us to comply with or maintain all applicable financial covenants and ratios and to comply with all other applicable covenants could result in an event of default with respect to the Debt Agreements. If we are unable to obtain a waiver from our lenders in the event of any non-compliance, our lenders could accelerate the maturity of any outstanding indebtedness and terminate the commitments to make further extensions of credit (including our ability to borrow under our revolving credit facility). Any failure to comply with these covenants could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

Risks Related to Ownership of Our Common Stock

The price of our common stock has been and may continue to be volatile, which could lead to securities litigation brought against us or cause investors to lose the value of their investment.

The price at which our common stock trades has experienced significant volatility in prior years and may continue to be volatile. Various factors have impacted, and may continue to impact, the price of our common stock, including among others:

- variances in our quarterly financial results compared to research analyst expectations;
- changes in financial estimates and recommendations by securities analysts;
- changes in our estimates, guidance or business plans;
- changes in management;
- changes or proposed changes in health care laws or regulations or enforcement of these laws and regulations, or announcements relating to these matters;
- changes in the Medicare, Medicaid and private insurance payment rates for home health and hospice;
- the operating and stock price performance of other comparable companies;
- announcements by us or our competitors of significant contracts, acquisitions, strategic partnerships, joint ventures or capital commitments;
- general economic and stock market conditions; or
- other factors described in this "Risk Factors" section and elsewhere in this Annual Report on Form 10-K.

Additionally, if the proposed merger with UnitedHealth Group is not completed within the expected timeframe, or at all, we may experience negative reactions from the financial markets, including negative impacts on our stock price, and it is uncertain when, if ever, the price of our shares would return to the prices at which our shares currently trade.

The stock market in general, and the NASDAQ Global Select Market ("NASDAQ") in particular, has experienced price and volume fluctuations that we believe have often been unrelated or disproportionate to the operating performance of health care provider companies. These broad market and industry factors may materially reduce the market price of our common stock, regardless of our operating performance. As a result, investors may not be able to sell their common stock at or above the purchase price. In addition, securities class-action cases have often been brought against companies following periods of volatility in the market price of their securities. Such litigation, if instituted against us, could result in substantial costs and a diversion of management's attention and resources.

The activities of short sellers could reduce the price or prevent increases in the price of our common stock. "Short sale" is defined as the sale of stock by an investor that the investor does not own. Typically, investors who sell short believe the price of the stock will fall, and anticipate selling shares at a higher price than the purchase price at which they will buy the stock. As of December 31, 2023, investors held a short position of approximately 2.9 million shares of our common stock which represented 9% of our outstanding common stock. The anticipated downward pressure on our stock price due to actual or anticipated sales of our stock by some institutions or individuals who engage in short sales of our common stock could cause our stock price to decline.

Our Board of Directors may use anti-takeover provisions or issue stock to discourage a change of control.

We are party to the Merger Agreement with UnitedHealth Group, which will result in a change in control of Amedisys, if completed. As such, the below anti-takeover provisions are inapplicable to the proposed Merger.

Our certificate of incorporation currently authorizes us to issue up to 60,000,000 shares of common stock and 5,000,000 shares of undesignated preferred stock. Our Board of Directors may cause us to issue additional stock to discourage an attempt to obtain control of our company. For example, shares of stock could be sold to purchasers who might support our Board of Directors in a control contest or to dilute the voting or other rights of a person seeking to obtain control. In addition, our Board of Directors could cause us to issue preferred stock entitling holders to vote separately on any proposed transaction, convert preferred stock into common stock, demand redemption at a specified price in connection with a change in control or exercise other rights designed to impede a takeover.

The issuance of additional shares may, among other things, dilute the earnings and equity per share of our common stock and the voting rights of common stockholders.

We have implemented other anti-takeover provisions or provisions that could have an anti-takeover effect, including advance notice requirements for director nominations and stockholder proposals, no cumulative voting for directors, requirements that director vacancies are filled by remaining directors (including vacancies resulting from removal) and that the number of directors is fixed by the Board of Directors as well as the ability for the Board of Directors to increase or decrease the size of the Board of Directors without stockholder approval (within the range set forth in our Certificate of Incorporation and Bylaws). These provisions, and others that our Board of Directors may adopt hereafter, may discourage offers 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 change of control.

Our Bylaws designate the Court of Chancery of the State of Delaware or, if the Court of Chancery does not have jurisdiction, the federal court for the District of Delaware, as the sole and exclusive forum for certain types of actions and proceedings that may be initiated by our stockholders, which could discourage lawsuits against us and our directors, officers, employees and stockholders.

Our Bylaws provide that unless we otherwise consent to the selection of an alternative forum, the Court of Chancery of the State of Delaware or, if the Court of Chancery does not have jurisdiction, the federal court for the District of Delaware, will be the sole and exclusive forum for any derivative action or proceeding brought on behalf of us, any action asserting a claim of breach of a fiduciary duty owed by any of our directors, officers, employees or agents to us or our stockholders, any action asserting a claim arising pursuant to any provision of the Delaware General Corporation Law or our Certificate of Incorporation or Bylaws or any action asserting a claim governed by the internal affairs doctrine. This provision would not apply to claims brought to enforce a duty or liability created by the Securities Exchange Act of 1934, as amended (the "Exchange Act") or any other claim for which the federal courts have exclusive jurisdiction.

In addition, our Bylaws provide that the federal district courts of the United States will be the exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act of 1933, as amended (the "Securities Act"), unless we consent in writing to the selection of an alternative forum.

These exclusive forum provisions may limit the ability of our stockholders to bring a claim in a judicial forum that such stockholders find favorable for disputes with us or our directors or officers, which may discourage such lawsuits against us and our directors, officers, employees and agents.

ITEM 1B. UNRESOLVED STAFF COMMENTS

None.

ITEM 1C. CYBERSECURITY

Amedisys recognizes the importance of assessing, identifying and managing material risks associated with cybersecurity threats, as such term is defined in Item 106(a) of Regulation S-K. These risks include, among other things, operational disruption, intellectual property theft, fraud, extortion, harm to employees or patients, violation of privacy or security laws and other litigation and legal risk. Amedisys has implemented various cybersecurity processes, technologies and controls to enhance our efforts to assess, identify and manage such material risks.

Amedisys deploys a range of tools and services, including regular network and endpoint monitoring, vulnerability assessments and penetration testing, to inform our leadership team of cybersecurity-based risks. In addition, we schedule tabletop exercises with management and other employees to test our cyber incident response plans. Amedisys has also received HITRUST certification for our internally developed applications which allows us to baseline our program to industry standards and best practices.

Our cybersecurity program includes controls designed to identify, protect against, detect, respond to and recover from cybersecurity incidents (as such term is defined in Item 106(a) of Regulation S-K) and to provide for the availability of critical data and systems to maintain regulatory compliance. These controls include the following activities:

- Closely monitoring emerging data protection laws and implementing needed changes to our processes in order to comply.
- Conducting annual cybersecurity management and incident training for all employees of the organization.
- Requiring employees and third parties who provide services on our behalf to treat customer information and data with care.

- Leveraging the HITRUST incident handling framework to help us identify, protect, detect, respond and recover when there is an actual or potential cybersecurity incident.
- Carrying information security risk insurance that provides protection against the potential losses arising from a cybersecurity incident.

Additionally, Amedisys performs periodic internal and third-party assessments to test our cybersecurity controls and regularly evaluates our policies and procedures surrounding our handling and control of personal data and the systems we have in place to help protect us from cybersecurity threats or personal data breaches.

Amedisys has established a cybersecurity risk management process that includes internal reporting of significant cybersecurity risk to our Enterprise Risk Management Committee ("ERMC") on a quarterly basis. In addition, our incident response plan includes processes to triage, assess severity, escalate, contain, investigate and remediate the incident, as well as to comply with potentially applicable legal obligations and mitigate brand and reputational damage. These processes are assessed annually during our penetration testing.

Our risk management processes also address cybersecurity threat risks associated with our use of third-party service providers, including those in our supply chain or those who have access to our customer and employee data or our systems. In addition, cybersecurity considerations affect the selection and oversight of our third-party service providers. Amedisys performs diligence on third parties that have access to our systems, data or facilities that house such systems or data and monitors cybersecurity threat risks identified through such diligence.

We face a number of cybersecurity risks in connection with our business (see Part I, Item 1A. "Risk Factors – Risks Related to our Operations – Our business depends on our information systems. A cyber-attack, security breach or our inability to effectively integrate, manage and keep our information systems secure and operational could disrupt our operations."). Although such risks have not materially impacted our business strategy, results of operations or financial condition to date, we have experienced threats to and breaches of our data and systems, including malware and computer virus attacks.

The Audit Committee of the Board of Directors oversees our cybersecurity risk exposures and the steps taken by management to monitor and mitigate cybersecurity risks. On an annual basis, management provides the Audit Committee with an overview of our cybersecurity threat risk management and strategy covering topics such as data security posture, results from third-party assessments, progress towards pre-determined risk mitigation related goals, our incident response plan and cybersecurity threat risks or incidents and developments, as well as the steps management has taken to respond to such risks. The Audit Committee also receives materials, including a cybersecurity briefing, indicating current and emerging cybersecurity threat risks and describing the Company's ability to mitigate those risks.

The members of management who are responsible for assessing and managing cyber risk are the Chief Information Security Officer and the Chief Information Officer of the Company who, combined, have over 30 years of experience in managing cybersecurity. The ERMC has ultimate responsibility for the risk management of cyber risk and is informed about and monitors the prevention, detection, mitigation and remediation of cybersecurity incidents in addition to the cyber incident response and reporting processes.

ITEM 2. PROPERTIES

Our executive office is located in Nashville, Tennessee in a leased property consisting of 8,784 square feet; our corporate headquarters is located in Baton Rouge, Louisiana in a leased property consisting of 95,657 square feet. We believe we have adequate space to accommodate our corporate staff located in these locations for the foreseeable future.

In addition to our executive office and corporate headquarters, we also lease facilities for our home health and hospice care centers and our high acuity care joint ventures. Generally, our leases have an initial term of five years, but range from one to ten years. Most of our leases also contain early termination options and renewal options. The following table shows the location of our 346 Medicare-certified home health care centers, 165 Medicare-certified hospice care centers and 11 high acuity care markets at December 31, 2023:

State	Home Health	Hospice	High Acuity Care	State	Home Health	Hospice	High Acuity Care
Alabama	29	10	—	Nebraska	1	7	—
Arizona	3	1	1	New Hampshire	3	3	—
Arkansas	7	—	1	New Jersey	2	7	—
California	4	1	—	New York	6	—	1
Connecticut	1	1	—	North Carolina	13	7	—
Delaware	2	2	—	Ohio	4	5	—
Florida	15	7	—	Oklahoma	7	1	—
Georgia	56	9	—	Oregon	3	1	—
Illinois	2	—	—	Pennsylvania	9	20	2
Indiana	5	5	—	Rhode Island	1	2	—
Iowa	—	1	—	South Carolina	26	8	1
Kansas	1	1	—	South Dakota	—	1	
Kentucky	17	—	—	Tennessee	45	15	—
Louisiana	8	5	—	Texas	16	12	1
Maine	3	4	—	Virginia	14	5	—
Maryland	9	3	—	Washington	2	—	1
Massachusetts	6	10	—	West Virginia	11	6	—
Michigan	—	—	1	Wisconsin	—	3	2
Mississippi	8	—	—	Washington, D.C.	1	—	—
Missouri	6	2	—	Total	346	165	11

ITEM 3. LEGAL PROCEEDINGS

See Part II, Item 8, Note 12 – Commitments and Contingencies for information concerning our legal proceedings.

ITEM 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

ITEM 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information and Holders

Our common stock trades on the NASDAQ Global Select Market under the trading symbol "AMED." As of February 16, 2024, there were approximately 458 holders of record of our common stock. This number of holders of record does not represent the actual number of beneficial owners of our common stock because shares are frequently held in "street name" by securities dealers and others for the benefit of individual owners who have the right to vote their shares.

Dividend Policy

We have not declared or paid any cash dividends on our common stock or any other of our securities and do not expect to pay cash dividends for the foreseeable future. We currently intend to retain our future earnings, if any, to fund the development and growth of our business. Future decisions concerning the payment of dividends will depend upon our results of operations, financial condition, capital expenditure plans and debt service requirements, as well as such other factors that our Board of Directors, in its sole discretion, may consider relevant. In addition, our outstanding indebtedness restricts, and we anticipate any additional future indebtedness may restrict, our ability to pay cash dividends; provided, however, that we may pay dividends (i) payable solely in our equity securities or (ii) cash dividends if (1) no default or event of default under the Third Amended Credit Agreement shall have occurred and be continuing at the time of such dividend or would result therefrom, and (2) we demonstrate that, upon giving pro forma effect to such dividend, our consolidated leverage ratio (as defined in the Third Amended Credit Agreement) is less than 2.75 to 1.0.

Purchases of Equity Securities

The following table provides information with respect to purchases made by us of shares of our common stock during each of the months during the three-month period ended December 31, 2023. The amounts below only relate to employee stock activity as the Merger Agreement limits the Company's ability to repurchase shares of common stock prior to the completion of the Merger, subject to certain exceptions.

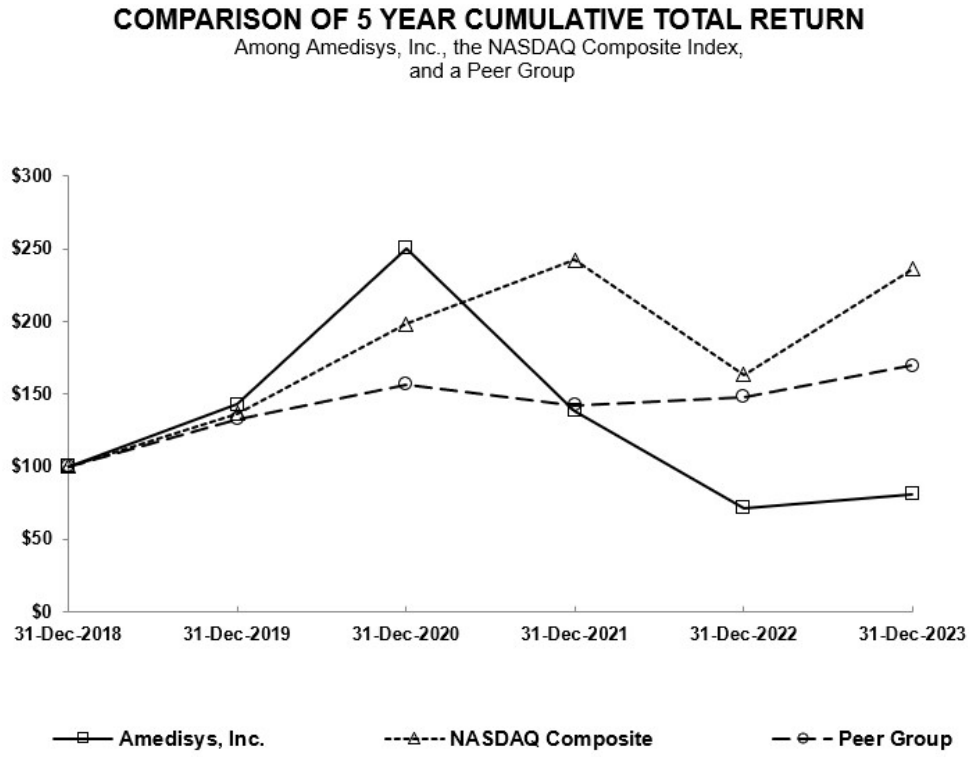
Period	(a) Total Number of Shares (or Units) Purchased		(b) Average Price Paid per Share (or Unit)	(c) Total Number of Shares (or Units) Purchased as Part of Publicly Announced Plans or Programs	(d) Maximum Number (or Approximate Dollar Value) of Shares (or Units) That May Yet Be Purchased Under the Plans or Programs	
October 1, 2023 to October 31, 2023	509		$ 92.74	—	$ 100,000,000	
November 1, 2023 to November 30, 2023	—		—	—	100,000,000	
December 1, 2023 to December 31, 2023	31,084		95.41	—	100,000,000	
	31,593	(1)	$ 95.37	—	$ 100,000,000	(2)

(1) Includes shares of common stock surrendered to us by certain employees to satisfy tax withholding and/or strike price obligations in connection with the vesting of non-vested stock and the exercise of stock options previously awarded to such employees under our 2018 Omnibus Incentive Compensation Plan.

(2) Represents amounts remaining as of December 31, 2023 under the $100 million 2023 Repurchase Program, which was authorized by our Board of Directors on February 2, 2023 and expired on December 31, 2023.

Stock Performance Graph

The Performance Graph below compares the cumulative total stockholder return on our common stock, $0.001 par value per share, for the five-year period ended December 31, 2023 with the cumulative total return on the NASDAQ composite index and an industry peer group over the same period (assuming the investment of $100 in our common stock, the NASDAQ composite index and the industry peer group on December 31, 2018 and the reinvestment of dividends). The peer group we selected is comprised of: Addus Homecare Corporation ("ADUS"), Chemed Corporation ("CHE"), Encompass Health Corporation ("EHC") and National Healthcare Corporation ("NHC"). The cumulative total stockholder return on the following graph is historical and is not necessarily indicative of future stock price performance. No cash dividends have been paid on our common stock.



	12/31/2018	12/31/2019	12/31/2020	12/31/2021	12/31/2022	12/31/2023
Amedisys, Inc.	$ 100.00	$ 142.53	$ 250.47	$ 138.23	$ 71.33	$ 81.17
NASDAQ Composite	$ 100.00	$ 136.69	$ 198.10	$ 242.03	$ 163.28	$ 236.17
Peer Group	$ 100.00	$ 132.91	$ 156.73	$ 142.46	$ 148.05	$ 169.52

This stock performance information is "furnished" and shall not be deemed to be "soliciting material" or subject to Regulation 14A under the Exchange Act, shall not be deemed "filed" for purposes of Section 18 of the Exchange Act or otherwise subject to the liabilities of that section, and shall not be deemed incorporated by reference in any filing under the Securities Act or the Exchange Act, whether made before or after the date of this report and irrespective of any general incorporation by reference language in any such filing, except to the extent we specifically incorporate the information by reference.

ITEM 6. [RESERVED]

ITEM 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

The following discussion and analysis provides information we believe is relevant to an assessment and understanding of our results of operations and financial condition for 2023, 2022 and 2021. This discussion should be read in conjunction with our audited financial statements included in Item 8, "Financial Statements and Supplementary Data" and Part I, Item 1, "Business" of this Annual Report on Form 10-K. The following analysis contains forward-looking statements about our future revenues, operating results and expectations. See "Special Caution Concerning Forward-Looking Statements" for a discussion of the risks, assumptions and uncertainties affecting these statements as well as Part I, Item 1A. "Risk Factors."

For a discussion of a comparison of the years ended December 31, 2022 and December 31, 2021, please refer to "Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K for the year ended December 31, 2022, filed with the Securities and Exchange Commission on February 16, 2023.

Overview

We are a provider of high-quality in-home healthcare and related services to the chronic, co-morbid, aging American population, with approximately 73%, 74% and 75% of our consolidated net service revenue derived from Medicare for 2023, 2022 and 2021, respectively.

Our operations involve servicing patients through our three reportable business segments: home health, hospice and high acuity care. We divested our personal care business on March 31, 2023. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from an illness, injury or surgery. Our hospice segment provides care that is designed to provide comfort and support for those who are facing a terminal illness. Our high acuity care segment delivers the essential elements of inpatient hospital, palliative and skilled nursing facility ("SNF") care to patients in their homes. As of December 31, 2023, we owned and operated 346 Medicare-certified home health care centers, 165 Medicare-certified hospice care centers and 10 admitting high acuity care joint ventures in 37 states within the United States and the District of Columbia.

Care Centers Summary (Includes Unconsolidated Joint Ventures)

	Home Health	Hospice	Personal Care	High Acuity Care [1]
At December 31, 2020	320	180	14	—
Acquisitions/Expansions/De novos	11	1	—	7
Closed/Consolidated	—	(6)	—	—
At December 31, 2021	331	175	14	7
Acquisitions/Expansions/De novos	27	—	—	2
Closed/Consolidated	(11)	(11)	(1)	(1)
At December 31, 2022	347	164	13	8
Acquisitions/Expansions/De novos	2	1	—	2
Closed/Consolidated	(3)	—	(13)	—
At December 31, 2023	346	165	—	10

(1) As of December 31, 2023, we have 10 admitting high acuity care joint ventures, which operate in 11 markets.

Proposed Merger

On June 26, 2023, Amedisys, UnitedHealth Group Incorporated, a Delaware corporation ("UnitedHealth Group"), and Aurora Holdings Merger Sub Inc., a Delaware corporation and a wholly owned subsidiary of UnitedHealth Group ("Merger Sub"), entered into an Agreement and Plan of Merger (the "Merger Agreement"), pursuant to which Merger Sub will merge with and into Amedisys with Amedisys continuing as the surviving corporation and becoming a wholly owned subsidiary of UnitedHealth Group (the "Merger").

Subject to the terms and conditions set forth in the Merger Agreement, at the effective time of the Merger (the "Effective Time"), by virtue of the Merger: (i) each share of Amedisys common stock ("Amedisys Common Stock") held in treasury by Amedisys or owned by UnitedHealth Group or Merger Sub or any of their respective subsidiaries, in each case, immediately prior to the Effective Time will be cancelled (collectively, "cancelled shares") without consideration; and (ii) each share of

Amedisys Common Stock, other than any cancelled shares, issued and outstanding immediately prior to the Effective Time will be converted into the right to receive $101 per share in cash, without interest, less any applicable withholding taxes.

The Merger is subject to a number of conditions to closing as specified in the Merger Agreement. These closing conditions include, among others, (i) approval by Amedisys stockholders at the Amedisys Stockholders Meeting (as defined in the Merger Agreement) of the proposal to adopt the Merger Agreement, which approval was obtained on September 8, 2023; (ii) the expiration or termination of the applicable waiting period (and any extension thereof) under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (iii) the receipt of the required state regulatory approvals; (iv) the absence of any law or order that has the effect of enjoining or otherwise prohibiting the completion of the Merger; and (v) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the transactions contemplated by the Merger Agreement under all applicable antitrust laws without the imposition by any governmental entity of any term, condition, obligation, requirement, limitation, prohibition, remedy, sanction or other action that has resulted in or would reasonably be expected to result in a Burdensome Condition (as defined in the Merger Agreement). Due to these conditions and other contingencies, there can be no assurance that the Merger will be successfully completed. During the periods prior to and including the date of the closing of the Merger, we expect to incur significant additional merger-related expenses. See Part I, Item 1A. “Risk Factors.”

Termination of Option Care Heath, Inc. ("OPCH") Merger Agreement

As previously disclosed in Amedisys’ Current Report on Form 8-K filed with the SEC on May 3, 2023 and its Quarterly Report on Form 10-Q filed with the SEC on May 4, 2023, Amedisys entered into an Agreement and Plan of Merger on May 3, 2023 (the “OPCH Merger Agreement”) with OPCH, a Delaware corporation, and Uintah Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of OPCH (“OPCH Merger Sub”). On June 26, 2023, Amedisys, OPCH and OPCH Merger Sub entered into the Termination Agreement (the “Termination Agreement”), pursuant to which the parties thereto agreed to terminate the OPCH Merger Agreement and grant mutual releases by the parties of all claims against the other parties based upon, arising from, in connection with or relating to the OPCH Merger Agreement. Pursuant to the terms of the Termination Agreement, each of the termination of the OPCH Merger Agreement and the mutual releases provided for in the Termination Agreement would become effective upon receipt by OPCH of a $106,000,000 termination fee payable by, or on behalf of, Amedisys within 24 hours of the execution of the Termination Agreement (i.e., before the market open on June 27, 2023). On June 26, 2023, following the execution of the Termination Agreement, UnitedHealth Group, on behalf of Amedisys, delivered funds to OPCH in an amount equal to $106,000,000, representing the termination fee payable to OPCH under the OPCH Merger Agreement and the Termination Agreement, satisfying the condition precedent to the effectiveness of the termination of the OPCH Merger Agreement and the releases contained in the Termination Agreement. If the Merger Agreement is terminated under certain specified circumstances, Amedisys may be required to reimburse UnitedHealth Group for the $106,000,000 termination fee that UnitedHealth Group, on Amedisys’ behalf, paid to OPCH in addition to the $125,000,000 termination fee payable by Amedisys to UnitedHealth Group upon termination of the Merger Agreement. The $106,000,000 termination fee was recorded to other income (expense) within our consolidated statement of operations with a corresponding liability to termination fee paid by UnitedHealth Group within our consolidated balance sheet during the year ended December 31, 2023.

Executive Leadership

On March 13, 2023, our Board of Directors named Richard Ashworth as the Company’s President and Chief Executive Officer and elected Mr. Ashworth as a director, all effective April 10, 2023. Paul B. Kusserow ceased serving as Chief Executive Officer effective April 10, 2023 but continues to serve as Chairman of the Board.

Personal Care Divestiture

On February 10, 2023, we signed a definitive agreement to sell our personal care business (excluding the Florida operations, which were closed during the three-month period ended March 31, 2023). The divestiture closed on March 31, 2023. We received net proceeds of $47.8 million and recognized a loss of $2.2 million in connection with the divestiture.

2023 Developments

- Maintained the highest Quality of Patient Care star rating in the home health industry of 4.35 with 96% of our care centers at 4+ Stars
- Outperformed the industry on all Hospice Item Set ("HIS") measures
- Released our second annual Environmental, Social and Governance ("ESG") Report
- Performed more than 10.6 million visits

- Expanded our usage and relationship with Medalogix, a predictive data and analytics company, helping to further optimize our current business and positioning us to work more closely with Medicare Advantage payors
- Entered into a new risk-based palliative care contract with BlueCross BlueShield of Tennessee
- Generated $137 million in cash flow from operations
- Continued to execute on a clinical optimization plan to gain efficiencies and clinical capacity

2024 Strategy

- Further advance our industry leading Quality of Patient Care star scores in home health and drive best-in-class hospice quality as measured by the Hospice Care Index
- Continue to better the communities and patients we serve by further incorporating ESG practices into our business operations
- Advance our culture and sense of belonging through diversity and inclusion initiatives
- Build a learning culture through world class leadership development
- Reduce turnover in all roles, especially focused on critical clinician positions
- Consistently grow all lines of business organically and inorganically
- Expand our high acuity care line of business via new joint venture partnerships, vendor models and palliative care relationships
- Continue to execute on initiatives to hire and retain clinicians
- Continue reorganization initiatives to increase efficiency in our operating model

Financial Performance

On a consolidated basis, operating income decreased $24 million on a $13 million increase in net service revenue. Significant drivers of the $24 million decrease in operating income were merger-related expenses, higher incentive compensation costs and the return of sequestration. Additionally, wage inflation and a shift in our home health volumes from episodic to non-episodic payors negatively impacted performance.

Our home health segment was positively impacted by total volume growth, an increase in our non-Medicare revenue per visit resulting from rate increases and improvements in clinician utilization. These items were partially offset by a shift in our payor mix and labor pressures.

Our hospice segment experienced a decline in our average daily census, which is the main driver of hospice revenue, primarily due to a decline in hospice admissions as well as prior year care center closures.

We completed the sale of our personal care business on March 31, 2023.

Our high acuity care segment results reflect growth in our home recovery care services offset by investments in resources to support the first performance year of our new risk-based palliative care contract as well as future palliative care arrangements.

Economic and Industry Factors

Our segments operate in a highly fragmented and highly competitive industry. The degree of competitiveness for our home health and hospice care centers varies based upon whether our care centers operate in states that require a certificate of need ("CON"), permit of approval ("POA") or facility needs review ("FNR"). In such states, expansion by existing providers or entry into the market by new providers is permitted only where the determination is made by state health authorities that a given amount of unmet healthcare need exists. Currently, 67% and 33% of our home health and hospice care centers, respectively, operate in CON, POA or FNR states.

As the Federal government continues to debate a reduction in expenditures and a reform of the Medicare system, our industry continues to face reimbursement pressures. These reform efforts 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 centers.

Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. The impact of inflation on the Company is primarily in the area of labor costs, supply costs, fuel costs and mileage reimbursements. The healthcare industry is labor intensive. We have experienced, and expect to continue to experience, increases in wage costs. In addition, increases in healthcare costs are typically higher than inflation and impact our costs under our employee benefit plans.

The Centers for Medicare and Medicaid Services ("CMS") Payment Updates

Hospice

On July 28, 2023, CMS issued the final rule to update hospice payment rates and the wage index for fiscal year 2024, effective for services provided beginning October 1, 2023. CMS estimates hospices serving Medicare beneficiaries will see a 3.1% increase in payments. This increase is the result of a 3.3% market basket adjustment as required under PPACA less a 0.2% productivity adjustment. Additionally, CMS increased the aggregate cap amount by 3.1% to $33,494. Based on our analysis of the final rule, we expect our impact to be in line with the 3.1% increase.

Home Health

On November 1, 2023, CMS issued the Calendar Year 2024 Final Rule for Medicare home health providers. CMS estimates that the final rule will result in an 0.8% increase in payments to home health providers. This increase is the result of a 3.0% payment update (3.3% market basket adjustment less a 0.3% productivity adjustment) and an increase of 0.4% for the update to the fixed-dollar loss ratio used in determining outlier payments offset by a permanent adjustment of -2.6% based on the difference between assumed and actual behavior changes resulting from the implementation of PDGM. The -2.6% permanent adjustment was derived from a -2.890% adjustment which was only applied to the 30-day payment rate and not the low utilization payment adjustment. The -2.890% is only half of the total proposed adjustment. The remaining adjustment is to be considered in future rulemaking. Based on our analysis of the final rule, we expect our impact to be in line with the 0.8% increase.

In addition to permanent adjustments, CMS also has discretion to make temporary adjustments through calendar year 2026; however, CMS has elected not to implement a temporary adjustment for calendar year 2024.

On July 5, 2023, the National Association for Home Care and Hospice ("NAHC"), the leading national home health trade association, filed suit against CMS in the United States District Court for the District of Columbia over the implementation of the payment cuts CMS made in the CY 2023 Final Rule effective January 1, 2023; that litigation remains pending.

The following payment adjustments are effective for each of the years indicated based on CMS' final rules:

	Home Health			Hospice		
	2024	2023	2022	2024[1]	2023	2022
Market Basket Update	3.3 %	4.1 %	3.1 %	3.3 %	4.1 %	2.7 %
Rural Add-On Adjustment	—	—	(0.1)	—	—	—
Productivity Adjustment	(0.3)	(0.1)	(0.5)	(0.2)	(0.3)	(0.7)
Behavioral Adjustment	(2.6)	(3.5)	—	—	—	—
Fixed-Dollar Loss Ratio Adjustment	0.4	0.2	0.7	—	—	—
Estimated Industry Impact	0.8 %	0.7 %	3.2 %	3.1 %	3.8 %	2.0 %
Estimated Company-Specific Impact[2]	0.8 %	— %	3.2 %	3.1 %	3.8 %	2.0 %

(1) Effective for services provided from October 1, 2023 to September 30, 2024.

(2) Our company-specific impact of the home health final rule could differ depending on differences in the wage index, our patient case mix and other factors, such as low utilization payment adjustments ("LUPAs") or outliers, which are described in more detail under Critical Accounting Estimates below. Our company-specific impact of the hospice final rule could differ based on our mix of patients and differences in the wage index.

Sequestration

In March 2020, Congress passed the bipartisan Coronavirus Aid, Relief and Economic Security Act ("CARES Act") which provided for the suspension of the 2% reduction of Medicare claim reimbursements ("sequestration") for the period May 1, 2020 through December 31, 2020. During 2020 and 2021, Congress passed additional COVID-19 relief legislation which extended the 2% suspension of sequestration through March 31, 2022; sequestration was reinstated as a 1% reduction to Medicare claim reimbursements for the period April 1, 2022 through June 30, 2022 and was fully reinstated as a 2% reduction to Medicare claim reimbursements effective July 1, 2022. The reinstatement of sequestration has resulted in a reduction of our net service revenue.

Governmental Inquiries and Investigations and Other Litigation

See Item 8, Note 12 – Commitments and Contingencies to our consolidated financial statements for a discussion of and updates regarding legal proceedings and investigations we are involved in. No assurances can be given as to the timing or outcome of these items.

Results of Operations

Consolidated

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

	For the Years Ended December 31,		
	2023	2022	2021
Net service revenue	$ 2,236.4	$ 2,223.2	$ 2,214.1
Other operating income	—	—	13.3
Cost of service, inclusive of depreciation	1,245.5	1,260.4	1,233.4
Gross margin	990.9	962.8	994.0
% of net service revenue	*44.3 %*	*43.3 %*	*44.9 %*
General and administrative expenses	816.8	754.1	711.2
% of net service revenue	*36.5 %*	*33.9 %*	*32.1 %*
Depreciation and amortization	17.7	24.9	30.9
Investment impairment	—	3.0	—
Operating income	156.4	180.8	251.9
Total other (expense) income, net	(116.8)	(20.5)	28.3
Income tax expense	(50.6)	(42.5)	(70.1)
Effective income tax rate	*127.7 %*	*26.5 %*	*25.0 %*
Net (loss) income	(10.9)	117.7	210.2
Net loss (income) attributable to noncontrolling interests	1.2	0.9	(1.1)
Net (loss) income attributable to Amedisys, Inc.	$ (9.7)	$ 118.6	$ 209.1

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

On a consolidated basis, our operating income decreased $24 million on a $13 million increase in net service revenue. Our year-over-year results were impacted by merger-related expenses totaling $37 million, higher incentive compensation costs totaling $27 million (resulting primarily from the reversal of incentive plan accruals and lower field incentive payouts in the prior year due to under-performance and incremental expenses associated with our CEO transition), the return of sequestration (prior year included a benefit of $13 million associated with the suspension of sequestration), the acquisitions of Evolution and AssistedCare on April 1, 2022 (which combined contributed $10 million in incremental revenue and an operating loss of $1 million to the current year), the divestiture of our personal care line of business (which contributed an incremental $46 million in revenue and $4 million in operating income in the prior year), a $3 million impairment charge recorded in the prior year in connection with the wind down of operations of one of our high acuity care joint ventures and a $9 million reduction to net service revenue in the prior year related to our Infinity ZPIC audits (see Note 12 – Commitments and Contingencies to our consolidated financial statements for additional information regarding the Infinity ZPIC audits).

