Risk Factors Comparison 2024-03-14 to 2023-03-16 Form: 10-K

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You should carefully consider the risks described below, as well as other information contained in this report, including the consolidated financial statements and the notes thereto and " Management' s Discussion and Analysis of Financial Condition and Results of Operations. " The occurrence of any of the events discussed below could significantly and adversely affect our business, prospects, results of operations, financial condition, and cash flows. Risks Related to Our Business and Industry Competition among home health, hospice and durable medical equipment companies is intense. The home health and hospice services and durable medical equipment industries are highly competitive. We compete with a variety of other companies in providing home health and hospice services and durable medical equipment, some of which may have greater financial and other resources and may be more established in their respective communities. Competing companies may offer newer or different services from those offered by us and may thereby attract customers who are presently receiving our home health and hospice services and durable medical equipment. If we are unable to react competitively to new developments, our operating results may suffer. In many areas in which our home health, hospice and durable medical equipment programs are located, we compete with a large number of organizations, including: • community- based home health providers; • national, regional and local companies; • national, regional and local hospice agencies; • hospital- based home health agencies; and • nursing homes. Some of our current and potential competitors have or may obtain significantly greater marketing and financial resources than we have or may obtain. We also compete with a number of non- profit organizations that can finance acquisitions and capital expenditures on a tax- exempt basis or receive charitable contributions that are unavailable to us. We compete based on the availability of personnel, the quality of services, the expertise of staff, and, in certain instances, on the price of our services. In home health and hospice markets that do not require a CON, POA, or similar approval, there are relatively few barriers to entry. Accordingly, other companies, including hospitals and other healthcare organizations that are not currently providing services, may expand their services to include home health and hospice services or similar services. If states with such existing laws remove such barriers, we could face increased competition in these states. We may encounter increased competition in the future that could negatively impact patient referrals to us, limit our ability to maintain or increase our market position and could have a material adverse effect on our business, financial position, results of operations and liquidity. If any large national healthcare entities that do not currently directly compete with us move into the home health or hospice market, competition could significantly increase. Larger, national healthcare entities have significant financial resources and extensive technology infrastructure. In addition, companies that currently compete in certain of our services could begin competing with additional services through the acquisition of an existing company or de novo expansion into these services. Our competitors may also develop joint ventures with providers, referral sources and payers, which could result in increased competition. Managed care organizations, such as health maintenance organizations (" HMOs ") and preferred provider organizations (" PPOs "), and other third- party payers continue to consolidate, which enhances their ability to influence the delivery of healthcare services. Consequently, the healthcare 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 payers, including managed care payers, seek to negotiate discounted fee structures or the assumption by healthcare 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 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 contractually obligated to refer patients to us and may refer their patients to other providers. In addition, our relationships with referral sources are subject to compliance with federal and state healthcare laws, such as the federal Anti-Kickback Statute ~~and ,~~ the **federal** Stark Law **, and similar state laws** . Our growth and profitability depend, in part, on our ability to establish and maintain close working relationships with these patient referral sources, comply with applicable laws with respect to such relationships, and to increase awareness and acceptance of the benefits of home health and hospice services by our referral sources and their patients. There can also be no assurance that other market participants will not attempt to steer patients to competing health services providers. 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. Our business, financial condition and results of operations may be materially adversely affected by **national public health emergencies including** a resurgence of the COVID- 19 pandemic **, variants of the virus, or other public health emergencies** . The COVID- 19 pandemic ~~has~~ adversely impacted economic activity and conditions worldwide, including workforces, liquidity, capital markets, consumer behavior, supply chains and macroeconomic conditions. The surge in COVID- 19 cases in 2021 attributable to the Delta and Omicron variants, as well as the effect of vaccine mandates, placed significant pressure on caregiver recruitment and retention ~~. This reduced the number of available caregivers to provide services to our patients thereby reducing organic patient volumes in 2021 as compared to 2020. The surge in COVID- 19 cases also increased costs associated with securing and retaining available caregivers, including significant hiring and retention incentives in the fourth quarter of fiscal year 2021~~ . While the direct effects of the pandemic on our business have significantly lessened since the first quarter of fiscal year 2022 as a result of declining

infection rates and the normalization of living with COVID- 19 following the increase in accessibility to COVID- 19 vaccines and antiviral treatments, there is no guarantee that we will be able to attract and retain qualified caregivers in quantities to meet existing demand for our services and return our organic patient volumes to pre- pandemic levels. The PHE associated with COVID- 19 ~~is currently set to expire~~ **expired** ~~on~~ **in** May ~~11,~~ 2023. The extent to which a future COVID- 19 outbreak could impact our business and operating results in the future depends on future developments that are highly uncertain and cannot be accurately predicted ~~, including new information that may emerge concerning COVID- 19 and variants of the virus and the actions to contain or treat their impact, as well as the impact of any new federal, state and local mandates or other regulations associated with COVID- 19~~ . The impacts of any future **public health emergencies** ~~resurgence of the COVID- 19 pandemic~~ on our results of operations may include: decreased demand for our services; lower volumes of our services provided, including due to lack of availability of caregivers in the workforce; interruptions in the provision of our services, including due to the interruption of the operations of our referral sources; increased costs of services in order to attract and retain qualified caregivers; increased costs necessary to comply with federal, state and local mandates and other regulations associated with ~~COVID- 19~~ **any public health emergency** ; civil monetary penalties from CMS if we are unable to comply with ~~the IFR (defined below) requiring COVID- 19 vaccinations~~ **vaccination requirements** ~~, lower reimbursement rates due to any negative impacts of the pending PHE expiration on state Medicaid budgets as enhanced Federal matching funds for the Medicaid program begin to sunset; lower patient volumes resulting from any negative impacts of reinstatement of the redetermination process for Medicaid eligibility on April 1, 2023~~ ; and a reduction in our liquidity position, which may limit our ability to service our indebtedness and our future ability to incur additional indebtedness or financing. All of these possibilities could in the future have a material and adverse impact on our business, results of operations and financial condition ~~. Federal, state and private party mandates or standards requiring vaccination or testing of employees could negatively impact our ability to attract and retain employees and could add increased administrative burden, which in turn could adversely affect our profitability and ability to grow. Aveanna is subject to federal and state regulations regarding mandatory vaccination and / or COVID- 19 testing of its employees. In addition, certain health system or other referral sources have imposed requirements which mandate certain Aveanna employees to be vaccinated or tested in order to service patients of such entities. On November 5, 2021, the Occupational Safety and Health Administration (" OSHA ") issued the COVID- 19 Vaccination and Testing Emergency Temporary Standard (" ETS ") implementing certain workplace safety elements related to COVID- 19 vaccination and / or testing requirements for all employers with 100 or more employees. On November 6, 2021, the United States Fifth Circuit Court of Appeals granted a nationwide stay of OSHA' s ETS. On December 17, 2021, the United States Sixth Circuit Court of Appeals, which had been chosen by lottery to review multi- district litigation concerning the ETS, dissolved the Fifth Circuit' s injunction, allowing OSHA to proceed with implementing the ETS. On January 13, 2022, the Supreme Court of the United States (the " Supreme Court ") issued a ruling which ordered that the ETS be stayed pending the disposition of appeal pending before the Sixth Circuit and any future appeals. In light of the Supreme Court' s ruling, on January 25, 2022, OSHA withdrew the ETS as an enforceable emergency temporary standard, effective January 26, 2022. Notwithstanding the withdrawal of the ETS, OSHA continues to strongly encourage the vaccination of workers against continuing dangers posed by COVID- 19 in the workplace and OSHA continues to inspect employer worksites for COVID- 19 safety under the agency' s current standards, including the COVID- 19 National Emphasis Program, which targets high- risk industries (to include home care services), as well as housekeeping and respiratory standards, and the Occupational Safety and Health Act' s general duty clause. Moreover, although OSHA is withdrawing the vaccination and testing ETS as an enforceable emergency temporary standard, OSHA has not withdrawn that ETS as a proposed rule and has prioritized resources to finalize a permanent COVID- 19 healthcare standard. Furthermore, on November 4, 2021, CMS issued an interim final rule (" IFR ") requiring COVID- 19 vaccinations for workers in most health care settings covered by applicable " Conditions of Participation, " including home health and hospice facilities, that participate in Medicare and Medicaid programs. The IFR was effective as of November 5, 2021. Under the IFR, all covered healthcare workers and related support staff must be fully vaccinated by February 28, 2022. The vaccination requirement applies to all eligible staff working at a facility that participates in Medicare and Medicaid programs, regardless of clinical responsibility or patient care, including staff who work in offsite locations, such as homes, clinics or administrative offices. The requirement does not apply to individuals who provide services 100 % remotely and have no direct contact with patients and other staff. The IFR requires health care providers to establish a process or policy to ensure covered staff, except for those individuals who are granted a religious or medical exemption, are fully vaccinated over two phases. Following numerous legal challenges to the IFR, on January 13, 2021, the Supreme Court allowed the IFR to go into effect by staying injunctions preventing its enforcement. On October 26, 2022, CMS issued guidance and survey procedures for all healthcare provider types (including home health agencies and hospices) related to assessing and maintaining compliance with the staff vaccination regulatory requirements identified in the IFR. These federal and state mandates, as well additional restrictions imposed by hospital systems or other referrers, could increase the challenges of maintaining and growing our number of employees across all functions and will create operational burdens necessary to track vaccination status and enforce weekly COVID- 19 testing of non- vaccinated employees for the remaining jurisdictions with testing requirements. These vaccination mandates could lead to additional employee turnover, including turnover caused by employees moving to companies with service lines that are not covered by the IFR. If we are unable to continue to attract and retain employees at our current level, we could be required to increase employee compensation in an effort to prevent understaffing of our operations. An increase in our expenses or in the number of employee vacancies could materially and adversely affect our growth and profitability. The IFR also conflicts with various state laws and mandates prohibiting COVID- 19 vaccination mandates. The IFR requirements place the Company in the position of either violating federal regulations or applicable state laws, which could result in state agency fines and licensure revocation for possible non- compliance with state vaccine mandate prohibitions, which could have a material and adverse effect on our results of operations~~ . The cost of healthcare is funded substantially by government and private insurance programs. If such funding is

reduced or limited or no longer available, our business may be adversely impacted. Third- party payers including Medicare, Medicaid and private health insurance payers provide substantially all funding for our home health and hospice services, and we cannot control reimbursement rates. During the past several years, third- party healthcare payers in the adult home care and hospice space, such as federal and state governments, insurance companies and employers, have undertaken cost containment initiatives. As part of the efforts, such payers increasingly are demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk relating to paying for care provided, often in exchange for exclusive or preferred participation in their benefit plans. We expect efforts to impose greater discounts and more stringent cost controls by government and other third- party payers to continue, thereby reducing the payments we receive for our services. For example, the Medicaid Integrity Program is increasing the scrutiny placed on Medicaid payments and could result in recoupments of alleged overpayments. CMS conducts similar audits on Medicare payments which may also result in recoupments of alleged overpayments. These payer audits are conducted by CMS contractors, many of whom are incentivized based upon the dollar value of said recoupments, specifically Recovery Audit Contractor (" RAC ") and Supplemental Medical Review Contractor (" SMRC ") **audits, as well as the Unified Program Integrity Contractors (" UPIC ") program and the Zone Program Integrity Contractor (" UPIC ") program** audits. While most audits are conducted on a post payment basis, including RAC, ZPIC, UPIC, and SMRC audits, CMS also performs Targeted Probe and Educate (" TPE ") audits on all home health and hospice providers to help reduce provider billing errors and educate providers on appropriate billing practices. These audits occasionally result in recoupment of Medicare reimbursement. Similarly, private third- party payers may be successful in negotiating reduced reimbursement schedules for our services. Fixed fee schedules, capitation payment arrangements, exclusion from participation in or inability to reach agreements with private insurance organizations or government funded programs, reduction or elimination of payments or an increase in the payments at a rate that is less than the increase in our costs, or other factors affecting payments for healthcare services over which we have no control could have a material adverse effect on our business, prospects, results of operations and financial condition. Further, we cannot assure you that our services will be considered cost- effective by third- party payers, that reimbursement will continue to be available, or that changes to third- party payer reimbursement policies will not have a material adverse effect on our ability to sell our services on a profitable basis, if at all. Reimbursement for the home health and hospice services that we provide is primarily through Medicare, Medicaid and managed care providers. Payments received from Medicare are subject to changes made through federal legislation and regulation. Payments received from Medicaid may vary from state to state. These payments are subject to statutory and regulatory changes, administrative rulings, interpretations and determinations concerning patient eligibility requirements, funding levels and the method of calculating payments or reimbursements. When such changes are implemented, we also must modify our internal billing processes and procedures accordingly, which can require significant time and expense. We cannot assure you that reimbursement payments under governmental payer programs, including 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. These changes, including retroactive adjustments, if adopted in the future by CMS, could have a material adverse effect on our business, financial position, results of operations and liquidity. Changes to Medicare rates or methods governing Medicare payments for our services could materially adversely affect our business. We derive substantial revenue from Medicare for our adult home health and hospice services. Reductions in Medicare rates or changes in the way Medicare pays for services could cause our revenue for these services to decline, perhaps materially. Reductions in Medicare reimbursement could be caused by many factors, including: • administrative or legislative changes to the base rates under the applicable prospective payment systems; • the reduction or elimination of annual rate increases; • the imposition or increase by Medicare of mechanisms shifting more responsibility for a portion of payment to beneficiaries, such as co-payments; • adjustments to the relative components of the wage index used in determining reimbursement rates; • changes to case mix or therapy thresholds; or • the reclassification of home health resource groups or long- term care diagnosis- related groups. We receive payments from Medicare for our adult home health and hospice services based on the level of care provided to our patients. As a result, our profitability largely depends upon our ability to manage the cost of providing these services. We cannot be assured that reimbursement payments under governmental payer programs, including Medicare, will remain at comparable levels to the present or will be sufficient to cover the costs allocable for patient services. Any changes could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flow. Medicare currently provides for an annual adjustment of the various payment rates, such as the base episode rate for our home nursing services, based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation. This adjustment could be eliminated or reduced in any given year. Also, beginning on April 1, 2013, Medicare reimbursement was cut an additional 2 % through sequestration as mandated by the Budget Control Act of 2011 and American Taxpayer Relief Act of 2011. The Coronavirus Aid, Relief, and Economic Security (CARES) Act (the " CARES Act "), the Consolidated Appropriations Act of 2021, and the Act to Prevent Across- the- Board Direct Spending Cuts suspended the 2 % sequestration mandated by the Budget Control Act of 2011 and the American Relief Act of 2011 through December 31, 2021. In December 2021, Congress extended the suspension of the automatic 2 % reduction through March 2022 and reduced the sequestration adjustment to 1 % beginning on April 1, 2022 through June 30, 2022, with the full 2 % reduction for sequestration resuming thereafter. Further, Medicare routinely reclassifies home health resource groups. As a result of those reclassifications, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our results of operations, net income and cash flows could be adversely impacted. Additionally, CMS changed the HHPPS case-mix adjustment methodology through the use of a new PDGM for home health payments. This change was implemented on January 1, 2020, and also includes a change in the unit of payment from a 60- day payment period to a 30- day payment period and eliminates the use of therapy visits in the determination of payments. While the changes are intended to be implemented in a

budget- neutral manner to the industry, the ultimate impact will vary by provider based on factors including patient mix and admission source. Additionally, in arriving at the calculation of a rate that is budget- neutral, CMS has made numerous assumptions about behavioral changes. The application of these assumptions could negatively impact our rates of reimbursement and have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. In June 2019, CMS implemented the Review Choice Demonstration (" RCD") Project for home health providers who submit claims to Palmetto GBA Medicare Administrative Contractor, specifically home health providers in Illinois, Ohio, Texas, North Carolina, and Florida. On September 1, 2021, CMS mandated participation for North Carolina and Florida providers. The Demonstration Project runs in six- month cycles until July 31, 2024, and is intended to reduce the number of Medicare appeals, and improve provider compliance with Medicare program requirements. Upon initiation of RCD or Cycle 1, HHAs had three initial choices; pre- claim review of 100 % of claims; post- payment review; or minimal post- payment review with a 25 % payment reduction. HHAs must have met a 90 % target full provisional affirmation rate based on a minimum 10 requests / claims submitted to have successfully completed Cycle 1. For those HHAs who met the target affirmation rate and demonstrated compliance with certain Medicare rules, an additional review option of 5 % Spot Check Review was available to choose for subsequent Cycles 2- 6. Our home health business in the states of Florida and North Carolina are subject to the requirements of the RCD Project. These states recently finished Cycle 4 **- 5** of the six total cycles ~~with~~ **and** Cycle **6** ~~5 expected to begin~~ **began** on **January** ~~or about May~~ 1, ~~2023~~ **2024** . If we do not comply with the requirements of the RCD Project we are at risk for significant advance payment or post- payment reviews and our reimbursement from the Medicare program could be delayed or reduced, thereby adversely impacting our results of operations, net income and cash flows. Additionally, states participating in the RCD Project are excluded from certain other CMS Audits referenced above. The Consolidated Appropriations Act passed by Congress at the end of 2022 (also referred to as the " Omnibus Budget Bill ") contained several provisions that could impact our business. As to budget enforcement rules previously enacted by Congress, Section 1001 of the Omnibus Budget Bill waives Statutory Pay- As- You- Go (S- PAYGO) for two years through December 31, 2024. The S- PAYGO 4 % mandatory sequestration of Medicare benefit payments that previously would have become effective on January 1, 2023 has now been delayed until January 1, 2025. Additionally, Section 4163 of the Omnibus Budget Bill extended the current Budget Control Act (BCA) mandatory sequestration of 2 % of Medicare benefits through the first six (6) months of ~~2032~~ **2023** and revised the sequestration percentages for fiscal years 2030 through 2032 to 2 %. On ~~October 31~~ **November 13** , ~~2022~~ **2023** , CMS issued the Calendar Year (" CY ") ~~2023~~ **2024** Home Health Prospective Payment System Rate Update and Home Infusion Therapy Services Payment Update Final Rule which became effective on January 1, ~~2023~~ **2024** . Key provisions of the ~~2023~~ **2024** Final Rule include: • The CY ~~2023~~ **2024** 30- day base payment rate under PDGM was reduced by 1 %. • CMS finalized its budget neutrality methodology for making ~~temporary and~~ permanent behavioral adjustments. oThe permanent behavioral adjustment (reduction) of ~~7~~ **5** . ~~85~~ **78** % to home health payments ~~will be phased in over two years, beginning on January 1, 2023~~ . oHalf of the permanent behavioral adjustment (reduction), ~~3~~ **2** . ~~925~~ **89** %, is applied to the 30- day base payment rate beginning on January 1, ~~2023. oThe remaining half of the permanent behavioral adjustment (reduction), 3. 925 %, will be applied to the 30- day base payment rate beginning on January 1,~~ 2024 ~~in order to achieve the full reduction of 7. 85 %~~ . • The annual market basket update was an increase of ~~4~~ **3** . ~~0~~ **3** % to the CY ~~2023~~ **2024** 30- day base payment rate. ~~oThis represents a 4. 1 % increase for the annual inflation update, with a 0. 1 % negative productivity adjustment.~~ While we will make every effort to mitigate the impact of ~~forthcoming~~ behavioral adjustments in 2024, we cannot assure you that implementation and application of the remaining ~~3~~ **2** . ~~925~~ **89** % behavioral adjustment (reduction) beginning on January 1, 2024 will not have a material adverse effect on our business. The implementation of alternative payment models and the transition of Medicaid and Medicare beneficiaries to managed care organizations may limit our market share and could adversely affect our revenues. The healthcare industry in general is facing uncertainty associated with the efforts to identify and implement alternative delivery payment models and workable coordinated care. Many government and commercial payers are transitioning providers to alternative payment models that are designed to promote cost- efficiency, quality and coordination of care. For example, accountable care organizations (" ACOs ") incentivize hospitals, physician groups, and other providers to organize and coordinate patient care while reducing unnecessary costs. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Providers are then paid based on the overall value and quality (as determined by outcomes) of the services they provide to a patient rather than the number of services they provide. Pursuant to the ACA, CMS has established several separate ACO programs, the largest of which is the Medicare Shared Savings Program (" MSSP "). CMS established the MSSP to facilitate coordination and cooperation among providers to improve the quality of care for Medicare fee- for- service beneficiaries and to reduce costs. Eligible providers, hospitals and suppliers may participate in the MSSP by creating, participating in or contracting with an ACO. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. According to CMS, ~~483~~ **480** MSSP ACOs served over ~~11~~ **13** million patients as of January 1, ~~2022~~ **2024** . ~~As of~~ **Beginning on** January 1, 2023, CMS transitioned to the Accountable Care Organization Realizing Equity, Access and Community Health (" REACH ") Model, requiring ACO participants to meet several provisions on promoting health equity, including the creation of a health equity plan. If we are not included in these programs, or if ACOs establish programs that overlap with our services, we are at risk for losing market share, including a loss of our current business. Other alternative payment models may be presented by the government and commercial payers to control costs that subject our company to financial risk. Broad- based implementation of a new delivery payment model would represent a significant transformation for us and the healthcare industry generally. The development of new delivery and payment systems will almost certainly take significant time and expense. We cannot predict at this time what effect alternative payment models may have on our company. We may be similarly impacted by increased enrollment of Medicare and Medicaid beneficiaries in managed care plans, shifting away from traditional fee- for- service models. Under a managed Medicare plan, also known as Medicare Advantage, the federal government contracts with private health insurers to provide

Medicare benefits and the insurers may choose to offer supplemental benefits. Approximately **51 %** ~~two- fifths~~ of all Medicare beneficiaries were enrolled in a Medicare Advantage plan in ~~2021~~ **2023** , a figure that continues to grow. Beginning in 2019, CMS allowed Medicare Advantage plans to offer certain personal care services as a supplemental benefit. Enrollment in managed Medicaid plans is also growing, as states are increasingly relying on managed care organizations to deliver Medicaid program services as a strategy to control costs and manage resources. We cannot assure you that we will be successful in our efforts to be included in managed plan networks, that we will be able to secure favorable contracts with all or some of the managed care organizations, that our reimbursement under these programs will remain at current levels, that the authorizations for services will remain at current levels or that our profitability will remain at levels consistent with past performance. We may also face increased competition for managed care contracts as a result of state regulation and limitations. In addition, operational processes may not be well- defined as a state transitions Medicaid recipients to managed care. For example, membership, new referrals and the related authorization for services to be provided may be delayed, which may result in delays in service delivery to consumers or in payment for services rendered. Difficulties with operational processes associated with new managed care contracts may negatively affect our revenue growth rates, cash flow and profitability for services provided. Because we are limited in our ability to control reimbursement rates received for our services, our business could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services. We receive fixed payments at rates established through federal and state legislation from Medicare and Medicaid, our most significant payers, for our services. Consequently, our profitability largely depends upon our ability to manage the costs of providing these services. We cannot be assured that reimbursement payments under Medicare and Medicaid 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. Additionally, non-government payer rates are difficult for us to negotiate as such payers are under pressure to reduce their own costs. As a result, we have sought to 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. Delays in collection or non- collection of our patient accounts receivable, or recoupment of payments previously received, particularly during the business integration process, or during system transitions, or in connection with complying with EVV data collection and submission requirements, could adversely affect our business, financial position, results of operations and liquidity. Prompt billing and collection are important factors in our liquidity and our business is characterized by delays from the time we provide services to the time we receive payment for these services. We bill numerous and varied payers, such as Medicare, Medicaid and private insurance payers. These different payers typically have different billing requirements that must be satisfied prior to receiving payment for services rendered. Reimbursement is typically conditioned on our documenting medical necessity and correctly applying diagnosis codes. Incorrect or incomplete documentation and billing information could result in non- payment for services rendered. Billing and collection of our patient accounts receivable with Medicare and Medicaid are further subject to the complex regulations that govern Medicare and Medicaid reimbursement, and to rules imposed by nongovernment payers. For example, recent efforts have focused on improved coordination of regulation across the various types of Medicaid programs through which personal care services are offered. The 21st Century Cures Act, as amended, mandated that states implement EVV, which is used to collect home visit data, such as when the visit begins and ends. In several states, providers are now required to obtain state licenses or registrations and must comply with laws and regulations governing standards of practice. Providers must dedicate substantial resources to ensure continuing compliance with all applicable regulations and significant expenditures may be necessary to offer new services or to expand into new markets. The failure to comply with regulatory requirements could lead to the termination of rights to participate in federal and state- sponsored programs, repayment of payments previously received, and the suspension or revocation of licenses. We believe new licensing requirements and regulations, including EVV, the increasing focus on improving health outcomes, the rising cost and complexity of operations, technology and pressure on reimbursement rates due to constrained government resources may discourage new providers and may encourage industry consolidation. Further, states that fail to meet federally imposed EVV deadlines could potentially lose, without an application for a good cause extension, an escalating amount of their funding. Each state has different timelines and methodologies, including the data aggregators and processors used by each state, for implementing respective EVV process requirements. In order to comply with current and future state and federal regulations around EVV use, we utilize several different vendors. In states with an “ open ” model, the payer is able to choose its preferred EVV vendor. In states mandating the EVV vendor, a “ closed ” system, we utilize whichever vendor the state has mandated. In both cases, we have built interfaces between the EVV vendor and our clinical scheduling, documentation, and billing systems utilized in the respective branch and corporate locations. To the extent that our EVV vendors fail to support these processes, our internal operations could be negatively affected. To the extent that states fail to properly implement EVV, or that we fail to comply with new EVV data collection and submission requirements, our internal operations could be negatively affected. Our inability to collect and submit the data required by EVV regulations could negatively impact our ability to retain previously received payments or could subject us to future payment delays, which could have a material adverse effect on our business, financial position, results of operations and liquidity. In addition, timing delays in billings and collections may cause working capital shortages. Working capital management, including prompt and diligent billing and collection, is an important factor in our financial position and results of operations and in maintaining liquidity. It is possible that Medicare, Medicaid, documentation support, system problems or other provider issues or industry trends, particularly with respect to newly acquired entities for which we have limited operational experience, 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. The timing of payments made under the Medicare and Medicaid programs is subject to governmental budgetary constraints, which may result in an increased period of time between submission of claims and