Excluding these items, our operating income increased $46 million on a $53 million increase in net service revenue due to the hospice rate increase, home health volume growth and non-Medicare rate increases, savings associated with clinical optimization and reorganization initiatives, improvements in clinician utilization, lower COVID-related costs and lower depreciation and amortization partially offset by lower hospice average daily census, a shift in our home health payor mix, planned wage increases, wage inflation and an increase in our general and administrative expenses.

Our operating results reflect a $63 million increase in our general and administrative expenses compared to the prior year. Excluding our merger-related expenses ($37 million), the impact of the higher incentive compensation costs described above ($26 million) and incremental expenses related to our acquisitions in the current year ($3 million) and our personal care line of business in the prior year ($7 million), our general and administrative expenses increased $4 million (1%) primarily due to planned wage increases, higher insurance-related costs, recruiting fees and information technology fees, a favorable legal settlement recognized in the prior year and a change in the presentation of gains on the sale of fleet vehicles which are reflected

in other income (expense) within our consolidated statement of operations as of January 1, 2023 due to the modification of our fleet leases. These items were partially offset by lower acquisition and integration costs, lower staffing levels, savings associated with clinical optimization and reorganization initiatives, lower travel spend and severance costs incurred in the prior year.

Total other expense includes the following items (amounts in millions):

	For the Years Ended December 31,	
	2023	2022
Interest income	$ 3.3	$ 0.2
Interest expense	(31.3)	(22.2)
Equity in earnings (loss) from equity method investments	10.8	(0.1)
Merger termination fee	(106.0)	—
Miscellaneous, net	6.5	1.6
Total other expense	$ (116.8)	$ (20.5)

The merger termination fee represents the fee associated with Amedisys' termination of the OPCH Merger Agreement. The fee was paid by UnitedHealth Group on Amedisys' behalf. Amedisys may be required to reimburse UnitedHealth Group for the termination fee payment under certain circumstances (see Note 5 – Mergers, Acquisitions and Dispositions to our consolidated financial statements for additional information).

Home Health Segment

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

	For the Years Ended December 31,		
	2023	2022	2021
Financial Information *(in millions)*[6]:			
Medicare	$ 874.2	$ 896.5	$ 914.5
Non-Medicare	529.4	465.2	439.3
Net service revenue	1,403.6	1,361.7	1,353.8
Other operating income	—	—	7.3
Cost of service, inclusive of depreciation	801.1	773.9	756.6
Gross margin	602.5	587.8	604.5
General and administrative expenses	363.5	351.1	328.5
Depreciation and amortization	6.0	4.0	4.3
Operating income	$ 233.0	$ 232.7	$ 271.7
Same Store Growth[1]:			
Medicare revenue	(3 %)	(5 %)	8 %
Non-Medicare revenue	13 %	2 %	9 %
Total admissions	6 %	3 %	6 %
Total volume[2]	4 %	— %	5 %
Key Statistical Data - Total[3][6]:			
Admissions	399,752	376,399	353,075
Recertifications	179,719	178,445	183,134
Total volume	579,471	554,844	536,209
Medicare completed episodes	295,017	305,455	311,531
Average Medicare revenue per completed episode[4]	$ 2,998	$ 3,013	$ 2,959
Medicare visits per completed episode[5]	12.4	12.9	13.9
Visiting clinician cost per visit	$ 103.31	$ 100.03	$ 93.44
Clinical manager cost per visit	11.58	11.19	9.75
Total cost per visit	$ 114.89	$ 111.22	$ 103.19
Visits	6,972,929	6,958,541	7,331,935

(1) Same store information represents the percent change in our Medicare, Non-Medicare and Total revenue, admissions or volume for the period as a percent of the Medicare, Non-Medicare and Total revenue, admissions or volume of the prior period. Same store is defined as care centers that we have operated for at least the last twelve months and startups that are an expansion of a same store care center.
(2) Total volume includes all admissions and recertifications.
(3) Total includes acquisitions, start-ups and de novos.
(4) Average Medicare revenue per completed episode is the average Medicare revenue earned for each Medicare completed episode of care. Average Medicare revenue per completed episode reflects the suspension of sequestration for the period May 1, 2020 through March 31, 2022 and the reinstatement of sequestration at 1% effective April 1, 2022 and at 2% effective July 1, 2022.
(5) Medicare visits per completed episode are the home health Medicare visits on completed episodes divided by the home health Medicare episodes completed during the period.
(6) Prior years have been recast to conform to the current year presentation.

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

Operating Results

On March 23, 2022, we entered into a transaction with one of our high acuity care health system partners in which our health system partner contributed its home health operations to one of our existing high acuity care joint ventures. The home health operations were reflected in our high acuity care segment during 2022. Effective January 1, 2023, the operating results of this home health care center are included within our home health segment. Prior periods have been recast to conform to the current year presentation.

Overall, our operating income remained flat on a $42 million increase in net service revenue. Our year over year results were impacted by higher incentive compensation costs totaling $8 million resulting primarily from the reversal of incentive plan accruals and lower field incentive payouts in the prior year due to under-performance, the April 1, 2022 acquisitions of Evolution and AssistedCare (which combined contributed $10 million in incremental net service revenue and an operating loss of $1 million to the current year), a prior year benefit of $7 million in connection with the suspension of sequestration and a $9 million reduction to net service revenue recorded in the prior year related to our Infinity ZPIC audits discussed above.

Excluding these items, our operating income increased $7 million on a $30 million increase in net service revenue. Our operating income was positively impacted by same store total volume growth, non-Medicare rate increases and improvement in our operating performance driven by improvements in clinician utilization. These items were partially offset by a shift in our payor mix, planned wage increases, wage inflation, an increase in depreciation and amortization and higher general and administrative expenses.

Net Service Revenue

Excluding our acquisitions, the sequestration benefit recognized in the prior year and the Infinity ZPIC audits discussed above, our net service revenue increased $30 million due to 4% same store total volume growth and an increase in our non-Medicare revenue per visit resulting from rate increases partially offset by a shift in our payor mix. Our volumes continue to be impacted by staffing shortages driven by the competitive labor market.

Cost of Service, Inclusive of Depreciation

Overall, our total cost of service increased 4% primarily due to a 3% increase in our total cost per visit resulting from planned wage increases, an increase in new hire pay, wage inflation and visit mix partially offset by lower COVID-19 costs. Our visits year over year were relatively flat as increases in visits driven by growth in volumes were partially offset by improvements in clinician utilization evidenced by a decline of 0.5 visits per Medicare completed episode.

General and Administrative Expenses

Our general and administrative expenses increased $12 million. Excluding our acquisitions ($3 million) and the impact of the higher incentive compensation costs described above ($6 million), our general and administrative expenses increased $3 million primarily due to planned wage increases, higher information technology fees and higher insurance-related costs partially offset by lower staffing levels, savings associated with clinical optimization and reorganization initiatives, lower travel spend and higher severance costs incurred in the prior year.

Hospice Segment

The following table summarizes our hospice segment results of operations:

	For the Years Ended December 31,		
	2023	2022	2021
Financial Information *(in millions):*			
Medicare	$ 754.0	$ 744.1	$ 750.1
Non-Medicare	44.8	43.7	41.7
Net service revenue	798.8	787.8	791.8
Other operating income	—	—	6.0
Cost of service, inclusive of depreciation	412.2	426.5	425.2
Gross margin	386.6	361.3	372.6
General and administrative expenses	193.1	203.3	198.4
Depreciation and amortization	3.0	2.3	2.7
Operating income	$ 190.5	$ 155.7	$ 171.5
Same Store Growth[(1)]:			
Medicare revenue	1 %	(1 %)	— %
Hospice admissions	(5 %)	(1 %)	2 %
Average daily census	(1 %)	(1 %)	(4 %)
Key Statistical Data - Total[(2)]:			
Hospice admissions	49,587	52,656	53,507
Average daily census	12,863	13,091	13,271
Revenue per day, net	$ 170.14	$ 164.88	$ 163.47
Cost of service per day	$ 87.80	$ 89.26	$ 87.77
Average discharge length of stay	93	91	94

(1) Same store information represents the percent change in our Medicare revenue, Hospice admissions or average daily census for the period as a percent of the Medicare revenue, Hospice admissions or average daily census of the prior period. Same store is defined as care centers that we have operated for at least the last twelve months and startups that are an expansion of a same store care center.

(2) Total includes acquisitions and de novos.

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

Operating Results

Overall, our operating income increased $35 million on an $11 million increase in net service revenue. Our year over year results were impacted by a prior year benefit of $6 million related to the suspension of sequestration and higher incentive compensation costs totaling $2 million resulting primarily from the reversal of incentive plan accruals and lower field incentive payouts in the prior year due to under-performance. Excluding these items, our operating income increased $43 million on a $17 million increase in net service revenue primarily due to the increases in reimbursement effective October 1, 2022 and 2023, savings associated with clinical optimization and reorganization initiatives, lower staffing levels and a decrease in our general and administrative expenses. These items were partially offset by a decline in our hospice average daily census, planned wage increases and wage inflation.

Net Service Revenue

Excluding the sequestration benefit recognized in the prior year, our net service revenue increased $17 million as the increases in reimbursement effective October 1, 2022 and 2023 were partially offset by a decline in our average daily census resulting from a decline in our hospice admissions as well as care center closures.

Cost of Service, Inclusive of Depreciation

Our hospice cost of service decreased 3% primarily due to a 2% decrease in our cost of service per day and a 2% decline in our total average daily census. The 2% decrease in our cost of service per day is due to savings associated with clinical optimization and reorganization initiatives, lower staffing levels, lower utilization of contractors to supplement our staffing levels, lower COVID-19 costs and a new pharmacy contract effective during the three-month period ended June 30, 2023. These items were partially offset by planned wage increases and wage inflation.

General and Administrative Expenses

Our general and administrative expenses decreased $10 million. Excluding the impact of the higher incentive compensation costs described above, our general and administrative expenses decreased $8 million primarily due to reductions in staffing levels and lower travel spend partially offset by planned wage increases.

Personal Care Segment

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

	For the Years Ended December 31,		
	2023	2022	2021
Financial Information *(in millions)*:			
Medicare	$ —	$ —	$ —
Non-Medicare	15.0	61.4	65.0
Net service revenue	15.0	61.4	65.0
Cost of service, inclusive of depreciation	11.1	46.7	49.1
Gross margin	3.9	14.7	15.9
General and administrative expenses	2.3	9.2	11.2
Depreciation and amortization	—	0.1	0.2
Operating income	$ 1.6	$ 5.4	$ 4.5
Key Statistical Data - Total:			
Billable hours	440,464	1,851,563	2,275,511
Clients served	7,892	10,448	12,074
Shifts	191,379	791,596	974,409
Revenue per hour	$ 33.97	$ 33.15	$ 28.54
Revenue per shift	$ 78.19	$ 77.55	$ 66.66
Hours per shift	2.3	2.3	2.3

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

We completed the sale of our personal care business on March 31, 2023.

High Acuity Care Segment

The following table summarizes our high acuity care segment results of operations:

	For the Years Ended December 31,		
	2023	2022	2021[2]
Financial Information *(in millions)*[1]:			
Medicare	$ —	$ —	$ —
Non-Medicare	19.0	12.3	3.5
Net service revenue	19.0	12.3	3.5
Cost of service, inclusive of depreciation	21.1	13.3	2.5
Gross margin	(2.1)	(1.0)	1.0
General and administrative expenses	20.4	19.7	6.6
Depreciation and amortization	3.1	3.3	1.3
Investment impairment	—	3.0	—
Operating loss	$ (25.6)	$ (27.0)	$ (6.9)
Key Statistical Data - Total:			
Full risk admissions	648	448	107
Limited risk admissions	1,804	1,142	413
Total admissions	2,452	1,590	520
Full risk revenue per episode	$ 10,565	$ 11,273	$ 10,457
Limited risk revenue per episode	$ 6,187	$ 5,553	$ 5,693
Number of admitting joint ventures	10	8	7

(1) Prior years have been recast to conform to the current year presentation.

(2) Acquired Contessa Health on August 1, 2021.

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

Operating Results

In connection with our reorganization initiatives, we transitioned corporate functions that were previously included within our high acuity care segment to the corporate support function effective January 1, 2023. Additionally, we moved the home health operations of one of our high acuity care joint ventures to our home health segment effective January 1, 2023. Prior periods have been recast to conform to the current year presentation.

Our year over year results reflect growth in our home recovery care services which was offset by an increase in our cost of service resulting from investments in resources to support the first performance year of our new risk-based palliative care contract as well as future palliative care arrangements. Additionally, prior year results include an impairment charge recorded in connection with the wind down of the operations of one of our joint ventures.

We expect our high acuity care segment to continue to generate operating losses; however, we also expect improvement as we leverage our operating structure through growth in current and future joint ventures and expansion of palliative care at home arrangements.

Net Service Revenue

Our net service revenue increased as a result of growth in our home recovery care services. Our high acuity care segment provides home recovery care services for high acuity patients on either a full risk or limited risk basis, each with different reimbursement arrangements. Full risk admissions are admissions for which we assume the financial risk for all related healthcare services during a 30-day or 60-day episodic period in exchange for a fixed contracted bundled rate. Limited risk admissions are admissions for which we assume the risk for certain healthcare services during the remainder of an inpatient acute stay serviced at the patient's home in exchange for a contracted per diem payment.

Cost of Service, Inclusive of Depreciation

Our cost of service consists primarily of medical costs associated with direct clinician care provided to our patients during the applicable episode period, costs associated with our virtual care unit (“VCU”), which enables us to provide monitoring services and facilitates virtual patient rounding visits via telehealth and costs associated with resources to support our new risk-based palliative care at home contract as well as other palliative care arrangements. The increase in cost of service over prior year is primarily related to growth in our home recovery care services and investments in resources to support our palliative care programs.

General and Administrative Expenses

Our general and administrative expenses, which primarily consist of salaries and benefits, increased approximately $1 million. We have made significant investments to build the clinical, operational and technological infrastructure necessary to support the development and future growth of home recovery care and palliative care programs on a national scale.

Corporate

The following table summarizes our corporate results of operations:

	For the Years Ended December 31,		
	2023	**2022**	**2021**
Financial Information *(in millions)*[(1)]:			
General and administrative expenses	$ 237.5	$ 170.8	$ 166.5
Depreciation and amortization	5.6	15.2	22.4
Total operating expenses	$ 243.1	$ 186.0	$ 188.9

(1) Prior years have been recast to conform to the current year presentation.

Corporate expenses consist of costs related to our executive management and corporate and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration.

Year Ended December 31, 2023 Compared to the Year Ended December 31, 2022

In connection with our reorganization initiatives, we transitioned corporate functions that were previously included within our high acuity care segment to the corporate support function effective January 1, 2023. Prior periods have been recast to conform to the current year presentation.

Corporate general and administrative expenses increased approximately $67 million during the year ended December 31, 2023, which is inclusive of merger-related expenses totaling $37 million and higher incentive compensation costs totaling $18 million resulting primarily from the reversal of incentive plan accruals in the prior year due to under-performance and incremental expenses associated with our CEO transition. Excluding these costs, our corporate general and administrative expenses increased $12 million primarily due to planned wage increases, higher recruiting fees and information technology fees, costs associated with our clinical optimization and reorganization initiatives, a favorable legal settlement recognized in the prior year and a change in the presentation of gains on the sale of fleet vehicles which are reflected in other income (expense) within our consolidated statement of operations as of January 1, 2023 due to the modification of our fleet leases. These items were partially offset by lower acquisition and integration costs and severance costs incurred in the prior year.

Corporate depreciation and amortization decreased $10 million during the year ended December 31, 2023 due to a reduction in amortization expense related to acquired names and non-compete agreements that were fully amortized as of December 31, 2022.

Liquidity and Capital Resources

Cash Flows

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

	For the Years Ended December 31,		
	2023	2022	2021
Cash provided by operating activities	$ 137.2	$ 133.3	$ 188.9
Cash provided by (used in) investing activities	35.1	(94.5)	(281.6)
Cash (used in) provided by financing activities	(87.5)	(30.4)	55.1
Net increase (decrease) in cash, cash equivalents and restricted cash	84.7	8.4	(37.6)
Cash, cash equivalents and restricted cash at beginning of period	54.1	45.8	83.4
Cash, cash equivalents and restricted cash at end of period	$ 138.9	$ 54.1	$ 45.8

Cash provided by operating activities for 2023, 2022 and 2021 has provided sufficient liquidity to fund our operations and finance our capital expenditures, both routine and non-routine. Changes in our cash provided by operating activities during the past three years were primarily the result of fluctuations in our net income, the collections of our accounts receivable and the timing of payments of accrued expenses. Cash provided by operating activities increased $3.9 million during 2023 compared to 2022 primarily due to the timing of the payment of accrued expenses and a change in the presentation of payments associated with our fleet vehicles due to the modification of our fleet leases effective January 1, 2023 (financing activity in the current year versus operating activity in the prior year). These items were partially offset by the payment of merger-related expenses and an increase in days revenue outstanding. Cash provided by operating activities decreased $55.6 million during 2022 compared to 2021 primarily due to the payment of a full year of operating expenses for our high acuity care segment compared to only five months in the prior year, the repayment of $38.0 million in connection with our Infinity ZPIC audits (see Item 8, Note 12 – Commitments and Contingencies to our consolidated financial statements for additional information), lower collections due to the reinstatement of sequestration and an increase in days revenue outstanding.

Our investing activities primarily consist of the purchase of property and equipment and technology assets, investments and acquisitions/divestitures. Cash provided by investing activities totaled $35.1 million during 2023 and was related to the divestiture of our personal care line of business partially offset by the purchase of software licenses and property and equipment. Cash used in investing activities totaled $94.5 million during 2022 and was primarily related to acquisition spend and investments.

Our financing activities primarily consist of borrowings under our term loan and/or revolving credit facility, repayments of borrowings, the remittance of taxes associated with shares withheld on non-cash compensation, proceeds related to the exercise of stock options, proceeds related to the purchase of stock under our employee stock purchase plan and our purchase of company stock under our stock repurchase programs. Cash used in financing activities totaled $87.5 million during 2023 and $30.4 million during 2022. The $57.1 million change is primarily due to the repayment of borrowings. Net proceeds from the divestiture of our personal care line of business were used to pay down a portion of our outstanding term loan balance during 2023. Cash used in financing activities totaled $30.4 million during 2022; cash provided by financing activities totaled $55.1 million during 2021. The $85.5 million change is primarily due to borrowings to fund acquisitions in 2021.

Liquidity

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

During 2023, we invested $12.7 million in capital expenditures and technology assets as compared to $7.2 million and $6.7 million during 2022 and 2021, respectively. Our capital expenditures and investments in technology assets for 2024 are expected to be approximately $6.0 million to $8.0 million, excluding the impact of any future acquisitions.

As of December 31, 2023, we had $126.5 million in cash and cash equivalents and $518.9 million in availability under our $550.0 million Revolving Credit Facility.

Based on our operating forecasts and our debt service requirements, we believe we will have sufficient liquidity to fund our operations, capital requirements and debt service requirements for the next twelve months and beyond.

Outstanding Patient Accounts Receivable

Our patient accounts receivable increased $16.6 million from December 31, 2022 primarily due to an increase in days revenue outstanding. Our days revenue outstanding, net at December 31, 2023 was 47.7 days which is an increase of 1.6 days from December 31, 2022. Our cash collection as a percentage of revenue was 100% and 101% for the twelve-month periods ended December 31, 2023 and 2022, respectively.

Our patient accounts receivable includes unbilled receivables which are aged based upon the initial service date. We monitor unbilled receivables on a care center by care center basis to ensure that all efforts are made to bill claims within timely filing deadlines. Our unbilled patient accounts receivable may be impacted by pre-claim reviews required by the Medicare Administrative Contractors in the six Review Choice Demonstration states or under the Targeted Probe and Educate program, voluntary pre-bill edits and reviews, efforts to secure needed documentation to bill (orders, consents, etc.), integrations of recent acquisitions, changes of ownership and any regulatory and procedural updates impacting claim submission. The timely filing deadline for Medicare is one year from the date of the last billable service in the 30-day billing period and varies by state for Medicaid-reimburseable services and among insurance companies and other private payors.

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

	0-90	91-180	181-365	Over 365	Total
At December 31, 2023:					
Medicare patient accounts receivable	$ 190.3	$ 16.1	$ 6.4	$ 1.9	$ 214.7
Other patient accounts receivable:					
Medicaid	17.8	1.4	0.5	—	19.7
Private	67.4	6.6	5.0	—	79.0
Total	$ 85.2	$ 8.0	$ 5.5	$ —	$ 98.7
Total patient accounts receivable					$ 313.4
Days revenue outstanding[(1)]					47.7

	0-90	91-180	181-365	Over 365	Total
At December 31, 2022:					
Medicare patient accounts receivable	$ 179.9	$ 11.4	$ 5.1	$ 0.1	$ 196.5
Other patient accounts receivable:					
Medicaid	16.3	1.4	0.7	—	18.4
Private	67.5	8.7	5.7	—	81.9
Total	$ 83.8	$ 10.1	$ 6.4	$ —	$ 100.3
Total patient accounts receivable					$ 296.8
Days revenue outstanding[(1)]					46.1

(1) Our calculation of days revenue outstanding is derived by dividing our ending patient accounts receivable at December 31, 2023 and 2022 by our average daily net service revenue for the three-month periods ended December 31, 2023 and 2022, respectively.

Indebtedness

Second Amendment to the Credit Agreement

On July 30, 2021, we entered into the Second Amendment to our Credit Agreement (as amended by the Second Amendment, the "Second Amended Credit Agreement"). The Second Amended Credit Agreement provided for a senior secured credit facility in an initial aggregate principal amount of up to $1.0 billion, which included a $550.0 million Revolving Credit Facility and a term loan facility with a principal amount of up to $450.0 million (the "Amended Term Loan Facility" and collectively with the Revolving Credit Facility, the "Amended Credit Facility").

Third Amendment to the Credit Agreement

On March 10, 2023, we entered into the Third Amendment to our Credit Agreement (as amended by the Third Amendment, the "Third Amended Credit Agreement"). The Third Amended Credit Agreement (i) formally replaced the use of the London Interbank Offered Rate ("LIBOR") with the Secured Overnight Financing Rate ("SOFR") for interest rate pricing and (ii) allowed for the disposition of our personal care business.

The loans issued under the Amended Credit Facility bear interest on a per annum basis, at our election, at either: (i) the Base Rate plus the Applicable Rate or (ii) the Term SOFR plus the Applicable Rate. The “Base Rate” means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Term SOFR plus 1% per annum. The “Term SOFR” means the quoted rate per annum equal to the SOFR for an interest period of one or three months (as selected by us) plus the SOFR adjustment of 0.10%.

In accordance with the requirements under our Third Amended Credit Agreement, net proceeds received from the divestiture of our personal care line of business were used to prepay a portion of our Amended Term Loan Facility during the year ended December 31, 2023.

Our weighted average interest rate for borrowings under our Amended Term Loan Facility was 6.8% for the year ended December 31, 2023 and 3.2% for the year ended December 31, 2022. As of December 31, 2023, we had no outstanding borrowings under our $550.0 million Revolving Credit Facility. Our weighted average interest rate for borrowings under our $550.0 million Revolving Credit Facility was 6.2% for the year ended December 31, 2023 and 3.4% for the year ended December 31, 2022.

As of December 31, 2023, our consolidated leverage ratio was 2.3, our consolidated interest coverage ratio was 4.9, and we are in compliance with our covenants under the Third Amended Credit Agreement.

As of December 31, 2023, our availability under our $550.0 million Revolving Credit Facility was $518.9 million as we have no outstanding borrowings and $31.1 million outstanding in letters of credit.

See Item 8, Note 9 – Long Term Obligations to our consolidated financial statements for additional details on our outstanding long-term obligations.

Stock Repurchase Programs

On December 23, 2020, we announced that our Board of Directors authorized a stock repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2021 (the "2021 Share Repurchase Program"). Pursuant to this program, we repurchased 446,832 shares of our common stock at a weighted average price of $223.49 per share and a total cost of approximately $100 million during the year ended December 31, 2021. The repurchased shares were classified as treasury shares. The 2021 Share Repurchase Program expired on December 31, 2021.

On August 2, 2021, our Board of Directors authorized a share repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2022 to commence upon the completion of the Company's 2021 Share Repurchase Program (the "2022 Share Repurchase Program"). Pursuant to this program, we repurchased 150,000 shares of our common stock at a weighted average price of $115.64 per share and a total cost of approximately $17 million during the year ended December 31, 2022. The repurchased shares were classified as treasury shares. The 2022 Share Repurchase Program expired on December 31, 2022.

On February 2, 2023, our Board of Directors authorized a share repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2023 (the "2023 Share Repurchase Program"). We did not repurchase any shares under the 2023 Share Repurchase Program as the Merger Agreement limited our ability to repurchase shares of our common stock prior to the completion of the Merger, subject to certain exceptions. The 2023 Share Repurchase Program expired on December 31, 2023.

Under the terms of the 2021, 2022 and 2023 Share Repurchase Programs, we were allowed to repurchase shares from time to time through open market purchases, unsolicited or solicited privately negotiated transactions, an accelerated stock repurchase program, and/or a trading plan in compliance with Exchange Act Rule 10b5-1. The timing and the amount of the repurchases were determined by management based on a number of factors, including but not limited to share price, trading volume and general market conditions, as well as on working capital requirements, general business conditions and other factors. Effective January 1, 2023, repurchases became subject to a 1% excise tax under the Inflation Reduction Act.

Contractual Obligations

Our future contractual obligations at December 31, 2023 were as follows (amounts in millions):

	Payments Due by Period				
	Total	Less than 1 Year	2-3 Years	4-5 Years	After 5 Years
Long-term obligations	$ 371.9	$ 22.5	$ 349.4	$ —	$ —
Interest on long-term obligations (1)	73.2	29.7	43.5	—	—
Finance leases	28.9	13.8	12.9	1.8	0.4
Operating leases	89.0	26.3	42.2	19.4	1.1
Purchase obligations (2)	6.8	5.6	1.2	—	—
	$ 569.8	$ 97.9	$ 449.2	$ 21.2	$ 1.5

(1) Interest on debt with variable rates was calculated using the current rate for that particular debt instrument at December 31, 2023.

(2) Purchase obligations are primarily related to information technology contracts and software licenses as well as potential penalties associated with the early termination of certain contracts.

Inflation

Our operations have been materially impacted by the current inflationary environment as we have experienced higher labor costs and increases in supply costs, fuel costs and mileage reimbursements. We expect inflation to continue to impact our operations in 2024. As of December 31, 2023, the impacts of inflation on our results of operations have been partially mitigated by rate increases, improvements in clinician utilization and reductions in staffing levels and clinical optimization and reorganization initiatives. No assurance can be given as to our ability to offset the impacts of inflation in the future.

Critical Accounting Estimates

The discussion and analysis of our financial condition and results of operations is based upon our consolidated financial statements, which have been prepared in accordance with U.S. Generally Accepted Accounting Principles (“U.S. GAAP”). The preparation of these financial statements requires us to make estimates and judgments that affect the reported amounts of assets, liabilities, revenue and expenses and related disclosures of contingent assets and liabilities. On an ongoing basis, we evaluate our estimates, including those related to revenue recognition, collectability of accounts receivable, reserves related to insurance and litigation, business combinations, goodwill, intangible assets, income taxes and contingencies. We base these estimates on our historical experience and various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Actual results experienced may vary materially and adversely from our estimates. To the extent there are material differences between our estimates and the actual results, our future results of operations may be affected.

We believe the following critical accounting policies represent our most significant judgments and estimates used in the preparation of our consolidated financial statements.

Revenue Recognition

We account for service revenue from contracts with customers in accordance with Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, and as such, we recognize service revenue in the period in which we satisfy our performance obligations under our contracts by transferring our promised services to our customers in amounts that reflect the consideration to which we expect to be entitled in exchange for providing patient care, which are the transaction prices allocated to the distinct services. Our cost of obtaining contracts is not material.

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

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

We determine the transaction price based on gross charges for services provided, reduced by estimates for contractual and non-contractual revenue adjustments. Contractual revenue adjustments 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. Non-contractual revenue adjustments include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from audits and payment reviews and adjustments arising from our inability to obtain appropriate billing documentation, authorizations or face-to-face documentation. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change.

Non-contractual revenue adjustments are recorded for self-pay, uninsured patients and other payors by major payor class based on our historical collection experience, aged accounts receivable by payor and current industry conditions. The non-contractual revenue adjustments represent the difference between amounts billed and amounts we expect to collect based on our collection history with similar payors. We assess our ability to collect for the healthcare services provided at the time of patient admission based on our 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 payment reviews.

We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

We determine our estimates for non-contractual revenue adjustments related to our inability to obtain appropriate billing documentation, authorizations or face-to-face documentation based on our historical collection experience.

Home Health Revenue Recognition

Medicare Revenue

All Medicare contracts are required to have a signed plan of care which represents a single performance obligation, comprised of the delivery of a series of distinct services that are substantially similar and have a similar pattern of transfer to the customer. Accordingly, we account for the series of services ("episode") as a single performance obligation satisfied over time, as the customer simultaneously receives and consumes the benefits of the goods and services provided. An episode starts the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier, with multiple continuous episodes allowed. Each 60-day episode includes two 30-day periods of care.

Net service revenue is recorded based on the established Federal Medicare home health payment rate for a 30-day period of care. ASC 606 notes that if an entity has a right to consideration from a customer in an amount that corresponds directly with the value of the entity's performance completed to date, the entity may recognize revenue in the amount to which the entity has a right to invoice. We have elected to apply the "right to invoice" practical expedient, and therefore, our revenue recognition is based on the reimbursement we are entitled to for each 30-day period of care. We utilize our historical average length of stay for each 30-day period of care as the measure of progress towards the satisfaction of our performance obligation.

The Patient-Driven Groupings Model ("PDGM") uses timing, admission source, functional impairment levels and principal and other diagnoses to case-mix adjust payments. The case-mix adjusted payment for a 30-day period of care is subject to additional adjustments based on certain variables, including, but not limited to (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits provided was less than the established threshold, which ranges from two to six visits and varies for every case-mix group; (c) a partial payment if a patient is transferred to another provider or from another provider before completing the 30-day period of care; and (d) the applicable geographic wage index. Payments for routine and non-routine supplies are included in the 30-day payment rate.

Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. We estimate the impact of such adjustments based on our historical collection experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record this estimate during the period in which services are rendered to revenue with a corresponding reduction to patient accounts receivable.

Amounts due from Medicare include variable consideration for retroactive revenue adjustments due to settlements of audits and payment reviews. We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

The Medicare home health benefit requires that beneficiaries be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services and receive treatment under a plan of care established and periodically reviewed by a physician.

Effective January 1, 2022, the Centers for Medicare and Medicaid Services ("CMS") implemented a new notice of admission ("NOA") process. The NOA process requires a one-time submission for each patient that establishes the home health period of care and covers all contiguous 30-day periods of care until the patient is discharged from home health services. If the NOA is not submitted timely, a payment reduction is applied equal to 1/30 of the 30-day payment rate for each day from the start of care date until the date the NOA is submitted.

Non-Medicare Revenue

Payments from non-Medicare payors are either a percentage of Medicare rates, per-visit rates or case rates depending upon the terms and conditions established with such payors. Approximately 30% of our managed care contract volume affords us the opportunity to receive additional payments if we achieve certain quality or process metrics as defined in each contract (e.g. star ratings and acute-care hospitalization rates). We record revenue associated with these metrics at the time the amounts are probable and estimable.

Episodic-based Revenue. We recognize revenue in a similar manner as we recognize Medicare revenue for amounts that are paid by other insurance carriers, including Medicare Advantage programs; however, these amounts can vary based upon the negotiated terms, the majority of which range from 90% to 100% of Medicare rates.

Non-episodic based Revenue. For our per visit contracts, gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates. For our case rate contracts, gross revenue is recorded over our historical average length of stay using the established case rate for each admission. Contractual revenue adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue. We also make non-contractual revenue adjustments to non-episodic revenue based on our historical experience to reflect the estimated transaction price. We receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Under our case rate contracts, we may receive reimbursement before all services are rendered. Any cash received that exceeds the associated revenue earned is recorded to deferred revenue in accrued expenses within our consolidated balance sheets.