subsequent payment under specific programs, most notably under the Medicare and Medicaid managed care programs, which in many cases pay claims significantly slower than traditional Medicare or state Medicaid programs do as a result of more complicated authorization, billing and collecting processes that are required by Medicare and Medicaid managed care programs. In addition, we may experience delays in reimbursement as a result of the failure to receive prompt approvals related to change of ownership applications for acquired or other facilities or from delays caused by our or other third parties' information system failures. Furthermore, the proliferation of Medicare and Medicaid managed care programs could have a material adverse impact on the results of our operations as a result of more complicated authorization, billing and collection requirements implemented by such programs. A change in our estimates of collectability or a delay in collection of accounts receivable could adversely affect our results of operations and liquidity. The estimates are based on a variety of factors, including our historical associative collection rate of revenue recognized for patient services, the age of unbilled receivables, and the age of billed receivables. A deterioration in our associative collection rate of revenue recognized or the overall aging of accounts receivable, including, without limitation, in connection with our transition and integration of acquired companies, and the attendant movement of underlying billing and collection operations from legacy systems to future systems, could have a material negative impact on our results of operations and liquidity and we could be required to record impairment charges on our financial statements. Failure to maintain the security and functionality of our information systems, or to defend against or otherwise prevent a cybersecurity attack or breach, could adversely affect our business, financial position, results of operations and liquidity. We collect, store, use, retain, disclose, transfer and otherwise process a significant amount of confidential, sensitive and personal information from and about our actual and potential patients and our employees, including tax information, patient health information and payroll data. In addition to internal resources, we rely on third- party service providers in providing our services, including to provide continual maintenance and enhancements and security of any protected data. Such third- party service providers have access to confidential, sensitive and personal information about our patients and employees, and some of these service providers in turn subcontract with other third- party service providers. Through contractual provisions **, review from our cybersecurity team, our Vulnerability Management Framework,** and third- party risk management processes, we take steps to require that our service providers, and their subcontractors, protect our confidential, sensitive and personal information. However, due to the size and complexity of our technology platform and services, the amount of confidential, sensitive and personal information that we store and the number of patients, employees and third- party service providers with access to confidential, sensitive and personal information, we are potentially vulnerable to a variety of intentional and inadvertent cybersecurity attacks and other security- related incidents and threats, which could result in a material adverse effect on our business, financial position, results of operations and liquidity. Threats to our information technology systems and data security can take a variety of forms. Hackers may develop and deploy viruses, worms and other malicious software programs that attack our networks and data centers or those of our service providers. Additionally, unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud, trickery, or other forms of deceiving our employees or contractors, direct social engineering, phishing, credential stuffing, ransomware, denial or degradation of service attacks and similar types of attacks against any or all of us, our patients and our service providers. Other threats include inadvertent security breaches or theft, misuse, unauthorized access or other improper actions by our employees, patients, service providers and other business partners. Cybersecurity attacks and other security- related incidents are increasing in frequency and evolving in nature. We have implemented policy, procedural, technical, physical and administrative controls with the aim of protecting our networks, applications, bank accounts, and the confidential, sensitive and personal information entrusted to us from such threats. Specifically, we have **cybersecurity management processes, independent of enterprise risk management, which adhere to an internally developed Intelligence Policy and a Vulnerability Management Framework, and in accordance therewith we have** installed privacy protection systems and devices on our network and point of care tablets in an attempt to prevent unauthorized access to information in our database **. In addition, a dedicated Assistant Vice President of Cybersecurity, who reports to the Chief Information Officer, has been tasked with managing the Company' s cybersecurity program and related policies, under ultimate oversight by the Audit Committee of the Board of Directors** . However, given the unpredictability of the timing, nature and scope of cybersecurity attacks and other security- related incidents, our technology may fail to adequately secure the confidential health information and personally identifiable information we maintain in our databases and there can be no assurance that **our data and cybersecurity risk management infrastructure or** any security procedures and controls that ~~we or~~ our service providers have implemented will be sufficient to prevent such incidents from occurring. Furthermore, because the methods of attack and deception change frequently, are increasingly complex and sophisticated, and can originate from a wide variety of sources, including third parties such as service providers and even nation- state actors, it is possible that we may not be able to anticipate, detect, appropriately react and respond to, or implement effective preventative measures against, all cybersecurity attacks and other security- related incidents. As a result, our business, financial condition, results of operations and liquidity could be materially and adversely affected. The occurrence of any actual or attempted cybersecurity attack or other security- related incident, the reporting of such an incident, whether accurate or not, or our failure to make adequate or timely disclosures to the public or law enforcement agencies following any such event, whether due to delayed discovery or a failure to follow existing protocols, could result in liability to our patients and / or regulators, which could result in significant fines, litigation penalties, orders, sanctions, adverse publicity, litigation or actions against us or our service providers by governmental bodies and other regulatory authorities, patients or third parties, that could have a material adverse effect on our business, consolidated financial condition, results of operations, cash flows and liquidity. Any such proceeding or action, any related indemnification obligation, even if we are not held liable, and any resulting negative publicity, could harm our business, damage our reputation, force us to incur significant expenses in defense of these proceedings, increase the costs of conducting our business, distract the attention of management or result in the imposition of financial liability. We may be required to expend significant capital and other resources to protect against the

threat of cybersecurity attacks and security breaches or to alleviate problems caused by breaches, including unauthorized access to patient data and personally identifiable information stored in our information systems, the introduction of computer viruses or other malicious software programs to our systems, cybersecurity attacks, email phishing schemes, network disruption, denial of service attacks, malware and ransomware. A cybersecurity attack or other incident that bypasses our, our patients' or third- party service providers' information system' s security **, or the information system' s security of vendors or counterparties to our patients' or third- party service providers,** could cause a security breach that may lead to a material disruption to our information systems infrastructure or business and may involve a significant loss of business or patient health information and other confidential, sensitive or personal information. If a cybersecurity attack or other unauthorized attempt to access our systems or facilities, or those of our patients or third- party service providers **, directly or indirectly** , were to be successful, it could result in the theft, destruction, loss, misappropriation or release of confidential, sensitive or personal information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cybersecurity attack or other unauthorized attempt to access our systems or facilities, or those of our patients or third- party service providers, also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payers or other third parties and could subject us to substantial sanctions, fines and damages and other additional civil and criminal penalties under HIPAA, the HITECH Act, the HIPAA Omnibus Rule (the " Omnibus Rule ") and other federal and state privacy laws, in addition to litigation with those affected. We, our patients, and our third- party service providers have been the victims of these types of threats, attacks and security breaches in the past. **On** ~~For example, in~~ February **21,** ~~2020~~ **2024** , ~~the Company advised the Office~~ **Change Healthcare, a subsidiary of UnitedHealth Group that acts as an intermediary** for **processing** ~~Civil Rights,~~ certain ~~potentially~~ **payment claims we submit through certain third- party revenue cycle management solutions for payors (" third- party vendors "), notified our third- party vendors of a cybersecurity incident. In response to the incident, both our third- party vendors and Change Healthcare severed the service connections between their respective systems. The Change Healthcare incident has not** affected ~~persons~~ **our operations, except our ability to submit payment claims through these particular third- party vendors. In the event the Change Healthcare service is not restored in a timely fashion, we may experience payment collection delays as we turn to alternative channels to submit certain claims. As of the date hereof, the incident has affected approximately sixteen business days of billings for certain claims and could, depending on when Change Healthcare restores its service or our full implementation of alternative claims submission arrangements, result in** ~~and~~ - **an** ~~applicable State Attorneys General that consumer information~~ **increase in our patient accounts receivable balances and a decrease in our Net cash provided by** (**used in** ~~including social security numbers and financial account information~~) **operating activities** ~~may have been illegally accessed by an unauthorized third party. The Company hired leading forensic firms to support its investigation, assess its systems and implement measures to bolster its security. Based on its investigation, the Company determined that the intruder may have accessed certain employee email accounts between July 9, 2019 and August 24, 2019. The Company notified approximately 170, 000 current and former patients that certain information may have been copied and transferred, although there was no confirmation of any unauthorized acquisition, disclosure, use of, or access to such information as a result of the incident. Following the incident, the Company received notice that a class action complaint had been filed against the Company in the U. S. District Court~~ for ~~the Northern District of Georgia. The complaint alleged, among other things, that the Company failed to take the necessary security precautions to protect patient information and prevent the data breach and that the Company failed to provide timely and adequate notice to affected persons that their personal information had been subject to unauthorized access. This class action litigation was settled on October 19, 2022. The court appointed Claims Administrator has notified those individuals in the identified class of their rights and responsibilities under the settlement agreement. The exact amount of the settlement will depend on the total number of timely claims filed and whether claimants successfully supplement their claims. The Claims Administrator is expected to submit a final claims calculation report in~~ the first quarter of ~~fiscal year 2023~~ **2024** ~~and funding of the settlement is anticipated prior to the close of the first quarter of fiscal year 2023~~ . **We** ~~The settlement of the class action claims is anticipated to be less than $ 500, 000. There is a related regulatory enforcement matter in the Commonwealth of Massachusetts that has been resolved in principle in the amount of $ 425, 000; however, the Company is expected to incur additional expenses related to the remedial requirements of this settlement decree, which have not been finalized. The Company has insurance coverage and contingency plans for certain potential liabilities relating to the data breach, and we~~ expect ~~coverage for certain of the amounts we anticipate paying in connection with the foregoing settlements. Nevertheless, the coverage may be insufficient~~ to **fund** ~~satisfy all claims and liabilities related thereto and the Company will be responsible for deductibles and~~ any **increase in working capital resulting from** ~~other~~ -- **the** ~~expenses that may be incurred in excess of insurance coverage~~ **billing and payment disruption through cash on hand and draws on our Securitization Facility and Revolving Credit Facility** . No security measures, procedures, technology or amount of preparation can provide guaranteed protection from these threats, or ensure that we, our patients and our third- party service providers will not be victims again in the future. Similar events, like the cyber- attack described above may occur again in the future. Failure to maintain the security and functionality of our information systems and related software, or to defend a cybersecurity attack or other attempt to gain unauthorized access to our systems, facilities or patient health information could expose us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, the HHS Office of Inspector General (" OIG ") or State Attorneys General), litigation with those affected by the data breach, loss of patients, disputes with payers and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations and liquidity. Healthcare reform and other regulations could adversely affect our customers, which could have an adverse effect on their ability to make timely payments to us for our products and services. There are continuing efforts to

reform governmental healthcare programs by federal and state governments that could result in major changes in the healthcare delivery and reimbursement system on a national and state level. The ACA and other laws and regulations that limit or restrict Medicare and Medicaid payments to our customers could adversely impact our customers, resulting in their inability to pay us, or pay us in a timely manner, for our services. Efforts to repeal or substantially modify provisions of the ACA continue in the federal courts. Federal regulatory agencies continue to modify ACA regulations and guidance related to the ACA, often as a result of presidential directives. The ultimate outcomes of efforts to expand the ACA, substantially amend its provisions or change the funding for the ACA is unknown. Though we cannot predict what, if any, reform proposals will be adopted, healthcare reform and legislation may have a material adverse effect on our business and our financial condition, results of operations and cash flows. Any future efforts to challenge, repeal or replace the ACA or implement alternative reform measures may result in reduced funding for state Medicaid programs, lower numbers of insured individuals, reduced coverage for insured individuals and could impact providers and other healthcare industry participants. See " Risk Factors — Risks Related to Our Regulatory Framework. " Changes in the case- mix of our patients, as well as payer mix and payment methodologies, may have a material adverse effect on our profitability. The sources and amounts of our patient revenues is determined by a number of factors, including the mix of patients and the rates of reimbursement among third- party payers. Changes in the case- mix of our patients as well as the third- party payer mix among Medicare, Medicaid and private payers may significantly affect our profitability. In particular, any significant increase in our Medicare or Medicaid population, or decrease in Medicare or Medicaid payments could have a material adverse effect on our financial position, results of operations and cash flow, particularly if states operating these programs continue to limit, or more aggressively seek limits on, reimbursement rates or service levels. Changes in payment methodologies by third- party payers could have a material adverse effect on our financial position, results of operations and cash flow. ~~In~~ **On** November ~~2018~~ **1** , ~~CMS issued the Calendar Year 2019 Home Health Final Rule, which provided for the first payment rate increase for home health providers since 2010. In the 2019 rule, CMS also issued proposed payment changes for Medicare home health providers for 2020~~ **2023** . ~~These proposed changes included changes to the HHPPS case- mix adjustment methodology through the use of a new reimbursement methodology, PDGM, for home health payments. As a result, the unit of payment changed from a 60- day payment episode to a 30- day payment episode and the use of therapy visits in the determination of payments was eliminated. While the proposed changes are supposed to be implemented in a budget neutral manner to the industry, the ultimate impact will vary by provider based on factors including patient mix and admission source. On October 31, 2019, CMS released its notice of final rulemaking for calendar year 2020 for home health agencies under the HHPPS (the " 2020 HH Rule "). The 2020 HH Rule finalized the implementation of PDGM for 2020. In addition to the significant changes to the home health reimbursement model related to PDGM discussed above, the 2020 HH Rule requires additional quality reporting measures and significantly increases the standardized patient assessment data elements collected by providers beginning in 2022. On October 31, 2022~~ , CMS released its final rule for fiscal year ~~2023~~ **2024** (the " ~~2023~~ **2024** HH Rule "). With respect to Medicare reimbursement rates, the ~~2023~~ **2024** HH Rule implements a home health payment increase of 0. ~~7~~ **8** %. This reflects a market basket increase of ~~4~~ **3** . ~~1~~ **3** % and an outlier payment increase of 0. ~~2~~ **4** % offset by a productivity adjustment of- 0. ~~1~~ **3** % and a PDGM behavioral assumption adjustment of- ~~3~~ **5** . ~~925~~ **78** % ~~. The full PDGM behavioral adjustment is- 7. 85 % but CMS is phasing this in over two years with- 3. 925 % in 2023 and the remaining- 3. 925 % cut projected to occur in 2024~~ . CMS projects the overall impact of the- ~~3~~ **5** . ~~925~~ **78** % adjustment to be- ~~3~~ **2** . ~~5~~ **89** % as the adjustment is only made to the 30- day payment rate and not Low Utilization Payment Adjustment (LUPA) rates. Any future significant changes in CMS reimbursement methodology, or future decreases in reimbursement rates could have a material adverse effect on our business, financial condition, results of operations and cash flows. If we are unable to provide consistently high quality of care, our business **and consolidated financial condition, results of operations, and cash flows** will be adversely impacted. Providing quality patient care is fundamental to 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 is becoming increasingly important within our industry. Effective October 2012, Medicare began to impose 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. If we should fail to achieve or exceed these averages, it may affect 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. Quality reporting requirements may negatively impact Medicare reimbursement. Hospice quality reporting was mandated by the ACA, which directs the Secretary of HHS to establish quality reporting requirements for hospice programs. Failure to submit required quality data will result in a 2 %- point 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. The IMPACT Act requires the submission of standardized data by home health agencies. 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. Similarly, in the Calendar Year 2015 Home Health Final Rule, CMS established a new " Pay- for- Reporting Performance Requirement " with which provider compliance with quality