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are predetermined daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounted for 97% of our total Medicare hospice service revenue for each of 2023, 2022 and 2021, respectively. 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.

We make adjustments to Medicare revenue for non-contractual revenue adjustments, which include our inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these non-contractual revenue adjustments based on our historical collection experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record it during the period services are rendered.

Amounts due from Medicare include variable consideration for retroactive revenue adjustments due to settlements of audits and payment reviews. We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

Additionally, our hospice service revenue is subject to certain limitations on payments from Medicare which are considered variable consideration. We are subject to an inpatient cap limit and an overall Medicare payment cap for each provider number. We monitor these caps on a provider-by-provider basis and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in accrued expenses within our consolidated balance sheets. Providers are required to self-report and pay their estimated cap liability by February 28th of the following year. As of December 31, 2023, we have recorded $2.3 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2017 through September 30, 2024. As of December 31, 2022, we had recorded $4.3 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2016 through September 30, 2023.

Hospice Non-Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per day rates, as applicable. Contractual revenue adjustments are recorded for the difference between our standard rates and the contractual rates to be realized from patients, third-party payors and others for services provided and are deducted from gross revenue to determine our net service revenue. We also make non-contractual adjustments to non-Medicare revenue based on our historical experience to reflect the estimated transaction price.

Personal Care Revenue Recognition

Personal Care Revenue

For the periods prior to the divestiture of our personal care line of business on March 31, 2023, we generated net service revenues by providing our services directly to patients based on authorized hours, visits or units determined by the relevant agency, at a rate that was either contractual or fixed by legislation. Net service revenue was recognized at the time services were rendered based on gross charges for the services provided, reduced by estimates for contractual and non-contractual revenue adjustments. We received payment for providing such services from payors, including state and local governmental agencies, managed care organizations, commercial insurers and private consumers. Payors included the following elder service agencies: Aging Services Access Points ("ASAPs"), Senior Care Options ("SCOs"), Program of All-Inclusive Care for the Elderly ("PACE") and the Veterans Administration ("VA").

High Acuity Care Revenue Recognition

High Acuity Care Revenue

Our revenues are primarily derived from contracts with (1) health insurance plans for the coordination and provision of home recovery care services to clinically-eligible patients who are enrolled members in those insurance plans and (2) health system partners for the coordination and provision of home recovery care services to clinically-eligible patients who are discharged early from a health system facility to complete their inpatient stay at home.

Under our health insurance plan contracts, we provide home recovery care services, which include hospital-equivalent ("H@H") and skilled nursing facility ("SNF") equivalent services ("SNF@H"), for high acuity care patients on a full risk basis whereby we assume the financial risk for the coordination and payment of all hospital or SNF replacement medical services necessary to treat the medical condition for which the patient was diagnosed in a home-based setting for a 30-day (H@H) or 60-day (SNF@H) episode of care in exchange for a fixed contracted bundled rate. For H@H programs, the fixed rate is based on the assigned diagnosis related group ("DRG") and the 30-day post-discharge related spend. For SNF@H programs, the fixed rate is based on the 60-day post-discharge related spend. Our performance obligation is the coordination and provision of patient care in accordance with physicians' orders over either a 30-day or 60-day episode of care. The majority of our care coordination services and direct patient care is provided in the first five to seven days of the episode period (the "acute phase"). Monitoring services and follow-up direct patient care, as deemed necessary by the treating physician, are provided throughout the remainder of the episode. Since the majority of our services are provided during the acute phase, we recognize net service revenue over the acute phase based on gross charges for the services provided per the applicable managed care contract rates, reduced by estimates for revenue adjustments.

Under our contracts with health system partners, we provide home recovery care services for high acuity patients on a limited risk basis whereby we assume the risk for certain healthcare services during the remainder of an inpatient acute stay serviced at the patient's home (completing H@H - "CH@H") in exchange for a contracted per diem rate. The performance obligation is the coordination and provision of required medical services, as determined by the treating physician, for each day the patient receives inpatient-equivalent care at home. As such, net service revenue is recognized as services are administered and as our performance obligations are satisfied on a per diem basis, reduced by estimates for revenue adjustments.

We recognize adjustments to revenue during the period in which changes to estimates of assigned patient diagnoses or episode terminations become known, in accordance with the applicable managed care contracts. For certain health insurance plans, revenue is reduced by amounts owed by enrollees to healthcare providers under deductible, coinsurance or copay provisions of health insurance plan policies, since those amounts are repaid to the health insurance plans by us as part of a retrospective reconciliation process.

Goodwill and Other Intangible Assets

As of December 31, 2023, we had a goodwill balance of $1,244.7 million. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include, but are not limited to, a significant adverse change in the business environment, regulatory environment or legal factors, or a substantial decline in the market capitalization of our stock.

U.S. GAAP allows for annual impairment testing to be done on a qualitative basis to determine if it is more likely than not that the fair value of a reporting unit exceeds its carrying value. If it is determined that it is not more likely than not that the fair value of the reporting units exceeds its carrying value, then a quantitative analysis is performed. During 2023, we performed a

qualitative assessment to determine if it was more likely than not that the fair value of our reporting units were less than their carrying values by evaluating relevant events and circumstances including financial performance, market conditions and share price. Based on this assessment, we concluded that the goodwill associated with our home health and hospice reporting units was not considered at risk of impairment as of October 31, 2023. In addition to the qualitative assessment, we also performed a quantitative analysis using an income approach for our high acuity care reporting unit due to delays in achieving our long-term projections established as of the August 2021 acquisition date. This quantitative analysis required us to make estimates and assumptions surrounding projected revenues and costs, growth rates and discount rates. Based on this analysis, we concluded that the goodwill associated with our high acuity care reporting unit was not impaired as of October 31, 2023.

As of December 31, 2023, we had an other intangible assets balance of $102.7 million. Intangible assets consist of certificates of need, licenses, acquired names, non-compete agreements and technology. As of December 31, 2023, our non-compete agreements and amortizable acquired names were fully amortized. We amortize non-compete agreements and acquired names that we do not intend to use indefinitely on a straight-line basis over their estimated useful lives, which are generally two to three years for non-compete agreements and up to three years for acquired names. We amortize technology over its estimated useful service life, which is generally up to seven years. Our indefinite-lived intangible assets are reviewed for impairment annually or more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the intangible asset below its carrying amount. We performed a qualitative assessment of our indefinite-lived intangible assets during 2023 and determined that there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our indefinite-lived intangible assets would be less than their carrying amounts.

ITEM 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to market risk from fluctuations in interest rates. Our Term Loan and Revolving Credit Facility carry a floating interest rate which is tied to the Secured Overnight Financing Rate ("SOFR") and the Prime Rate, and therefore, our consolidated statements of operations and our consolidated statements of cash flows are exposed to changes in interest rates. As of December 31, 2023, the total amount of outstanding debt subject to interest rate fluctuations was $371.9 million. A 1.0% interest rate change would cause interest expense to change by approximately $3.7 million annually, assuming the Company makes no principal repayments.

ITEM 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Amedisys, Inc.:

Opinion on the Consolidated Financial Statements

We have audited the accompanying consolidated balance sheets of Amedisys, Inc. and subsidiaries (the Company) as of December 31, 2023 and 2022, the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2023, 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, 2023 and 2022, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2023, 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, 2023, 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 22, 2024 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 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 the consolidated financial statements are free of material misstatement, whether due to error or fraud. Our audit 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 audit 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 audit provides a reasonable basis for our opinion.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate 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 critical audit matters 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 matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Evaluation of the non-contractual revenue adjustment estimates for Home Health

As discussed in Note 2 to the consolidated financial statements, the Company determines the transaction price for revenue contracts based on gross charges for services provided, reduced by estimates for contractual and non-contractual revenue adjustments. Non-contractual revenue adjustments include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from payment reviews and adjustments arising from the Company's inability to obtain appropriate billing documentation, authorizations or face-to-face documentation. Non-contractual revenue adjustments are recorded based on the Company's historical collection experience, aged accounts receivable by payor and current industry conditions. The non-contractual revenue adjustments represent the difference between amounts billed and amounts the Company expects to collect based on its collection history with similar payors.

We identified the evaluation of the non-contractual revenue adjustment estimates noted above for the Home Health segment as a critical audit matter. Subjective auditor judgment was required to evaluate the historical collection experience used by the Company when developing the non-contractual revenue adjustment estimate. Specifically, the significant judgments related to evaluating the relevance of historical collection experience to the determination of the estimate, which included evaluation of current business and industry 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 related to the Company's home health revenue process, including controls over the significant judgments for estimating non-contractual revenue adjustments noted above. We assessed the outcome of the estimation of non-contractual revenue adjustments in the prior period to identify circumstances or conditions that are relevant to the determination of the current year estimate. To assess the current year method and the relevance of the historical collection experience, we tested a sample of accounts receivable that were written off in the current year. In addition, we also evaluated current business and economic conditions and trends relevant to the estimation of non-contractual revenue adjustments.

Goodwill impairment assessment of the high acuity care reporting unit

As discussed in Notes 2 and 6 to the consolidated financial statements, the goodwill balance as of December 31, 2023 was $1,244.7 million, of which $231.1 million related to the high acuity care reporting unit. The Company performs goodwill impairment testing on an annual basis as of October 31, and whenever events or changes in circumstances indicate that it is more likely than not that the carrying value of a reporting unit exceeds its fair value. As of October 31, 2023, the Company performed a quantitative assessment of its high acuity care reporting unit using an income approach.

We identified the assessment of the fair value of the high acuity care reporting unit used in the goodwill impairment test as a critical audit matter. A high degree of subjective auditor judgment was required to evaluate certain assumptions used to develop the fair value of the high acuity care reporting unit. Specifically, the revenue growth rate and discount rate assumptions were challenging to evaluate as they were based on subjective determinations of future market and economic conditions. Minor changes in these key assumptions could have had a significant effect on the Company's assessment of the fair value of the high acuity care reporting unit. Additionally, the audit effort associated with the discount rate required specialized skills and knowledge.

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 related to the goodwill impairment process. This included controls relating to the determination of the revenue growth rates and discount rate used in the goodwill impairment test. We evaluated the reasonableness of the Company's projected revenue growth rates by comparing them to industry and third-party data. In addition, we involved valuation professionals with specialized skills and knowledge, who assisted in evaluating the discount rate used by the Company by independently developing a range of discount rates using publicly available market data for comparable companies and comparing the fair value of the high acuity care reporting unit developed using the independently developed range of discount rates and the Company's cash flow forecasts to the Company's fair value estimate.

/s/ KPMG LLP

We have served as the Company's auditor since 2002.

Baton Rouge, Louisiana

February 22, 2024

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

	As of December 31,	
	2023	2022
ASSETS		
Current assets:		
Cash and cash equivalents	$ 126,450	$ 40,540
Restricted cash	12,413	13,593
Patient accounts receivable	313,373	296,785
Prepaid expenses	14,639	11,628
Other current assets	30,060	26,415
Total current assets	496,935	388,961
Property and equipment, net of accumulated depreciation of $92,422 and $101,364	41,845	16,026
Operating lease right of use assets	88,939	102,856
Goodwill	1,244,679	1,287,399
Intangible assets, net of accumulated amortization of $14,008 and $14,604	102,675	101,167
Other assets	85,097	79,836
Total assets	$ 2,060,170	$ 1,976,245
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 28,237	$ 43,735
Payroll and employee benefits	136,835	125,387
Accrued expenses	140,049	137,390
Termination fee paid by UnitedHealth Group	106,000	—
Current portion of long-term obligations	36,314	15,496
Current portion of operating lease liabilities	26,286	33,521
Total current liabilities	473,721	355,529
Long-term obligations, less current portion	361,862	419,420
Operating lease liabilities, less current portion	62,751	69,504
Deferred income tax liabilities	40,635	20,411
Other long-term obligations	1,418	4,808
Total liabilities	940,387	869,672
Commitments and Contingencies – Note 12		
Equity:		
Preferred stock, $0.001 par value, 5,000,000 shares authorized; none issued or outstanding	—	—
Common stock, $0.001 par value, 60,000,000 shares authorized; 38,131,478 and 37,891,186 shares issued; and 32,667,631 and 32,511,465 shares outstanding	38	38
Additional paid-in capital	787,177	755,063
Treasury stock at cost, 5,463,847 and 5,379,721 shares of common stock	(468,626)	(461,200)
Retained earnings	747,925	757,672
Total Amedisys, Inc. stockholders' equity	1,066,514	1,051,573
Noncontrolling interests	53,269	55,000
Total equity	1,119,783	1,106,573
Total liabilities and equity	$ 2,060,170	$ 1,976,245

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

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

	For the Years Ended December 31,		
	2023	**2022**	**2021**
Net service revenue	$ 2,236,382	$ 2,223,199	$ 2,214,112
Other operating income	—	—	13,300
Operating expenses:			
Cost of service, inclusive of depreciation	1,245,509	1,260,425	1,233,356
General and administrative expenses:			
Salaries and benefits	516,049	508,791	474,718
Non-cash compensation	26,082	16,560	23,809
Merger-related expenses	36,672	—	—
Depreciation and amortization	17,747	24,935	30,901
Investment impairment	—	3,009	—
Other	237,929	228,707	212,713
Total operating expenses	2,079,988	2,042,427	1,975,497
Operating income	156,394	180,772	251,915
Other income (expense):			
Interest income	3,270	178	49
Interest expense	(31,274)	(22,228)	(9,525)
Equity in earnings (loss) from equity method investments	10,760	(45)	4,949
Merger termination fee	(106,000)	—	—
Gain on equity method investments	—	—	31,098
Miscellaneous, net	6,473	1,567	1,745
Total other (expense) income, net	(116,771)	(20,528)	28,316
Income before income taxes	39,623	160,244	280,231
Income tax expense	(50,559)	(42,545)	(70,065)
Net (loss) income	(10,936)	117,699	210,166
Net loss (income) attributable to noncontrolling interests	1,189	910	(1,094)
Net (loss) income attributable to Amedisys, Inc.	$ (9,747)	$ 118,609	$ 209,072
Basic earnings per common share:			
Net (loss) income attributable to Amedisys, Inc. common stockholders	$ (0.30)	$ 3.65	$ 6.41
Weighted average shares outstanding	32,599	32,517	32,642
Diluted earnings per common share:			
Net (loss) income attributable to Amedisys, Inc. common stockholders	$ (0.30)	$ 3.63	$ 6.34
Weighted average shares outstanding	32,599	32,653	32,972

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(Amounts in thousands)

	For the Years Ended December 31,		
	2023	**2022**	**2021**
Net (loss) income	$ (10,936)	$ 117,699	$ 210,166
Other comprehensive income	—	—	—
Comprehensive (loss) income	(10,936)	117,699	210,166
Comprehensive loss (income) attributable to non-controlling interests	1,189	910	(1,094)
Comprehensive (loss) income attributable to Amedisys, Inc.	$ (9,747)	$ 118,609	$ 209,072

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

AMEDISYS, INC. AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(Amounts in thousands, except common stock shares)

	Total	Common Stock		Additional Paid-in Capital	Treasury Stock	Retained Earnings	Noncontrolling Interests
		Shares	Amount				
Balance, December 31, 2020	$ 810,741	37,470,212	$ 38	$ 698,287	$ (319,092)	$ 429,991	$ 1,517
Issuance of stock – employee stock purchase plan	3,968	20,823	—	3,968	—	—	—
Issuance/(cancellation) of non-vested stock	—	151,365	—	—	—	—	—
Exercise of stock options	2,054	32,468	—	2,054	—	—	—
Non-cash compensation	23,809	—	—	23,809	—	—	—
Surrendered shares	(16,898)	—	—	—	(16,898)	—	—
Shares repurchased	(99,878)	—	—	—	(99,878)	—	—
Noncontrolling interest contributions	250	—	—	—	—	—	250
Noncontrolling interest distributions	(1,747)	—	—	—	—	—	(1,747)
Acquired noncontrolling interest	43,858	—	—	—	—	—	43,858
Net income	210,166	—	—	—	—	209,072	1,094
Balance, December 31, 2021	976,323	37,674,868	38	728,118	(435,868)	639,063	44,972
Issuance of stock – employee stock purchase plan	3,848	36,206	—	3,848	—	—	—
Issuance/(cancellation) of non-vested stock	—	142,477	—	—	—	—	—
Exercise of stock options	2,304	37,635	—	2,304	—	—	—
Non-cash compensation	16,560	—	—	16,560	—	—	—
Surrendered shares	(7,981)	—	—	—	(7,981)	—	—
Shares repurchased	(17,351)	—	—	—	(17,351)	—	—
Noncontrolling interest contributions	12,401	—	—	—	—	—	12,401
Noncontrolling interest distributions	(1,561)	—	—	—	—	—	(1,561)
Sale of noncontrolling interest	4,331	—	—	4,233	—	—	98
Net income	117,699	—	—	—	—	118,609	(910)
Balance, December 31, 2022	1,106,573	37,891,186	38	755,063	(461,200)	757,672	55,000
Issuance of stock – employee stock purchase plan	2,602	37,408	—	2,602	—	—	—
Issuance/(cancellation) of non-vested stock	—	189,951	—	—	—	—	—
Exercise of stock options	100	12,933	—	100	—	—	—
Non-cash compensation	29,024	—	—	29,024	—	—	—
Surrendered shares	(6,529)	—	—	897	(7,426)	—	—
Purchase of noncontrolling interest	(630)	—	—	(509)	—	—	(121)
Noncontrolling interest contributions	1,452	—	—	—	—	—	1,452
Noncontrolling interest distributions	(1,873)	—	—	—	—	—	(1,873)
Net loss	(10,936)	—	—	—	—	(9,747)	(1,189)
Balance, December 31, 2023	$ 1,119,783	38,131,478	$ 38	$ 787,177	$ (468,626)	$ 747,925	$ 53,269

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

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

	For the Years Ended December 31,		
	2023	**2022**	**2021**
Cash Flows from Operating Activities:			
Net (loss) income	$ (10,936)	$ 117,699	$ 210,166
Adjustments to reconcile net (loss) income to net cash provided by operating activities:			
Depreciation and amortization (inclusive of depreciation included in cost of service)	23,847	24,935	30,901
Non-cash compensation	29,024	16,560	23,809
Amortization and impairment of operating lease right of use assets	33,996	46,029	40,364
Loss (gain) on disposal of property and equipment	319	519	(124)
Gain on equity method investments	—	—	(31,098)
Deferred income taxes	20,655	23,377	44,582
Loss on personal care divestiture	2,186	—	—
Merger termination fee	106,000	—	—
Equity in (earnings) loss from equity method investments	(10,760)	45	(4,949)
Amortization of deferred debt issuance costs	991	991	917
Return on equity method investments	5,073	5,163	5,343
Investment impairment	—	3,009	—
Changes in operating assets and liabilities, net of impact of acquisitions:			
Patient accounts receivable	(26,727)	(14,230)	(18,030)
Other current assets	(6,638)	(3,525)	(12,202)
Operating lease right of use assets	(3,786)	(3,242)	(3,060)
Other assets	189	438	(1,017)
Accounts payable	(15,816)	4,894	(4,353)
Accrued expenses	23,694	(39,382)	(26,915)
Other long-term obligations	(3,390)	(8,822)	(28,796)
Operating lease liabilities	(30,733)	(41,175)	(36,645)
Net cash provided by operating activities	137,188	133,283	188,893
Cash Flows from Investing Activities:			
Proceeds from the sale of deferred compensation plan assets	54	252	135
Proceeds from the sale of property and equipment	136	66	144
Purchases of property and equipment	(5,620)	(6,165)	(6,302)
Investments in technology assets	(7,093)	(1,050)	(419)
Investment in equity method investee	—	(637)	(200)
Purchase of cost method investment	—	(15,000)	(5,000)
Return of investment	150	—	—
Proceeds from personal care divestiture	47,787	—	—
Acquisitions of businesses, net of cash acquired	(350)	(71,952)	(269,965)
Net cash provided by (used in) investing activities	35,064	(94,486)	(281,607)
Cash Flows from Financing Activities:			
Proceeds from issuance of stock upon exercise of stock options	100	2,304	2,054
Proceeds from issuance of stock to employee stock purchase plan	2,602	3,848	3,968
Shares withheld to pay taxes on non-cash compensation	(6,529)	(7,981)	(16,898)
Noncontrolling interest contributions	1,452	3,501	250
Noncontrolling interest distributions	(1,873)	(1,561)	(1,747)
Proceeds from sale of noncontrolling interest	—	5,817	—
Purchase of noncontrolling interest	(800)	—	—
Proceeds from borrowings under term loan	—	—	290,312
Proceeds from borrowings under revolving line of credit	23,000	534,500	500,700
Repayments of borrowings under revolving line of credit	(23,000)	(534,500)	(551,700)
Principal payments of long-term obligations	(76,013)	(13,296)	(9,143)
Debt issuance costs	—	—	(2,792)
Provider relief fund advance	—	—	(60,000)
Purchase of company stock	—	(17,351)	(99,878)
Payment of accrued contingent consideration	(6,461)	(5,714)	—
Net cash (used in) provided by financing activities	(87,522)	(30,433)	55,126
Net increase (decrease) in cash, cash equivalents and restricted cash	84,730	8,364	(37,588)
Cash, cash equivalents and restricted cash at beginning of period	54,133	45,769	83,357
Cash, cash equivalents and restricted cash at end of period	$ 138,863	$ 54,133	$ 45,769

	For the Years Ended December 31,		
	2023	2022	2021
Supplemental Disclosures of Cash Flow Information:			
Cash paid for interest	$ 29,766	$ 14,939	$ 5,291
Cash paid for Infinity ZPIC interest	$ —	$ 12,755	$ —
Cash paid for income taxes, net of refunds received	$ 29,127	$ 24,013	$ 34,097
Supplemental Disclosures of Non-Cash Activity:			
Accrued contingent consideration	$ —	$ 19,195	$ —
Noncontrolling interest contribution	$ —	$ 8,900	$ —

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

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

Amedisys, Inc., a Delaware corporation (together with its consolidated subsidiaries, referred to herein as “Amedisys,” “we,” “us,” or “our”), is a multi-state provider of home health, hospice and high acuity care services with approximately 73%, 74% and 75% of our consolidated net service revenue derived from Medicare for 2023, 2022 and 2021, respectively. As of December 31, 2023, we owned and operated 346 Medicare-certified home health care centers, 165 Medicare-certified hospice care centers and 10 admitting high acuity care joint ventures in 37 states within the United States and the District of Columbia. We divested our personal care business on March 31, 2023.

Amedisys and UnitedHealth Group Incorporated Merger

On June 26, 2023, Amedisys, UnitedHealth Group Incorporated, a Delaware corporation ("UnitedHealth Group"), and Aurora Holdings Merger Sub Inc., a Delaware corporation and a wholly owned subsidiary of UnitedHealth Group ("Merger Sub"), entered into an Agreement and Plan of Merger, pursuant to which Merger Sub will merge with and into Amedisys with Amedisys continuing as the surviving corporation and becoming a wholly owned subsidiary of UnitedHealth Group. See Note 5 – Mergers, Acquisitions and Dispositions for additional information.

Recently Adopted Accounting Pronouncements

During 2021, the Company adopted Accounting Standards Update ("ASU") 2020-10, *Codification Improvements*, which included minor technical corrections and clarifications to improve consistency and clarify the application of various provisions of the codification by amending the codification to include all disclosure guidance in the appropriate disclosure sections and by amending and adding new headings, cross referencing to other guidance and refining or correcting terminology. Our adoption of this standard did not have a material effect on our consolidated financial statements.

During 2021, the Company adopted ASU 2021-10, *Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance*, which was intended to increase transparency around financial reporting regarding government assistance by requiring disclosure of information about (1) the types of government assistance received, (2) an entity's accounting for the government assistance received and (3) the effect of the assistance on an entity's financial statements. The ASU was effective for annual periods beginning after December 15, 2021, with early adoption permitted. See Note 4 – Novel Coronavirus Pandemic ("COVID-19") for the disclosures associated with this standard.

Recently Issued Accounting Pronouncements

In December 2023, the Financial Accounting Standards Board ("FASB") issued ASU 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures*, which is intended to improve income tax disclosures by requiring disaggregated information about a reporting entity's effective tax rate reconciliation and information on income taxes paid. The guidance is effective for annual periods beginning after December 15, 2024 on a prospective basis, with early adoption permitted. We are currently evaluating the impact the adoption of this ASU may have on our financial reporting.

In November 2023, the FASB issued ASU 2023-07, *Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures*, which is intended to improve reportable segment disclosure requirements, primarily through enhanced disclosures about significant segment expenses. The guidance is effective for fiscal years beginning after December 15, 2023, and interim periods within fiscal years beginning after December 15, 2024, with early adoption permitted. The guidance is to be applied retrospectively to all prior periods presented in the financial statements based on the significant expense categories identified and disclosed in the period of adoption. We are currently evaluating the impact the adoption of this ASU may have on our financial reporting.

In August 2023, the FASB issued ASU 2023-05, *Business Combinations - Joint Venture Formations (Topic 805): Recognition and Initial Measurement*, which requires that a joint venture initially measure all contributions received upon its formation at fair value. The guidance is effective for joint ventures with a formation date on or after January 1, 2025 on a prospective basis. We are currently evaluating the impact the adoption of this ASU may have on our financial reporting.

In March 2020, the FASB issued ASU 2020-04, *Reference Rate Reform (Topic 848): Facilitation of the Effects of Reference Rate Reform on Financial Reporting*, which provides optional expedients and exceptions for applying U.S. Generally Accepted Accounting Principles ("U.S. GAAP") to contract modifications and hedging relationships that reference the London Inter-Bank Offered Rate ("LIBOR") or another reference rate expected to be discontinued, subject to meeting certain criteria. In January 2021, the FASB issued ASU 2021-01, *Reference Rate Reform (Topic 848): Scope*, which adds implementation guidance to ASU 2020-04 to clarify certain optional expedients in Topic 848. The guidance in ASU 2020-04 and ASU 2021-01 was effective upon issuance and may generally be applied prospectively through December 31, 2022. In December 2022, the FASB issued ASU 2022-06, *Reference Rate Reform (Topic 848): Deferral of the Sunset Date of Topic 848,* which deferred the sunset date of Topic 848 from December 31, 2022 to December 31, 2024. These standards did not have an effect on our consolidated financial statements.

Use of Estimates

Our accounting and reporting policies conform with U.S. GAAP. In preparing the consolidated financial statements, we are required to make estimates and assumptions that impact the amounts reported in the consolidated financial statements and accompanying notes. The Company's critical accounting estimates include revenue recognition and testing for the impairment of goodwill and other intangible assets. Actual results could materially differ from those estimates.

Principles of Consolidation

These consolidated financial statements include the accounts of Amedisys, Inc. and our wholly owned subsidiaries. All significant intercompany accounts and transactions have been eliminated in our accompanying consolidated financial statements, and business combinations accounted for as purchases have been included in our consolidated financial statements from their respective dates of acquisition. In addition to our wholly owned subsidiaries, we also have certain equity investments that are accounted for as set forth in Note 3 – Investments.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Revenue Recognition

We account for service revenue from contracts with customers in accordance with Accounting Standards Codification ("ASC") 606, *Revenue from Contracts with Customers*, and as such, we recognize service revenue in the period in which we satisfy our performance obligations under our contracts by transferring our promised services to our customers in amounts that reflect the consideration to which we expect to be entitled in exchange for providing patient care, which are the transaction prices allocated to the distinct services. Our cost of obtaining contracts is not material.

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

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

We determine the transaction price based on gross charges for services provided, reduced by estimates for contractual and non-contractual revenue adjustments. Contractual revenue adjustments 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. Non-contractual revenue adjustments include discounts provided to self-pay, uninsured patients or other payors, adjustments resulting from audits and payment reviews and adjustments arising from our inability to obtain appropriate billing documentation, authorizations or face-to-face documentation. Subsequent changes to the estimate of the transaction price are recorded as adjustments to net service revenue in the period of change.

Non-contractual revenue adjustments are recorded for self-pay, uninsured patients and other payors by major payor class based on our historical collection experience, aged accounts receivable by payor and current industry conditions. The non-contractual revenue adjustments represent the difference between amounts billed and amounts we expect to collect based on our collection history with similar payors. We assess our ability to collect for the healthcare services provided at the time of patient admission

based on our 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 payment reviews. We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

We determine our estimates for non-contractual revenue adjustments related to our inability to obtain appropriate billing documentation, authorizations or face-to-face documentation based on our historical collection experience.

Net service revenue by payor class as a percentage of total net service revenue for each of our operating segments as described in Note 15 – Segment Information is as follows:

	As of December 31,		
	2023	2022	2021
Home Health:			
Medicare	39 %	40 %	41 %
Non-Medicare - Episodic-based	8 %	8 %	8 %
Non-Medicare - Non-episodic based	15 %	13 %	12 %
Hospice:			
Medicare	34 %	33 %	34 %
Non-Medicare	2 %	2 %	2 %
Personal Care [1]	1 %	3 %	3 %
High Acuity Care [2]	1 %	1 %	— %
	100 %	100 %	100 %

(1) We divested our personal care business on March 31, 2023.
(2) We acquired Contessa Health on August 1, 2021.

Home Health Revenue Recognition

Medicare Revenue

All Medicare contracts are required to have a signed plan of care which represents a single performance obligation, comprised of the delivery of a series of distinct services that are substantially similar and have a similar pattern of transfer to the customer. Accordingly, we account for the series of services ("episode") as a single performance obligation satisfied over time, as the customer simultaneously receives and consumes the benefits of the goods and services provided. An episode starts the first day a billable visit is performed and ends 60 days later or upon discharge, if earlier, with multiple continuous episodes allowed. Each 60-day episode includes two 30-day periods of care.

Net service revenue is recorded based on the established Federal Medicare home health payment rate for a 30-day period of care. ASC 606 notes that if an entity has a right to consideration from a customer in an amount that corresponds directly with the value of the entity's performance completed to date, the entity may recognize revenue in the amount to which the entity has a right to invoice. We have elected to apply the "right to invoice" practical expedient, and therefore, our revenue recognition is based on the reimbursement we are entitled to for each 30-day period of care. We utilize our historical average length of stay for each 30-day period of care as the measure of progress towards the satisfaction of our performance obligation.

The Patient-Driven Groupings Model ("PDGM") uses timing, admission source, functional impairment levels and principal and other diagnoses to case-mix adjust payments. The case-mix adjusted payment for a 30-day period of care is subject to additional adjustments based on certain variables, including, but not limited to (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment ("LUPA") if the number of visits provided was less than the established threshold, which ranges from two to six visits and varies for every case-mix group; (c) a partial payment if a patient is transferred to another provider or from another provider before completing the 30-day period of care; and (d) the applicable geographic wage index. Payments for routine and non-routine supplies are included in the 30-day payment rate.

Medicare can also make various adjustments to payments received if we are unable to produce appropriate billing documentation or acceptable authorizations. We estimate the impact of such adjustments based on our historical collection experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record this estimate during the period in which services are rendered to revenue with a corresponding reduction to patient accounts receivable.

Amounts due from Medicare include variable consideration for retroactive revenue adjustments due to settlements of audits and payment reviews. We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

The Medicare home health benefit requires that beneficiaries be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services and receive treatment under a plan of care established and periodically reviewed by a physician.

Effective January 1, 2022, the Centers for Medicare and Medicaid Services ("CMS") implemented a new notice of admission ("NOA") process. The NOA process requires a one-time submission for each patient that establishes the home health period of care and covers all contiguous 30-day periods of care until the patient is discharged from home health services. If the NOA is not submitted timely, a payment reduction is applied equal to 1/30 of the 30-day payment rate for each day from the start of care date until the date the NOA is submitted.

Non-Medicare Revenue

Payments from non-Medicare payors are either a percentage of Medicare rates, per-visit rates or case rates depending upon the terms and conditions established with such payors. Approximately 30% of our managed care contract volume affords us the opportunity to receive additional payments if we achieve certain quality or process metrics as defined in each contract (e.g. star ratings and acute-care hospitalization rates). We record revenue associated with these metrics at the time the amounts are probable and estimable.

Episodic-based Revenue. We recognize revenue in a similar manner as we recognize Medicare revenue for amounts that are paid by other insurance carriers, including Medicare Advantage programs; however, these amounts can vary based upon the negotiated terms, the majority of which range from 90% to 100% of Medicare rates.

Non-episodic based Revenue. For our per visit contracts, gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established or estimated per-visit rates. For our case rate contracts, gross revenue is recorded over our historical average length of stay using the established case rate for each admission. Contractual revenue adjustments are recorded for the difference between our standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue. We also make non-contractual revenue adjustments to non-episodic revenue based on our historical experience to reflect the estimated transaction price. We receive a minimal amount of our net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Under our case rate contracts, we may receive reimbursement before all services are rendered. Any cash received that exceeds the associated revenue earned is recorded to deferred revenue in accrued expenses within our consolidated balance sheets.

Hospice Revenue Recognition

Hospice Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are predetermined daily or hourly rates for each of the four levels of care we deliver. The four levels of care are routine care, general inpatient care, continuous home care and respite care. Routine care accounted for 97% of our total Medicare hospice service revenue for each of 2023, 2022 and 2021, respectively. 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.

We make adjustments to Medicare revenue for non-contractual revenue adjustments, which include our inability to obtain appropriate billing documentation or acceptable authorizations and other reasons unrelated to credit risk. We estimate the impact of these non-contractual revenue adjustments based on our historical collection experience, which primarily includes a historical collection rate of over 99% on Medicare claims, and record it during the period services are rendered.

Amounts due from Medicare include variable consideration for retroactive revenue adjustments due to settlements of audits and payment reviews. We determine our estimates for non-contractual revenue adjustments related to audits and payment reviews based on our historical experience and success rates in the claim appeals and adjudication process.

Additionally, our hospice service revenue is subject to certain limitations on payments from Medicare which are considered variable consideration. We are subject to an inpatient cap limit and an overall Medicare payment cap for each provider number. We monitor these caps on a provider-by-provider basis and estimate amounts due back to Medicare if we estimate a cap has been exceeded. We record these adjustments as a reduction to revenue and an increase in accrued expenses within our consolidated balance sheets. Providers are required to self-report and pay their estimated cap liability by February 28th of the following year. As of December 31, 2023, we have recorded $2.3 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2017 through September 30, 2024. As of December 31, 2022, we had recorded $4.3 million for estimated amounts due back to Medicare in accrued expenses for the Federal cap years ended October 31, 2016 through September 30, 2023.

Hospice Non-Medicare Revenue

Gross revenue is recorded on an accrual basis based upon the date of service at amounts equal to our established rates or estimated per day rates, as applicable. Contractual revenue adjustments are recorded for the difference between our standard rates and the contractual rates to be realized from patients, third-party payors and others for services provided and are deducted from gross revenue to determine our net service revenue. We also make non-contractual adjustments to non-Medicare revenue based on our historical experience to reflect the estimated transaction price.

Personal Care Revenue Recognition

Personal Care Revenue

For the periods prior to the divestiture of our personal care line of business on March 31, 2023, we generated net service revenues by providing our services directly to patients based on authorized hours, visits or units determined by the relevant agency, at a rate that was either contractual or fixed by legislation. Net service revenue was recognized at the time services were rendered based on gross charges for the services provided, reduced by estimates for contractual and non-contractual revenue adjustments. We received payment for providing such services from payors, including state and local governmental agencies, managed care organizations, commercial insurers and private consumers. Payors included the following elder service agencies: Aging Services Access Points ("ASAPs"), Senior Care Options ("SCOs"), Program of All-Inclusive Care for the Elderly ("PACE") and the Veterans Administration ("VA").

High Acuity Care Revenue Recognition

High Acuity Care Revenue

Our revenues are primarily derived from contracts with (1) health insurance plans for the coordination and provision of home recovery care services to clinically-eligible patients who are enrolled members in those insurance plans and (2) health system partners for the coordination and provision of home recovery care services to clinically-eligible patients who are discharged early from a health system facility to complete their inpatient stay at home.

Under our health insurance plan contracts, we provide home recovery care services, which include hospital-equivalent ("H@H") and skilled nursing facility ("SNF") equivalent services ("SNF@H"), for high acuity care patients on a full risk basis whereby we assume the financial risk for the coordination and payment of all hospital or SNF replacement medical services necessary to treat the medical condition for which the patient was diagnosed in a home-based setting for a 30-day (H@H) or 60-day (SNF@H) episode of care in exchange for a fixed contracted bundled rate. For H@H programs, the fixed rate is based on the assigned diagnosis related group ("DRG") and the 30-day post-discharge related spend. For SNF@H programs, the fixed rate is based on the 60-day post-discharge related spend. Our performance obligation is the coordination and provision of patient care in accordance with physicians' orders over either a 30-day or 60-day episode of care. The majority of our care coordination services and direct patient care is provided in the first five to seven days of the episode period (the "acute phase"). Monitoring services and follow-up direct patient care, as deemed necessary by the treating physician, are provided throughout the remainder of the episode. Since the majority of our services are provided during the acute phase, we recognize net service revenue over the acute phase based on gross charges for the services provided per the applicable managed care contract rates, reduced by estimates for revenue adjustments.

Under our contracts with health system partners, we provide home recovery care services for high acuity patients on a limited risk basis whereby we assume the risk for certain healthcare services during the remainder of an inpatient acute stay serviced at the patient's home (completing H@H - "CH@H") in exchange for a contracted per diem rate. The performance obligation is the coordination and provision of required medical services, as determined by the treating physician, for each day the patient receives inpatient-equivalent care at home. As such, net service revenue is recognized as services are administered and as our performance obligations are satisfied on a per diem basis, reduced by estimates for revenue adjustments.

We recognize adjustments to revenue during the period in which changes to estimates of assigned patient diagnoses or episode terminations become known, in accordance with the applicable managed care contracts. For certain health insurance plans, revenue is reduced by amounts owed by enrollees to healthcare providers under deductible, coinsurance or copay provisions of health insurance plan policies, since those amounts are repaid to the health insurance plans by us as part of a retrospective reconciliation process.

Government Grants

We account for government grants in accordance with ASC 832, *Government Assistance,* by applying the grant model in accordance with International Accounting Standard ("IAS") 20, *Accounting for Government Grants and Disclosure of Government Assistance*, and as such, we recognize grant income on a systematic basis in line with the recognition of expenses or the loss of revenues for which the grants are intended to compensate. We recognize grants once both of the following conditions are met: (1) we are able to comply with the relevant conditions of the grant and (2) the grant will be received. See Note 4 – Novel Coronavirus Pandemic ("COVID-19") for additional information on our accounting for government funds received under the Coronavirus Aid, Relief and Economic Security Act ("CARES Act").

Cash, Cash Equivalents and Restricted Cash

Cash and cash equivalents include money market funds, certificates of deposit and all highly liquid debt instruments with maturities of three months or less when purchased. The Company maintains cash with commercial banks, which are insured by the Federal Deposit Insurance Corporation ("FDIC"). At various times, the Company has deposits in these financial institutions in excess of the amount insured by the FDIC. The Company has not experienced any losses related to these balances and believes its credit risk to be minimal. The carrying amounts of our cash and cash equivalents approximate their fair values, which are primarily based on Level 1 inputs.

Restricted cash includes cash and cash equivalents that are not available for ordinary business use. As of December 31, 2023 and 2022, we had $12.4 million and $13.6 million, respectively, classified as restricted cash related to funds placed into escrow accounts in connection with the indemnity, closing payment and other provisions within the purchase agreements of our acquisitions and divestitures. See Note 5 – Mergers, Acquisitions and Dispositions for additional information.

The following table summarizes the balances related to our cash, cash equivalents and restricted cash (amounts in millions):

	As of December 31,	
	2023	2022
Cash and cash equivalents	$ 126.5	$ 40.5
Restricted cash	12.4	13.6
Cash, cash equivalents and restricted cash	$ 138.9	$ 54.1

Patient Accounts Receivable

We report accounts receivable from services rendered at their estimated transaction price, which includes contractual and non-contractual revenue adjustments based on the amounts expected to be due from payors. Our patient accounts receivable are uncollateralized and consist of amounts due from Medicare, Medicaid, other third-party payors and patients. Our non-Medicare third-party payor base is comprised of a diverse group of payors that are geographically dispersed across the country. As of December 31, 2023, there is no single payor, other than Medicare, that accounts for more than 10% of our total outstanding patient receivables. Thus, we believe there are no other significant concentrations of receivables that would subject us to any significant credit risk in the collection of our patient accounts receivable. We write off accounts on a monthly basis once we have exhausted our collection efforts and deem an account to be uncollectible. We believe the collectability risk associated with our Medicare accounts, which represented 69% and 67% of our net patient accounts receivable at December 31, 2023 and 2022, respectively, is limited due to our historical collection rate of over 99% from Medicare and the fact that Medicare is a U.S. government payor.

We do not believe there are any significant concentrations of revenues from any payor that would subject us to any significant credit risk in the collection of our accounts receivable.

Medicare Home Health

For our home health patients, our pre-billing process includes verifying that we are eligible for payment from Medicare for the services that we provide to our patients. Our Medicare billing begins with a process to ensure that our billings are accurate through the utilization of an electronic Medicare claim review. We bill Medicare following the end of each 30-day period of care or upon discharge, if earlier, for the services provided to the patient.

Medicare Hospice

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

Non-Medicare Home Health, Hospice, Personal Care and High Acuity Care

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

Property and Equipment

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

We assess the impairment of a long-lived asset group whenever events or changes in circumstances indicate that the asset's carrying value may not be recoverable. Factors we consider important that could trigger an impairment review include but are not limited to the following:

- A significant change in the extent or manner in which the long-lived asset group is being used.
- A significant change in the business climate that could affect the value of the long-lived asset group.
- A significant change in the market value of the assets included in the asset group.

If we determine that the carrying value of long-lived assets may not be recoverable, we compare the carrying value of the asset group to the undiscounted cash flows expected to be generated by the asset group. If the carrying value exceeds the

undiscounted cash flows, an impairment charge is indicated. An impairment charge is recognized to the extent that the carrying value of the asset group exceeds its fair value.

We generally provide for depreciation over the following estimated useful service lives.

	Years
Buildings	39
Leasehold improvements	Lesser of lease term or expected useful life
Equipment and furniture	3 to 7
Vehicles	5
Computer software	2 to 7
Leased copiers	Lesser of lease term or expected useful life
Leased fleet	Lesser of lease term or expected useful life

The following table summarizes the balances related to our property and equipment for 2023 and 2022 (amounts in millions):

	As of December 31,	
	2023	2022
Buildings and leasehold improvements	$ 11.0	$ 9.7
Equipment and furniture	40.0	56.9
Finance leases	39.8	4.1
Computer software	43.4	46.7
	134.2	117.4
Less: Accumulated depreciation	(92.4)	(101.4)
	$ 41.8	$ 16.0

Depreciation expense for 2023, 2022 and 2021 was $18.2 million, $11.5 million and $12.1 million, respectively.

Business Combinations

We account for acquisitions using the acquisition method of accounting in accordance with ASC 805, *Business Combinations*. Acquisitions are accounted for as purchases and are included in our consolidated financial statements from their respective acquisition dates. Assets acquired, liabilities assumed and noncontrolling interests, if any, are measured at fair value on the acquisition date using the appropriate valuation method. Goodwill generated from acquisitions is recognized for the excess of the purchase price over tangible and identifiable intangible assets. In determining the fair value of identifiable intangible assets and any noncontrolling interests, we use various valuation techniques including the income approach, the cost approach and the market approach. These valuation methods require us to make estimates and assumptions surrounding projected revenues and costs, growth rates and discount rates.

Goodwill and Other Intangible Assets

As of December 31, 2023, we had a goodwill balance of $1,244.7 million. Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the reporting unit below its carrying amount. These events or circumstances include, but are not limited to, a significant adverse change in the business environment, regulatory environment or legal factors or a substantial decline in the market capitalization of our stock.

Each of our operating segments described in Note 15 – Segment Information is considered to represent an individual reporting unit for goodwill impairment testing purposes. We consider each of our home health care centers to constitute an individual business for which discrete financial information is available. However, since these care centers have substantially similar operating and economic characteristics and resource allocations and since significant investment decisions concerning these businesses are centralized and the benefits broadly distributed, we have aggregated these care centers and deemed them to constitute a single reporting unit. We have applied this same aggregation principle to our hospice care centers and high acuity care joint ventures and have also deemed each of them to be a single reporting unit.

During 2023, we performed a qualitative assessment to determine if it was more likely than not that the fair value of our reporting units were less than their carrying values by evaluating relevant events and circumstances including financial performance, market conditions and share price. Based on this assessment, we concluded that the goodwill associated with our home health and hospice reporting units was not considered at risk of impairment as of October 31, 2023. In addition to the qualitative assessment, we also performed a quantitative analysis using an income approach for our high acuity care reporting unit due to delays in achieving our long-term projections established as of the August 2021 acquisition date. This quantitative analysis required us to make estimates and assumptions surrounding projected revenues and costs, growth rates and discount rates. Based on this analysis, we concluded that the goodwill associated with our high acuity care reporting unit was not impaired as of October 31, 2023.

As of December 31, 2023, we had an other intangible assets balance of $102.7 million. Intangible assets consist of certificates of need, licenses, acquired names, non-compete agreements and technology. As of December 31, 2023, our non-compete agreements and amortizable acquired names were fully amortized. We amortize non-compete agreements and acquired names that we do not intend to use indefinitely on a straight-line basis over their estimated useful lives, which are generally two to three years for non-compete agreements and up to three years for acquired names. We amortize technology over its estimated useful service life, which is generally up to seven years. Our indefinite-lived intangible assets are reviewed for impairment annually or more frequently if events occur or circumstances change that would more likely than not reduce the fair value of the intangible asset below its carrying amount. We performed a qualitative assessment of our indefinite-lived intangible assets during 2023 and determined that there have been no material developments, events, changes in operating performance or other circumstances that would cause management to believe it is more likely than not that the fair value of any of our indefinite-lived intangible assets would be less than their carrying amounts.

Debt Issuance Costs

We amortize deferred debt issuance costs related to our long-term obligations over the term of the obligation through interest expense, unless the debt is extinguished, in which case unamortized balances are immediately expensed. The unamortized debt issuance costs of $2.6 million at December 31, 2023 will be amortized over a weighted-average amortization period of 2.6 years.

Fair Value of Financial Instruments

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

		Fair Value at Reporting Date Using		
Financial Instrument	Carrying Value as of December 31, 2023	Quoted Prices in Active Markets for Identical Items (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-term obligations	$ 371.9	$ —	$ 360.6	$ —

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

- Level 1 – Quoted prices in active markets for identical assets and liabilities.
- Level 2 – Inputs other than Level 1 that are observable, either directly or indirectly, such as quoted prices for similar assets or liabilities, quoted prices in markets that are not active or other inputs that are observable or can be corroborated by observable market data for substantially the full term of the assets or liabilities.
- Level 3 – Unobservable inputs that are supported by little or no market activity and are significant to the fair value of the assets or liabilities.

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

Income Taxes

We use the asset and liability approach for measuring deferred tax assets and liabilities based on temporary differences existing at each balance sheet date using currently enacted tax rates. Our deferred tax calculation requires us to make certain estimates about future operations. Deferred tax assets are reduced by a valuation allowance when we believe it is more likely than not that some portion or all of the deferred tax assets will not be realized. The effect of a change in tax rate is recognized as income or expense in the period that includes the enactment date.

Management regularly assesses the ability to realize deferred tax assets based upon the weight of available evidence, including such factors as the recent earnings history and expected future taxable income. In the event future taxable income is below management's estimates or is generated in tax jurisdictions different than projected, we could be required to increase the valuation allowance for deferred tax assets. This would result in an increase in our effective tax rate.

Share-Based Compensation

We record all share-based compensation as expense in the financial statements measured at the fair value of the award. We recognize compensation cost on a straight-line basis over the requisite service period for each separately vesting portion of the award. Share-based compensation expense for 2023, 2022 and 2021 was $29.0 million, $16.6 million and $23.8 million, respectively, and the total income tax benefit recognized for these expenses was $7.5 million, $4.3 million and $6.0 million, respectively, prior to the application of the income tax compensation rules under Internal Revenue Code section 162(m) ("162(m)"). As of December 31, 2023, the income tax benefit recognized for the three-year period was reduced by a cumulative $2.7 million, pursuant to 162(m).

Weighted-Average Shares Outstanding

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

	For the Years Ended December 31,		
	2023	2022	2021
Weighted average number of shares outstanding – basic	32,599	32,517	32,642
Effect of dilutive securities:			
Stock options	—	39	122
Non-vested stock and stock units	—	97	208
Weighted average number of shares outstanding – diluted	32,599	32,653	32,972
Anti-dilutive securities	619	303	114

Advertising Costs

We expense advertising costs as incurred. Advertising expense for 2023, 2022 and 2021 was $7.2 million, $7.3 million and $7.4 million, respectively.

3. INVESTMENTS

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

We account for investments in entities in which we have the ability to exercise significant influence under the equity method if we hold 50% or less of the voting stock and the entity is not a VIE in which we are the primary beneficiary. The book value of investments that we account for under the equity method of accounting totaled $46.1 million and $40.5 million as of December 31, 2023 and 2022, respectively, and is reflected in other assets within our consolidated balance sheets.

We account for investments in entities in which we have less than 20% ownership interest under the cost method of accounting if we do not have the ability to exercise significant influence over the investee. During 2022, we made a $15.0 million investment in a home health benefit manager, which is accounted for under the cost method. During 2021, we made a $5.0 million investment in a workforce optimization company, which is accounted for under the cost method. The book value of investments that we account for under the cost method of accounting was $20.0 million as of December 31, 2023 and 2022 and is reflected in other assets within our consolidated balance sheets.

During the three-month period ended December 31, 2022, we sold a 49% interest in two of our home health care centers while maintaining a controlling interest in the newly formed joint venture. We are consolidating this joint venture. The total cash consideration received for the 49% noncontrolling interest was $1.9 million. In connection with the transaction, we recorded an after-tax gain of $1.4 million; this gain was recorded to additional paid-in capital within our consolidated balance sheet. During the three-month period ended September 30, 2022, we sold a 30% interest in two of our home health care centers while maintaining a controlling interest in the newly formed joint venture. We are consolidating this joint venture. The total cash consideration received for the 30% noncontrolling interest was $3.9 million. In connection with the transaction, we recorded an after-tax gain of $2.9 million; this gain was recorded to additional paid-in capital within our consolidated balance sheet.

During 2021, a third-party acquired a majority of the issued and outstanding membership interests of one of our equity method investments, Medalogix, for cash, with the remaining membership interests rolling over into a newly formed entity that includes Medalogix as well as another healthcare predictive data and analytics company. We rolled over 100% of our ownership interest in Medalogix to the newly formed entity, and in connection with this transaction, we recognized a $31.1 million gain based on the purchase price of Medalogix, which is reflected in gain on equity method investments within our consolidated statements of operations.

Our high acuity care segment includes interests in several joint ventures with health system partners and a professional corporation that employs clinicians. Each of these entities meets the criteria to be classified as a VIE. As of December 31, 2023, we are consolidating all but one of our admitting joint ventures with health system partners as well as the professional corporation as we have concluded that we are the primary beneficiary of these VIEs; the joint venture that is not consolidated is accounted for under the equity method of accounting. We have management agreements in place with each of the consolidated entities whereby we manage the entities and run the day-to-day operations. As such, we possess the power to direct the activities that most significantly impact the economic performance of the VIEs. The significant activities include, but are not limited to, negotiating provider and payor contracts, establishing patient care policies and protocols, making employment and compensation decisions, developing the operating and capital budgets, performing marketing activities and providing accounting support. We also have the obligation to absorb any expected losses and the right to receive benefits. Additionally, from time to time we may be required to provide joint venture funding.

During the year ended December 31, 2022, we recorded a $3.0 million impairment charge in connection with the wind down of operations of one of our high acuity care joint ventures accounted for under the equity method of accounting.

The terms of the agreements with each VIE prohibit us from using the assets of the VIE to satisfy the obligations of other entities. The carrying amount of the VIEs' assets and liabilities included in our consolidated balance sheets are as follows (amounts in millions):

	As of December 31,	
	2023	2022
ASSETS		
Current assets:		
Cash and cash equivalents	$ 8.8	$ 15.6
Patient accounts receivable	9.0	6.1
Other current assets	0.1	0.6
Total current assets	17.9	22.3
Property and equipment	0.1	0.1
Operating lease right of use assets	0.1	0.1
Goodwill	8.5	8.5
Intangible assets	0.4	0.4
Other assets	0.3	0.2
Total assets	$ 27.3	$ 31.6
LIABILITIES		
Current liabilities:		
Accounts payable	$ 0.5	$ 0.1
Payroll and employee benefits	0.9	0.5
Accrued expenses	7.9	5.8
Operating lease liabilities	—	0.1
Current portion of long-term obligations	—	0.2
Total liabilities	$ 9.3	$ 6.7

4. NOVEL CORONAVIRUS PANDEMIC ("COVID-19")

On March 27, 2020, the CARES Act was signed into legislation. The CARES Act provided for $175 billion to healthcare providers, including hospitals on the front lines of the COVID-19 pandemic. Of this total allocated amount, $30 billion was distributed immediately to providers based on their proportionate share of Medicare fee-for-service reimbursements in 2019. Healthcare providers were required to sign an attestation confirming receipt of the Provider Relief Fund ("PRF") funds and agree to the terms and conditions of payment. Our home health and hospice segments received approximately $100 million from the first $30 billion of funds distributed to healthcare providers in April 2020, which is inclusive of $2 million related to our joint venture care centers (equity method investments). We also acquired approximately $6 million of PRF funds in connection with the acquisition of AseraCare Hospice ("AseraCare"). Under the terms and conditions for receipt of the payment, we were allowed to use the funds to cover lost revenues and health care costs related to COVID-19 through June 30, 2021, and we were required to properly and fully document the use of these funds in reports to the U.S. Department of Health and Human Services ("HHS"). All required reporting was completed during the three-month period ended September 30, 2021, and our audit report was submitted to HHS on September 26, 2022.

For our wholly-owned subsidiaries, we utilized PRF funds to the extent we had qualifying COVID-19 expenses; we did not use PRF funds to cover lost revenues resulting from COVID-19. The grant income associated with the COVID-19 expenses incurred through June 30, 2021 is reflected in other operating income within our consolidated statements of operations.

We did not fully utilize the funds received; all unutilized funds were repaid in October 2021. In summary, the total funds that we received from the CARES Act PRF were accounted for as follows (amounts in millions):

	Amount
Funds utilized through June 30, 2021 by consolidated entities	$ 46.6
Funds repaid to the government by consolidated entities (excludes $0.2 million of interest repaid)	58.3
Funds utilized through June 30, 2021 by unconsolidated joint ventures	1.3
Funds repaid to the government by unconsolidated joint ventures	0.6
	$ 106.8

The CARES Act also provided for the temporary suspension of the 2% reduction of Medicare claim reimbursements ("sequestration") for the period May 1, 2020 through December 31, 2020. During 2020 and 2021, Congress passed additional COVID-19 relief legislation which extended the 2% suspension of sequestration through March 31, 2022; sequestration was reinstated as a 1% reduction to Medicare claim reimbursements effective April 1, 2022 and a 2% reduction to Medicare claim reimbursements effective July 1, 2022. We recognized benefits to net service revenue totaling $13 million and $36 million during 2022 and 2021, respectively.

Additionally, the CARES Act provided for the deferral of the employer share of social security tax (6.2%), effective for payments due after the enactment date through December 31, 2020. During 2020, we deferred payment of approximately $55 million of social security taxes. Approximately $27 million was paid during December 2021; the remaining balance was paid during December 2022.

5. MERGERS, ACQUISITIONS AND DISPOSITIONS

Mergers

On June 26, 2023, Amedisys, UnitedHealth Group Incorporated, a Delaware corporation ("UnitedHealth Group"), and Aurora Holdings Merger Sub Inc., a Delaware corporation and a wholly owned subsidiary of UnitedHealth Group ("Merger Sub"), entered into an Agreement and Plan of Merger (the "Merger Agreement"), pursuant to which Merger Sub will merge with and into Amedisys with Amedisys continuing as the surviving corporation and becoming a wholly owned subsidiary of UnitedHealth Group (the “Merger”).

Subject to the terms and conditions set forth in the Merger Agreement, at the effective time of the Merger (the "Effective Time"), by virtue of the Merger: (i) each share of Amedisys common stock (“Amedisys Common Stock”) held in treasury by Amedisys or owned by UnitedHealth Group or Merger Sub or any of their respective subsidiaries, in each case, immediately prior to the Effective Time will be cancelled (collectively, “cancelled shares”) without consideration; and (ii) each share of Amedisys Common Stock, other than any cancelled shares, issued and outstanding immediately prior to the Effective Time will be converted into the right to receive $101 per share in cash, without interest, less any applicable withholding taxes.

The Merger is subject to a number of conditions to closing as specified in the Merger Agreement. These closing conditions include, among others, (i) approval by Amedisys stockholders at the Amedisys Stockholders Meeting (as defined in the Merger Agreement) of the proposal to adopt the Merger Agreement, which approval was obtained on September 8, 2023; (ii) the expiration or termination of the applicable waiting period (and any extension thereof) under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended; (iii) the receipt of the required state regulatory approvals; (iv) the absence of any law or order that has the effect of enjoining or otherwise prohibiting the completion of the Merger; and (v) the expiration or early termination of the waiting period (and any extension thereof) applicable to the consummation of the transactions contemplated by the Merger Agreement under all applicable antitrust laws without the imposition by any governmental entity of any term, condition, obligation, requirement, limitation, prohibition, remedy, sanction or other action that has resulted in or would reasonably be expected to result in a Burdensome Condition (as defined in the Merger Agreement).

As previously disclosed in Amedisys’ Current Report on Form 8-K filed with the SEC on May 3, 2023 and its Quarterly Report on Form 10-Q filed with the SEC on May 4, 2023, Amedisys entered into an Agreement and Plan of Merger on May 3, 2023 (the “OPCH Merger Agreement”) with Option Care Health, Inc., a Delaware corporation (“OPCH”), and Uintah Merger Sub, Inc., a Delaware corporation and wholly-owned subsidiary of OPCH (“OPCH Merger Sub”). On June 26, 2023, Amedisys, OPCH and OPCH Merger Sub entered into the Termination Agreement (the “Termination Agreement”), pursuant to which the parties thereto agreed to terminate the OPCH Merger Agreement and grant mutual releases by the parties of all claims against the other parties based upon, arising from, in connection with or relating to the OPCH Merger Agreement. Pursuant to the terms of the Termination Agreement, each of the termination of the OPCH Merger Agreement and the mutual releases provided for in

the Termination Agreement would become effective upon receipt by OPCH of a $106,000,000 termination fee payable by, or on behalf of, Amedisys within 24 hours of the execution of the Termination Agreement (i.e., before the market open on June 27, 2023). On June 26, 2023, following the execution of the Termination Agreement, UnitedHealth Group, on behalf of Amedisys, delivered funds to OPCH in an amount equal to $106,000,000, representing the termination fee payable to OPCH under the OPCH Merger Agreement and the Termination Agreement, satisfying the condition precedent to the effectiveness of the termination of the OPCH Merger Agreement and the releases contained in the Termination Agreement. If the Merger Agreement is terminated under certain specified circumstances, Amedisys may be required to reimburse UnitedHealth Group for the $106,000,000 termination fee that UnitedHealth Group, on Amedisys' behalf, paid to OPCH in addition to the $125,000,000 termination fee payable by Amedisys to UnitedHealth Group upon termination of the Merger Agreement. The $106,000,000 termination fee was recorded to other income (expense) within our consolidated statement of operations with a corresponding liability to termination fee paid by UnitedHealth Group within our consolidated balance sheet during the year ended December 31, 2023.

Acquisitions

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

2023 Acquisitions

On January 20, 2023, we acquired the regulatory assets of a home health provider in West Virginia for a purchase price of $0.4 million. The purchase price was paid with cash on hand on the date of the transaction. We recorded goodwill of $0.3 million and other intangibles (certificate of need) of $0.1 million in connection with the acquisition.

2022 Acquisitions

On March 23, 2022, we entered into a transaction with one of our high acuity care health system partners in which we contributed cash and our health system partner contributed its home health operations to one of our existing high acuity care joint ventures. As a result of this transaction, we recorded goodwill of $8.5 million, other intangibles of $0.4 million (certificate of need and licenses) and noncontrolling interest of $8.9 million within our consolidated balance sheet. The fair value of noncontrolling interest was determined using an income approach and a market approach.

On April 1, 2022, we acquired 15 home health care centers from Evolution Health, LLC, a division of Envision Healthcare, doing business as Guardian Healthcare, Gem City, and Care Connection of Cincinnati ("Evolution"), for an estimated purchase price of $67.8 million. A portion of the purchase price ($51.1 million) was paid to the seller with cash on hand and proceeds from borrowings under our Revolving Credit Facility. The remainder ($16.7 million) was placed into an escrow account in accordance with the closing payment, indemnity and other provisions within the purchase agreement.

Of the total $16.7 million placed into escrow, $1.0 million was set aside for the closing payment adjustment. The closing payment calculated on the acquisition date included estimates for cash, working capital and various other items. Under the purchase agreement, the purchase price was subject to an adjustment for any differences between estimated amounts included in the closing payment and actual amounts at close. The closing payment adjustment, which was finalized during 2022, reduced the purchase price by $1.3 million from $67.8 million to $66.5 million. The remaining $15.7 million placed into escrow relates to certain outstanding matters existing as of the acquisition date as well as potential losses the Company may incur for which the seller has an obligation to indemnify the Company. The amounts in escrow will either be paid to third parties as outstanding matters are resolved or to the seller at certain intervals in the future. As of December 31, 2023, $9.6 million of the $16.7 million has been released from escrow; $7.1 million plus interest remains in escrow and is reflected as restricted cash within our consolidated balance sheet. Corresponding liabilities related to these contingent consideration arrangements are reflected in accrued expenses within our consolidated balance sheet as of December 31, 2023.

$15 million of goodwill recorded for this acquisition will be deductible for income tax purposes over approximately two to five years.

Evolution contributed $29.7 million in net service revenue and an operating loss of $2.3 million during the year ended December 31, 2023 and $29.4 million in net service revenue and an operating loss of $5.3 million during the year ended December 31, 2022.

The Company finalized its valuation of the assets acquired and liabilities assumed during the three-month period ended March 31, 2023. As a result of our review, total assets acquired decreased by $0.2 million (primarily patient accounts receivable) and total liabilities assumed remained flat; these adjustments resulted in a $0.2 million increase in goodwill. The total consideration of $66.5 million has been allocated to assets acquired and liabilities assumed as of the acquisition date as follows (amounts in millions):

	Amount
ASSETS	
Patient accounts receivable	$ 7.3
Prepaid expenses	0.2
Other current assets	0.1
Property and equipment	1.9
Operating lease right of use assets	3.2
Intangible assets (licenses)	1.3
Deferred income tax asset	0.1
Other assets	0.1
Total assets acquired	$ 14.2
LIABILITIES	
Accounts payable	$ (0.8)
Payroll and employee benefits	(2.6)
Accrued expenses	(2.6)
Operating lease liabilities	(2.8)
Current portion of long-term obligations	(0.6)
Total liabilities assumed	(9.4)
Net identifiable assets acquired	$ 4.8
Goodwill	61.7
Total consideration	$ 66.5

On April 1, 2022, we acquired two home health locations from AssistedCare Home Health, Inc. and RH Homecare Services, LLC, doing business as AssistedCare Home Health and AssistedCare of the Carolinas ("AssistedCare"), respectively, for a purchase price of $24.7 million. A portion of the purchase price ($22.2 million) was paid to the seller with cash on hand and proceeds from borrowings under our Revolving Credit Facility. The remainder ($2.5 million) was placed into an escrow account in accordance with the indemnity provisions within the purchase agreement and was classified as restricted cash within our consolidated balance sheet. A corresponding liability related to this contingent consideration arrangement was also reflected in accrued expenses within our consolidated balance sheet. The $2.5 million was released from escrow during the three-month period ended December 31, 2023.

We recorded goodwill of $24.0 million and other intangibles of $0.7 million in connection with the acquisition. Intangible assets acquired include licenses ($0.5 million), certificates of need ($0.2 million) and acquired names (less than $0.1 million). The acquired names were amortized over a weighted average period of one year. The entire amount of goodwill recorded for this acquisition will be deductible for income tax purposes over approximately 15 years.

AssistedCare contributed $7.0 million in net service revenue and operating income of $0.5 million during the year ended December 31, 2023 and $6.1 million in net service revenue and operating income of $0.8 million during the year ended December 31, 2022.

Dispositions

On February 10, 2023, we signed a definitive agreement to sell our personal care business (excluding the Florida operations, which were closed during the three-month period ended March 31, 2023). The divestiture closed on March 31, 2023. We received net proceeds of $47.8 million and recognized a $2.2 million loss during the three-month period ended March 31, 2023, which is reflected in miscellaneous, net within our consolidated statement of operations. The net proceeds of $47.8 million is inclusive of $6.0 million that was placed into an escrow account in accordance with the closing payment and indemnity provisions within the purchase agreement.

Of the total $6.0 million placed into escrow, $1.0 million was set aside for the closing payment adjustment. The closing payment calculated on the acquisition date included estimates for cash, working capital and various other items. Under the purchase agreement, the purchase price was subject to an adjustment for any differences between estimated amounts included in the closing payment and actual amounts at close. The closing payment adjustment was finalized during 2023 with $0.1 million being paid to Amedisys by the buyer. The $1.0 million in escrow related to the closing payment adjustment was released to Amedisys during the fourth quarter. The remaining $5.0 million placed into escrow relates to potential losses for which the Company may have to indemnify the buyer. As of December 31, 2023, the $5.0 million plus interest remains in escrow and is reflected as restricted cash within our consolidated balance sheet as of December 31, 2023.

The disposition of our personal care business did not qualify as a discontinued operation because it did not represent a change in strategy that has or will have a major effect on the Company's operations or financial results.

We derecognized goodwill of $43.1 million in connection with the divestiture. The carrying amounts of the assets and liabilities associated with our personal care reporting unit included in our consolidated balance sheet as of December 31, 2022 were as follows (amounts in millions):

	As of December 31, 2022
ASSETS	
Current assets:	
Patient accounts receivable	$ 9.6
Prepaid expenses	0.1
Total current assets	9.7
Property and equipment	0.1
Operating lease right of use assets	2.5
Goodwill	43.1
Total assets	$ 55.4
LIABILITIES	
Current liabilities:	
Accounts payable	$ 0.4
Payroll and employee benefits	0.6
Accrued expenses	1.8
Current portion of operating lease liabilities	0.6
Total current liabilities	3.4
Operating lease liabilities, less current portion	1.9
Total liabilities	$ 5.3

6. GOODWILL AND OTHER INTANGIBLE ASSETS, NET

Goodwill

During 2023, 2022 and 2021, we did not record any goodwill impairment charges as a result of our annual impairment test and none of the goodwill associated with our reporting units was considered impaired as of October 31st of each respective year (the date of our annual goodwill impairment test).