reporting program requirements can be measured. Home health agencies that do not submit quality measure data to CMS are subject to a 2 % reduction in their annual home health payment update percentage. There can be no assurance that all our home health and hospice agencies will continue to meet quality reporting requirements in the future, which may result in one or more of our home health or hospice 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. Additionally, CMS initiated the Value Based Purchasing Demonstration (VBP) Project for nine states, including Arizona, Florida, Iowa, Massachusetts, Maryland, Nebraska, North Carolina, Tennessee, and Washington in 2016 for the purpose of using Medicare data to provide greater transparency on quality in order to deliver care based on value over volume. Data is pulled from OASIS, Medicare claims data and patient satisfaction scores. The Demonstration Project ended in December 2022 and effective January 1, 2023, CMS expanded VBP nationally to all providers. HHA performance in ~~2023~~ **2024** will determine payments in ~~2025~~ **2026** . Our hospice operations are subject to annual Medicare caps. If any of our hospice providers exceeds such caps, our business and consolidated financial condition, results of operations **,** and cash flows could be materially adversely affected. Medicare payments to a hospice are subject to an inpatient cap amount and an overall payment cap amount, which are calculated and published by CMS on an annual basis covering the period from November 1 through October 31. If payments received under any of our hospice operations exceeds any of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations **,** and cash flows. 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. We believe that there is a growing trend of patient utilization of managed care. Accordingly, we seek to diversify our payer sources by increasing the business we already do with managed care companies, such as HMOs and PPOs. However, we may not be successful in these efforts. There is also a risk that any favorable managed care contracts that we have may be terminated on short notice, because managed care contracts typically permit the payer to terminate the contract without cause, typically upon 90 days' notice, but in some cases upon a shorter notice period. The ability to terminate on short notice without cause can provide such companies with leverage to reduce volume or obtain favorable pricing to the detriment of our business strategy, and managed care contracts are subject to frequent change as a result of renegotiations and renewals. Our failure to negotiate, secure, and maintain favorable managed care contracts could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Furthermore, managed care contracts typically have complicated authorization, billing and collection provisions. Our inability to properly obtain authorizations from managed care programs or accurately bill managed care programs could result in material denied claims, or expose us to material repayment obligations, thereby materially adversely impacting our results of operations. The home health and hospice industries have historically experienced shortages in qualified employees and management, and competition for qualified personnel may increase our labor costs and reduce profitability. We compete with other healthcare providers for our employees, both professional employees and management. If we are unable to attract and retain qualified personnel, 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. Our ability to attract and retain qualified personnel depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. ~~During the COVID- 19 pandemic, our ability to attract and retain qualified personnel may also depend on our ability to appropriately protect these personnel from exposure to the virus, and upon the effect of vaccine mandates.~~ We cannot be assured we will succeed in any of these areas. In some markets, the lack of availability of medical personnel is a significant operating issue facing all healthcare providers ~~. This issue may be exacerbated if immigration is more limited in the future and by a resurgence of the COVID- 19 pandemic~~ . If the demand for home health and / or hospice services continues to exceed the supply of available and qualified personnel, we and our competitors may be forced to offer higher compensation and other benefits to attract and retain them. Since the COVID- 19 pandemic in 2020, we experienced increased caregiver recruitment and retention costs, including hiring and retention incentives, as well as higher base compensation rates as we passed reimbursement rate increases from our payers through to our caregivers. While the impacts on us of the COVID- 19 pandemic began to subside in the second quarter of fiscal year 2022, the labor markets remained challenging as a result of both shortages in workforce and inflationary wage pressures, which have constrained our ability to recruit and retain caregivers to meet patient demand. For example, recruitment of qualified caregivers in our private duty services businesses is highly competitive. The majority of our HHH and PDN caregivers are ~~Licensed Practical Nurses (" ~~LPN ~~")~~ and we compete for this labor pool both with competitors in our private duty services industry as well as other healthcare organizations outside our industry, to include hospitals. Hospitals and other healthcare providers have expanded LPN utilization in their labor pools. Even if we were to offer higher compensation and other benefits, there can be no assurance that these individuals will choose to join or continue to work for us. In addition, if we expand our operations into geographic areas where healthcare providers historically have been unionized, or if any of our 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. We currently have no union employees, so an increase in labor union activity could have a significant impact on our labor costs. Furthermore, the competitive market for this labor force has created turnover as many seek to take advantage of the supply of available positions, each offering new and more attractive wage and benefit packages. In addition to the wage pressures inherent in this environment, the cost of training new employees amid the turnover rates may cause added pressure on our operating results. If our labor costs continue to increase, we may not experience reimbursement rate or pricing increases to offset these additional costs. Our ability to pass along increased labor costs is limited, which could significantly affect our business and consolidated financial condition, results of operations **,** and cash flows. Any economic downturn, deepening of an economic downturn or federal and state budget pressures may result in a reduction in payments and

covered services. While we believe that our services are not typically sensitive to general declines in the federal and state economies, the erosion in the tax base caused by a general economic downturn can cause restrictions on the federal and state governments' abilities to obtain financing and a decline in spending. In the wake of the 2008 economic recession, most states faced unprecedented declines in tax revenues and, as a result, record budget gaps. If the economy were to contract into a recession (for example, as a result of **a public health emergency** ~~the global COVID- 19 pandemic~~ , inflation or as a result of the recent significant increase in prevailing interest rates), our government payers or other counterparties that owe us money could be delayed in obtaining, or may not be able to obtain, necessary funding and / or financing to meet their cash flow needs. As a result, we may face increased pricing pressure, termination of contracts, reimbursement rate cuts or reimbursement delays from Medicare and Medicaid and other governmental payers, which could adversely impact our **business and consolidated financial condition,** results of operations **,** and cash flows. Adverse developments in the United States could lead to a reduction in federal government expenditures, including governmentally funded programs in which we participate, such as Medicare and Medicaid. In addition, if at any time the federal government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the federal government may stop or delay making payments on its obligations, including funding for Medicare and Medicaid. Failure of the federal 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 U. S. 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 Medicare and / or Medicaid, 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 an automatic reduction in certain Medicare home health payments. Medicaid outlays may also be significantly affected by state budget pressures, and 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 ~~. There is a high degree of uncertainty regarding the implementation and impact of the CARES Act and other existing or future stimulus legislation, if any. There can be no assurance as to the total amount of financial assistance or types of assistance we will receive, that we will be able to comply with the applicable terms and conditions to retain such assistance, that we will be able to benefit from provisions intended to increase access to resources and ease regulatory burdens for health care providers or that additional stimulus legislation will be enacted. The CARES Act is a $ 2 trillion economic stimulus package signed into law on March 27, 2020, in response to the COVID- 19 pandemic. In an effort to stabilize the U. S. economy, the CARES Act provides for cash payments to individuals and loans and grants to small businesses, among other measures. The CARES Act also appropriates $ 100 billion in funding to HHS for hospitals and other healthcare providers to be distributed through the previously established Public Health and Social Services Emergency Fund (the " PHSSEF "). Following passage of the CARES Act, on April 24, 2020, H. R. 266, commonly known as the Paycheck Protection Program and Health Care Enhancement Act (the " PPPHCE Act "), was signed into law, which provides an additional $ 75 billion appropriation to the PHSSEF on the same terms and conditions as the CARES Act. These funds are intended to reimburse eligible providers and suppliers for healthcare- related expenses or lost revenues attributable to COVID- 19. Recipients are not required to repay PHSSEF funds, provided that they attest to and comply with certain terms and conditions, including limitations on balance billing and restrictions against using PHSSEF funds to reimburse expenses or losses that other sources are obligated to reimburse. HHS originally allocated $ 50 billion of the CARES Act Provider Relief Fund (" PRF ") for general distribution to Medicare providers impacted by COVID- 19, to be distributed on a proportional basis to providers' share of 2018 patient revenue. HHS also distributed $ 18 billion to eligible Medicaid and CHIP providers that have not received a payment from the original PRF' s $ 50 billion general distribution allocation and billed state Medicaid programs or Medicaid managed care plans for healthcare- related services between January 1, 2018 and May 31, 2020. The Company began applying for these Medicaid PRF payments in June 2020. As of January 2, 2021, we had received $ 25. 1 million in PRF payments as a result of applications made by the Company; we repaid this amount in full on March 5, 2021. In December 2021, we also received PRF payments from HHS totaling $ 2. 5 million, which we repaid in full in December 2021. Certain of the companies we acquired in 2020 and 2021, including the 2021 HHH Acquisitions (as defined herein), received and retained PRF Funds prior to the respective acquisition closing dates, approximately $ 12. 1 million in aggregate. Certain of the companies acquired in the 2021 HHH Acquisitions are subject to on- going audits of the PRF payments received prior to our acquisition. The CARES Act also makes other forms of financial assistance available to health care providers, including Medicare and Medicaid payments adjustments and an expansion of the Medicare Accelerated and Advance Payment Program, which makes available advance payments of Medicare funds in order to increase cash flow to providers. Some of the measures in the CARES Act and the PPPHCE Act allow for flexibility in delivery of care and various financial supports for health care providers are available only until the PHE for the COVID- 19 pandemic has ended. The PHE determination is currently set to expire on May 11, 2023. The federal government and the state governments may consider additional stimulus and relief efforts, but we are unable to predict whether additional stimulus measures will be enacted or their impact. Companies that we acquire in the future may have received, or elected to receive, financial or other types of assistance under the CARES Act, PPPHCE Act or future legislation, if any, and we may incur additional costs to bring such acquired companies into compliance with such laws or our elections thereunder. The HHS has indicated that for- profit commercial organizations, such as the companies we acquired that received and retained PRF funds prior to the acquisition closing dates, are required to include PRF payments in determining whether they are required to have certain audits performed. If HHS conducts an audit resulting in findings or allegations of noncompliance with applicable requirements for use of such PRF payments, it could result in a material payment obligation for us. We will continue to monitor~~

~~our compliance with the terms and conditions of the PRF, including demonstrating that the distributions received have been used for healthcare- related expenses or lost revenue attributable to COVID- 19. If we are unable to attest to or comply with current or future terms and conditions, then our ability to retain some or all of the distributions received may be impacted. There is a high degree of uncertainty regarding the implementation and impact of the American Rescue Plan Act (" ARPA ") and other existing or future stimulus legislation, if any. There can be no assurance as to the total amount of ARPA financial assistance or types of assistance we will receive, that we will be able to comply with the applicable terms and conditions to retain such assistance, that we will be able to benefit from provisions intended to increase access to resources and ease regulatory burdens for health care providers or that additional stimulus legislation will be enacted. On March 11, 2021 President Biden signed ARPA into law. ARPA is a federal stimulus bill designed to aid public health and economic recovery from the COVID- 19 pandemic. ARPA includes $ 350 billion in emergency funding for state, local, territorial and tribal governments, known as the Coronavirus State and Local Fiscal Recovery Funds (" ARPA Recovery Funds "). States must obligate the ARPA Recovery Funds by December 31, 2024 and spend such funds by December 31, 2026. Usage of the ARPA Recovery Funds is subject to the requirements specified in the United States Treasury Department' s Final Rule issued on January 6, 2022. The Final Rule provides states with substantial flexibility in utilizing ARPA Relief Funds, including to support public health expenditures such as vaccination programs and testing, and PPE purchases, as well as providing premium pay for essential workers, including those in home- care settings, among many other things. States may not use ARPA Recovery Funds to fund tax cuts, fund budget deficits, or to support public employee pensions. During the fiscal year ended December 31, 2022 we received $ 6. 3 million of ARPA Recovery Funds from various states, $ 5. 0 million of which we recognized as revenue in our consolidated statements of operations, and $ 1. 3 million of which we recorded in other current liabilities on our consolidated balance sheet at December 31, 2022. We may receive additional ARPA Recovery Funds in the future, however we cannot estimate the amount or timing of any future receipts. These funds are not subject to repayment, provided we are able to attest and comply with any terms and conditions of such funding, as applicable. If we are unable to attest to attest or comply with current or future terms and conditions, our ability to retain some or all of the ARPA Recovery Funds received may be impacted, which is unknown at this time~~ . Our business is dependent on the availability, integrity and security of internal and external information systems and IT services, but there are risks of business disruption associated with new business systems and technology initiatives. We are dependent on the proper functioning, availability and uninterrupted operation of our information systems and related software programs. Our information systems require an ongoing commitment of significant resources to maintain, protect and enhance existing systems and develop new systems to keep pace with continuing changes in technology, evolving industry and regulatory standards, and changing patient preferences. Costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our business. We may also incur additional costs in relation to any new systems, procedures and controls and additional management attention could be required in order to ensure an efficient integration, placing burdens on our internal resources. In addition, certain software supporting our business and information systems are licensed to us by third- party software developers. Our inability, or the inability of such third parties, to continue to maintain and upgrade our information systems and software could disrupt or reduce the efficiency of our operations. Hardware, software, or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise information security. In the ordinary course of business, we implement new or upgraded business and information technology systems for our various businesses to meet our operational needs. Implementation disruptions or the failure of new systems and technology initiatives to operate in accordance with expectations could have a material adverse effect on our business, financial position results of operations and liquidity. Moreover, in connection with recent and future acquisitions, it is necessary for us to continue to create an integrated business from the various acquired entities. This requires the establishment of a common management team to guide the acquired companies, the conversion of numerous information systems to a common operating system, the establishment of a brand identity for the acquired companies, the streamlining of the operating structure to optimize efficiency and customer service and a reassessment of the inventory and supplier base to ensure the availability of products at competitive prices. As a result of our historical acquisition activities, we have acquired additional information systems. We have been taking steps to reduce the number of systems we operate, have upgraded and expanded our information systems capabilities, and are gradually migrating to fewer information systems. No assurance can be given that these various actions can be completed without disruption to the business, in a short period of time or that anticipated improvements in operating performance can be achieved. Though we have taken steps to protect the safety and security of our information systems and the patient health information and other data maintained within those systems, there can be no assurance that our safety and security measures and disaster recovery plan (and those of our third- party service providers) will prevent damage to, or interruption or breach of, our information systems and operations. **See also " — Failure to maintain the security and functionality of our information systems, or to defend against or otherwise prevent a cybersecurity attack or breach, could adversely affect our business, financial position, results of operations and liquidity. "** Our IT and information systems may fail to operate properly (for example, by capturing patient data erroneously) or become disabled as a result of events that are beyond our control. For example, our information systems are vulnerable to damage or interruption from fire, flood, earthquake, terrorist attacks, natural disasters, power loss, telecommunications failure, break- ins, attacks from malicious third parties, improper operation, computer viruses, unauthorized entry, data loss, cybersecurity attacks, acts or war and similar events. Some of our systems are not fully redundant, and our disaster recovery planning may not be sufficient for all eventualities. Additionally, because the techniques used to obtain unauthorized access, disable, or degrade service, or sabotage systems change frequently and may be difficult to detect for long periods of time, we may be unable to anticipate these techniques or implement adequate preventive measures. Any such failure of IT and information systems could adversely affect our reputation, our ability to effect transactions and service customers and merchants, disrupt our business or result in the misuse