The following table summarizes the activity related to our goodwill for 2023 and 2022 (amounts in millions):

	Goodwill				
	Home Health	Hospice	Personal Care	High Acuity Care	Total
Balances at December 31, 2021[1]	$ 118.2	$ 800.9	$ 43.1	$ 233.9	$ 1,196.1
Additions	85.6	—	—	8.5	94.1
Adjustments[2]	—	—	—	(2.8)	(2.8)
Balances at December 31, 2022	203.8	800.9	43.1	239.6	1,287.4
Additions	0.3	—	—	—	0.3
Adjustments[3]	0.2	—	—	—	0.2
Reclass between segments[4]	8.5	—	—	(8.5)	—
Divestitures[5]	—	—	(43.1)	—	(43.1)
Balances at December 31, 2023	$ 212.7	$ 800.9	$ —	$ 231.1	$ 1,244.7

(1) Net of prior years' accumulated impairment losses of $730.0 million within the home health reporting unit.
(2) The Company finalized its valuation of the assets acquired, liabilities assumed and noncontrolling interests in connection with the acquisition of Contessa on August 1, 2021.
(3) The Company finalized its valuation of the assets acquired and liabilities assumed in connection with the acquisition of Evolution on April 1, 2022. See Note 5 – Mergers, Acquisitions and Dispositions for additional information.
(4) Effective January 1, 2023, we transitioned from the high acuity care segment to the home health segment the operations of a home health care center that was contributed to the high acuity care segment by one of our health system partners during 2022. See Note 5 – Mergers, Acquisitions and Dispositions and Note 15 – Segment Information for additional information.
(5) The Company divested its personal care business on March 31, 2023.

Other Intangible Assets, net

During 2023 and 2022, we did not record any impairment charges related to our other intangible assets.

The following table summarizes the activity related to our other intangible assets, net for 2023 and 2022 (amounts in millions):

	Other Intangible Assets, Net					
	Certificates of Need and Licenses	Acquired Names - Unamortizable	Acquired Names -Amortizable	Non-Compete Agreements	Technology[3]	Total
Balances at December 31, 2021[1]	$ 47.1	$ 35.6	$ 3.1	$ 6.4	$ 19.0	$ 111.2
Additions	2.4	—	—	—	1.1	3.5
Amortization[2]	(2.8)	—	(3.1)	(4.6)	(3.0)	(13.5)
Balances at December 31, 2022	46.7	35.6	—	1.8	17.1	101.2
Additions	0.1	—	—	—	7.1	7.2
Amortization[2]	(0.1)	—	—	(1.8)	(3.8)	(5.7)
Balances at December 31, 2023	$ 46.7	$ 35.6	$ —	$ —	$ 20.4	$ 102.7

(1) Net of prior years' accumulated amortization of $7.2 million for acquired names and $8.3 million for non-compete agreements.
(2) Amortization of certificates of need and licenses is related to care centers that were closed during 2022 and 2023.
(3) The weighted average remaining amortization period of our technology is 4.6 years.

The estimated aggregate amortization expense related to intangible assets for each of the five succeeding years is as follows (amounts in millions):

	Intangible Asset Amortization
2024	$ 4.5
2025	4.5
2026	4.5
2027	4.5
2028	2.4
	$ 20.4

See Note 5 – Mergers, Acquisitions and Dispositions for further details on additions to goodwill and other intangible assets, net.

7. DETAILS OF CERTAIN BALANCE SHEET ACCOUNTS

Additional information regarding certain balance sheet accounts is presented below (amounts in millions):

	As of December 31,	
	2023	2022
Other current assets:		
Payroll tax escrow	$ 7.0	$ 7.6
Income tax receivable	8.0	8.8
Due from joint ventures	6.8	3.6
Other	8.3	6.4
	$ 30.1	$ 26.4
Other assets:		
Workers' compensation deposits	$ 0.2	$ 0.3
Health insurance deposits	1.5	0.9
Other miscellaneous deposits	1.0	1.0
Indemnity receivable	13.6	13.6
Equity method investments	46.1	40.5
Cost method investments	20.0	20.0
Other	2.7	3.5
	$ 85.1	$ 79.8
Accrued expenses:		
Health insurance	$ 18.2	$ 16.2
Workers' compensation	41.8	40.6
Legal settlements and other audits	24.6	29.9
Charity care	2.7	1.9
Estimated Medicare cap liability	2.3	4.3
Hospice accruals (room and board, general in-patient and other)	23.3	19.1
Patient and payor liabilities	15.1	8.9
Accrued contingent consideration	7.1	10.5
Accrued interest	1.1	0.2
Other	3.8	5.8
	$ 140.0	$ 137.4
Other long-term obligations:		
Deferred compensation plan liability	$ 0.6	$ 0.6
Accrued contingent consideration	—	3.2
Other	0.8	1.0
	$ 1.4	$ 4.8

8. LEASES

We determine whether an arrangement is a lease at inception. We have operating leases, primarily for offices, that expire at various dates over the next seven years. We have finance leases covering certain office equipment and fleet vehicles that expire at various dates over the next six years. Our leases do not contain any restrictive covenants.

Our office leases generally contain renewal options for periods ranging from one to five years. Because we are not reasonably certain to exercise these renewal options, the options are not considered in determining the lease term, and payments associated with the option years are excluded from lease payments. Our office leases also generally include termination options, which allow for early termination of the lease after the first one to three years. Because we are not reasonably certain to exercise these termination options, the options are not considered in determining the lease term; payments for the full lease term are included in lease payments. Our office leases do not contain any material residual value guarantees.

Effective January 1, 2023, the master lease agreement for our fleet leases was modified to remove the residual value guarantee provided by the lessor on each of our fleet leases. The modification resulted in a change in the classification of our fleet leases from operating leases to finance leases. In connection with the modification, we reclassified approximately $15 million from the operating lease asset and liability accounts to the property and equipment and current/long-term obligations accounts within our consolidated balance sheet. Additionally, following the modification, expenses associated with our fleet leases are reflected in depreciation expense and interest expense within our consolidated statement of operations as opposed to cost of service and general and administrative expenses, which is where the expenses were reflected in prior periods.

Our fleet leases include a term of 367 days with monthly renewal options thereafter. Our fleet leases also include terminal rental adjustment clauses (“TRAC”), which provide for a final rental payment adjustment at the end of the lease, typically based on the amount realized from the sale of the vehicle. The TRAC is structured such that it will almost always result in a significant payment by us to the lessor if the renewal option is not exercised. Based on the significance of the TRAC adjustment at the initial lease expiration, we believe that it is reasonably certain that we will exercise the monthly renewal options; therefore, the renewal options are considered in determining the lease term, and payments associated with the renewal options are included in lease payments.

For our fleet and office equipment leases, we use the implicit rate in the lease as the discount rate. For our office leases, the implicit rate is typically not available, so we use our incremental borrowing rate as the discount rate. Our lease agreements include both lease and non-lease components. We have elected the practical expedient that allows us to not separate lease and non-lease components for all of our leases.

Payments due under our operating and finance leases include fixed payments as well as variable payments. For our office leases, variable payments include amounts for our proportionate share of operating expenses, utilities, property taxes, insurance, common area maintenance and other facility-related expenses. For our vehicle and equipment leases, variable payments consist of sales tax.

The components of lease cost for the years ended December 31, 2023 and 2022 are as follows (amounts in millions):

	For the Years Ended December 31,	
	2023	2022
Operating lease cost:		
Operating lease cost	$ 33.8	$ 43.9
Impairment of operating lease right of use ("ROU") assets	0.2	2.1
Total operating lease cost	34.0	46.0
Finance lease cost:		
Loss on termination	—	0.5
Amortization of ROU assets	5.8	1.8
Interest on lease liabilities	1.6	0.1
Total finance lease cost	7.4	2.4
Variable lease cost	3.7	3.4
Short-term lease cost	—	—
Total lease cost	$ 45.1	$ 51.8

Amounts reported in the consolidated balance sheets as of December 31, 2023 and 2022 for our operating leases are as follows (amounts in millions):

	As of December 31,	
	2023	2022
Operating lease ROU assets	$ 88.9	$ 102.9
Current portion of operating lease liabilities	26.3	33.5
Operating lease liabilities, less current portion	62.7	69.5
Total operating lease liabilities	$ 89.0	$ 103.0

Amounts reported in the consolidated balance sheets as of December 31, 2023 and 2022 for finance leases are included in the table below. The finance lease ROU assets are recorded within property and equipment, net of accumulated depreciation within our consolidated balance sheets. The finance lease liabilities are recorded within current portion of long-term obligations and long-term obligations, less current portion within our consolidated balance sheets.

	As of December 31,	
	2023	2022
Finance lease ROU assets	$ 39.8	$ 4.1
Accumulated amortization	(11.2)	(1.8)
Finance lease ROU assets, net	$ 28.6	$ 2.3
Current installments of obligations under finance leases	$ 13.8	$ 1.2
Long-term portion of obligations under finance leases	15.1	1.1
Total finance lease liabilities	$ 28.9	$ 2.3

Supplemental cash flow information and non-cash activity related to our leases are as follows (amounts in millions):

	For the Years Ended December 31,	
	2023	2022
Cash paid for amounts included in the measurement of lease liabilities and ROU assets:		
Operating cash flow from operating leases	$ (34.5)	$ (44.4)
Financing cash flow from finance leases	(11.6)	(1.5)
ROU assets obtained in exchange for lease obligations:		
Operating leases	$ 33.9	$ 45.1
Finance leases	40.0	2.1
Reductions to ROU assets resulting from reductions to lease obligations:		
Operating leases	$ (15.2)	$ (4.2)
Finance leases	(1.7)	(0.6)

Amounts disclosed for ROU assets obtained in exchange for lease obligations include amounts added to the carrying amount of ROU assets resulting from lease modifications and reassessments.

Weighted average remaining lease terms and discount rates for our leases as of December 31, 2023 and 2022 are as follows:

	As of December 31,	
	2023	2022
Weighted average remaining lease term (years):		
Operating leases	3.6	3.5
Finance leases	2.6	2.1
Weighted average discount rate:		
Operating leases	4.2 %	3.4 %
Finance leases	6.6 %	5.3 %

Maturities of lease liabilities as of December 31, 2023 are as follows (amounts in millions):

	Operating Leases	Finance Leases
2024	$ 29.5	$ 14.7
2025	26.1	10.9
2026	19.7	3.7
2027	13.2	0.9
2028	7.1	0.9
Thereafter	1.2	0.4
Total undiscounted lease payments	96.8	31.5
Less: Imputed interest	(7.8)	(2.6)
Total lease liabilities	$ 89.0	$ 28.9

9. LONG-TERM OBLIGATIONS

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

	As of December 31,	
	2023	2022
$450.0 million Term Loan; interest rate at Base Rate plus Applicable Rate or Term SOFR plus Applicable Rate (7.2% at December 31, 2023); due July 30, 2026	$ 371.9	$ 435.9
$550.0 million Revolving Credit Facility; interest only payments; interest rate at Base Rate plus Applicable Rate or Term SOFR plus Applicable Rate; due July 30, 2026	—	—
Promissory notes	—	0.2
Finance leases	28.9	2.3
Principal amount of long-term obligations	400.8	438.4
Deferred debt issuance costs	(2.6)	(3.5)
	398.2	434.9
Current portion of long-term obligations	(36.3)	(15.5)
Long-term obligations, less current portion	$ 361.9	$ 419.4

Maturities of debt as of December 31, 2023 are as follows (amounts in millions):

	Long-Term Obligations
2024	$ 36.3
2025	32.3
2026	330.0
2027	0.9
2028	0.9
2029	0.4
	$ 400.8

Credit Agreement

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

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

First Amendment to the Credit Agreement

On February 4, 2019, we entered into the First Amendment to the Credit Agreement (as amended by the First Amendment, the “Amended Credit Agreement”). The Amended Credit Agreement provided for a senior secured credit facility in an initial aggregate principal amount of up to $725.0 million, which included the $550.0 million Revolving Credit Facility under the Credit Agreement, and a term loan facility with a principal amount of up to $175.0 million (the “Term Loan Facility” and collectively with the Revolving Credit Facility, the “Credit Facility”), which was added by the First Amendment.

We borrowed the entire principal amount of the Term Loan Facility on February 4, 2019 in order to fund a portion of the purchase price of the Compassionate Care Hospice ("CCH") acquisition, with the remainder of the purchase price and associated transactional fees and expenses funded by proceeds from the Revolving Credit Facility.

Second Amendment to the Credit Agreement

On July 30, 2021, we entered into the Second Amendment to our Credit Agreement (as amended by the Second Amendment, the "Second Amended Credit Agreement"). The Second Amended Credit Agreement provided for a senior secured credit facility in an initial aggregate principal amount of up to $1.0 billion, which included the $550.0 million Revolving Credit Facility and a term loan facility with a principal amount of up to $450.0 million (the "Amended Term Loan Facility" and collectively with the Revolving Credit Facility, the "Amended Credit Facility").

Net proceeds from the $450.0 million Amended Term Loan Facility were used to fund the Contessa acquisition.

In connection with our entry into the Second Amended Credit Agreement during the year ended December 31, 2021, we recorded $2.8 million in deferred debt issuance costs as long-term obligations, less current portion within our consolidated balance sheet.

Third Amendment to the Credit Agreement

On March 10, 2023, we entered into the Third Amendment to our Credit Agreement (as amended by the Third Amendment, the "Third Amended Credit Agreement"). The Third Amended Credit Agreement (i) formally replaced the use of the London Interbank Offered Rate ("LIBOR") with the Secured Overnight Financing Rate ("SOFR") for interest rate pricing and (ii) allowed for the disposition of our personal care business.

The loans issued under the Amended Credit Facility bear interest on a per annum basis, at our election, at either: (i) the Base Rate plus the Applicable Rate or (ii) the Term SOFR plus the Applicable Rate. The “Base Rate” means a fluctuating rate per annum equal to the highest of (a) the federal funds rate plus 0.50% per annum, (b) the prime rate of interest established by the Administrative Agent, and (c) the Term SOFR plus 1% per annum. The “Term SOFR” means the quoted rate per annum equal to the SOFR for an interest period of one or three months (as selected by us) plus the SOFR adjustment of 0.10%. The “Applicable Rate” is based on the consolidated leverage ratio and is presented in the table below. As of December 31, 2023, the Applicable Rate is 0.75% per annum for Base Rate Loans and 1.75% per annum for Term SOFR Loans. We are also subject to a commitment fee and letter of credit fee under the terms of the Third Amended Credit Agreement, as presented in the table below.

Pricing Tier	Consolidated Leverage Ratio	Base Rate Loans	Term SOFR Loans and SOFR Daily Floating Rate Loans	Commitment Fee	Letter of Credit Fee
I	> 3.00 to 1.0	1.00 %	2.00 %	0.30 %	1.75 %
II	≤ 3.00 to 1.0 but > 2.00 to 1.0	0.75 %	1.75 %	0.25 %	1.50 %
III	≤ 2.00 to 1.0 but > 0.75 to 1.0	0.50 %	1.50 %	0.20 %	1.25 %
IV	≤ 0.75 to 1.0	0.25 %	1.25 %	0.15 %	1.00 %

The final maturity date of the Amended Credit Facility is July 30, 2026. The Revolving Credit Facility will terminate and be due and payable as of the final maturity date. The Amended Term Loan Facility, however, is subject to quarterly amortization of principal in the amount of (i) 0.625% for the period commencing on July 30, 2021 and ending on September 30, 2023, and (ii) 1.250% for the period commencing on October 1, 2023 and ending on July 30, 2026. The remaining balance of the Amended Term Loan Facility must be paid upon the final maturity date. In addition to the scheduled amortization of the Amended Term Loan Facility, and subject to customary exceptions and reinvestment rights, we are required to prepay the Amended Term Loan Facility first and the Revolving Credit Facility second with 100% of all net cash proceeds received by any loan party or any subsidiary thereof in connection with (a) any asset sale or disposition where such loan party receives net cash proceeds in excess of $5 million or (b) any debt issuance that is not permitted under the Third Amended Credit Agreement.

In accordance with the requirements above, net proceeds received from the divestiture of our personal care line of business were used to prepay a portion of our Amended Term Loan Facility during the year ended December 31, 2023.

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

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

Our weighted average interest rate for borrowings under our Amended Term Loan Facility was 6.8% for the year ended December 31, 2023 and 3.2% for the year ended December 31, 2022. As of December 31, 2023, we had no outstanding borrowings under our $550.0 million Revolving Credit Facility. Our weighted average interest rate for borrowings under our $550.0 million Revolving Credit Facility was 6.2% for the year ended December 31, 2023 and 3.4% for the year ended December 31, 2022.

As of December 31, 2023, our consolidated leverage ratio was 2.3, our consolidated interest coverage ratio was 4.9 and we are in compliance with our covenants under the Third Amended Credit Agreement.

As of December 31, 2023, our availability under our $550.0 million Revolving Credit Facility was $518.9 million as we have no outstanding borrowings and $31.1 million outstanding in letters of credit.

Joinder Agreements

In connection with the CCH acquisition, we entered into a Joinder Agreement, dated as of February 4, 2019 (the "CCH Joinder"), pursuant to which CCH and its subsidiaries were made parties to, and became subject to the terms and conditions of, the Amended Credit Agreement (now the Third Amended Credit Agreement), the Amended and Restated Security Agreement, dated as of June 29, 2018 (the "Amended and Restated Security Agreement"), and the Amended and Restated Pledge Agreement, dated as of June 29, 2018 (the "Amended and Restated Pledge Agreement"). In connection with the AseraCare acquisition, we entered into a Joinder Agreement, dated as of June 12, 2020, pursuant to which the AseraCare entities were made parties to, and became subject to the terms and conditions of, the Amended Credit Agreement (now the Third Amended Credit Agreement), the Amended and Restated Security Agreement and the Amended and Restated Pledge Agreement (the "AseraCare Joinder"). In connection with the Contessa acquisition and the Second Amendment, we entered into a Joinder Agreement, dated as of September 3, 2021, pursuant to which Contessa and its subsidiaries and Asana Hospice ("Asana"), which we acquired on January 1, 2020, and its subsidiaries were made parties to, and became subject to the terms and conditions of, the Second Amended Credit Agreement (now the Third Amended Credit Agreement), the Amended and Restated Security Agreement and the Amended and Restated Pledge Agreement (the "Contessa and Asana Joinder," and together with the CCH Joinder and the AseraCare Joinder, the "Joinders").

Pursuant to the Joinders, the Amended and Restated Security Agreement and the Amended and Restated Pledge Agreement, CCH and its subsidiaries, the AseraCare entities, Contessa and its subsidiaries and Asana and its subsidiaries granted in favor of the Administrative Agent a first lien security interest in substantially all of their personal property assets and pledged to the Administrative Agent each of their respective subsidiaries' issued and outstanding equity interests. CCH and its subsidiaries, the AseraCare entities, Contessa and its subsidiaries and Asana and its subsidiaries also guaranteed our obligations, whether now existing or arising after the respective effective dates of the Joinders, under the Third Amended Credit Agreement pursuant to the terms of the Joinders and the Third Amended Credit Agreement.

Finance Leases

Our outstanding finance leases totaling $28.9 million relate to leased equipment and fleet vehicles and bear interest rates ranging from 3.0% to 8.1%.

Effective January 1, 2023, the master lease agreement for our fleet leases was modified to remove the residual value guarantee provided by the lessor on each of our fleet leases. The modification resulted in a change in the classification of our fleet leases from operating leases to finance leases. In connection with the modification, we reclassified approximately $15 million from the operating lease asset and liability accounts to the property and equipment and current/long-term obligations accounts within our consolidated balance sheet.

10. INCOME TAXES

Income taxes attributable to continuing operations consist of the following (amounts in millions):

	For the Years Ended December 31,		
	2023	2022	2021
Current income tax expense:			
Federal	$ 21.1	$ 12.2	$ 20.3
State and local	8.8	7.0	5.2
	29.9	19.2	25.5
Deferred income tax expense:			
Federal	17.5	20.4	35.9
State and local	3.2	2.9	8.7
	20.7	23.3	44.6
Income tax expense	$ 50.6	$ 42.5	$ 70.1

Total income tax expense for the years ended December 31, 2023, 2022 and 2021 was allocated as follows (amounts in millions):

	For the Years Ended December 31,		
	2023	2022	2021
Income from continuing operations	$ 50.6	$ 42.5	$ 70.1
Interest expense	—	(0.7)	0.1
Goodwill	(0.3)	(2.7)	3.1
Tax expense recorded to additional paid-in capital	(0.2)	1.5	—
Total	$ 50.1	$ 40.6	$ 73.3

A reconciliation of significant differences between the reported amount of income tax expense and the expected amount of income tax expense that would result from applying the U.S. federal statutory income tax rate of 21% to income before income taxes is as follows:

	For the Years Ended December 31,		
	2023[1]	2022	2021
Income tax expense at U.S. federal statutory rate	21.0 %	21.0 %	21.0 %
State and local income taxes, net of federal income tax benefit	26.0	5.6	5.0
Excess tax benefits from share-based compensation	3.4	0.3	(2.1)
Non-deductible executive compensation	5.5	0.8	1.2
Unrecognized tax benefits[2]	—	(1.7)	—
Merger-related expenses	13.7	—	—
Merger termination fee	56.2	—	—
Other items, net[3]	1.9	0.5	(0.1)
Income tax expense	127.7 %	26.5 %	25.0 %

(1) The information provided for the year ended December 31, 2023 does not provide a meaningful reconciliation of the effective tax rate and is not comparable to other periods. The effective tax rate for the year is influenced by the relationship of the amount of "effective tax rate drivers" (i.e. non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions, etc.) to income or loss before taxes. For the year ended December 31, 2023, the company incurred merger related expenses totaling $36.7 million and a $106.0 million merger termination fee, which are significant and unusual reductions to income before taxes and "effective tax rate drivers." Consequently, for 2023, the relationship between the "effective tax rate drivers" and income before taxes is distorted, resulting in an unusual effective tax rate.

(2) For the year ended December 31, 2022, the Company recognized $2.7 million of federal uncertain tax positions due to a lapse of the statute of limitations.

(3) Includes various items such as non-deductible expenses, non-taxable income, tax credits, valuation allowance, uncertain tax positions and return-to-accrual adjustments.

As of December 31, 2023 and 2022, the Company had income taxes receivable of $8.0 million and $8.8 million, respectively, included in other current assets within our consolidated balance sheets.

Deferred tax assets (liabilities) consist of the following components (amounts in millions):

	As of December 31,	
	2023	2022
Deferred tax assets:		
Accrued payroll and employee benefits	$ 17.1	$ 14.1
Workers' compensation	10.9	10.6
Share-based compensation	7.1	5.7
Legal and compliance matters	3.9	4.7
Lease liability	25.6	27.8
Net operating loss carryforwards	8.9	11.6
Tax credit carryforwards	2.7	2.9
Other assets	0.2	0.2
Gross deferred tax assets	76.4	77.6
Less: valuation allowance	(5.4)	(5.2)
Net deferred tax assets	71.0	72.4
Deferred tax liabilities:		
Property and equipment[(1)]	(13.5)	(6.6)
Amortization of intangible assets	(61.7)	(48.5)
Investment in partnerships	(10.8)	(10.0)
Right of use asset	(24.9)	(27.0)
Other liabilities	(0.7)	(0.7)
Gross deferred tax liabilities	(111.6)	(92.8)
Deferred income taxes	$ (40.6)	$ (20.4)

(1) Effective January 1, 2023, the classification of fleet leases changed from operating leases to finance leases for both GAAP and tax purposes. As a result, for GAAP purposes, the Company recorded the expenses associated with the fleet leases in depreciation expense and interest expense. For tax purposes, the Company accelerated the depreciation expense through bonus depreciation. As a result of accelerated tax depreciation on the fleet vehicles, a deferred tax liability of $8.1 million was recorded for the year ended December 31, 2023.

As of December 31, 2023, we have U.S. net operating loss ("NOL") carryforwards of $10.2 million that are available to reduce future taxable income and may be carried forward indefinitely. While the NOL carryforwards are not subject to expiration, the annual NOL amount that is available to offset future taxable income is subject to limitation. The NOL carryforwards were acquired as part of the stock purchase of Contessa on August 1, 2021. Under Section 382 of the Internal Revenue Code of 1986, as amended ("Section 382"), substantial changes in a Company's ownership may limit the amount of NOL carryforwards that can be utilized annually to offset future taxable income. As a result of the ownership change, the Company determined that there is an annual limitation, pursuant to Section 382, on the amount of NOL carryforwards that may be utilized to offset future taxable income.

As of December 31, 2023, we have state NOL carryforwards of $135.4 million that are available to reduce future taxable income and various state tax credits totaling $3.4 million available to reduce future state income taxes. The state NOL and tax credit carryforwards expire at various times.

As of December 31, 2023 and 2022, the valuation allowance for deferred tax assets, which is related to certain state NOLs, was $5.4 million and $5.2 million, respectively. The net change in the total valuation allowance for the years ended December 31, 2023 and 2022 was an increase of $0.2 million and an increase of $1.9 million, respectively. The $0.2 million increase in the valuation allowance for the year ended December 31, 2023 is due to the creation of state NOL carryforwards in jurisdictions that require separate company reporting and where the Company does not expect to have sufficient separate company future taxable income available to offset the state NOL carryforwards.

In assessing the realizability of deferred tax assets, management considers whether it is more likely than not that some portion or all of the deferred tax assets will not be realized. The ultimate realization of deferred tax assets is dependent upon the generation of future taxable income in those jurisdictions during the periods in which those temporary differences become deductible. Management considers the scheduled reversal of deferred tax liabilities (including the impact of available carryback and carryforward periods), projected future taxable income and tax-planning strategies in making this assessment. In order to fully realize the deferred tax assets, the Company will need to generate future taxable income before the expiration of the carryforwards governed by the tax code. Based on the current level of pre-tax earnings, the Company will generate the minimum amount of future taxable income needed to support the realization of the deferred tax assets. As a result, as of December 31, 2023, management believes that it is more likely than not that we will realize the benefits of these deferred tax assets, net of the existing valuation allowances. The amount of the deferred tax asset considered realizable, however, could be reduced in the near term if estimates of future taxable income during the carryforward period are reduced.

Uncertain Tax Positions

We account for uncertain tax positions in accordance with the authoritative guidance for uncertain tax positions. A reconciliation of the beginning and ending amount of unrecognized tax benefits is as follows (amounts in millions):

	For the Years Ended December 31,		
	2023	2022	2021
Balance at beginning of period	$ —	$ 2.7	$ 2.7
Additions for tax positions related to current year	—	—	—
Additions for tax positions related to prior year	—	—	—
Reductions for tax positions related to prior years	—	—	—
Lapse of statute of limitations	—	(2.7)	—
Settlements	—	—	—
Balance at end of period	$ —	$ —	$ 2.7

During 2022, the statute of limitations lapsed, ultimately removing the uncertainty surrounding the Company's ability to recognize the tax positions, if challenged under audit. As a result, the Company recognized a $2.7 million income tax benefit and corresponding reduction in our effective tax rate for the period ended December 31, 2022. The Company has no uncertain tax positions related to tax years that remain subject to examination by relevant tax authorities. As of December 31, 2023, no liability for unrecognized tax benefits was necessary, and no change in assessment is expected within the next 12 months.

For the period ended December 31, 2022, the Company recorded a $0.7 million benefit as a component of interest expense as a result of the lapse of the statute of limitations and corresponding release of the reserve for uncertain tax positions. No interest expense or benefit was recorded for the period ended December 31, 2023. There was no accrued interest related to uncertain tax positions included in the consolidated balance sheet at December 31, 2023 or December 31, 2022.

We are subject to income taxes in the U.S. and in many individual states, with significant operations in Louisiana, South Carolina, Alabama, Georgia, Massachusetts and Tennessee. We are open to examination in the U.S. and in various individual states for the tax years ended December 31, 2017 through December 31, 2023. We are also open to examination in various states for the years ended 2007 through 2023 resulting from NOLs generated and available for carryforward from those years.

11. CAPITAL STOCK AND SHARE-BASED COMPENSATION

We are authorized by our Certificate of Incorporation to issue 60,000,000 shares of common stock, $0.001 par value and 5,000,000 shares of preferred stock, $0.001 par value. As of December 31, 2023, there were 38,131,478 and 32,667,631 shares of common stock issued and outstanding, respectively, and no shares of preferred stock issued or outstanding. Our Board of Directors is authorized to fix the dividend rights and terms, conversion and voting rights, redemption rights and other privileges and restrictions applicable to our preferred stock.

Share-Based Awards

On March 29, 2018, our Board of Directors and the Compensation Committee approved, subject to stockholder approval, the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan (the "2018 Plan"). On June 6, 2018, our stockholders approved the 2018 Plan at the Company's annual meeting of stockholders. The 2018 Plan replaces our 2008 Omnibus Incentive Compensation Plan (the "2008 Plan"), which terminated on June 6, 2018 when the stockholders approved the 2018 Plan. The 2018 Plan, as amended to date, authorizes the grant of various types of equity-based awards, such as stock awards, restricted stock units, stock appreciation rights and stock options to eligible participants, which include all of our employees and all employees of our 50% or more owned subsidiaries, our non-employee directors and certain consultants. The vesting terms of the awards may be tied to continued employment (or, for our non-employee directors, continued service on the Board of Directors) and/or achievement of certain pre-determined performance goals. The 2018 Plan is administered by the Compensation Committee of our Board of Directors, which determines, within the provisions of the 2018 Plan, those eligible participants to whom, and the times at which, awards shall be granted. The Compensation Committee, in its discretion, may delegate its authority and duties under the 2018 Plan to specified officers; however, only the Compensation Committee may approve the terms of awards to our executive officers.

Equity-based awards may be granted for a number of shares not to exceed, in the aggregate, approximately 2.5 million shares of common stock. We had approximately 1.2 million shares available at December 31, 2023. The price per share for stock options shall be no less than the greater of (a) 100% of the fair value of a share of common stock on the date the option is granted or (b) the aggregate par value of the shares of our common stock on the date the option is granted. If a stock option is granted to any owner of 10% or more of the total combined voting power of us and our subsidiaries, the price is to be at least 110% of the fair value of a share of our common stock on the date the award is granted. Each equity-based award vests ratably over a one year to four year period, with the exception of those issued under contractual arrangements that specify otherwise, and may be exercised during a period as determined by our Compensation Committee or as otherwise approved by our Compensation Committee. The contractual terms of stock options exercised shall not exceed ten years from the date such option is granted. The Company analyzes historical data of forfeited awards to develop an estimated forfeiture rate that is applied to the Company's non-cash compensation expense; however, all non-cash compensation expense is adjusted to reflect actual vestings and forfeitures.

Employee Stock Purchase Plan ("ESPP")

We have a plan whereby our eligible employees may purchase our common stock at 85% of the market price at the time of purchase. The total number of shares of our common stock authorized for issuance under our ESPP is 4,500,000. There have been no purchases under the plan since the second quarter offering period as commencement of an offering period after the date of the Merger Agreement is prohibited under the Merger Agreement. The following is a detail of the purchases that were made under the plan:

Employee Stock Purchase Plan Period	Shares Issued	Price
2021 and Prior	3,195,155	$ 18.98
January 1, 2022 to March 31, 2022	6,184	146.45
April 1, 2022 to June 30, 2022	10,814	89.35
July 1, 2022 to September 30, 2022	12,047	82.27
October 1, 2022 to December 31, 2022	11,498	71.01
January 1, 2023 to March 31, 2023	14,995	62.52
April 1, 2023 to June 30, 2023	10,915	77.72
July 1, 2023 to September 30, 2023	—	—
October 1, 2023 to December 31, 2023	—	—
	3,261,608	

ESPP expense included in general and administrative expense in our accompanying consolidated statements of operations was $0.3 million, $0.7 million and $0.7 million for 2023, 2022 and 2021, respectively.

Stock Options

We use the Black-Scholes option pricing model to estimate the fair value of our stock options. There were 55,280, 33,656 and 40,788 options granted during 2023, 2022 and 2021, respectively. Stock option compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $2.1 million, $1.7 million and $3.6 million for 2023, 2022 and 2021, respectively.

The fair values of the stock option awards were estimated using the following assumptions for 2023, 2022 and 2021:

	For the Years Ended December 31,		
	2023	2022	2021
Risk Free Rate	3.45% - 4.06%	1.91%	0.80% - 1.35%
Expected Volatility	43.07% - 43.27%	40.97%	39.84% - 41.40%
Expected Term	6.00 years	6.25 years	6.25 years
Weighted Average Fair Value	$39.70	$61.31	$107.45
Dividend Yield	—%	—%	—%

We used the simplified method to estimate the expected term for the stock options granted during 2023, 2022 and 2021 as adequate historical experience is not available to provide a reasonable estimate.