of patient or patient data, financial loss or liability to our patients, the loss of a supplier or regulatory intervention or reputational damage. 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 data capture, medical documentation, billing, collections, assessment of internal controls and management and reporting capabilities, as well as on our business, financial position, results of operations and liquidity. We develop and maintain portions of our clinical software systems in house. Failure of, or problems with, our systems could harm our business and operating results. We develop and utilize clinical, appointment scheduling and billing software systems, including our " Aveanna Connect " software, to collect assessment data, log patient visits, generate medical orders, schedule patients' appointments and monitor treatments and outcomes in accordance with established medical standards. The system integrates billing and collections functionality as well as accounting, human resource, payroll, and employee benefits programs provided by third parties. We also develop and utilize internal applications and interfaces to collect and submit the data required by EVV regulations, for example GPS coordinates. Problems with, or the failure of, our technology and systems could negatively impact data capture, billing, collections and management and reporting capabilities. Any such problems or failures could adversely affect our operations and reputation, result in significant costs to us, and impair our ability to provide our services in the future. Additionally, our software utilizes open source software and any defects or security vulnerabilities in such open source software, or any requirement to publicly disclose all or part of the source code to our software or to make available any derivative works of the open source code on unfavorable terms or at no cost, could harm our business, financial condition, results of operations and liquidity. The costs incurred in correcting any errors or problems may be substantial, may negatively affect the public' s perception of our services and could adversely affect our profitability. If any of our home health or hospice agencies fail to comply with the conditions of participation in the Medicare program, that agency could be terminated from Medicare, which could adversely affect our revenue and net income. Our home health and hospice agencies must comply with the extensive conditions of participation in the Medicare program. These conditions generally require our home health and hospice agencies to meet specified standards relating to personnel, patient rights, patient care, patient records, administrative reporting and legal compliance. If a home health agency or hospice fails to meet any of the Medicare conditions of participation, that home health agency or hospice may receive a notice of deficiency from the applicable surveyor or accreditor. If that home health agency or hospice then fails to institute a plan of correction to correct the deficiency within the time period provided by the surveyor or accreditor, that home health agency or hospice could be terminated from the Medicare program. We respond in the ordinary course to deficiency notices issued by surveyors or accreditors. Any termination of one or more of our home health or hospice agencies from the Medicare program for failure to satisfy the Medicare conditions of participation could adversely affect our revenue and net income. We may not be able to adequately obtain and maintain our intellectual property and proprietary rights, which could impair our ability to protect and enforce intellectual property and our brand. We rely on a combination of trademark law, trade secret protection, contractual restrictions and other intellectual property laws and confidentiality procedures to establish and protect our proprietary rights. We have not applied for any patents and cannot give assurances that any patent applications will be made by us or that, if they are made, they will be granted. We may, over time, strategically increase our intellectual property investment through additional trademark, patent and other intellectual property filings, which could be expensive and time- consuming and are not guaranteed to result in the issuance of registrations. Even if we are successful in obtaining a particular patent, trademark or copyright registration, it is expensive to enforce our rights, including through maintenance costs, monitoring, sending demand letters, initiating administrative proceedings and filing lawsuits. In addition to registering material and eligible intellectual property, we rely to a degree on contractual restrictions to prevent others from exploiting our intellectual property rights. However, the enforceability of these provisions is subject to various state and federal laws and is therefore uncertain. Our failure to develop and properly manage new intellectual property could hurt our market position and business opportunities. Furthermore, recent changes to U. S. intellectual property laws may jeopardize the enforceability and validity of our intellectual property portfolio. Although we have generally taken measures to protect our intellectual property rights, there can be no assurance that the steps that we have taken to protect our intellectual property will prevent third parties from infringing or misappropriating our intellectual property or deter independent development of equivalent or superior intellectual property rights by others. We will not be able to protect our intellectual property rights if we are unable to enforce our rights or if we do not detect or determine the extent of unauthorized use of our intellectual property rights. If we are unable to prevent third parties from adopting, registering or using trademarks and trade dress that infringe, dilute, or otherwise violate our trademark rights, the value of our brands could be diminished, and our business could be adversely affected. Our intellectual property rights may be infringed, misappropriated or challenged, which could result in them being narrowed in scope or declared invalid or unenforceable. Similarly, our reliance on unpatented proprietary information, such as trade secrets and confidential information, depends in part on agreements we have in place with employees, independent contractors and other third parties that allocate ownership of intellectual property and place restrictions on the use and disclosure of this intellectual property. These agreements may be insufficient or may be breached, in either case potentially resulting in the unauthorized use or disclosure of our trade secrets and other intellectual property, including to our competitors, which could cause us to lose any competitive advantage resulting from this intellectual property, and we cannot be certain that we will have adequate remedies for any breach. We cannot guarantee that we have entered into such agreements with each party that may have or have had access to our trade secrets or proprietary information or otherwise developed intellectual property for us, including our software, technology and processes. Individuals not subject to invention assignment agreements may make adverse ownership claims to our current and future intellectual property. Additionally, to the extent that our employees, independent contractors, or other third parties with whom we do business use intellectual property owned by others in their work for us, disputes may arise as to the rights in related or resulting know- how and inventions. There can be no assurance that our intellectual property rights will be sufficient to protect against others offering products or services that are substantially similar to ours and that compete with our business. We may become subject to

intellectual property disputes, which could be costly and may subject us to significant liability and increased costs of doing business. We may become involved in lawsuits to protect or enforce our intellectual property rights, and we may be subject to claims by third parties that we have infringed, misappropriated or otherwise violated their intellectual property. Even if we believe that intellectual property related claims are without merit, litigation may be necessary to determine the scope and validity of intellectual property or proprietary rights of others or to protect or enforce our intellectual property rights. The ultimate outcome of any allegation is often uncertain and, regardless of the outcome, any such claim, with or without merit, may be time- consuming, result in costly litigation, divert management' s time and attention from our business, and require us to, among other things, redesign or stop providing our products or services, pay substantial amounts to satisfy judgments or settle claims or lawsuits, pay substantial royalty or licensing fees, or satisfy indemnification obligations that we have with certain parties with whom we have commercial relationships. 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. Our failure to obtain necessary license or other rights, or litigation or claims arising out of intellectual property matters, may harm or restrict our business. Even if we were able to obtain a license, it could be non- exclusive, thereby giving our competitors and other third parties access to the same technologies licensed to us. In addition, we could be found liable for significant monetary damages, including treble damages and attorneys' fees, if we are found to have willfully infringed a patent or other intellectual property right. Any such litigation or the failure to obtain any necessary licenses or other rights, could adversely impact our business, financial position, results of operations and liquidity. We have substantial indebtedness, which will increase our vulnerability to general adverse economic and industry conditions and may limit our ability to pursue strategic alternatives and react to changes in our business and industry or pay dividends. We have a substantial amount of indebtedness. As of December ~~31~~ **30**, ~~2022~~ **2023**, we had $ 1, ~~464~~ **470** million principal amount outstanding under our Senior Secured Credit Facilities (as defined below) as well as our Securitization Facility (as defined below) ~~(~~with approximately $ ~~180~~ **168**. ~~0~~ **1** million borrowing capacity under our Revolving Credit Facility (as defined below) as well as our Securitization Facility (as defined below). Our high degree of leverage could have important consequences for our investors. For example, it may make it more difficult for us to make payments on our Senior Secured Credit Facilities or it may restrict our access to borrowings under our Revolving Credit Facility; increase our vulnerability to general economic and industry conditions, including recessions and periods of significant inflation and financial market volatility; expose us to the risk of increased interest rates as certain of our borrowings, including borrowings under the Senior Secured Credit Facilities, are at variable rates of interest; require us to use a substantial portion of our cash flow from operations to service our indebtedness, thereby reducing our ability to fund working capital and other expenses; limit our ability to refinance existing indebtedness on favorable terms or at all or borrow additional funds in the future for, among other things, working capital, acquisitions or debt service requirements; limit our flexibility in planning for, or reacting to, changes in our business and the industries in which we operate; and place us at a competitive disadvantage compared to competitors that have less indebtedness. In addition, the Senior Secured Credit Facilities and Revolving Credit Facility contain customary restrictive covenants that limit our ability to engage in activities that may be in our long- term best interest. Those covenants include restrictions on our ability to, among other things, incur additional indebtedness, incur liens, pay dividends and make other payments in respect of capital stock, make acquisitions, investments, loans and advances, transfer or sell assets and enter into certain transactions with our affiliates, and in certain circumstances, including if our Revolving Credit Facility becomes more than 30 % utilized and we exceed our maintenance leverage covenant, restrict our access to borrowings under our Revolving Credit Facility. Our failure to comply with those covenants could result in an event of default which, if not cured or waived, could result in the acceleration of all our debt under the Senior Secured Credit Facilities. **Our Securitization Facility contains certain restrictive covenants including a cash dominion provision which may limit our access to certain operating cash accounts in the event of default.** Any such event of default or acceleration could have a material adverse effect on our business ~~,~~ **and consolidated** financial condition ~~and~~ **,** results of operations **, and cash flows**. Furthermore, the terms of any future debt we may incur could have further additional restrictive covenants. We may not be able to maintain compliance with these covenants in the future, and in the event that we are not able to maintain compliance, we cannot assure you that we will be able to obtain waivers from the lenders or amend the covenants. If we are unable to extend the maturity date of our ~~Securitization Facility~~ **debt facilities as needed** on a long- term basis, this could have a material adverse effect on our business. Our ~~Securitization Facility~~ **debt facilities will** ~~matures on November 11, 2024~~ **mature and the outstanding obligations thereunder will become due in forthcoming years**. If we are unable to extend the maturity ~~date~~ **dates** of ~~the securitization~~ **our debt**, this would result in ~~the~~ outstanding ~~balance~~ **balances** becoming due and payable **in full** ~~on the maturity date~~, which could have a material adverse effect on our business ~~,~~ **and consolidated** financial condition ~~and~~ **,** results of operations **, and cash flows**. Our variable rate indebtedness subjects us to interest rate risk, which could cause our indebtedness service obligations to increase significantly. **Our variable rate debt instruments are primarily indexed to the secured overnight financing rate (" SOFR ") and have a SOFR floor of 50 basis points. Our outstanding variable rate indebtedness at December 30, 2023 was $ 1, 470 million. While we have interest caps and interest rate swap agreements currently in place that protect us from exposure to increases in SOFR above 2. 96 %, to the extent we incur variable rate debt in excess of aggregate notional amount of such instruments or are unable to obtain similar coverage following expiration of such instruments, we may be unable to mitigate our interest rate risk.** The U. S. Federal Reserve Board significantly increased the federal funds rate in 2022 and **2023** ~~has indicated that further rate increases may be announced in the short- term~~ to combat rising inflation in the United States, which has increased the borrowing costs on our variable rate debt and may increase the cost of any new debt we incur. Any further additional federal fund rate increases could in turn make our financing activities, including those related to our acquisition activity, more costly and limit our ability to refinance existing debt when it matures or pay higher interest rates upon refinancing and increase interest expense on

refinanced indebtedness. If interest rates continue to increase, our debt service obligations on our variable rate indebtedness would likewise increase even though the amount borrowed remained the same, and our net income and cash flows, including cash available for servicing our indebtedness, would correspondingly decrease, which could have a material adverse effect on our overall financial condition. ~~In addition, a transition away from the London Interbank Offered Rate (" LIBOR ") as a benchmark for establishing the applicable interest rate may affect the cost of servicing our debt under the Senior Secured Credit Facilities. In 2017, the Financial Conduct Authority of the United Kingdom announced that it planned to phase out LIBOR by the end of calendar year 2021. In March 2021, the Financial Conduct Authority of the United Kingdom extended the transition dates of certain LIBOR tenors (including all U. S. dollar LIBOR tenors other than one- week and two- month U. S. dollar LIBOR tenors) to June 30, 2023, after which LIBOR reference rates will cease to be provided. The Federal Reserve Bank of New York has begun publishing a Secured Overnight Funding Rate (" SOFR "), which is intended to replace U. S. dollar LIBOR, and central banks in several other jurisdictions have also announced plans for alternative reference rates for other currencies. These reforms may cause LIBOR to perform differently than in the past or to disappear entirely. Our variable rate debt instruments are primarily indexed to LIBOR and have a LIBOR floor of 50 basis points. Our outstanding variable rate indebtedness at December 31, 2022 was $ 1, 464 million. We also have interest rate swap agreements in place with an aggregate notional amount of $ 520 million that converts $ 520 million of our variable rate debt to a fixed rate. The notional amounts of the swap agreements represent balances used to calculate the exchange of cash flows and are not our assets or liabilities. In addition, we are also party to interest caps with aggregate notional amount of $ 880 million, which mature in February 2027. The interest rate caps protect us from exposure to increases in LIBOR above 3. 0 %.~~ See " Management' s Discussion and Analysis of Financial Condition and Results of Operations — Liquidity and Capital Resources — Indebtedness ". ~~Each of the First Lien Credit Agreement the Second Lien Credit Agreement provides that SOFR may be used as the LIBOR replacement rate for borrowings under the Senior Secured Credit Facilities unless the Company and its lenders agree to an alternative reference rate based on prevailing market convention at the replacement date. SOFR is calculated differently from LIBOR and has inherent differences, including SOFR' s limited historical data and that LIBOR is an unsecured lending rate while SOFR is a secured lending rate, which could give rise to uncertainties and volatility in the benchmark rates. While we continue to evaluate the potential impact of a transition to SOFR, these changes could result in interest obligations for the Company' s Senior Secured Credit Facilities that are more than or do not otherwise correlate exactly over time with the payments that would have been made on such debt if LIBOR was available in its current form, including a potential increase in our overall interest expense. The use of another alternative reference rate, or other reforms could also cause the interest rate calculated for the Company' s Senior Secured Credit Facilities to be materially different than expected. We continue to monitor developments related to the LIBOR transition and / or identification of an alternative, market- accepted rate. The impact related to any changes cannot be predicted at this time. In addition, the overall financial market may be disrupted as a result of the phase- out or replacement of LIBOR. Disruption in the financial market could have a material adverse effect on our business, financial condition and results of operations.~~ We may not be able to identify, acquire, successfully integrate and obtain financing for strategic and accretive acquisitions. We regularly evaluate opportunities to acquire other companies and have undertaken, and may in the future undertake, strategic and accretive acquisitions. To the extent our ~~future~~ growth strategy includes strategic and accretive acquisitions, we cannot assure you that we will successfully identify suitable acquisition candidates, obtain financing for such acquisitions, if necessary, consummate such potential acquisitions or efficiently integrate any acquired entities or successfully expand into new markets as a result of our acquisitions. If we are unable to successfully execute on such a strategy in the future, our ~~future~~ growth could be limited. We believe that there are risks related to acquiring companies, including overpaying for acquisitions, losing key employees of acquired companies or legacy companies, failing to effectively integrate acquired companies, the assumption of liabilities and exposure to unforeseen liabilities of acquired branch, regional and corporate operations, and failing to achieve potential synergies or remove transition, integration or non- recurring costs. Historically, we have funded acquisitions primarily through our credit facilities, and there is no guarantee that we will be able to obtain financing for any future acquisition on favorable terms, if at all. Furthermore, in certain circumstances, we could be required to pay or be involved in disputes relating to termination fees or liquidated damages if an acquisition is not consummated. If we become obligated to pay a termination fee or liquidated damages, the payment could have a material adverse effect on our business ~~,~~ **and consolidated** financial condition ~~or ,~~ results of operations **, and cash flows** . Upon consummation of an acquisition, the integration process could divert the attention of management, and any difficulties or problems encountered in the transition process could have a material adverse effect on our business, financial condition or results of operations. In particular, the integration process may temporarily redirect resources previously focused on reducing cost of services, resulting in lower gross profits in relation to sales. The process of combining companies could cause the interruption of, or a loss of momentum in, the activities of the respective businesses, which could have an adverse effect on their combined operations. Additionally, in some acquisitions, we may have to renegotiate, or risk losing, one or more third- party payer contracts. We may also be unable to immediately collect the accounts receivable of an acquired entity while we align the payer payment systems and accounts with our own systems. Finally, certain transactions can require licensure changes which, in turn, result in disruptions in payment for services. We may also make strategic divestitures from time to time. With respect to any divestiture, we may encounter difficulty finding potential acquirers or other divestiture options on favorable terms. Any divestiture could affect our profitability as a result of the gains or losses on such sale of a business or service, the loss of the operating income resulting from such sale or the costs or liabilities that are not assumed by the acquirer (i. e., stranded costs) that may negatively impact profitability subsequent to any divestiture. The Company may also be required to recognize impairment charges as a result of a divestiture. Federal regulation may impair our ability to consummate acquisitions or open new branch locations. Changes in federal laws or regulations may materially adversely impact future acquisitions. For example, the Social Security Act provides the Secretary of HHS 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 agency acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health agencies – those that either enrolled in Medicare or underwent a change in majority ownership fewer than 36 months prior to the acquisition – from assuming the Medicare billing privileges of the acquired branch locations. The 36 Month Rule may restrict bona fide transactions and potentially block new investments in home health agencies. These changes in federal laws and regulations, and similar future changes, may further increase competition for acquisition targets and could have a material adverse effect on any acquisition strategy. We are exposed to various risks related to legal proceedings, claims and governmental inquiries that could adversely affect our operating results. The nature of our business exposes us to various liability claims, which may exceed the level of our insurance coverage, meaning that our insurance may not fully protect us. We are a party to lawsuits, claims and governmental inquiries in the normal course of our business. See Note ~~14~~ **13** – Commitments and Contingencies to the Consolidated Financial Statements included in Part II, Item 8, of this Annual Report on Form 10- K. Responding to lawsuits brought against us and governmental inquiries or legal actions that we may initiate, can often be expensive and time- consuming and disruptive to normal business operations. Moreover, the results of complex legal proceedings and governmental inquiries are difficult to predict. Unfavorable outcomes from these claims, lawsuits and governmental inquiries could adversely affect our business, results of operations or financial condition, and we could incur substantial monetary liability and / or be required to change our business practices. The nature of our business subjects us to inherent risk of professional liability and substantial damage awards. Healthcare providers have become subject to an increasing number of legal actions alleging malpractice or related legal theories in recent years, many of which involve large monetary claims and significant defense costs. In general, we coordinate care for medically fragile children and adults and end- of- life care for adults through our own network of full time and part- time employed clinicians, including registered nurses, licensed practical nurses, licensed therapists, certified nursing assistants, home health aides, therapy assistants and other similar providers. Although we carefully screen all of the providers in our network and actively remove those that fall below a certain quality threshold, we cannot be certain that a provider will not incur tort liability, including medical malpractice, in treating one of our referred patients. As the referring party in such a case, we could be found negligent if our screening and monitoring procedures are deemed inadequate. The nurses and other healthcare professionals we employ could be considered our agents and, as a result, we could be held liable for their medical negligence ~~. Moreover, we could be liable if our COVID- 19 screening, monitoring and / or safety protocols are deemed inadequate to stop the transmission of the COVID- 19 virus from our nurses and healthcare professionals to our patients~~ . Additionally, although we do not grant, deny or adjudicate claims for payment of benefits and we do not believe that we engage in the corporate practice of medicine or the delivery of medical services, there can be no assurance that we will not be subject to claims or litigation related to the authorization or denial of claims for payment of benefits to allegations that we have engaged in fee splitting, which may be prohibited under state laws, or to allegations that we engage in the corporate practice of medicine or the delivery of medical services. While we do not design or manufacture the products sold by our MS segment, there can be no assurance that we will not be subject to product liability claims related to such products and that such claims will not result in liability in excess of our insurance coverage. Moreover, we could also be subject to potential litigation associated with compliance with various laws and governmental regulations at the federal or state levels, such as those relating to the protection of persons with disabilities, employment, health, safety, security and other regulations under which we operate. We maintain professional liability insurance to provide coverage to us and our subsidiaries against these litigation claims and potential litigation 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 or if our insurance carriers successfully deny coverage, will not have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. 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 and our ability to attract and retain patients and employees. Our balance sheet includes a significant amount of goodwill and intangible assets. An impairment in the carrying value of goodwill could negatively impact our consolidated results of operations and total assets. Our balance sheet includes a significant amount of goodwill and intangible assets. Goodwill and intangible assets, net, together accounted for approximately ~~73~~ **71** % of total assets on our balance sheet as of December ~~31~~ **30** , ~~2022~~ **2023** . The impairment of a significant portion of these assets would negatively affect our financial condition or results of operations. We regularly evaluate whether events and circumstances have occurred indicating that any portion of our intangible assets and goodwill may not be recoverable. When factors indicate that intangible assets and goodwill should be evaluated for possible impairment, we may be required to reduce the carrying value of these assets. During ~~our annual goodwill impairment test during the fourth quarter of fiscal year 2021, we identified that the carrying value of four of our PDS reporting units exceeded their estimated fair values. As such, we determined that the goodwill associated with our reporting units was impaired and recorded an impairment charge, net of tax effect, of approximately $ 117. 7 million to reduce goodwill associated with our reporting units. During~~ fiscal year 2022, we performed an interim impairment assessment as of July 2, 2022. Based on that assessment, we determined the carrying value of five of our six reporting units across our three segments exceeded their respective fair values and accordingly recorded an aggregate goodwill impairment charge of $ 470. 2 million during the three- month period ended July 2, 2022. During our annual goodwill impairment assessment during the fourth quarter of fiscal year 2022, we determined that the carrying value of five of our six reporting units across our three segments exceeded their respective fair values, and accordingly, recorded an aggregate goodwill impairment charge of $ 205. 1 million during the three- month period ended December 31, 2022 **. During fiscal year 2023, we performed an interim impairment assessment as of September 30, 2023. We identified that the carrying value of the HHH reporting**

unit exceeded its estimated fair value. As such, we determined that the goodwill associated with the reporting unit was impaired and recorded an impairment charge, net of tax effect, of approximately $ 105. 1 million to reduce goodwill associated with the reporting unit. No additional impairment was taken during our annual impairment assessment during the fourth quarter of fiscal year 2023 . We cannot currently estimate the timing and amount of any future reductions in carrying value. Moreover, when we acquire a business, we record goodwill as the excess of the consideration transferred plus the fair value of any non- controlling interest in the target at the acquisition date over the fair values of the identifiable net assets acquired. In accordance with Accounting Standards Codification Topic 350 " Intangibles — Goodwill and Other, " we test goodwill for impairment annually and on an interim date if factors or indicators become apparent that would require an interim test. In evaluating the potential for impairment of goodwill, we make assumptions regarding future operating performance, business trends, and market and economic conditions. Such analyses further require us to make judgmental assumptions about referrals, sales, operating margins, growth rates, and discount rates. There are inherent uncertainties related to these factors and to management' s judgment in applying these factors to the assessment of goodwill recoverability. We could be required to evaluate the recoverability of goodwill prior to the annual assessment if we experience disruptions to the business, significant unexpected declines in operating results or divestitures of a significant component of our business. We can provide no assurance that a material impairment charge will not occur in a future period. Such an impairment could have a material adverse effect on our business, financial position, results of operations and liquidity. If we are unable to maintain our corporate reputation, or there is adverse publicity or changes in public perception of our services, 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 applicable Medicare and Medicaid requirements and the other laws to which we are subject. For example, while we believe that the services we provide are of high quality, if our " quality measures, " which are published annually online by CMS, are deemed to be not of the highest value, our reputation could be negatively affected. Adverse publicity surrounding any aspect of our business, including our failure to provide proper care, litigation, changes in public perception of our services, or failure on our part to comply with applicable Medicare and Medicaid 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 and of patients to use our services. We are sensitive to regional weather conditions that may adversely affect our operations. Our operations are directly affected in the short- term by the weather conditions in certain of our regions of operation, particularly along coastal areas in the United States, which may be subject to hurricanes. Weather conditions, including tornadoes, significant rain, snow, sleet, freezing rain or ice, or other factors beyond our control, such as wildfires, could disrupt patient scheduling, displace our patients and caregivers or force certain of our facilities to close temporarily or for an extended period of time, thereby reducing patient volumes. Therefore, our business is sensitive to the weather conditions of these regions. Moreover, physical effects of climate change such as increases in temperature, sea levels, the severity of weather events and the frequency of natural disasters, such as hurricanes, tropical storms, tornadoes, wildfires, floods and earthquakes, among other effects, could disrupt our operations. While we have disaster recovery systems and business continuity plans in place, any disruptions in our disaster recovery systems or the failure of these systems to operate as expected could, depending on the magnitude of the problem, adversely affect our operating results by limiting our capacity to effectively monitor and control our operations. Although we maintain insurance coverage, we cannot guarantee that our insurance coverage will be adequate to cover any losses or that we will be able to maintain insurance at a reasonable cost in the future. Accordingly, our operating results may vary from quarter to quarter, depending on the impact of these weather conditions, and if our losses from business interruption or property damage that result from such weather conditions exceed the amount for which we are insured, our results of operations and financial condition would be adversely affected. We may be more vulnerable to the effects of a public health catastrophe than other businesses due to the nature of our patients, and a regional or global socio- political or other catastrophic event could severely disrupt our business. We believe that the majority of our patients are individuals with complex medical challenges, many of whom may be more vulnerable than the general public during a pandemic or other public health catastrophe. Our employees are also at greater risk of contracting contagious diseases due to their increased exposure to vulnerable patients. For example, if another pandemic were to occur, we could suffer significant losses to our consumer population or a reduction in the availability of our employees and, at a high cost, be required to hire replacements for affected workers. Enrollment for our services could experience sharp declines if families decide healthcare workers should not be brought into their homes during a health pandemic. Local, regional or national governments might limit or ban public interactions to halt or delay the spread of diseases causing business disruptions and the temporary closure of our centers. Accordingly, certain public health catastrophes could have a material adverse effect on our **business and consolidated** financial condition ~~and~~ **,** results of operations **, and cash flows** . Other unforeseen events, including acts of violence, war, terrorism and other international, regional or local instability or conflicts (including labor issues), embargoes, natural disasters such as earthquakes, whether occurring in the United States or abroad, could restrict or disrupt our operations. Enrollment in our Support Services or day health centers, for example, could experience sharp declines as patients and their families may avoid venturing out in public as a result of one or more of these events. We depend on the services of our executive officers and other key employees. We depend greatly on the efforts of our executive officers and other key employees to manage our operations. We believe future success will depend upon our ability to continue to attract, motivate and retain highly skilled managerial, sales and marketing, divisional, regional and agency director personnel. The loss or departure of any one of these executives or other key employees could have a material adverse effect on our business and consolidated financial condition, results of operations **,** and cash flows. Our ability to use our net operating losses to offset future taxable income may be subject to certain limitations. In general, under Section 382 of the U. S. Internal Revenue Code of 1986, as amended (the " Code "), a corporation that undergoes an " ownership change " is subject to limitations on its ability to utilize its pre- change net operating losses (" NOLs ") and interest expense carryovers to offset future taxable income. A Section 382 " ownership change " generally occurs if one or more stockholders or groups of stockholders who own at least 5 % of our