The following table presents our stock option activity for 2023:

	Number of Shares	Weighted Average Exercise Price	Weighted Average Contractual Life (Years)
Outstanding options at January 1, 2023	218,612	$ 142.86	6.56
Granted	55,280	84.48	
Exercised	(12,933)	77.05	
Canceled, forfeited or expired	(15,621)	179.84	
Outstanding options at December 31, 2023	245,338	$ 130.82	6.19
Exercisable options at December 31, 2023	173,319	$ 129.05	5.21

The aggregate intrinsic value of our outstanding options and exercisable options at December 31, 2023 was $1.4 million and $1.0 million, respectively. Total intrinsic value of options exercised was $0.2 million, $1.5 million and $5.1 million for 2023, 2022 and 2021, respectively. The tax benefit from stock options exercised during the period amounted to $0.1 million, $0.4 million and $1.0 million for 2023, 2022 and 2021, respectively.

The following table presents our non-vested stock option activity for 2023:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock options at January 1, 2023	55,326	$ 83.79
Granted	55,280	39.70
Vested	(34,810)	65.66
Forfeited	(3,777)	86.69
Non-vested stock options at December 31, 2023	72,019	$ 58.56

At December 31, 2023, there was $1.8 million of unrecognized compensation cost related to stock options that we expect to be recognized over a weighted-average period of 1.5 years.

Non-Vested Stock Units

We refer to restricted stock units subject to service-based or a combination of service-based and performance-based vesting conditions as “non-vested stock units.” We issue non-vested stock unit awards that are service-based, performance-based or a combination of both with vesting terms ranging from one to four years. Based on the terms and conditions of these awards, we determine if the awards should be recorded as either equity or liability instruments. The compensation expense is determined based on the market price of our common stock at the date of grant, applied to the total number of units that are anticipated to vest, unless the award specifies differently. Shares of stock are not issued to the recipient until the stock unit awards have vested and after the pre-determined delivery date has occurred.

Non-Vested Stock Units – Service-Based ("Service-Based Non-Vested Stock Units")

Service-based non-vested stock unit compensation expense included in general and administrative expenses in our accompanying consolidated statements of operations was $24.2 million, $12.1 million and $9.4 million for 2023, 2022 and 2021, respectively.

The following table presents our service-based non-vested stock units activity for 2023:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2023	263,153	$ 141.62
Granted	458,872	81.18
Vested	(167,734)	108.55
Canceled, forfeited or expired	(55,765)	128.04
Non-vested stock units at December 31, 2023	498,526	$ 98.63

The weighted average grant date fair value of service-based non-vested stock units granted was $81.18, $115.07 and $234.42 in 2023, 2022 and 2021, respectively.

At December 31, 2023, there was $28.5 million of unrecognized compensation cost related to our service-based non-vested stock units that we expect to be recognized over a weighted average period of 2.0 years.

Non-Vested Stock Units – Service-Based and Performance-Based Awards ("Performance-Based Non-Vested Stock Units")

During 2023, we awarded performance-based awards to certain employees. The target level established by the award, which is based on the Company’s 2023 adjusted earnings before interest, taxes, depreciation and amortization (“Adjusted EBITDA”), provided for the recipients to receive an aggregate of 52,073 non-vested stock units if the target was achieved. For a select group of employees, if the target objective was surpassed to the point of achieving the projected maximum payout, the recipients would receive an additional aggregate of 51,756 non-vested stock units during the three-month period ended March 31, 2024. The 2023 performance-based objective established by the award was satisfied at 127.23%. The number of non-vested stock units that were earned based on achievement of the Adjusted EBITDA measure will be adjusted upward or downward (from 75% to 125%) based on the Company’s three-year relative total shareholder return ("TSR") and will cliff vest after the end of the three-year performance period ending December 31, 2025.

Additionally, in connection with the appointment of our new chief executive officer, we awarded 62,641 performance-based non-vested stock units (at the target level of performance) to Mr. Ashworth on April 12, 2023, which will cliff vest on April 12, 2028, assuming Mr. Ashworth remains continuously employed on such date. The number of non-vested stock units that may be earned for this award is based on the Company's volume-weighted average price ("VWAP") market cap at the end of a three-year performance period to be determined as of December 31, 2025, with an actual payout of 50% to 300% of the target number of performance-based non-vested stock units, depending on the level of performance achieved once a threshold level of performance is met.

Performance-based non-vested stock units compensation expense included in general and administrative expenses in our consolidated statements of operations was $2.4 million, $2.2 million and $10.2 million for 2023, 2022 and 2021, respectively.

The following table presents our performance-based non-vested stock units activity for 2023:

	Number of Shares	Weighted Average Grant Date Fair Value
Non-vested stock units at January 1, 2023	68,047	$ 144.55
Granted	114,714	82.00
Vested	(21,688)	159.47
Canceled, forfeited or expired	(39,845)	125.48
Non-vested stock units at December 31, 2023	121,228	$ 88.96

The weighted average grant date fair value of performance-based non-vested stock units granted was $82.00, $133.70 and $262.67 in 2023, 2022 and 2021, respectively.

At December 31, 2023, there was $9.3 million in unrecognized compensation costs related to our performance-based non-vested stock units that we expect to be recognized over a weighted average period of 3.1 years.

12. COMMITMENTS AND CONTINGENCIES

Legal Proceedings – Ongoing

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

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

Legal Proceedings - Completed

Subpoena Duces Tecum and Civil Investigative Demands Issued by the U.S. Department of Justice

On May 7, 2021, the U.S. Department of Justice notified the Company that they were closing their investigation into the below-referenced Subpoena Duces Tecum ("Subpoena") and civil investigative demands ("CIDs"). At the time, we had $6.5 million recorded to accrued expenses in our consolidated balance sheet related to these matters. We reversed this accrual during the year ended December 31, 2021.

On May 21, 2015, we received a Subpoena issued by the U.S. Department of Justice. The Subpoena requested the delivery of information regarding 53 identified hospice patients to the United States Attorney's Office for the District of Massachusetts. It also requested the delivery of documents relating to our hospice clinical and business operations and related compliance activities. The Subpoena generally covered the period from January 1, 2011 through May 21, 2015.

On November 3, 2015, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Morgantown, West Virginia area. The CID requested the delivery of information to the United States Attorney's Office for the Northern District of West Virginia regarding 66 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Morgantown area. The CID generally covered the period from January 1, 2009 through August 31, 2015.

On June 27, 2016, we received a CID issued by the U.S. Department of Justice pursuant to the federal False Claims Act relating to claims submitted to Medicare and/or Medicaid for hospice services provided through designated facilities in the Parkersburg, West Virginia area. The CID requested the delivery of information to the United States Attorney's Office for the Southern District of West Virginia regarding 68 identified hospice patients, as well as documents relating to our hospice clinical and business operations in the Parkersburg area. The CID generally covered the period from January 1, 2011 through June 20, 2016.

Third-Party Audits – Ongoing

From time to time, in the ordinary course of business, we are subject to audits under various governmental programs in which third-party firms engaged by CMS, including Recovery Audit Contractors ("RACs"), Zone Program Integrity Contractors ("ZPICs"), Uniform Program Integrity Contractors ("UPICs"), Program Safeguard Contractors ("PSCs"), Medicaid Integrity Contractors ("MICs"), Supplemental Medical Review Contractors ("SMRCs") and the Office of the Inspector General ("OIG"), conduct extensive reviews of claims data to identify potential improper payments. We cannot predict the ultimate outcome of any regulatory reviews or other governmental audits and investigations.

In July 2010, our subsidiary that provides hospice services in Florence, South Carolina received from a ZPIC a request for records regarding a sample of 30 beneficiaries who received services from the subsidiary during the period of January 1, 2008 through March 31, 2010 (the “Review Period”) to determine whether the underlying services met pertinent Medicare payment requirements. We acquired the hospice operations subject to this review on August 1, 2009; the Review Period covers time periods both before and after our ownership of these hospice operations. Based on the ZPIC’s findings for 16 beneficiaries, which were extrapolated to all claims for hospice services provided by the Florence subsidiary billed during the Review Period, on June 6, 2011, the Medicare Administrative Contractor ("MAC") for the subsidiary issued a notice of overpayment seeking recovery from our subsidiary of an alleged overpayment. We dispute these findings, and our Florence subsidiary has filed appeals through the Original Medicare Standard Appeals Process, in which we are seeking to have those findings overturned. An administrative law judge ("ALJ") hearing was held in early January 2015. On January 18, 2016, we received a letter dated January 6, 2016 referencing the ALJ hearing decision for the overpayment issued on June 6, 2011. The decision was partially favorable with a new overpayment amount of $3.7 million with a balance owed of $5.6 million including interest based on 9 disputed claims (originally 16). We filed an appeal to the Medicare Appeals Council on the remaining 9 disputed claims and also argued that the statistical method used to select the sample was not valid. No assurances can be given as to the timing or outcome of the Medicare Appeals Council decision. As of December 31, 2023, Medicare has withheld payments of $5.7 million (including additional interest) as part of their standard procedures once this level of the appeal process has been reached. In the event we are not able to recoup this alleged overpayment, we are entitled to be indemnified by the prior owners of the hospice operations for amounts relating to the period prior to August 1, 2009. On January 10, 2019, an arbitration panel from the American Health Lawyers Association determined that the prior owners' liability for their indemnification obligation was $2.8 million. This amount is recorded as an indemnity receivable within other assets in our consolidated balance sheets.

In July 2016, the Company received a request for medical records from SafeGuard Services, L.L.C (“SafeGuard”), a ZPIC, related to services provided by some of the care centers that the Company acquired from Infinity Home Care, L.L.C. The review period covered time periods both before and after our ownership of the care centers, which were acquired on December 31, 2015. In August 2017, the Company received Requests for Repayment from Palmetto GBA, LLC (“Palmetto”) regarding Infinity Home Care of Lakeland, LLC, (“Lakeland Care Centers”) and Infinity Home Care of Pinellas, LLC, (“Clearwater Care Center”). The Palmetto letters were based on a statistical extrapolation performed by SafeGuard which alleged an overpayment of $34.0 million for the Lakeland Care Centers on a universe of 72 Medicare claims totaling $0.2 million in actual claims payments and an overpayment of $4.8 million for the Clearwater Care Center on a universe of 70 Medicare claims totaling $0.2 million in actual claims payments.

As a result of partially successful Level I and Level II Administrative Appeals, the alleged overpayment for the Lakeland Care Centers was reduced to $26.0 million and the alleged overpayment for the Clearwater Care Center was reduced to $3.3 million. The Company filed Level III Administrative Appeals, and the ALJ hearings regarding the Lakeland Request for Repayment and the Clearwater Request for Repayment were held in April 2022. The Company received the results of the ALJ hearings in June 2022. The ALJ decisions for both the Clearwater Care Center and the Lakeland Care Centers were partially favorable for the claims that were reviewed, but the extrapolations were upheld. As a result, we increased our total accrual related to these matters from $17.4 million to $25.2 million, excluding interest. The repayments for the Lakeland Care Centers totaling $34.3 million ($22.8 million extrapolated repayment plus $11.5 million accrued interest) and the Clearwater Care Center totaling $3.7 million ($2.4 million extrapolated repayment plus $1.2 million accrued interest) were made during the year ended December 31, 2022. Additionally, we wrote off $1.5 million of receivables that were impacted by these matters. We expect to be indemnified by the prior owners, upon exhaustion of the parties' appeal rights, for approximately $10.9 million and have recorded this amount within other assets in our consolidated balance sheets as of December 31, 2023 and 2022.

Insurance

We are obligated for certain costs associated with our insurance programs, including employee health, workers’ compensation, professional liability and fleet. While we maintain various insurance programs to cover these risks, we are self-insured for a substantial portion of our potential claims. We recognize our obligations associated with these costs, up to specified deductible limits in the period in which a claim is incurred, including with respect to both reported claims and claims incurred but not reported. These costs have generally been estimated based on historical data of our claims experience. Such estimates, and the resulting reserves, are reviewed and updated by us on a quarterly basis.

The following table presents details of our insurance programs, including amounts recorded, for the periods indicated within accrued expenses in our consolidated balance sheets. The amounts below represent our total estimated liability for individual claims that are less than our noted insurance coverage amounts, which can include outstanding claims and claims incurred but not reported (amounts in millions).

Type of Insurance	As of December 31, 2023	2022
Health insurance	$ 18.2	$ 16.2
Workers' compensation	42.0	40.8
Professional liability	5.4	5.0
	65.6	62.0
Less: long-term portion	(0.2)	(0.2)
	$ 65.4	$ 61.8

Our health insurance has an exposure limit of $1.3 million for any individual covered life. Our workers compensation insurance has a retention limit of $2.0 million per incident. Our professional liability insurance has a retention limit of $0.3 million per incident. Our fleet insurance has an exposure limit of $0.4 million per accident.

Severance

We have commitments related to our severance plans applicable to a number of our senior executives and senior management, which generally commit us to pay severance benefits under certain circumstances.

Other

We are subject to various other types of claims and disputes arising in the ordinary course of our business. While the resolution of such issues is not presently determinable, we believe that the ultimate resolution of such matters will not have a significant effect on our consolidated financial condition, results of operations or cash flows.

13. EMPLOYEE BENEFIT PLANS

401(k) Benefit Plan

We maintain a plan qualified under Section 401(k) of the Internal Revenue Code for all employees who have reached 21 years of age, effective the first month after their hire date. Under the plan, eligible employees may elect to defer a portion of their compensation, subject to Internal Revenue Service limits.

Our match of contributions to be made to each eligible employee contribution is $0.44 for every $1.00 contributed up to the first 6% of the employee's salary. The match is discretionary and thus is subject to change at the discretion of management. Our match of contributions is made in the form of cash. We expensed approximately $20.4 million, $18.6 million and $17.0 million related to our 401(k) benefit plan for 2023, 2022 and 2021, respectively.

Deferred Compensation Plan

We had a Deferred Compensation Plan for additional tax-deferred savings for a select group of management or highly compensated employees. Amounts credited under the Deferred Compensation Plan were funded into a rabbi trust, which is managed by a trustee. The trustee has the discretion to manage the assets of the Deferred Compensation Plan as deemed fit, thus, the assets are not necessarily reflective of the same investment choices that would have been made by the participants.

Effective January 1, 2015, all prospective salary deferrals ceased. Participants are allowed to make transactions with any remaining account balances as they wish per plan guidelines.

14. SHARE REPURCHASES

On December 23, 2020, we announced that our Board of Directors authorized a stock repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2021 (the "2021 Share Repurchase Program"). Pursuant to this program, we repurchased 446,832 shares of our common stock at a weighted average price of $223.49 per share and a total cost of approximately $100 million during the year ended December 31, 2021. The repurchased shares were classified as treasury shares. The 2021 Share Repurchase Program expired on December 31, 2021.

On August 2, 2021, our Board of Directors authorized a share repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2022 to commence upon the completion of the Company's 2021 Share Repurchase Program (the "2022 Share Repurchase Program"). Pursuant to this program, we repurchased 150,000 shares of our common stock at a weighted average price of $115.64 per share and a total cost of approximately

$17 million during the year ended December 31, 2022. The repurchased shares were classified as treasury shares. The 2022 Share Repurchase Program expired on December 31, 2022.

On February 2, 2023, our Board of Directors authorized a share repurchase program, under which we could repurchase up to $100 million of our outstanding common stock through December 31, 2023 (the "2023 Share Repurchase Program"). We did not repurchase any shares under the 2023 Share Repurchase Program as the Merger Agreement limited our ability to repurchase shares of our common stock prior to the completion of the Merger, subject to certain exceptions. The 2023 Share Repurchase Program expired on December 31, 2023.

Under the terms of the 2021 Share Repurchase Program, the 2022 Share Repurchase Program and the 2023 Share Repurchase Program, we were allowed to repurchase shares from time to time through open market purchases, unsolicited or solicited privately negotiated transactions, an accelerated stock repurchase program, and/or a trading plan in compliance with Exchange Act Rule 10b5-1. The timing and the amount of the repurchases were determined by management based on a number of factors, including but not limited to share price, trading volume and general market conditions, as well as on working capital requirements, general business conditions and other factors. Effective January 1, 2023, repurchases became subject to a 1% excise tax under the Inflation Reduction Act.

15. SEGMENT INFORMATION

Our operations involve servicing patients through our three reportable business segments: home health, hospice and high acuity care. We divested our personal care business on March 31, 2023. Our home health segment delivers a wide range of services in the homes of individuals who may be recovering from surgery, have a chronic disability or terminal illness or need assistance with completing important tasks. Our hospice segment provides palliative care and comfort to terminally ill patients and their families. Our high acuity care segment delivers the essential elements of inpatient hospital, palliative and SNF care to patients in their homes. Our personal care segment provided patients with assistance with the essential activities of daily living. The “other” column in the following tables consists of costs relating to executive management and administrative support functions, primarily information services, accounting, finance, billing and collections, legal, compliance, risk management, procurement, marketing, clinical administration, training, human resources and administration.

In connection with our reorganization initiatives, management has revised its measurement of our reportable segments' operating income (loss). Effective January 1, 2023, we transitioned corporate functions that were previously included within our high acuity care segment to the corporate support function in order to realize operational efficiencies. Additionally, effective January 1, 2023, we transitioned from the high acuity care segment to the home health segment the operations of a home health care center that was contributed to the high acuity care segment by one of our health system partners during 2022. Prior periods have been recast to conform to the current year presentation.

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

	For the Year Ended December 31, 2023					
	Home Health	Hospice	Personal Care[1]	High Acuity Care	Other[2]	Total
Net service revenue	$ 1,403.6	$ 798.8	$ 15.0	$ 19.0	$ —	$ 2,236.4
Cost of service, inclusive of depreciation	801.1	412.2	11.1	21.1	—	1,245.5
General and administrative expenses	363.5	193.1	2.3	20.4	237.5	816.8
Depreciation and amortization	6.0	3.0	—	3.1	5.6	17.7
Operating expenses	1,170.6	608.3	13.4	44.6	243.1	2,080.0
Operating income (loss)	$ 233.0	$ 190.5	$ 1.6	$ (25.6)	$ (243.1)	$ 156.4

(1) We divested our personal care business on March 31, 2023.
(2) General and administrative expenses for our corporate support function includes $36.7 million in merger-related expenses.

	For the Year Ended December 31, 2022					
	Home Health	Hospice	Personal Care	High Acuity Care	Other	Total
Net service revenue	$ 1,361.7	$ 787.8	$ 61.4	$ 12.3	$ —	$ 2,223.2
Cost of service	773.9	426.5	46.7	13.3	—	1,260.4
General and administrative expenses	351.1	203.3	9.2	19.7	170.8	754.1
Depreciation and amortization	4.0	2.3	0.1	3.3	15.2	24.9
Investment impairment	—	—	—	3.0	—	3.0
Operating expenses	1,129.0	632.1	56.0	39.3	186.0	2,042.4
Operating income (loss)	$ 232.7	$ 155.7	$ 5.4	$ (27.0)	$ (186.0)	$ 180.8

	For the Year Ended December 31, 2021					
	Home Health	Hospice	Personal Care	High Acuity Care	Other	Total
Net service revenue	$ 1,353.8	$ 791.8	$ 65.0	$ 3.5	$ —	$ 2,214.1
Other operating income	7.3	6.0	—	—	—	13.3
Cost of service	756.6	425.2	49.1	2.5	—	1,233.4
General and administrative expenses	328.5	198.4	11.2	6.6	166.5	711.2
Depreciation and amortization	4.3	2.7	0.2	1.3	22.4	30.9
Operating expenses	1,089.4	626.3	60.5	10.4	188.9	1,975.5
Operating income (loss)	$ 271.7	$ 171.5	$ 4.5	$ (6.9)	$ (188.9)	$ 251.9

16. RELATED PARTY TRANSACTIONS

We have an investment in Medalogix, a healthcare predictive data and analytics company, which is accounted for under the equity method. During the years ended December 31, 2023, 2022 and 2021, we incurred costs of approximately $11.3 million,$9.4 million and $5.7 million, respectively, in connection with our usage of Medalogix's analytics platforms.

We have an investment in a home health benefit manager, which is accounted for under the cost method. We incurred costs of approximately $0.5 million during the year ended December 31, 2023 in connection with our usage of the home health benefit manager's services.

ITEM 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

ITEM 9A. CONTROLS AND PROCEDURES

Evaluation of Disclosure Controls and Procedures

We have established disclosure controls and procedures which are designed to provide reasonable assurance of achieving their objectives and to ensure that information required to be disclosed in our reports filed under the Exchange Act is recorded, processed, summarized, disclosed and reported within the time periods specified in the SEC's rules and forms. This information is also accumulated and communicated to our management, including our principal executive officer and principal financial officer, and Board of Directors to allow timely decisions regarding required disclosure.

In connection with the preparation of this Annual Report on Form 10-K, as of December 31, 2023, under the supervision and with the participation of our principal executive officer and principal financial officer, our management conducted an evaluation of the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15d-15(e) promulgated under the Exchange Act.

Based on this evaluation, our principal executive officer and principal financial officer concluded that our disclosure controls and procedures were effective at a reasonable assurance level as of December 31, 2023, the end of the period covered by this Annual Report on Form 10-K.

Management's Annual Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over our financial reporting, as such term is defined in Rules 13a-15(f) and 15d-15(f) promulgated under the Exchange Act. Under the supervision and with the participation of our principal executive officer and our principal financial officer, our management conducted an evaluation of the effectiveness of our 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. Based on this evaluation under the framework in *Internal Control – Integrated Framework (2013)*, our management concluded our internal control over financial reporting was effective as of December 31, 2023.

KPMG LLP, the independent registered public accounting firm that audited our consolidated financial statements included in this Form 10-K, has issued a report on our internal control over financial reporting, which is included herein.

Changes in Internal Controls

There were no changes in our internal control over financial reporting (as defined in Exchange Act Rule 13a-15(f)) that occurred during the quarter ended December 31, 2023 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Inherent Limitations on Effectiveness of Controls

Our management, including our principal executive officer and principal financial officer, does not expect that our disclosure controls or our internal controls over financial reporting will prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. The design of a control system must reflect the fact that there are resource constraints, and the benefits of controls must be considered relative to their costs. Further, because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud, if any, have been detected. These inherent limitations include the realities that judgments in decision-making can be faulty and that breakdowns can occur because of simple error or mistake. Controls can also be circumvented by the individual acts of some persons, by collusion of two or more people, or by management override of the controls. The design of any system of controls is based in part on certain assumptions about the likelihood of future events, and there can be no assurance that any design will succeed in achieving its stated goals under all potential future conditions. Projections of any evaluation of controls' effectiveness to future periods are subject to risks. Over time, controls may become inadequate because of changes in conditions or deterioration in the degree of compliance with policies and procedures. Our disclosure controls and procedures are designed to provide reasonable assurance of achieving their objectives and, based on an evaluation of our controls and procedures, our principal executive officer and our principal financial officer concluded our disclosure controls and procedures were effective at a reasonable assurance level as of December 31, 2023, the end of the period covered by this Annual Report.

Report of Independent Registered Public Accounting Firm

To the Stockholders and Board of Directors
Amedisys, Inc.:

Opinion on Internal Control Over Financial Reporting

We have audited Amedisys, Inc. and subsidiaries' (the Company) internal control over financial reporting as of December 31, 2023, 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, 2023, 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, 2023 and 2022, the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2023, and the related notes (collectively, the consolidated financial statements), and our report dated February 22, 2024 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

Baton Rouge, Louisiana
February 22, 2024

ITEM 9B. OTHER INFORMATION

None.

ITEM 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

ITEM 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this item is incorporated by reference to the 2024 Proxy Statement, or, in the event the registrant does not prepare and file the 2024 Proxy Statement, will be provided instead by amendment to this report, to be filed with the SEC within 120 days after the end of the year ended December 31, 2023.

Code of Conduct and Ethics

We have adopted a code of ethics that applies to all of our directors, officers and employees, including our principal executive officer, principal financial officer and principal accounting officer. This code of ethics is posted at our internet website, http://www.amedisys.com. Any amendments to, or waivers of, the code of ethics will be disclosed on our website promptly following the date of such amendment or waiver.

ITEM 11. EXECUTIVE COMPENSATION

The information required by this item is incorporated by reference to the 2024 Proxy Statement, or, in the event the registrant does not prepare and file the 2024 Proxy Statement, will be provided instead by amendment to this report, to be filed with the SEC within 120 days after the end of the year ended December 31, 2023.

ITEM 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this item is incorporated by reference to the 2024 Proxy Statement, or, in the event the registrant does not prepare and file the 2024 Proxy Statement, will be provided instead by amendment to this report, to be filed with the SEC within 120 days after the end of the year ended December 31, 2023.

ITEM 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this item is incorporated by reference to the 2024 Proxy Statement, or, in the event the registrant does not prepare and file the 2024 Proxy Statement, will be provided instead by amendment to this report, to be filed with the SEC within 120 days after the end of the year ended December 31, 2023.

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 is incorporated by reference to the 2024 Proxy Statement, or, in the event the registrant does not prepare and file the 2024 Proxy Statement, will be provided instead by amendment to this report, to be filed with the SEC within 120 days after the end of the year ended December 31, 2023.

PART IV

ITEM 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a)

1. Financial Statements
   All financial statements are set forth under Part II, Item 8 of this report.

2. Financial Statement Schedules
   There are no financial statement schedules included in this report as they are either not applicable or included in the financial statements.

3. Exhibits
   The Exhibits are listed in the Exhibit Index required by Item 601 of Regulation S-K preceding the signature page of this report.

ITEM 16. FORM 10-K SUMMARY

None.

EXHIBIT INDEX

The exhibits marked with the cross symbol (†) are filed and the exhibits marked with a double cross (††) are furnished with this Form 10-K. Any exhibits marked with the asterisk symbol (*) are management contracts or compensatory plans or arrangements filed pursuant to Item 601(b)(10)(iii) of Regulation S-K. The registrant agrees to furnish to the Commission supplementally upon request a copy of any schedules or exhibits omitted pursuant to Item 601(a)(5) of Regulation S-K of any exhibit set forth below.

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
2.1	Equity Purchase Agreement dated February 5, 2016, by and between the Company, as Purchaser, and Michael Trigilio, as Seller	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2016	0-24260	2.1
2.2	First Amendment to Equity Purchase Agreement, dated May 18, 2018, by and among the Company, Amedisys Personal Care, LLC, Associated Home Care, LLC, Elder Home Options, LLC and Michael Trigilio	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2018	0-24260	10.1
2.3	Share Repurchase Agreement, dated as of June 4, 2018, by and among the Company and the selling stockholders set forth on Schedule I thereto	The Company's Current Report on Form 8-K filed on June 4, 2018	0-24260	2.1
2.4	Stock Purchase Agreement, dated as of October 9, 2018, by and among Milton Heching, the Heching 2012 Exempt Irrevocable Trust, Amedisys Hospice, L.L.C., Compassionate Care Hospice Group, Inc., and solely for purposes of Sections 3.4, 4.3(a), 4.15 and Article VIII thereof, Amedisys, Inc.	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2018	0-24260	2.1
2.5	Securities Purchase Agreement, dated as of April 23, 2020, by and between Amedisys Hospice, L.L.C. and Golden Gate Ancillary LLC (Immaterial schedules and exhibits have been omitted pursuant to Item 601(a)(5) of Regulation S-K. The Company will furnish a copy of any omitted schedule or exhibit to the Securities and Exchange Commission upon request.)	The Company's Current Report on Form 8-K filed on April 27, 2020	0-24260	2.1
2.6	Agreement and Plan of Merger, dated as of June 27, 2021, by and among Amedisys Holding, L.L.C., Amedisys Commodore, L.L.C., Contessa Health, Inc., Shareholder Representative Services LLC, and, solely for purposes of Section 10.17, Amedisys, Inc. (Immaterial schedules and exhibits have been omitted pursuant to Item 601(a)(5) of Regulation S-K. The registrant agrees to furnish supplementally a copy of any omitted schedule or exhibit to the U.S. Securities and Exchange Commission upon request)	The Company's Current Report on Form 8-K filed on August 4, 2021	0-24260	2.1
2.7	Equity Purchase Agreement, by and among Associated Home Care, L.L.C., Amedisys Personal Care, LLC, Amedisys, Inc. and HouseWorks Holdings, LLC, dated February 10, 2023	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023	0-24260	2.1
2.8	Agreement and Plan of Merger, dated as of June 26, 2023, by and among UnitedHealth Group Incorporated, Aurora Holdings Merger Sub Inc. and Amedisys, Inc.	The Company's Current Report on Form 8-K filed on June 26, 2023	0-24260	2.1
3.1	Composite of Certificate of Incorporation of the Company inclusive of all amendments through June 14, 2007	The Company's Quarterly Report on Form 10-Q for the quarter ended June 30, 2007	0-24260	3.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
3.2	Amended and Restated By-Laws	The Company's Current Report on Form 8-K filed on December 16, 2022	0-24260	3.1
4.1	Common Stock Specimen	The Company's Registration Statement on Form S-3 filed August 20, 2007	333-145582	4.8
4.2	Description of Registrant's Securities Registered Pursuant to Section 12 of the Securities Exchange Act of 1934	The Company's Annual Report on Form 10-K for the year ended December 31, 2021	0-24260	4.2
10.1	Form of Director Indemnification Agreement dated February 12, 2009	The Company's Annual Report on Form 10-K for the year ended December 31, 2008	0-24260	10.1
10.2*	Amended and Restated Amedisys, Inc. Employee Stock Purchase Plan dated June 7, 2012	The Company's Current Report on Form 8-K filed June 8, 2012	0-24260	10.1
10.3*	Composite Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan (inclusive of Plan amendments dated June 7, 2012, October 25, 2012, April 23, 2015 and June 4, 2015, January 20, 2017, February 22, 2017 and September 25, 2018 and the full text of the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan)	The Company's Annual Report on Form 10-K for the year ended December 31, 2019	0-24260	10.3
10.4*	Form of Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.6
10.5*	Form of Performance Stock Option Award Agreement Issued under the Amedisys, Inc. 2008 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2014	0-24260	10.7
10.6*	Form of Stock Option Award Agreement Issued under the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2018	0-24260	10.10
10.7*	Form of Restricted Stock Unit Award Agreement Issued under the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2018	0-24260	10.11
10.8*	Form of Performance Restricted Stock Unit Award Agreement Issued under the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan	The Company's Annual Report on Form 10-K for the year ended December 31, 2018	0-24260	10.12
10.9*	Amended and Restated Employment Agreement dated as of September 27, 2018, by and among Amedisys, Inc., Amedisys Holding, L.L.C. and Paul B. Kusserow	The Company's Current Report on Form 8-K filed on October 3, 2018	0-24260	10.1
10.10*	Amedisys Holding, L.L.C. Amended and Restated Severance Plan for Executive Officers dated as of July 25, 2019	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2019	0-24260	10.1
10.11*	Confidential Separation Agreement and General Release between the Company and Stephen E. Seim	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2018	0-24260	10.1
10.12*	Composite Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan (inclusive of Plan amendments dated September 25, 2018 and October 21, 2020 and the full text of the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan)	The Company's Annual Report on Form 10-K for the year ended December 31, 2020	0-24260	10.16

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.13	Amended and Restated Credit Agreement dated as of June 29, 2018, among the Company and Amedisys Holding, L.L.C., as borrowers, certain subsidiaries of the Company party thereto as guarantors, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, JPMorgan Chase Bank, N.A., as Syndication Agent, Capital One Bank National Association, Citizens Bank, N.A., Compass Bank, Fifth Third Bank, Hancock Whitney Bank, Regions Bank, and Wells Fargo Bank, National Association, as Co-Documentation Agents, the lenders party thereto, Merrill Lynch, Pierce Fenner & Smith Incorporated, Citizens Bank N.A., Fifth Third Bank and JPMorgan Chase Bank, N.A., as Joint Lead Arrangers, and Merrill Lynch, Pierce, Fenner & Smith Incorporated and JPMorgan Chase Bank, N.A., as Joint Bookrunners	The Company's current Report on Form 8-K filed on July 2, 2018	0-24260	10.1
10.14	Amended and Restated Security Agreement, dated as of June 29, 2018, among the Company and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "grantors" on the signature pages thereto and Bank of America, N.A., in its capacity as Administrative Agent	The Company's current Report on Form 8-K filed on July 2, 2018	0-24260	10.2
10.15	Amended and Restated Pledge Agreement dated as of June 29, 2018, among the Company and Amedisys Holding, L.L.C., as borrowers, certain other parties identified as "pledgors" on the signature pages thereto, and Bank of America, N.A., in its capacity as Administrative Agent	The Company's current Report on Form 8-K filed on July 2, 2018	0-24260	10.3
10.16	Agreement and Plan of Merger dated October 31, 2015 by and among Amedisys Health Care West, L.L.C., IHC Acquisitions, L.L.C., Infinity Home Care, L.L.C., Axiom HealthEquity Holdings Management, LLC, Infinity Healthcare Holdings, LLC, and Amedisys, Inc.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.27
10.17	Agreement of Purchase and Sale dated as of November 25, 2015, between Amedisys, Inc., through its wholly-owned subsidiary, Amedisys Property, L.L.C., as seller and Franciscan Missionaries of Our Lady of the Lake Heath System, Inc., as purchaser.	The Company's Annual Report on Form 10-K for the year ended December 31, 2015	0-24260	10.28