stock increase their ownership by more than 50 percentage points over their lowest ownership percentage within a rolling three-year period. Similar rules may apply under state tax laws. As of December ~~31~~ **30**, ~~2022~~ **2023**, we had $ ~~63~~ **21**. 2 million of U. S. federal net operating loss carryforwards and $ ~~322~~ **380**. ~~4~~ **1** million of state and local net operating loss carryforwards. In addition, as of December ~~31~~ **30**, ~~2022~~ **2023**, we had an interest expense carryover of $ ~~252~~ **339**. ~~5~~ **0** million for federal purposes and in some states. Our ability to utilize NOLs and our interest expense carryovers may be currently subject to limitations due to prior ownership changes. In addition, future changes in our stock ownership, some of which are outside of our control, could result in an ownership change under Section 382 of the Code, further limiting our ability to utilize NOLs or interest expense carryovers arising prior to such ownership change in the future. There is also a risk that due to statutory or regulatory changes, such as suspensions on the use of NOLs, or other unforeseen reasons, our existing NOLs could expire or otherwise be unavailable to offset future income tax liabilities. We have recorded a full valuation allowance against the deferred tax assets attributable to our federal and certain state NOLs and interest carryovers. Unanticipated changes in tax law or adverse outcomes resulting from examination of our income or other tax returns could adversely affect our **consolidated** results of operations ~~and~~ **,** financial condition **, and cash flows**. We are subject to taxes by U. S. federal, state and local tax authorities. Our future effective tax rates could be subject to volatility or adversely affected by a number of factors, including: • allocation of expenses to and among different state taxing jurisdictions; • changes in the valuation of our deferred tax assets and liabilities; • expected timing and amount of the release of any tax valuation allowances; • tax effects of stock- based compensation; • costs related to intercompany restructurings; • future acquisitions or dispositions; • changes in tax laws, tax treaties, regulations or interpretations thereof; or • lower than anticipated future earnings in jurisdictions where we have lower statutory tax rates and higher than anticipated future earnings in jurisdictions where we have higher statutory tax rates. In addition, we may be subject to audits of our income, sales and other taxes by U. S. federal, state and local tax authorities. Outcomes from these audits could have an adverse effect on our ~~operating~~ **consolidated** results ~~and~~ **of operations,** financial condition ~~. Furthermore , as permitted by the CARES Act, in fiscal year 2020, we elected to defer certain payments of our employer share of Social Security taxes, approximately $ 51. 0 million in aggregate, that would have otherwise been required to be paid during the period beginning on March 27, 2020~~ and **cash flows** ~~ending December 31, 2020. The CARES Act allowed employers to deposit 50 % of the deferred taxes on or before December 31, 2021, and the remaining 50 % by December 31, 2022. As of December 31, 2022, the Company has repaid all deferred employer social security taxes to the U. S. Treasury. Accounting for the tax effects of the CARES Act and subsequent guidance issued requires complex new calculations to be performed and significant judgments in interpreting the legislation. Additional guidance may be issued on how the provisions of the CARES Act will be applied or otherwise administered that is different from our interpretation~~. Healthcare reform has initiated significant changes to the U. S. healthcare system. Various healthcare reform provisions became law upon enactment of the ACA. The reforms contained in the ACA have impacted each of our businesses in some manner. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services, and the underlying regulatory environment. The reforms include the possible modifications to the conditions of qualification for payment, bundling payments to cover both acute and post- acute care, and the imposition of enrollment limitations on new providers. The ACA also provides for reductions to the annual market basket payment updates for home health agencies, which could result in lower reimbursement than in preceding years, and additional annual " productivity adjustment " reductions to the annual market basket payment update as determined by CMS for home health agencies. Further, the ACA mandates changes to home health benefits under Medicare. For home health, the ACA mandates creation of a value- based purchasing program, development of quality measures, a decrease in home health reimbursement that began with federal fiscal year 2014 and was phased- in over a four- year period, and a reduction in the outlier cap. In addition, the ACA requires the Secretary of HHS to test different models for delivery of care, some of which would involve home health services. It also requires the Secretary to establish a national pilot program for integrated care for patients with certain conditions, bundling payment for acute hospital care, physician services, outpatient hospital services (including emergency department services), and post- acute care services, which would include home health. The Secretary is also required to conduct a study to evaluate costs and quality of care among efficient home health agencies regarding access to care and treating Medicare beneficiaries with varying severity levels of illness and provide a report to the U. S. Congress. For hospice, the ACA required state Medicaid benefits for children to include hospice care with disease- modifying treatment. In addition, the ACA mandates the creation of a hospice quality reporting program, ensuring public reporting of hospice quality data. Hospices failing to submit quality data will incur a 2 % reduction in hospice reimbursements for the following year. The ACA also requires a reduction in the market basket index, which beginning in 2013 is reduced by a productivity adjustment that fluctuates every year and an addition adjustment of 0. 3 %, reducing the Medicare hospice payment. These reductions in the market basket index came to an end in fiscal year 2021. For fiscal year ~~2023~~ **2024**, CMS increased the hospice market basket rate by ~~4~~ **3**. ~~1~~ **3** % and implemented a productivity adjustment of- 0. ~~3~~ **2** % resulting in a net hospice increase for fiscal year ~~2023~~ **2024** of 3. ~~8~~ **1** %. For patients enrolled in hospice for more than six months, the ACA mandates a face- to- face visit with a physician or nurse practitioner to confirm continued need for hospice enrollment. Potential efforts in the U. S. Congress to repeal, amend, modify, or retract funding for various aspects of the ACA create additional uncertainty about the ultimate impact of the ACA on us and the healthcare industry. In addition, a primary goal of healthcare reform is to reduce costs, which includes reductions in the reimbursement paid to us and other healthcare providers. Moreover, healthcare reform could negatively impact insurance companies, other third- party payers, our patients, as well as other healthcare providers, which may in turn negatively impact our business. As such, healthcare reforms and changes resulting from the ACA (including any repeal, amendment, modification or retraction thereof), as well as other similar healthcare reforms, including any potential change in the nature of services we provide, the methods or amount of payment we receive for such services, and the underlying regulatory environment, could have a material adverse effect on our business, financial position, results of operations and liquidity. We conduct business in a heavily regulated industry, and changes in regulations, the enforcement of these regulations, or violations

of regulations may result in increased costs or sanctions that reduce our revenues and profitability. In the ordinary course of our business, we are regularly subject to inquiries and audits by federal and state agencies that oversee applicable healthcare program participation and payment regulations. We also are subject to government investigations. We believe that the regulatory environment surrounding most segments of the healthcare industry remains intense. The extensive federal and state regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, billing, provision of services, conduct of operations, allowable costs, and prices for services, facility staffing requirements, qualifications and licensure of staff, environmental and occupational health and safety, and the confidentiality and security of health- related information. In particular, various laws, including the Stark Law, the Anti- Kickback Statute, anti- fraud, and anti- abuse amendments codified under the Social Security Act prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid by Medicare or other governmental programs. Sanctions for violating those anti- kickback, anti- fraud, and anti- abuse amendments include criminal penalties, civil sanctions, fines, and possible exclusion from government programs such as Medicare and Medicaid. Federal and state governments continue to pursue intensive enforcement policies resulting in a significant number of investigations, inspections, audits, citations of regulatory deficiencies, and other regulatory sanctions including demands for refund of overpayments, terminations from the Medicare and Medicaid programs, bans on Medicare and Medicaid payments for new admissions, and civil monetary penalties or criminal penalties. We expect audits under the CMS ~~Recovery Audit Contractor (“~~ RAC ~~”)~~ program, the CMS ~~Targeted Probe and Educate (“~~ TPE ~~”)~~ program, the ~~Unified Program Integrity Contractors (“~~ UPIC ~~”)~~ program and other federal and state audits evaluating the medical necessity of services to further intensify the regulatory environment surrounding the healthcare industry as third- party firms engaged by CMS and others conduct extensive reviews of claims data and medical and other records to identify improper payments to healthcare providers under the Medicare and Medicaid programs. If we fail to comply with the extensive laws, regulations and prohibitions applicable to our businesses, we could become ineligible to receive government program reimbursement, suffer civil or criminal penalties, or be required to make significant changes to our operations. In addition, we could be forced to expend considerable resources responding to investigations, audits or other enforcement actions related to these laws, regulations or prohibitions. Failure of our staff to satisfy applicable licensure requirements, or of our home health and hospice operations to satisfy applicable licensure and certification requirements could have a material adverse effect on our business, financial position, results of operations and liquidity. We are unable to predict the future course of federal and state regulation or legislation, including Medicare and Medicaid statutes and regulations, or the intensity of federal and state enforcement actions. Changes in the regulatory framework, including those associated with healthcare reform, and sanctions from various enforcement actions could have a material adverse effect on our business, financial position, results of operations and liquidity. Many states have CON laws or other regulatory provisions that may adversely impact our ability to expand into new markets and thereby limit our ability to grow and increase revenue. Many states have enacted CON or POA laws that require prior state approval to offer new or expanded healthcare services or open new healthcare facilities or expand services at existing facilities. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting either from population increases or a reduction in competing providers. These states ration the entry of new providers or services and the expansion of existing providers or services in their markets through a CON or other approval process, which is periodically evaluated and updated as required by applicable state law. The process is intended to promote comprehensive healthcare planning, assist in providing high- quality healthcare at the lowest possible cost and avoid unnecessary duplication by ensuring that only those healthcare facilities, services and operations that are needed will be built and opened. We operate home health centers and / or hospice services in the following CON states: Alabama, Georgia, North Carolina, South Carolina, Tennessee and Washington. In every state where required, our home health offices, hospice centers and branch locations possess a license and / or CON issued by the state health authority that determines the local service areas for the home health office, hospice office or branch location. In general, the process for opening a home health office, branch location or hospice begins by a provider submitting an application for licensure and certification to the state and federal regulatory bodies, and the completion of both an initial licensure and certification survey, which is followed by a testing period of transmitting data from the applicant to CMS. Once this process is complete, the provider receives a provider agreement and corresponding number and can begin billing for services that it provides unless a CON is required. For those states that require a CON, the provider must also complete a separate application process before billing can commence and receive required approvals for capital expenditures exceeding amounts above prescribed thresholds. Our costs of obtaining a CON in any new CON state in which we seek to operate could be significant, and we cannot assure you that we will be able to obtain the CONs or other required approvals in the future. Our failure or inability to obtain a required CON, license or any necessary approvals could adversely affect our ability to expand into new markets and to expand our services and facilities in existing markets. Furthermore, if a CON or other prior approval upon which we relied to invest in a healthcare center or other facility were to be revoked or lost through an appeal process, we may not be able to recover the value of our investment. CMS and state Medicaid agencies may, for a period of time, impose a moratorium against additional Medicaid enrollment for a particular type of service, upon a determination that a moratorium is necessary to prevent fraud, waste or abuse, or to limit an over- abundance of a type of Medicaid provider within a state. For example, on July 31, 2013, CMS implemented a six- month moratorium on new Medicare (and Medicaid) home health agencies in Florida’ s Miami- Dade County and Illinois’ Cook County. The moratorium on enrollment of additional home health agencies in the Medicare (and Medicaid programs) was a way to combat fraud, waste and abuse, while assuring patient access to care. Over the years, CMS has repeatedly renewed and extended the moratorium to the entire states of Florida, Illinois, Michigan and Texas. The CMS moratoria on new Medicare home health agencies were lifted on January 1, 2019; however, Florida requested that CMS extend the moratorium on new home health agency enrollments into its Medicaid program. Florida’ s moratorium on Medicaid home health agency provider