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.18	First Amendment to Amended and Restated Credit Agreement, dated as of February 4, 2019, by and among the Amedisys, Inc. and Amedisys Holding, L.L.C., as the borrowers, certain subsidiaries of the Company party thereto as guarantors, Bank of America, N.A., as the administrative agent, swingline lender and letter of credit issuer, JPMorganChase Bank, N.A., as syndication agent, Capital One Bank, National Association, Citizens Bank, N.A., Compass Bank, Fifth Third Bank, Hancock Whitney Bank, Regions Bank, and Wells Fargo Bank, National Association, as co-documentation agents, the lenders party thereto, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Citizens Bank, N.A., Fifth Third Bank and JPMorgan Chase Bank, N.A., as joint lead arrangers, and Merrill Lynch, Pierce, Fenner & Smith Incorporated and JPMorgan Chase Bank, N.A., as joint bookrunners	The Company's Current Report on Form 8-K filed on February 4, 2019	0-24260	10.1
10.19	Joinder Agreement, dated as of February 4, 2019, by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as the borrowers, each of the new subsidiary guarantors party thereto, and Bank of America, N.A., as the administrative agent	The Company's Current Report on Form 8-K filed on February 4, 2019	0-24260	10.2
10.20	Retirement and Consulting Agreement, dated as of February 13, 2019, by and between Amedisys, Inc. and Linda J. Hall	The Company's Current Report on Form 8-K filed on February 19, 2019	0-24260	10.1
10.21	Joinder Agreement, dated as of June 12, 2020, by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as the borrowers, each of the new subsidiary guarantors party thereto, and Bank of America, N.A., as the administrative agent (The schedules to the Joinder have been omitted pursuant to Item 601(a)(5) of Regulation S-K. The Company will furnish copies of the omitted schedules to the Securities and Exchange Commission upon request.)	The Company's Current Report on Form 8-K filed on June 15, 2020	0-24260	10.1
10.22*	Second Amendment to the Amedisys, Inc. 2018 Omnibus Incentive Compensation Plan, dated October 21, 2020	The Company's Annual Report on Form 10-K for the year ended December 31, 2020	0-24260	10.26
10.23*	Amendment to Amended and Restated Employment Agreement, dated as of February 18, 2021, by and between Amedisys, Inc. and Paul B. Kusserow	The Company's Current Report on Form 8-K filed on February 24, 2021	0-24260	10.1
10.24	Second Amendment to Amended and Restated Credit Agreement, dated as of July 30, 2021, by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as the borrowers, the Guarantors party thereto, the Lenders party thereto, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, and the other L/C Issuers party thereto (Immaterial schedules and exhibits have been omitted pursuant to Item 601(a)(5) of Regulation S-K. The Company agrees to furnish supplementally a copy of any omitted schedule or exhibit to the U.S. Securities and Exchange Commission upon request.)	The Company's Current Report on Form 8-K filed on August 4, 2021	0-24260	10.1

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
10.25*	Amedisys Holding, L.L.C. Severance Plan for Chief Executive Officer	The Company's Current Report on Form 8-K filed on January 10, 2022	0-24260	10.1
10.26*	Mutual Separation Agreement and General Release, by and between Amedisys, Inc. and David L. Kemmerly (including the Consulting Services Agreement attached as Exhibit A thereto)	The Company's Quarterly Report on Form 10-Q for the quarter ended September 30, 2022	0-24260	10.1
10.27*	Amendment No. 1 to Amedisys Holding, L.L.C. Amended and Restated Severance Plan for Executive Officers, dated as of November 21, 2022	The Company's Annual Report on Form 10-K for the year ended December 31, 2022	0-24260	10.27
10.28*	Separation Agreement and General Release by and between Amedisys, Inc. and Christopher T. Gerard	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023	0-24260	10.1
10.29	Third Amendment to Amended and Restated Credit Agreement, dated as of March 10, 2023, by and among Amedisys, Inc. and Amedisys Holding, L.L.C., as the borrowers, the Guarantors party thereto, the Lenders party thereto, Bank of America, N.A., as Administrative Agent, Swingline Lender and L/C Issuer, and the other L/C Issuers party thereto	The Company's Quarterly Report on Form 10-Q for the quarter ended March 31, 2023	0-24260	10.2
10.30	Termination Agreement, dated as of June 26, 2023, by and among Amedisys, Inc., Option Care Health, Inc. and Unitah Merger Sub, Inc.	The Company's Current Report on Form 8-K filed on June 26, 2023	0-24260	10.1
†10.31*	Limited Good Reason Waiver, by and between the Company and Richard Ashworth, dated June 26, 2023			
†10.32*	Limited Good Reason Waiver, by and between the Company and Scott G. Ginn, dated June 26, 2023			
†10.33*	Repayment Letter Agreement, by and between the Company and Richard Ashworth (280G mitigation acceleration), dated December 21, 2023			
†10.34*	Repayment Letter Agreement, by and between the Company and Adam Holton (280G mitigation acceleration), dated December 21, 2023			
†21.1	Subsidiaries of the Registrant			
†23.1	Consent of KPMG LLP			
†31.1	Certification of Richard Ashworth, Chief Executive Officer (principal executive officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002			
†31.2	Certification of Scott G. Ginn, Chief Operating Officer, Executive Vice President and Chief Financial Officer (principal financial officer), pursuant to Section 302 of the Sarbanes-Oxley Act of 2002			
††32.1	Certification of Richard Ashworth, Chief Executive Officer (principal executive officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002			

Exhibit Number	Document Description	Report or Registration Statement	SEC File or Registration Number	Exhibit or Other Reference
††32.2	Certification of Scott G. Ginn, Chief Operating Officer, Executive Vice President and Chief Financial Officer (principal financial officer), pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002			
†97.1	Amedisys, Inc. Policy for the Recovery of Erroneously Awarded Compensation			
†101.INS	Inline XBRL Instance - The instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.			
†101.SCH	Inline XBRL Taxonomy Extension Schema Document			
†101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document			
†101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase			
†101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document			
†101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document			
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)			

SIGNATURES

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

AMEDISYS, INC.

By: /S/ RICHARD ASHWORTH

Richard Ashworth,
President and Chief Executive Officer

Date: February 22, 2024

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

Signature	Title	Date
/S/ RICHARD ASHWORTH **Richard Ashworth**	Chief Executive Officer (Principal Executive Officer)	February 22, 2024
/S/ SCOTT G. GINN **Scott G. Ginn**	Chief Operating Officer, Executive Vice President and Chief Financial Officer (Principal Financial Officer)	February 22, 2024
/S/ ALLYSON D. GUIDROZ **Allyson D. Guidroz**	Principal Accounting Officer	February 22, 2024
/S/ VICKIE L. CAPPS **Vickie L. Capps**	Director	February 22, 2024
/S/ MOLLY COYE, MD **Molly Coye, MD**	Director	February 22, 2024
/S/ JULIE D. KLAPSTEIN **Julie D. Klapstein**	Lead Independent Director	February 22, 2024
/S/ TERESA L. KLINE **Teresa L. Kline**	Director	February 22, 2024
/S/ PAUL B. KUSSEROW **Paul B. Kusserow**	Director	February 22, 2024
/S/ BRUCE D. PERKINS **Bruce D. Perkins**	Director	February 22, 2024
/S/ JEFFREY A. RIDEOUT, MD **Jeffrey A. Rideout, MD**	Director	February 22, 2024
/S/ IVANETTA D. SAMUELS **Ivanetta D. Samuels**	Director	February 22, 2024

Exhibit 10.31

LIMITED GOOD REASON WAIVER

Reference is made to that certain Agreement and Plan of Merger by an among UnitedHealth Group Incorporated ("United"), Aurora Holdings Merger Sub Inc. and Amedisys, Inc. (the "Merger Agreement"), dated as of June 26, 2023, pursuant to which, upon and subject to the completion of the transactions contemplated by the Merger Agreement, the Company will become a wholly owned subsidiary of UnitedHealth Group Inc. (the "Merger"). All capitalized terms that are not otherwise defined in this Limited Good Reason Waiver shall have the definition set forth in the Special RSU Award Agreement attached hereto as Exhibit A.

The Participant understands that (i) all of the Participant's outstanding equity awards with the Company will be converted into United equity awards at the closing of the Merger (the "Closing"), and (ii) the Participant has severance rights under the CEO Severance Plan (the "Severance Plan") and certain rights to acceleration of his or her Company equity awards in accordance with the Omnibus Plan, in each case, which gives the Participant rights to resign from employment with the Company if "Good Reason" (as defined in the Omnibus Plan and the Severance Plan) is triggered or if the Participant experiences a "Qualifying Event" (as defined in the Omnibus Plan).

In consideration for the RSUs that are being granted to the Participant pursuant to the Special RSU Award Agreement attached hereto as Exhibit A with a grant date fair value of $2,500,000, the Participant agrees that from the date of the Closing through the six-month period following the Closing (the "Waiver Period"), the Participant will only be able to resign (i) with Good Reason as a result of a material reduction in the Participant's base salary (other than in connection with a proportionate reduction in the base salaries of all similarly situated senior officer-level employees) and receive the applicable rights and benefits under the Severance Plan and Omnibus Plan, as applicable, or (ii) as a result of a Qualifying Event (as defined in the Omnibus Plan) due to a relocation of the Participant's principal place of employment by more than 50 miles and receive the applicable rights under the Omnibus Plan. Following the Waiver Period, the Participant and the Company agree and acknowledge that the Participant's full Good Reason protection will apply as in effect immediately prior to the Waiver Period, including but not limited to such protection being based on any changes during the Waiver Period to his or her authority, responsibilities or duties as in effect immediately prior to the Effective Time (as defined in the Merger Agreement). The parties agree that the timing deadlines for triggering Good Reason (90 days' notice from triggering event, 150 days to terminate from triggering event) based on changes to authority, duties or responsibilities during the Waiver Period from those in effect immediately prior to the Effective Date, shall not apply and the timing deadlines shall begin on the six-month anniversary of the Effective Time and be as follows: (i) the Participant shall have a period of time of up to 30 days following the six-month anniversary of the Effective Time to provide notice of such triggering event, (ii) the Company shall have 30 days to cure such condition if curable and (iii) the Participant shall terminate employment within 60 days of the end of the Waiver Period. The arrangements set forth herein are intended to be in compliance with the short term deferral exemption to under Section 409A of the Internal Revenue Code.

This Waiver will become effective upon and subject to execution of the Merger Agreement.

[Signature Page follows]

AMEDISYS, INC.

By: /s/ Julie Klapstein
Julie Klapstein
Lead Independent Director

PARTICIPANT

/s/ Richard Ashworth
Richard Ashworth

[*Signature Page to Limited Good Reason Waiver*]

EXHIBIT A

AMEDISYS, INC. 2018 OMNIBUS INCENTIVE COMPENSATION PLAN

SPECIAL RESTRICTED SHARE UNIT AWARD AGREEMENT

This Special Restricted Share Unit Award Agreement (this "Agreement"), dated as of June 26, 2023 (the "Grant Date"), is by and between Amedisys, Inc., a Delaware corporation (the "Company"), and Richard Ashworth (the "Participant"). Capitalized terms used but not otherwise defined herein shall have the meaning ascribed to them in the Omnibus Plan (as defined below). This Agreement constitutes the Award Notice that is described in the Omnibus Plan.

RECITALS

WHEREAS, the Company has established and maintains its 2018 Omnibus Incentive Compensation Plan (as the same may be amended from time to time, the "Omnibus Plan") for the purposes that are stated therein; and

WHEREAS, the Compensation Committee of the Company's Board of Directors (the "Committee") has made an Award of Restricted Share Units ("RSUs") to the Participant on the Grant Date, subject to the terms of the Omnibus Plan and the terms that are contained herein;

NOW, THEREFORE, in consideration of the foregoing, and mutual agreements contained herein, the adequacy and sufficiency of which are hereby acknowledged, the Company and the Participant agree as follows:

1. Grant of RSUs.

(a) Award. This RSU Award is made with respect to 27,410 shares of Common Stock. Each RSU represents the right to receive a share of Common Stock, subject to the terms and conditions set forth in the Omnibus Plan and this Agreement. Prior to the vesting of RSUs hereunder, the Participant will not have any interest in the Common Stock subject to this Award or be entitled to any voting rights, dividends or any other rights and privileges of stockholders of the Company.

(b) Vesting Schedule. Subject to Section 3 of this Agreement, the RSUs granted under Section 1(a) shall vest, if at all, on each date specified in the following schedule (each such date, a "Vesting Date"), provided that the Participant has not incurred a termination of Employment (as defined in the Omnibus Plan) prior to such Vesting Date:

(i) 9,137 shares of Common Stock will become vested on the first anniversary of the Grant Date;

(ii) An additional 9,137 shares of Common Stock will become vested on the second anniversary of the Grant Date; and

(iii) An additional 9,136 shares of Common Stock will become vested on the third anniversary of the Grant Date.

(c) Stockholder Rights. At each respective Vesting Date, or such other times that this Award becomes vested, the Participant shall be deemed the owner of the Common Stock and will have all rights of a stockholder with respect thereto and the Company will promptly (but no later than the 15th day of the third month following the end of the calendar year in which

there is no longer a substantial risk of forfeiture with respect to the RSU) deliver such shares of Common Stock to the Participant; provided, however, that the Company shall be under no obligation to deliver Common Stock under this Award until all conditions stated in the Omnibus Plan with respect to regulatory approvals and listing requirements have been satisfied. For the avoidance of doubt, the substantial risk of forfeiture described in the previous sentence shall lapse in each case as of the earlier of the applicable Vesting Date set forth in the schedule in Section 1(b) and the date of termination due to death or Disability.

2. Restrictions on Transfer. This Agreement and the RSUs are not assignable or transferable other than by will or by the laws of descent and distribution or pursuant to certain domestic relations orders. The terms of this Agreement shall be binding on the Participant's heirs and successors and on the administrators and executors of the Participant's estate. Any attempt to transfer the Participant's rights under this Agreement or the RSUs granted hereby other than in accordance with the provisions of this Section 2 shall cause all rights of the Participant hereunder to be immediately forfeited.

3. Effect of Termination of Employment. The Participant's rights to the RSU on termination of Employment are described in the Omnibus Plan, as modified by the Limited Good Reason Waiver.

4. Tax Withholding. Prior to the issuance or delivery of Common Stock in connection with the vesting of the RSUs, payment must be made by the Participant of any federal, state, local or other taxes that become due on account of the Award. Such obligations shall be satisfied by withholding whole shares of Common Stock with an aggregate Fair Market Value equal to such obligations, unless the Participant makes other arrangements for withholding with the Company. The amount that is calculated for withholding shall not exceed the maximum withholding rate. Any fractional share of Common Stock remaining shall be paid in cash to the Participant.

5. Omnibus Plan Incorporated by Reference. This grant of RSUs is made pursuant to the Omnibus Plan, and in all respects will be interpreted in accordance with the Omnibus Plan, as amended. The Committee has the authority to interpret and construe this Agreement pursuant to the terms of the Omnibus Plan, and its decisions are conclusive as to any questions arising hereunder. The Participant hereby acknowledges receipt of the Omnibus Plan, which shall be deemed to be incorporated in and form a part hereof. In the event of any conflict between the terms of this Agreement and the terms of the Omnibus Plan, as the same may be amended and in effect from time to time, the terms of the Omnibus Plan shall prevail.

6. No Employment or Other Rights. This grant of RSUs does not confer upon the Participant any right to be continued in the Employment of the Company or any subsidiary or interfere in any way with the right of the Company to terminate the Participant's Employment at any time, for any reason, with or without cause, or to decrease the Participant's compensation or benefits. This grant of RSUs is a one-time benefit and does not create any contractual or other right to receive additional RSUs or other benefits in lieu of RSUs in the future.

7. Applicable Law. The validity, construction, interpretation and effect of this Agreement will be governed by and construed in accordance with the laws of the State of Delaware, without giving effect to the conflicts of laws provisions thereof.

8. Notice. Any notice to the Company provided for in this Agreement shall be addressed to Amedisys, Inc. at its principal business address in care of the Corporate Secretary of the Company, and any notice to the Participant will be addressed to the Participant at the current address shown on the books and records of the Company. Any notice shall be sent by registered or certified mail, overnight courier service or by electronic delivery.

9. Entire Agreement. This Agreement and the Omnibus Plan contain the entire agreement between the Participant and the Company regarding the grant of RSUs and supersede all prior arrangements or understandings with respect thereto.

10. Amendment. This Agreement may not be amended, modified or waived except by a written instrument signed by the party against whom enforcement of any such modification, amendment or waiver is sought.

11. Severability. The invalidity or unenforceability of any provision of the Omnibus Plan or this Agreement shall not affect the validity or enforceability of any other provision of the Omnibus Plan or this Agreement, and each provision of the Omnibus Plan and this Agreement shall be severable and enforceable to the extent permitted by law.

12. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which together will constitute one and the same instrument. Counterpart signature pages to this Agreement transmitted by facsimile transmission, by electronic mail in portable document format (.pdf), or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing an original signature.

13. Community Property. Without prejudice to the actual rights of the spouses as between each other, for all purposes of this Agreement, the Participant shall be treated as agent and attorney-in-fact for that interest held or claimed by his spouse with respect to this Agreement, the RSUs and any shares of Common Stock delivered in accordance with Section 1(c) of this Agreement, and the parties to this Agreement shall act in all matters as if the Participant was the sole owner of this Agreement and the shares of Common Stock. This appointment is coupled with an interest and is irrevocable.

14. Code Section 409A. The compensation and benefits payable pursuant this Agreement are intended to be exempt from the requirements of Internal Revenue Code Section 409A and Department of Treasury regulations and other interpretative guidance issued thereunder, including without limitation any such regulations or other such guidance that may be issued after the Grant Date (collectively, "Section 409A") and shall be interpreted in accordance with such intent. Notwithstanding anything herein to the contrary, neither the Company nor any of its affiliates shall have any liability to the Participant or to any other person if the payments and benefits provided in this Agreement that are intended to be exempt from Section 409A are not so exempt or for any taxes, interest or penalties imposed under Section 409A or any corresponding provision of state or local law.

[Signature page follows]

IN WITNESS WHEREOF, the Company has caused this Agreement to be executed by its duly authorized representative and the Participant has executed this Agreement effective as of the Grant Date.

DATE OF GRANT: **June 26, 2023**

AMEDISYS, INC.

By:
_/s/ Julie Klapstein_____
Julie Klapstein
Lead Independent Director

PARTICIPANT

/s/ Richard Ashworth
Richard Ashworth

Exhibit 10.32

LIMITED GOOD REASON WAIVER

Reference is made to that certain Agreement and Plan of Merger by an among UnitedHealth Group Incorporated ("United"), Aurora Holdings Merger Sub Inc. and Amedisys, Inc. (the "Merger Agreement"), dated as of June 26, 2023, pursuant to which, upon and subject to the completion of the transactions contemplated by the Merger Agreement, the Company will become a wholly owned subsidiary of UnitedHealth Group Inc. (the "Merger"). All capitalized terms that are not otherwise defined in this Limited Good Reason Waiver shall have the definition set forth in the Special RSU Award Agreement attached hereto as Exhibit A.

The Participant understands that (i) all of the Participant's outstanding equity awards with the Company will be converted into United equity awards at the closing of the Merger (the "Closing"), and (ii) the Participant has severance rights under the Executive Severance Plan (the "Severance Plan") and certain rights to acceleration of his or her Company equity awards in accordance with the Omnibus Plan, in each case, which gives the Participant rights to resign from employment with the Company if "Good Reason" (as defined in the Omnibus Plan and the Severance Plan) is triggered or if the Participant experiences a "Qualifying Event" (as defined in the Omnibus Plan).

In consideration for the RSUs that are being granted to the Participant pursuant to the Special RSU Award Agreement attached hereto as Exhibit A with a grant date fair value of $1,500,000, the Participant agrees that from the date of the Closing through the six-month period following the Closing (the "Waiver Period"), the Participant will only be able to resign (i) with Good Reason as a result of a material reduction in the Participant's base salary (other than in connection with a proportionate reduction in the base salaries of all similarly situated senior officer-level employees) and receive the applicable rights and benefits under the Severance Plan and Omnibus Plan, as applicable, or (ii) as a result of a Qualifying Event (as defined in the Omnibus Plan) due to a relocation of the Participant's principal place of employment by more than 50 miles and receive the applicable rights under the Omnibus Plan. Following the Waiver Period, the Participant and the Company agree and acknowledge that the Participant's full Good Reason protection will apply as in effect immediately prior to the Waiver Period, including but not limited to such protection being based on any changes during the Waiver Period to his or her authority, responsibilities or duties as in effect immediately prior to the Effective Time (as defined in the Merger Agreement). The parties agree that the timing deadlines for triggering Good Reason (90 days' notice from triggering event, 150 days to terminate from triggering event) based on changes to authority, duties or responsibilities during the Waiver Period from those in effect immediately prior to the Effective Date, shall not apply and the timing deadlines shall begin on the six-month anniversary of the Effective Time and be as follows: (i) the Participant shall have a period of time of up to 30 days following the six-month anniversary of the Effective Time to provide notice of such triggering event, (ii) the Company shall have 30 days to cure such condition if curable and (iii) the Participant shall terminate employment within 60 days of the end of the Waiver Period. The arrangements set forth herein are intended to be in compliance with the short term deferral exemption to under Section 409A of the Internal Revenue Code.

This Waiver will become effective upon and subject to execution of the Merger Agreement.

[Signature Page follows]

AMEDISYS, INC.

By:
/s/ Richard Ashworth
Richard Ashworth
Chief Executive Officer

[*Signature Page to Limited Good Reason Waiver*]

PARTICIPANT

/s/ Scott Ginn
Scott Ginn

[*Signature Page to Limited Good Reason Waiver*]

EXHIBIT A

AMEDISYS, INC. 2018 OMNIBUS INCENTIVE COMPENSATION PLAN

SPECIAL RESTRICTED SHARE UNIT AWARD AGREEMENT

This Special Restricted Share Unit Award Agreement (this "Agreement"), dated as of June 26, 2023 (the "Grant Date"), is by and between Amedisys, Inc., a Delaware corporation (the "Company"), and Scott Ginn (the "Participant"). Capitalized terms used but not otherwise defined herein shall have the meaning ascribed to them in the Omnibus Plan (as defined below). This Agreement constitutes the Award Notice that is described in the Omnibus Plan.

RECITALS

WHEREAS, the Company has established and maintains its 2018 Omnibus Incentive Compensation Plan (as the same may be amended from time to time, the "Omnibus Plan") for the purposes that are stated therein; and

WHEREAS, the Compensation Committee of the Company's Board of Directors (the "Committee") has made an Award of Restricted Share Units ("RSUs") to the Participant on the Grant Date, subject to the terms of the Omnibus Plan and the terms that are contained herein;

NOW, THEREFORE, in consideration of the foregoing, and mutual agreements contained herein, the adequacy and sufficiency of which are hereby acknowledged, the Company and the Participant agree as follows:

1. Grant of RSUs.

(a) Award. This RSU Award is made with respect to 16,446 shares of Common Stock. Each RSU represents the right to receive a share of Common Stock, subject to the terms and conditions set forth in the Omnibus Plan and this Agreement. Prior to the vesting of RSUs hereunder, the Participant will not have any interest in the Common Stock subject to this Award or be entitled to any voting rights, dividends or any other rights and privileges of stockholders of the Company.

(b) Vesting Schedule. Subject to Section 3 of this Agreement, the RSUs granted under Section 1(a) shall vest, if at all, on each date specified in the following schedule (each such date, a "Vesting Date"), provided that the Participant has not incurred a termination of Employment (as defined in the Omnibus Plan) prior to such Vesting Date:

(i) 5,482 shares of Common Stock will become vested on the first anniversary of the Grant Date;

(ii) An additional 5,482 shares of Common Stock will become vested on the second anniversary of the Grant Date; and

(iii) An additional 5,482 shares of Common Stock will become vested on the third anniversary of the Grant Date.

(c) Stockholder Rights. At each respective Vesting Date, or such other times that this Award becomes vested, the Participant shall be deemed the owner of the Common Stock and will have all rights of a stockholder with respect thereto and the Company will promptly (but no later than the 15th day of the third month following the end of the calendar year in which there is no longer a substantial risk of forfeiture with respect to the RSU) deliver such shares of

Common Stock to the Participant; provided, however, that the Company shall be under no obligation to deliver Common Stock under this Award until all conditions stated in the Omnibus Plan with respect to regulatory approvals and listing requirements have been satisfied. For the avoidance of doubt, the substantial risk of forfeiture described in the previous sentence shall lapse in each case as of the earlier of the applicable Vesting Date set forth in the schedule in Section 1(b) and the date of termination due to death or Disability.

2. Restrictions on Transfer. This Agreement and the RSUs are not assignable or transferable other than by will or by the laws of descent and distribution or pursuant to certain domestic relations orders. The terms of this Agreement shall be binding on the Participant's heirs and successors and on the administrators and executors of the Participant's estate. Any attempt to transfer the Participant's rights under this Agreement or the RSUs granted hereby other than in accordance with the provisions of this Section 2 shall cause all rights of the Participant hereunder to be immediately forfeited.

3. Effect of Termination of Employment. The Participant's rights to the RSU on termination of Employment are described in the Omnibus Plan, as modified by the Limited Good Reason Waiver.

4. Tax Withholding. Prior to the issuance or delivery of Common Stock in connection with the vesting of the RSUs, payment must be made by the Participant of any federal, state, local or other taxes that become due on account of the Award. Such obligations shall be satisfied by withholding whole shares of Common Stock with an aggregate Fair Market Value equal to such obligations, unless the Participant makes other arrangements for withholding with the Company. The amount that is calculated for withholding shall not exceed the maximum withholding rate. Any fractional share of Common Stock remaining shall be paid in cash to the Participant.

5. Omnibus Plan Incorporated by Reference. This grant of RSUs is made pursuant to the Omnibus Plan, and in all respects will be interpreted in accordance with the Omnibus Plan, as amended. The Committee has the authority to interpret and construe this Agreement pursuant to the terms of the Omnibus Plan, and its decisions are conclusive as to any questions arising hereunder. The Participant hereby acknowledges receipt of the Omnibus Plan, which shall be deemed to be incorporated in and form a part hereof. In the event of any conflict between the terms of this Agreement and the terms of the Omnibus Plan, as the same may be amended and in effect from time to time, the terms of the Omnibus Plan shall prevail.

6. No Employment or Other Rights. This grant of RSUs does not confer upon the Participant any right to be continued in the Employment of the Company or any subsidiary or interfere in any way with the right of the Company to terminate the Participant's Employment at any time, for any reason, with or without cause, or to decrease the Participant's compensation or benefits. This grant of RSUs is a one-time benefit and does not create any contractual or other right to receive additional RSUs or other benefits in lieu of RSUs in the future.

7. Applicable Law. The validity, construction, interpretation and effect of this Agreement will be governed by and construed in accordance with the laws of the State of Delaware, without giving effect to the conflicts of laws provisions thereof.

8. Notice. Any notice to the Company provided for in this Agreement shall be addressed to Amedisys, Inc. at its principal business address in care of the Corporate Secretary of the Company, and any notice to the Participant will be addressed to the Participant at the current address shown on the books and records of the Company. Any notice shall be sent by registered or certified mail, overnight courier service or by electronic delivery.

9. Entire Agreement. This Agreement and the Omnibus Plan contain the entire agreement between the Participant and the Company regarding the grant of RSUs and supersede all prior arrangements or understandings with respect thereto.

10. Amendment. This Agreement may not be amended, modified or waived except by a written instrument signed by the party against whom enforcement of any such modification, amendment or waiver is sought.

11. Severability. The invalidity or unenforceability of any provision of the Omnibus Plan or this Agreement shall not affect the validity or enforceability of any other provision of the Omnibus Plan or this Agreement, and each provision of the Omnibus Plan and this Agreement shall be severable and enforceable to the extent permitted by law.

12. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original but all of which together will constitute one and the same instrument. Counterpart signature pages to this Agreement transmitted by facsimile transmission, by electronic mail in portable document format (.pdf), or by any other electronic means intended to preserve the original graphic and pictorial appearance of a document, will have the same effect as physical delivery of the paper document bearing an original signature.

13. Community Property. Without prejudice to the actual rights of the spouses as between each other, for all purposes of this Agreement, the Participant shall be treated as agent and attorney-in-fact for that interest held or claimed by his spouse with respect to this Agreement, the RSUs and any shares of Common Stock delivered in accordance with Section 1(c) of this Agreement, and the parties to this Agreement shall act in all matters as if the Participant was the sole owner of this Agreement and the shares of Common Stock. This appointment is coupled with an interest and is irrevocable.

14. Code Section 409A. The compensation and benefits payable pursuant this Agreement are intended to be exempt from the requirements of Internal Revenue Code Section 409A and Department of Treasury regulations and other interpretative guidance issued thereunder, including without limitation any such regulations or other such guidance that may be issued after the Grant Date (collectively, "Section 409A") and shall be interpreted in accordance with such intent. Notwithstanding anything herein to the contrary, neither the Company nor any of its affiliates shall have any liability to the Participant or to any other person if the payments and benefits provided in this Agreement that are intended to be exempt from Section 409A are not so exempt or for any taxes, interest or penalties imposed under Section 409A or any corresponding provision of state or local law.

[Signature page follows]

IN WITNESS WHEREOF, the Company has caused this Agreement to be executed by its duly authorized representative and the Participant has executed this Agreement effective as of the Grant Date.

DATE OF GRANT: **June 26, 2023**

AMEDISYS, INC.

By:
/s/ Richard Ashworth
Richard Ashworth
Chief Executive Officer

PARTICIPANT

/s/ Scott Ginn
Scott Ginn

Exhibit 10.33

December 18, 2023

Richard Ashworth

Re: Accelerated Payments and Potential Repayment Obligations

Dear Richard:

This letter agreement (the "**Letter Agreement**") memorializes your agreement and understanding with Amedisys, Inc. (the "**Company**") regarding certain accelerated payments and vesting in connection with the anticipated completion of the merger contemplated by the Merger Agreement, dated as of June 26, 2023, by and between the Company, UnitedHealth Group Incorporated ("**Optum**") and Aurora Holdings Merger Sub Inc. (the "**Merger**").

In anticipation of the Merger, and as a 280G mitigation strategy, the Company will accelerate payment of all or a portion of your 2023 annual bonus payment and accelerate vesting of certain tranches of your unvested and outstanding equity awards, as outlined in Exhibit A attached hereto, in each case, less applicable tax withholdings, on or prior to December 31, 2023. You hereby acknowledge that the Company reserves the right to make adjustments to your future compensation to the extent the final determination of your 2023 annual bonus is less than target and the payment you are entitled to receive is less than the amount accelerated pursuant to this Letter Agreement.

In the event you are terminated for Cause or you resign for any reason other than Good Reason (each, as defined in the Amedisys 2018 Omnibus Incentive Compensation Plan, after giving effect to the provisions of that certain Limited Good Reason Waiver, dated as of June 26, 2023, by and between you and the Company), you hereby agree that you will promptly repay the after-tax amount of certain accelerated bonus amounts to the Company and/or Optum and/or immediately forfeit to the Company the after-tax number of shares underlying any equity awards accelerated (or repay to the Company and/or Optum the fair market value of such shares on the date of acceleration if you no longer own such shares), in each case as set forth in the next sentence. For purposes of clarity, the only payments subject to repayment and shares subject to forfeiture, in each case, pursuant to this Letter Agreement are those that are outstanding prior to the date of this Letter Agreement, have been accelerated into 2023 (in connection with the Company's 280G mitigation strategies) and which would not have been paid or vested by their terms prior to or in connection with your termination of employment.

The repayment obligations hereunder will terminate and will have no further effect with respect to Optum policies in the event the Merger is not consummated.

This letter agreement shall be governed and construed in accordance with the laws of the State of Delaware, without regard to conflicts of laws principles thereof and may be executed in separate counterparts, each of which is deemed to be an original and all of which taken together constitute one and the same agreement.

Please confirm your agreement by signing below.

Sincerely,

/s/ Adam Holton
Adam Holton
Chief People Officer

AGREED AND ACCEPTED BY: /s/ Richard Ashworth
Richard Ashworth

Exhibit A

Accelerated Bonus Amounts and Equity Awards

Accelerated 2023 Bonus Amount
$1,000,000

Grant Date	Number of Shares	Original Vesting Date
April 12, 2023	11,237[1]	February 20, 2024
April 12, 2023	5,220[2]	February 20, 2024
April 12, 2023	31,321	April 12, 2024
June 26, 2023	9,137	June 26, 2024

[1] Shares subject to a Stock Option award with an exercise price of $79.82 per share.
[2] Shares subject to a Restricted Stock Unit award.

Exhibit 10.34

December 18, 2023

Adam Holton

Re: Accelerated Payments and Potential Repayment Obligations

Dear Adam:

This letter agreement (the "**Letter Agreement**") memorializes your agreement and understanding with Amedisys, Inc. (the "**Company**") regarding certain accelerated payments and vesting in connection with the anticipated completion of the merger contemplated by the Merger Agreement, dated as of June 26, 2023, by and between the Company, UnitedHealth Group Incorporated ("**Optum**") and Aurora Holdings Merger Sub Inc. (the "**Merger**").

In anticipation of the Merger, and as a 280G mitigation strategy, the Company will accelerate payment of all or a portion of your 2023 annual bonus payment and accelerate vesting of certain tranches of your unvested and outstanding equity awards, as outlined in Exhibit A attached hereto, in each case, less applicable tax withholdings, on or prior to December 31, 2023. You hereby acknowledge that the Company reserves the right to make adjustments to your future compensation to the extent the final determination of your 2023 annual bonus is less than target and the payment you are entitled to receive is less than the amount accelerated pursuant to this Letter Agreement.

In the event you are terminated for Cause or you resign for any reason other than Good Reason (each, as defined in the Amedisys 2018 Omnibus Incentive Compensation Plan), you hereby agree that you will promptly repay the after-tax amount of certain accelerated bonus amounts to the Company and/or Optum and/or immediately forfeit to the Company the after-tax number of shares underlying any equity awards accelerated (or repay to the Company and/or Optum the fair market value of such shares on the date of acceleration if you no longer own such shares), in each case as set forth in the next sentence. For purposes of clarity, the only payments subject to repayment and shares subject to forfeiture, in each case, pursuant to this Letter Agreement are those that are outstanding prior to the date of this Letter Agreement, have been accelerated into 2023 (in connection with the Company's 280G mitigation strategies) and which would not have been paid or vested by their terms prior to or in connection with your termination of employment.

The repayment obligations hereunder will terminate and will have no further effect with respect to Optum policies in the event the Merger is not consummated.

This letter agreement shall be governed and construed in accordance with the laws of the State of Delaware, without regard to conflicts of laws principles thereof and may be executed in separate counterparts, each of which is deemed to be an original and all of which taken together constitute one and the same agreement.

Please confirm your agreement by signing below.

Sincerely,

/s/ Richard Ashworth
Richard Ashworth
Chief Executive Officer

AGREED AND ACCEPTED BY: /s/ Adam Holton
Adam Holton

Exhibit A

Accelerated Bonus Amounts and Equity Awards

Accelerated 2023 Bonus Amount
$311,250

Grant Date	Number of Shares	Original Vesting Date
October 20, 2022	1,295	October 20, 2024
February 23, 2023	455	February 20, 2024

Exhibit 21.1

LIST OF SUBSIDIARIES

CORPORATIONS

COMPASSIONATE CARE HOSPICE GROUP, INC., a Florida corporation
COMPASSIONATE CARE HOSPICE OF CENTRAL FLORIDA, INC., a Florida corporation
COMPASSIONATE CARE HOSPICE OF LAKE AND SUMTER, INC., a Florida corporation
COMPASSIONATE CARE HOSPICE OF MIAMI DADE AND THE FLORIDA KEYS, INC., a Florida corporation
GUARDIAN HEALTH CARE, INC., a Texas corporation
GUARDIAN HEALTH CARE GROUP, INC., a Delaware corporation
GUARDIAN HEALTH CARE HOLDINGS, INC., a Delaware corporation
HEALTH PRIORITY HOME CARE, INC., a Texas corporation
HI-TECH CARE, INC., a Florida Corporation
HOMECARE PREFERRED CHOICE, INC., a Delaware corporation
HOSPICE OF EASTERN CAROLINA, INC., a North Carolina corporation
HOSPICE PREFERRED CHOICE, INC., a Delaware corporation
INFINITY HOME CARE ACQUISITION CORP., a Florida corporation
JLM HEALTHCARE, INC., a Texas corporation
OHERBST, INC., a Texas corporation
S. FISHER & S. THOMAS, INC., a Texas corporation
TKG, INC., an Oklahoma corporation
VELITA SMITH HOME HEALTHCARE, Inc., a Texas corporation

LIMITED LIABILITY COMPANIES

ACCUMED HEALTH SERVICES, L.L.C., a Texas limited liability company
ACCUMED HOME HEALTH OF GEORGIA, L.L.C.., a Georgia limited liability company
ADVENTA HOSPICE, L.L.C., a Florida limited liability company
AGAPE HEALTH CARE AGENCY, LLC, an Ohio limited liability company
ALBERT GALLATIN HOME CARE AND HOSPICE SERVICES, LLC, a Delaware limited liability company
AMEDISYS ALABAMA, L.L.C., an Alabama limited liability company
AMEDISYS ARIZONA, L.L.C., an Arizona limited liability company
AMEDISYS ARKANSAS, LLC, an Arkansas limited liability company
AMEDISYS BA, LLC, a Delaware limited liability company
AMEDISYS DELAWARE, L.L.C., a Delaware limited liability company
AMEDISYS FLORIDA, L.L.C., a Florida limited liability company
AMEDISYS GEORGIA, L.L.C., a Georgia limited liability company
AMEDISYS HEALTH CARE WEST, L.L.C., a Delaware limited liability company
AMEDISYS HOLDING, L.L.C., a Louisiana limited liability company
AMEDISYS HOME HEALTH OF ALABAMA, L.L.C. an Alabama limited liability company
AMEDISYS HOME HEALTH OF NEBRASKA, L.L.C., a Nebraska limited liability company
AMEDISYS HOME HEALTH OF SOUTH CAROLINA, L.L.C. a South Carolina limited liability company
AMEDISYS HOME HEALTH OF VIRGINIA, L.L.C. a Virginia limited liability company
AMEDISYS HOSPICE, L.L.C., a Louisiana limited liability company
AMEDISYS IDAHO, L.L.C., an Idaho limited liability company
AMEDISYS ILLINOIS, L.L.C., an Illinois limited liability company
AMEDISYS INDIANA, L.L.C., an Indiana limited liability company
AMEDISYS KANSAS, L.L.C., a Kansas limited liability company
AMEDISYS LA ACQUISITIONS, L.L.C., a Louisiana limited liability company
AMEDISYS LOUISIANA, L.L.C., a Louisiana limited liability company
AMEDISYS MAINE, P.L.L.C., a Maine professional limited liability company
AMEDISYS MARYLAND, L.L.C., a Maryland limited liability company
AMEDISYS MISSISSIPPI, L.L.C., a Mississippi limited liability company
AMEDISYS MISSOURI, L.L.C., a Missouri limited liability company
AMEDISYS NEBRASKA, L.L.C., a Nebraska limited liability company
AMEDISYS NEW HAMPSHIRE, L.L.C., a New Hampshire limited liability company
AMEDISYS NEW JERSEY, L.L.C., a New Jersey limited liability company
AMEDISYS NORTH CAROLINA, L.L.C., a North Carolina limited liability company
AMEDISYS NORTHWEST, L.L.C., a Georgia limited liability company
AMEDISYS OHIO, L.L.C., an Ohio limited liability company

AMEDISYS OKLAHOMA, L.L.C., an Oklahoma limited liability company
AMEDISYS OREGON, L.L.C., an Oregon limited liability company
AMEDISYS PENNSYLVANIA, L.L.C., a Pennsylvania limited liability company
AMEDISYS PERSONAL CARE, LLC, an Alabama limited liability company
AMEDISYS RHODE ISLAND, L.L.C., a Rhode Island limited liability company
AMEDISYS SC, L.L.C., a South Carolina limited liability company
AMEDISYS SP-IN, L.L.C., an Indiana limited liability company
AMEDISYS SP-KY, L.L.C., a Kentucky limited liability company
AMEDISYS SP-OH, L.L.C., an Ohio limited liability company
AMEDISYS SP-TN, L.L.C., a Tennessee limited liability company
AMEDISYS TENNESSEE, L.L.C., a Tennessee limited liability company
AMEDISYS TEXAS, L.L.C., a Texas limited liability company
AMEDISYS TLC ACQUISITION, L.L.C., a Louisiana limited liability company
AMEDISYS WASHINGTON, L.L.C., a Washington limited liability company
AMEDISYS WEST VIRGINIA, L.L.C., a West Virginia limited liability company
AMEDISYS WISCONSIN, L.L.C., a Wisconsin limited liability company
ANGEL WATCH HOME CARE, L.L.C., a Florida limited liability company
ASANA HOSPICE CLEVELAND, LLC, a Delaware limited liability company
ASANA PALLIATIVE CLEVELAND, LLC, a Delaware limited liability company
ASERACARE HOSPICE – DEMOPOLIS, LLC, a Delaware limited liability company
ASERACARE HOSPICE – HAMILTON, LLC, a Delaware limited liability company
ASERACARE HOSPICE – JACKSON, LLC, a Delaware limited liability company
ASERACARE HOSPICE – MONROEVILLE, LLC, a Delaware limited liability company
ASERACARE HOSPICE – NEW HORIZONS, LLC, a Delaware limited liability company
ASERACARE HOSPICE – RUSSELLVILLE, LLC, a Delaware limited liability company
ASERACARE HOSPICE – SENTOBIA, LLC, a Delaware limited liability company
ASERACARE HOSPICE – TENNESSEE, LLC, a Delaware limited liability company
AVENIR VENTURES, L.L.C., a Louisiana limited liability company
BEACON HOSPICE, L.L.C., a Delaware limited liability company
CARE CONNECTION OF CINCINNATI, LLC, an Ohio limited liability company
COMPASSIONATE CARE HOSPICE, L.L.C., a Pennsylvania limited liability company
COMPASSIONATE CARE HOSPICE OF BRYAN TEXAS, LLC, a Texas limited liability company
COMPASSIONATE CARE HOSPICE OF CENTRAL GEORGIA, LLC, a Georgia limited liability company
COMPASSIONATE CARE HOSPICE OF CENTRAL LOUISIANA, LLC, a Louisiana limited liability company
COMPASSIONATE CARE HOSPICE OF CENTRAL TEXAS, LLC, a Texas limited liability company
COMPASSIONATE CARE HOSPICE OF CLIFTON, LLC, a New Jersey limited liability company
COMPASSIONATE CARE HOSPICE OF DELAWARE, LLC, a Delaware limited liability company
COMPASSIONATE CARE HOSPICE OF GWYNEDD, L.L.C., a Pennsylvania limited liability company
COMPASSIONATE CARE HOSPICE OF HOUSTON, LLC, a Texas limited liability company
COMPASSIONATE CARE HOSPICE OF ILLINOIS, LLC, an Illinois limited liability company
COMPASSIONATE CARE HOSPICE OF KANSAS CITY, LLC, a Kansas limited liability company
COMPASSIONATE CARE HOSPICE OF MARLTON, LLC, a New Jersey limited liability company
COMPASSIONATE CARE HOSPICE OF MASSACHUSETTS, LLC, a Massachusetts limited liability company
COMPASSIONATE CARE HOSPICE OF MICHIGAN, LLC, a Michigan limited liability company
COMPASSIONATE CARE HOSPICE OF MINNESOTA, LLC, a Minnesota limited liability company
COMPASSIONATE CARE HOSPICE OF NEW HAMPSHIRE, LLC, a New Hampshire limited liability company
COMPASSIONATE CARE HOSPICE OF NORTH TEXAS, LLC, a Texas limited liability company
COMPASSIONATE CARE HOSPICE OF NORTHERN GEORGIA, LLC, a Georgia limited liability company
COMPASSIONATE CARE HOSPICE OF NORTHERN NEW JERSEY, LLC, a New Jersey limited liability company
COMPASSIONATE CARE HOSPICE OF NORTHWESTERN PENNSYLVANIA, LLC, a Pennsylvania limited liability company
COMPASSIONATE CARE HOSPICE OF OHIO, LLC, an Ohio limited liability company
COMPASSIONATE CARE HOSPICE OF PITTSBURG, LLC, a Pennsylvania limited liability company
COMPASSIONATE CARE HOSPICE OF SAVANNAH, LLC, a Georgia limited liability company
COMPASSIONATE CARE HOSPICE OF SOUTH CAROLINA, LLC, a South Carolina limited liability company
COMPASSIONATE CARE HOSPICE OF SOUTHEASTERN MASSACHUSETTS, LLC, a Massachusetts limited liability company
COMPASSIONATE CARE HOSPICE OF SOUTHEASTERN TEXAS, LLC, a Texas limited liability company
COMPASSIONATE CARE HOSPICE OF SOUTHERN MISSISSIPPI, LLC, a Mississippi limited liability company COMPASSIONATE CARE HOSPICE OF THE CHESAPEAKE BAY, LLC, a Virginia limited liability company
COMPASSIONATE CARE HOSPICE OF THE DELMAR PENINSULA, LLC, a Delaware limited liability company

COMPASSIONATE CARE HOSPICE OF THE MIDWEST, LLC, a South Dakota limited liability company
COMPASSIONATE CARE HOSPICE OF WISCONSIN, LLC, a Wisconsin limited liability company
COMPREHENSIVE HOME HEALTHCARE SERVICES, L.L.C., a Tennessee limited liability company
EMERALD CARE, L.L.C., a North Carolina limited liability company
EVOLUTION HEALTH, L.L.C., a Delaware limited liability company
FAMILY HOME HEALTH CARE, L.L.C., a Kentucky limited liability company
GEM CITY HOME CARE, LLC, an Ohio limited liability company
GUARDIAN OHIO NEWCO, LLC, an Ohio limited liability company
HHC, L.L.C., a Tennessee limited liability company
HOME HEALTH OF ALEXANDRIA, L.L.C., a Louisiana limited liability company
HOME HEALTH PARTNERSHIP OPERATING COMPANY, L.L.C., a Texas limited liability company (100% owned by UMC Home Health and Hospice, an Amedisys Partner, L.L.C. JV)
HORIZONS HOSPICE CARE, L.L.C., an Alabama limited liability company
HOSPICE HOLDINGS DFW, LLC, a Texas limited liability company
HOSPICE HOLDINGS HARRISBURG, LLC, a Pennsylvania Limited Liability company
HOSPICE PARTNERSHIP OPERATING COMPANY, L.L.C., a Texas limited liability company (100% owned by UMC Home Health and Hospice, an Amedisys Partner, L.L.C. JV)
HOUSECALL HOME HEALTH, L.L.C., a Tennessee limited liability company
INFINITY HOME CARE, L.L.C., a Florida limited liability company
INFINITY HOME CARE OF JACKSONVILLE, LLC, a Florida limited liability company
INFINITY HOME CARE OF LAKELAND, LLC, a Florida limited liability company
INFINITY HOME CARE OF OCALA, LLC, a Florida limited liability company
INFINITY HOME CARE OF PORT CHARLOTTE, LLC, a Florida limited liability company
INFINITY HOMECARE OF DISTRICT 9, LLC, a Florida limited liability company
MISSOURI HOSPICE HOLDINGS, LLC, a Missouri limited liability company
MORGANTOWN HOSPICE, LLC, a Delaware limited liability company
NINE PALMS 1, L.L.C., a Virginia limited liability company
NINE PALMS 2, LLC, a Mississippi limited liability company
OHIO HOSPICE HOLDINGS, LLC, a Delaware limited liability company
PATHWAYS TO COMPASSION, LLC, a Nebraska limited liability company
PATHWAYS TO COMPASSION, LLC, a New Jersey limited liability company
PENNSYLVANIA HOSPICE HOLDINGS, LLC, a Pennsylvania limited liability company
TAYLOR HOSPICE HOLDINGS, LLC, a Pennsylvania limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES INTERNATIONAL, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF ERIE NIAGARA, LLC, a New York limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF GEORGIA, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF NASSAU SUFFOLK, LLC, a New York limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF NEW ENGLAND, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES OF WEST VIRGINIA, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES SOUTHEAST, LLC, a Delaware limited liability company
TENDER LOVING CARE HEALTH CARE SERVICES WESTERN, LLC, a Delaware limited liability company
TEXAS HOSPICE HOLDINGS, LLC, a Delaware limited liability company
TLC HOLDINGS I, L.L.C., a Delaware limited liability company
TLC HEALTH CARE SERVICES, L.L.C., a Delaware limited liability company
TUCSON HOME HEALTH, LLC, a Delaware limited liability company
WT HOSPICE HOLDINGS, LLC, a Pennsylvania limited liability company

JOINT VENTURES

AMEDISYS HOME HEALTH, A LAWRENCE MEDICAL CENTER PARTNER, L.L.C, a Delaware limited liability company **(66.67% ownership)**
BEAUFORT HOME HEALTH PARTNERS, L.L.C., a Delaware limited liability company **(70% ownership)**
GEORGETOWN HOSPITAL HOME HEALTH, LLC, a Delaware limited liability company **(70% ownership)**
MARIETTA HOME HEALTH AND HOSPICE, L.L.C., an Ohio limited liability company **(50% ownership)**
TRI-CITIES HOME HEALTH, LLC, a Delaware limited liability company **(50% ownership)**
WENTWORTH HOME CARE AND HOSPICE, LLC, a New Hampshire limited liability company **(50% ownership)**
UMC HOME HEALH AND HOSPICE, AN AMEDISYS PARTNER, L.L.C., a Texas limited liability company **(50% ownership)**

CONTESSA COMPANIES

BSW HOME RECOVERY CARE, LLC, a Texas limited liability company
CONTESSA HEALTH, INC., a Delaware corporation
CONTESSA HEALTH HOLDING COMPANY, LLC, a Delaware limited liability company
CONTESSA HEALTH MANAGEMENT COMPANY, LLC, a Delaware limited liability company
CONTESSA HEALTH OF FLORIDA, LLC, a Delaware limited liability company
CONTESSA HEALTH OF TENNESSEE, LLC, a Tennessee limited liability company
CONTRADO CLAIM, LLC, a Delaware limited liability company
DIGNITY HOME RECOVERY CARE, LLC, a Delaware limited liability company **(49.9% ownership)**
GUNDERSON HOSPITAL AT HOME, LLC, a Delaware limited liability company **(51% ownership)**
HENRY FORD HOME RECOVERY CARE, LLC, a Delaware limited liability company **(51% ownership)**
HOME RECOVERY CARE, LLC, a Delaware limited liability company **(51% ownership)**
MEMORIAL HERMAN HOME-BASED SERVICES, L.L.C., a Delaware corporation **(51.1% ownership)**
OGL HOLDINGS, LLC, a New York limited liability company
ONE GUSTAVE L. LEVY PLACE, LLC, a Delaware limited liability company **(51% ownership)**
ONE GUSTAVE L. LEVY PLACE INDEPENDENT PRACTICE ASSOCIATION, LLC, a New York limited liability company
PENN STATE HEALTH HOME RECOVERY CARE, LLC, a Delaware limited liability company **(51% ownership)**
PERSONALIZED RECOVERY CARE, LLC, a Delaware limited liability company **(51% ownership)**
PRISMA HEALTH HOME RECOVERY, LLC, a Delaware limited liability company **(51% ownership)**
SAINT THOMAS HOME RECOVERY CARE, LLC, a Tennessee limited liability company **(49% ownership)**
UAMS HEALTH COMPREHENSIVE CARE AT HOME, L.L.C., an Arkansas limited liability company

Exhibit 23.1

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the registration statements (No. 333-138255) on Form S-3 and (Nos. 333-60525, 333-51704, 333-53786, 333-143967, 333-152359, 333-182347, 333-205267, and 333-225461) on Form S-8 of our reports dated February 22, 2024, with respect to the consolidated financial statements of Amedisys, Inc. and the effectiveness of internal control over financial reporting.

/s/ KPMG LLP

Baton Rouge, Louisiana
February 22, 2024

Exhibit 31.1

CERTIFICATION

I, Richard Ashworth, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2023, of Amedisys, 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 22, 2024

/S/ Richard Ashworth

Richard Ashworth
Chief Executive Officer
(Principal Executive Officer)

Exhibit 31.2

CERTIFICATION

I, Scott G. Ginn, certify that:

1. I have reviewed this Annual Report on Form 10-K for the year ended December 31, 2023, of Amedisys, 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 22, 2024

/S/ Scott G. Ginn

Scott G. Ginn
Chief Operating Officer, Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

Exhibit 32.1

CERTIFICATION OF PRINCIPAL EXECUTIVE OFFICER 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 Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2023 (the "Report"), I, Richard Ashworth, Chief Executive Officer of the Company, hereby certify to my knowledge, 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 as of and for the periods presented in the Report.

Date: February 22, 2024

/S/ Richard Ashworth

Richard Ashworth
Chief Executive Officer
(Principal Executive Officer)

Exhibit 32.2

**CERTIFICATION OF PRINCIPAL FINANCIAL OFFICER 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 Amedisys, Inc. (the "Company") on Form 10-K for the year ended December 31, 2023 (the "Report"), I, Scott G. Ginn, Chief Operating Officer, Executive Vice President and Chief Financial Officer of the Company, hereby certify to my knowledge, 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 as of and for the periods presented in the Report.

Date: February 22, 2024

/S/ Scott G. Ginn

Scott G. Ginn
Chief Operating Officer, Executive Vice President and Chief Financial Officer
(Principal Financial Officer)

Exhibit 97.1

AMEDISYS, INC.

POLICY FOR THE
RECOVERY OF ERRONEOUSLY AWARDED COMPENSATION

1. Purpose. The purpose of this Policy is to describe the circumstances in which Executive Officers will be required to repay, return, or forfeit Erroneously Awarded Compensation to the Company. This Policy shall be interpreted to comply with Rule 10D-1 promulgated under the Securities Exchange Act of 1934, as amended, and the related listing rules of the Exchange, and, to the extent this Policy is deemed inconsistent with such rules in any manner, this Policy shall be treated as retroactively amended to be compliant with such rules. Capitalized terms shall have the meanings ascribed to such terms in Section 3 below.

2. Administration. This Policy shall be administered by the Committee. The Committee has full and final authority to make all determinations under this Policy, in each case to the extent permitted under the listing rules of the Exchange and in compliance with (or pursuant to an exemption from the application of) Section 409A of the Code. Any determinations made by the Committee shall be final and binding on all affected individuals.

3. Definitions. For purposes of this Policy, the following capitalized terms shall have the meanings set forth below.

(a) "***Accounting Restatement***" shall mean an accounting restatement due to the material noncompliance of the Company with any financial reporting requirement under the securities laws, including any required accounting restatement to correct an error in previously issued financial statements that is material to the previously issued financial statements (a "Big R" restatement), or that would result in a material misstatement if the error were corrected in the current period or left uncorrected in the current period (a "little r" restatement).

(b) "***Board***" shall mean the Board of Directors of the Company.

(c) "***Clawback Eligible Incentive Compensation***" shall mean all Incentive-based Compensation Received by an Executive Officer (i) on or after October 2, 2023, (ii) after beginning service as an Executive Officer, (iii) who served as an Executive Officer at any time during the applicable performance period for such Incentive-based Compensation (whether or not such Executive Officer is serving at the time the Erroneously Awarded Compensation is required to be repaid, returned, or forfeited to the Company Group), (iv) while the Company has a class of securities listed on a national securities exchange or a national securities association, and (v) during the applicable Clawback Period.

(d) "***Clawback Period***" shall mean, with respect to any Accounting Restatement, the three completed fiscal years of the Company immediately preceding the Restatement Date, including any transition period (that results from a change in the Company's fiscal year) of less than nine months within or immediately following those three completed fiscal years.

(e) "***Code***" shall mean the U.S. Internal Revenue Code of 1986, as amended. Any reference to a section of the Code or regulation thereunder includes such section or regulation, any valid regulation or other official guidance promulgated under such section, and any comparable provision of any future legislation or regulation amending, supplementing, or superseding such section or regulation.

(f) "***Committee***" shall mean the Compensation Committee (if composed entirely of independent directors) of the Board, or, in the absence of such a committee, a majority of the independent directors serving on the Board.

(g) "***Company***" shall mean Amedisys, Inc., a Delaware corporation.

(h) "***Company Group***" shall mean the Company, together with each of its direct and indirect subsidiaries.

(i) "***Effective Date***" shall mean October 2, 2023.

(j) "***Erroneously Awarded Compensation***" shall mean, with respect to each Executive Officer in connection with an Accounting Restatement, the amount of Clawback Eligible Incentive Compensation Received that exceeds the amount of Incentive-based Compensation that otherwise would have been Received had it been determined based on the restated amounts, computed without regard to any taxes paid. For Incentive-based Compensation based on (or derived from) stock price or total stockholder return where the amount of Erroneously Awarded Compensation is not subject to mathematical recalculation directly from the information in the applicable Accounting Restatement, the amount shall be determined by the Committee based on a reasonable estimate of the effect of the Accounting Restatement on the stock price or total stockholder return upon which the Incentive-based Compensation was Received (in which case, the Company shall maintain documentation of such determination of that reasonable estimate and provide such documentation to the Exchange). With respect to any compensation plans or programs of the Company Group that take into account Incentive-Based Compensation, the amount of Erroneously Awarded Compensation subject to recovery (or, to the extent such amount has not yet been paid, forfeiture) under this Policy includes, but is not limited to, the amount of Erroneously Awarded Compensation credited to any notional account and any notional earnings attributable thereto.

(k) "***Exchange***" shall mean a national securities exchange or national securities association on which the Company has listed securities.

(l) "***Executive Officer***" shall mean each individual who is currently or was previously designated as an "officer" of the Company in accordance with Rule 16a-1(f) of the Securities Exchange Act of 1934, as amended.

(m) "***Financial Reporting Measure***" shall mean a measure that is determined and presented in accordance with the accounting principles used in preparing the Company's financial statements, and any other measure that is derived wholly or in part from such measure. Stock price and total stockholder return (and any measure that is derived wholly or in part from stock price or total stockholder return) shall be considered Financial Reporting Measures for purposes of this Policy. For the avoidance of doubt, a Financial Reporting Measure need not be presented in the Company's financial statements or included in a filing with the SEC.

(n) "***Incentive-based Compensation***" shall mean any compensation that is granted, earned, or vested based wholly or in part upon the attainment of a Financial Reporting Measure.

(o) "***Policy***" shall mean this Policy for the Recovery of Erroneously Awarded Compensation, as the same may be amended and/or restated from time to time.

(p) "***Received***" shall, with respect to any Incentive-based Compensation, mean deemed receipt, and Incentive-based Compensation shall be deemed received in the Company's fiscal period during which the Financial Reporting Measure specified in the Incentive-based Compensation award is attained, even if payment or grant of the Incentive-based Compensation

occurs after the end of that period (subject to applicable law, including any Incentive-based Compensation the payment of which has been deferred). For the avoidance of doubt, Incentive-based Compensation that is subject to both a Financial Reporting Measure vesting condition and a service-based vesting condition shall be considered received when the relevant Financial Reporting Measure is achieved, even if the Incentive-based Compensation continues to be subject to the service-based vesting condition.

(q) "***Restatement Date***" shall mean the earlier to occur of (i) the date the Board, a committee of the Board or the officers of the Company authorized to take such action if Board action is not required, concludes, or reasonably should have concluded, that the Company is required to prepare an Accounting Restatement, or (ii) the date a court, regulator, or other legally authorized body directs the Company to prepare an Accounting Restatement.

(r) "***SEC***" shall mean the U.S. Securities and Exchange Commission.

4. Recovery of Erroneously Awarded Compensation.

(a) In the event that the Company is required to prepare an Accounting Restatement, the Company must recover, reasonably promptly, Erroneously Awarded Compensation Received by any Executive Officer during the applicable Clawback Period, in amounts determined by the Committee pursuant to this Policy. The Company's obligation to recover Erroneously Awarded Compensation is not dependent on if or when the Company files restated financial statements. Recovery under this Policy with respect to an Executive Officer shall not require the finding of any misconduct by such Executive Officer or such Executive Officer being found responsible for the accounting error leading to an Accounting Restatement. In the event of an Accounting Restatement, the Committee shall determine, in its sole and absolute discretion, the timing and method for promptly recovering Erroneously Awarded Compensation hereunder, including, without limitation, the cancellation of or offsetting against any planned future cash or equity-based awards, to the extent permitted under the listing rules of the Exchange and in compliance with (or pursuant to an exemption from the application of) Section 409A of the Code. The Committee has the power, in its sole discretion, to retain or obtain the advice of a compensation consultant, legal counsel or other adviser as it deems necessary or appropriate to carry out its duties under this Policy.

(b) Notwithstanding anything herein to the contrary, the Company shall not be required to take the actions contemplated by Section 4(a) above to the extent that one or more of the following conditions are met and the Committee determines that recovery would therefore be impracticable:

(i) The direct expense paid to a third party to assist in enforcing this Policy against an Executive Officer would exceed the amount to be recovered, after the Company has made a reasonable attempt to recover the applicable Erroneously Awarded Compensation, documented such attempts and provided such documentation to the Exchange; or

(ii) Recovery would likely cause an otherwise tax-qualified retirement plan, under which benefits are broadly available to employees of any member of the Company Group, to fail to meet the requirements of Section 401(a)(13) or Section 411(a) of the Code.

5. Reporting and Disclosure. The Company shall file all disclosures with respect to this Policy in accordance with the requirements of the federal securities laws, including the disclosures required by applicable SEC filings.

6. Indemnification Prohibition. No member of the Company Group shall be permitted to indemnify any Executive Officer against the loss of any Erroneously Awarded Compensation

that is repaid, returned, recovered, or forfeited pursuant to the terms of this Policy, including any payment or reimbursement for the cost of third-party insurance purchased by an Executive Officer to cover such losses incurred under this Policy. Further, no member of the Company Group shall enter into any agreement that exempts any Incentive-based Compensation from the application of this Policy or that waives the Company Group's right to recovery of any Erroneously Awarded Compensation, and this Policy shall supersede any such agreement (whether entered into before, on, or after the Effective Date).

7. Interpretation. The Committee is authorized to interpret and construe this Policy and to make all determinations necessary, appropriate, or advisable for the administration of this Policy.

8. Effective Date. This Policy shall be effective as of the Effective Date.

9. Amendment; **Termination**. The Committee may amend this Policy from time to time in its discretion and shall amend this Policy as it deems necessary, including as and when it determines that it is legally required by any federal securities laws, SEC rules, or the listing rules of the Exchange. The Committee may terminate this Policy at any time. Notwithstanding anything in this Section 9 to the contrary, no amendment or termination of this Policy shall be effective if such amendment or termination would (after taking into account any actions taken by the Company contemporaneously with such amendment or termination) cause the Company to violate any federal securities laws, SEC rules, or the listing rules of the Exchange.

10. Acknowledgment; Benefits Conditioned on Agreeing to this Policy. Each Executive Officer shall be required to sign and return to the Company, within thirty (30) calendar days following the later of (i) the Effective Date of this Policy or (ii) the date the individual becomes an Executive Officer, the Acknowledgment Form attached hereto as Exhibit A, pursuant to which such Executive Officer will agree to be bound by the terms of this Policy. Any employment agreement, equity award agreement, compensatory plan or any other agreement or arrangement with an Executive Officer shall be deemed to include, as a condition to the grant or receipt of any benefit thereunder, an agreement by the Executive Officer to abide by, and for such Executive Officer and his/her Incentive-based Compensation to be subject to, the terms of this Policy. For the avoidance of doubt, each Executive Officer will be fully bound by, and must comply with, this Policy, whether or not such Executive Officer has executed and returned such Acknowledgment Form to the Company.

11. Other Recoupment Rights; Company Claims. The Board intends that this Policy will be applied to the fullest extent of the law. This Policy should be considered as a supplement to any other clawback policy in effect now or in the future at the Company or any other member of the Company Group, and if such other policy provides that a greater amount of compensation shall be subject to clawback, such other policy shall apply to the amount in excess of the amount subject to clawback under this Policy. Any right of recoupment (or right to apply a forfeiture) under this Policy is in addition to, and not in lieu of, any other remedies or rights of recoupment (or forfeiture) that may be available to the Company Group under applicable law, regulation, or rule or pursuant to the terms of any similar policy in any employment agreement, compensation plan or program, award agreement, or similar document and any other legal remedies available to the Company Group, in each case to the extent permitted under the listing rules of the Exchange and in compliance with (or pursuant to an exemption from the application of) Section 409A of the Code. Nothing contained in this Policy, and no recoupment, recovery, or forfeiture as contemplated by this Policy, shall limit any claims, damages, or other legal remedies the Company Group may have against an Executive Officer arising out of or resulting from any actions or omissions by the Executive Officer.

11. Successors. This Policy shall be binding and enforceable against all Executive Officers and their beneficiaries, heirs, executors, administrators or other legal representatives.

Exhibit A

AMEDISYS, INC.
POLICY FOR THE
RECOVERY OF ERRONEOUSLY AWARDED COMPENSATION

ACKNOWLEDGMENT FORM

By signing below, the undersigned acknowledges and confirms that the undersigned has received and reviewed a copy of the Amedisys, Inc. Policy for the Recovery of Erroneously Awarded Compensation (the "***Policy***"). Capitalized terms used but not otherwise defined in this Acknowledgment Form (this "***Acknowledgment Form***") shall have the meanings ascribed to such terms in the Policy.

By signing this Acknowledgment Form, the undersigned acknowledges and agrees that the undersigned and the undersigned's Incentive-based Compensation are and will continue to be subject to the Policy and that the Policy will apply both during and after the undersigned's employment with any member of the Company Group. In the event of any inconsistency or conflict between the Policy and any prior, existing or future employment agreement, compensation plan or program, award agreement or similar document to which the undersigned is or becomes a party or that otherwise is or becomes applicable to the undersigned (collectively, "***compensation arrangements***"), the undersigned acknowledges and agrees that the Policy shall govern such compensation arrangements, and all such compensation arrangements are hereby automatically deemed amended to the extent necessary to give effect to the Policy. Further, by signing below, the undersigned agrees to abide by the terms of the Policy, including, without limitation, by (i) waiving any rights to indemnification or any claim to insurance under a policy paid for by the Company, in either case in connection with the recovery of Erroneously Awarded Compensation under the Policy, and (ii) returning any Erroneously Awarded Compensation to the extent required by the Policy.

Signature: _____

Print Name: _____

Date: _____