enrollment ended on August 30, 2021. In addition, we cannot predict whether any other states may adopt a similar Medicaid moratorium. A moratorium in any state in which we seek to, or currently, operate may prevent us from introducing, or disposing of, operations in that state, respectively, which may impair our future expansion or divestiture opportunities in some states. We face and are currently subject to reviews, audits and investigations under our contracts with federal and state government agencies and other payers, and these reviews, audits and investigations could have adverse findings that may negatively impact our business. As a result of our participation in the Medicare and Medicaid programs we face and are currently subject to various governmental reviews, audits, and investigations to verify our compliance with these programs and applicable laws and regulations. An increasing level of governmental and private resources are being devoted to the investigation of allegations of fraud and abuse in the Medicare and Medicaid programs, and federal and state regulatory authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act, the Medicare and Medicaid programs, and other applicable laws. We are routinely subject to audits under various government programs, including the RAC program, the SMRC program, the TPE program and the UPIC program, in which CMS engages third- party firms to conduct extensive reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program. In addition, we, like other healthcare providers, are subject to ongoing investigations by the OIG, the United States DOJ and State Attorneys General into the billing of services provided to Medicare and Medicaid patients, including whether such services were properly documented and billed, whether services provided were medically necessary, and general compliance with conditions of participation in the Medicare and Medicaid programs. Private pay sources such as third-party insurance and managed care entities also often reserve the right to conduct audits. Our costs to respond to and defend any such reviews, audits and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require us to refund or retroactively adjust amounts that have been paid under the relevant government program or from other payers. Further, an adverse review, audit or investigation could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include: (1) state or federal agencies imposing significant fines, penalties and other sanctions on us; (2) loss of our right to participate in the Medicare or Medicaid programs or one or more third- party payer networks; (3) indemnity claims asserted by patients and others for which we provide services; and (4) damage to our reputation in various markets, which could adversely affect our ability to attract patients and employees. If they were to occur, these consequences could have a material adverse effect on our business, financial position, results of operations and liquidity. We are subject to extensive and complex federal and state government laws and regulations that govern and restrict our relationships with physicians and other referral sources. The Anti- Kickback Statute, the Stark Law, the FCA and similar state laws materially restrict our relationships with physicians and other referral sources. We have a variety of financial relationships with referral sources who either refer or influence the referral of patients to our healthcare facilities, and these laws govern those relationships. The OIG has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti- Kickback Statute. On November 20, 2020, the OIG published its final rule revising the safe harbors to the Anti- Kickback Statute, aiming to reduce the regulatory barriers to care coordination and accelerate the transformation of the health care system into one that better pays for value and promotes care coordination. The OIG final rule implements seven new safe harbors and modifies four existing safe harbors. For example, the final rule clarifies how durable medical equipment companies may participate in protected care coordination arrangements involving digital health technology; modifies the existing safe harbor for personal services and management contracts to add flexibility for certain outcomes- based payments and part- time arrangements; expands and modifies mileage limits for local transportation for rural areas; and broadens the new safe harbor for cybersecurity technology and services to cover remuneration in the form of cybersecurity- related hardware. These revisions to the Anti- Kickback Statute safe harbors went into effect on January 19, 2021. While we endeavor to comply with the safe harbors, most of our current arrangements, including with physicians and other referral sources, may not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti- Kickback Statute but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti- Kickback Statute. Any financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti- Kickback Statute, failure to meet an exception under the Stark Law may result in a violation of the Stark Law, even if such violation is technical in nature. Additionally, if we violate the Anti- Kickback Statute or the Stark Law, or if we improperly bill for our services, we may be found to violate the FCA, either under a suit brought by the government or by a private person under a qui tam, or " whistleblower, " lawsuit. If we fail to comply with the Anti- Kickback Statute, the Stark Law, the FCA or other applicable laws and regulations, we could be subject to liabilities, including civil penalties (including the loss of our licenses to operate one or more facilities or healthcare activities), exclusion of one or more facilities or healthcare activities from participation in the Medicare, Medicaid, and other federal and state healthcare programs, and, for violations of certain laws and regulations, criminal penalties. We do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. In the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses. A determination that we have violated these laws, or the public announcement that we are being investigated for possible violations of these laws, could have a material adverse effect on our business, financial position, results of operations and liquidity, and our business reputation could suffer significantly. In addition, other legislation or regulations at the federal or state level may be adopted that could have a material adverse effect on our business, financial position, results of operations and liquidity. If we are found to have violated HIPAA, the HITECH Act, the Omnibus Rule or any other applicable privacy and security laws and regulations, as well as

contractual obligations, we could be subject to sanctions, fines, damages and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operation and liquidity. There are a number of federal and state laws, rules and regulations, as well as contractual obligations, relating to the protection, collection, storage, use, retention, security, disclosure, transfer and other processing of confidential, sensitive and personal information, including certain patient health information, such as patient records. Existing laws and regulations are constantly evolving, and new laws and regulations that apply to our business are being introduced at every level of government in the United States. In many cases, these laws and regulations apply not only to third- party transactions, but also to transfers of information between or among us, our affiliates and other parties with whom we conduct business. These laws and regulations may be interpreted and applied differently over time and from jurisdiction to jurisdiction, and it is possible that they will be interpreted and applied in ways that may have a material adverse effect on our business. We monitor legal developments in data privacy and security regulations at the local, state and federal level, however, the regulatory framework for data privacy and security worldwide is continuously evolving and developing and, as a result, interpretation and implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future. The management of PHI is subject to several regulations at the federal level, including HIPAA and the HITECH Act. The HIPAA privacy and security regulations protect medical records and other personal health information by limiting their use and disclosure, giving individuals the right to access, amend, and seek accounting of their own health information, and limiting most uses and disclosures of health information to the minimum amount reasonably necessary to accomplish the intended purpose. The HITECH Act strengthened HIPAA enforcement provisions and authorized State Attorneys General to bring civil actions for HIPAA violations. It permits the HHS to conduct audits of HIPAA compliance and impose significant civil monetary penalties even if we did not know or reasonably could not have known about the violation. The Omnibus Rule extended certain privacy and security regulations to business associates and their subcontractors that handle protected health information and imposed new requirements on HIPAA business associate contracts. The Omnibus Rule also clarified a covered entity' s (which is a healthcare provider, a health plan or healthcare clearinghouse) notification and reporting requirements in the event of a breach of unsecured protected health information. This reporting obligation supplements state laws that also may require notification in the event of a breach of personal information. If we are found to have violated the HIPAA privacy or security regulations or other federal or state laws protecting the confidentiality of patient health or personal information, including but not limited to the HITECH Act and the Omnibus Rule, we could be subject to sanctions, fines, damages and other additional civil or criminal penalties, including litigation with those affected, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial position, results of operations and liquidity. The federal government is also promoting the efficient exchange of electronic health information to improve health care. The 21st Century Cures Act prohibits information blocking by health care providers and certain other entities. Information blocking is defined as engaging in activities that are likely to interfere with, prevent or materially discourage access, exchange or use of electronic health information, subject to limited exceptions. Initiatives related to health care technology and interoperability may require changes to our operations, impose new and complex obligations on us, affect our relationships with other providers, vendors and other third parties and require investments in infrastructure. We may be subject to penalties for failure to comply. Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity and security of PHI. For example, various states, such as California ~~and~~ **,** Massachusetts, **and Washington** have implemented privacy laws and regulations, such as the California Confidentiality of Medical Information Act, that impose restrictive requirements regulating the use and disclosure of personally identifiable information, including PHI. These laws in many cases are more restrictive than, and may not be preempted by, the HIPAA rules and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues and potentially exposing us to additional expense, adverse publicity and liability. We also expect that there will continue to be new laws, regulations and industry standards concerning privacy, data protection and information security proposed and enacted in various jurisdictions. The U. S. Congress has considered, but not yet passed, several comprehensive federal data privacy bills over the past few years, such as the CONSENT Act, which was intended to be similar to the landmark 2018 European Union General Data Protection Regulation. We expect federal data privacy laws to continue to evolve. At the state and local level, there is increased focus on regulating the collection, storage, use, retention, security, disclosure, transfer and other processing of confidential, sensitive and personal information. In recent years, we have seen significant changes to data privacy regulations across the U. S., including the enactment of the CCPA, which went into effect on January 1, 2020. The CCPA creates new consumer rights, and corresponding obligations on covered businesses, relating to the access to, deletion of and sharing of personal information collected by covered businesses, including a consumer' s right to opt out of certain sales of the consumer' s personal information. The CCPA provides for civil penalties for violations, as well as a private right of action for certain data breaches that result in the loss of personal information. This private right of action may increase the likelihood of, and risks associated with, data breach litigation. It remains unclear how various provisions of the CCPA will be interpreted and enforced. Additionally, California voters approved a new privacy law, the California Privacy Rights Act (the " CPRA "), in the November 3, 2020 election. **Beginning** ~~Effective starting~~ on January 1, 2023, the CPRA ~~will~~ significantly ~~modify~~ **modified** the CCPA, including by expanding consumers' rights with respect to certain sensitive personal information. The CPRA also creates a new state agency that will be vested with authority to implement and enforce the CCPA and the CPRA. New legislation proposed or enacted in various other states will continue to shape the data privacy environment nationally. Certain state laws may be more stringent or broader in scope, or offer greater individual rights, with respect to confidential, sensitive and personal information than federal, international or other state laws, and such laws may differ from each other, which may complicate compliance efforts. In addition, all 50 U. S. states and the District of Columbia have enacted breach notification laws that may require us to notify patients, employees or regulators in the event of unauthorized access to or disclosure of personal or confidential information experienced by us or our service providers. These laws are not consistent, and compliance in the event

of a widespread data breach is difficult and may be costly. Moreover, states have been frequently amending existing laws, requiring attention to changing regulatory requirements. We also may be contractually required to notify patients or other counterparties of a security breach. Although we may have contractual protections with our service providers, any actual or perceived security breach could harm our reputation and brand, expose us to potential liability or require us to expend significant resources on data security and in responding to any such actual or perceived breach. Any contractual protections we may have from our service providers may not be sufficient to adequately protect us from any such liabilities and losses, and we may be unable to enforce any such contractual protections. In addition to government regulation, privacy advocates and industry groups have and may in the future propose self- regulatory standards from time to time. These and other industry standards may legally or contractually apply to us, or we may elect to comply with such standards. Complying with these various laws, rules, regulations and standards, and with any new laws or regulations changes to existing laws, could cause us to incur substantial costs that are likely to increase over time, require us to change our business practices in a manner adverse to our business, divert resources from other initiatives and projects, and restrict the way products and services involving data are offered, all of which may have a material adverse effect on our business. For example, we have incurred and expect to continue to incur additional costs to comply with the CCPA and other similar regulations. However, in the future we may be unable to make such changes and modifications to our business practices in a commercially reasonable manner, or at all. Given the rapid development of cybersecurity and data privacy laws, we expect to encounter inconsistent interpretation and enforcement of these laws and regulations, as well as frequent changes to these laws and regulations which may expose us to significant penalties or liability for non- compliance, the possibility of fines, lawsuits (including class action privacy litigation), regulatory investigations, criminal or civil sanctions, audits, adverse media coverage, public censure, other claims, significant costs for remediation and damage to our reputation, or otherwise have a material adverse effect on our business and operations. Any inability to adequately address data privacy or security- related concerns, even if unfounded, or to comply with applicable laws, regulations, standards and other obligations relating to data privacy and security, could result in additional cost and liability to us, damage our relationships with patients and have a material adverse effect on our business. We make public statements about our use and disclosure of personal information through our privacy policies, information provided on our website and press statements. Although we endeavor to comply with our public statements and documentation, we may at times fail to do so or be alleged to have failed to do so. The publication of our privacy policies and other statements that provide promises and assurances about data privacy and security can subject us to potential government or legal action if they are found to be deceptive, unfair or misrepresentative of our actual practices. Moreover, from time to time, concerns may be expressed about whether our products and services compromise the privacy of patients and others. Any concerns about our data privacy and security practices, even if unfounded, could damage the reputation of our businesses, discourage potential patients from our products and services and have a material adverse effect on our business. We are subject to federal, state and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time- off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment related expenses, could adversely impact our operations. We are required to comply with all applicable federal, state and local laws and regulations relating to employment, including occupational safety and health requirements, wage and hour and other compensation requirements, employee benefits, providing leave and sick pay, employment insurance, proper classification of workers as employees or independent contractors, immigration and equal employment opportunity laws. These laws and regulations can vary significantly among jurisdictions and can be highly technical. Notably, we are subject to the California Labor Code pursuant to which plaintiffs have filed representative actions under the California Private Attorney General Act seeking statutory penalties for alleged violations related to calculation of overtime pay, errors in wage statements, and meal and rest break violations, among other things. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal, state or local laws or regulations, or the interpretation thereof, requiring employers to provide specified benefits or rights to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any increased costs and expenses. Furthermore, any failure to comply with these laws requirements, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business. In addition, certain individuals and entities, known as excluded persons, are prohibited from receiving payment for their services rendered to Medicaid, Medicare and other federal and state healthcare program beneficiaries. If we inadvertently hire or contract with an excluded person, or if any of our current employees or contractors becomes an excluded person in the future without our knowledge, we may be subject to substantial civil penalties, including up to $ 20, 000 for each item or service furnished by the excluded person to a federal or state healthcare program beneficiary, an assessment of up to three times the amount claimed and exclusion from the program. Because we employ an average of at least 50 full- time employees in a calendar year, we are required to offer a minimum level of health coverage for 95 % of our full- time employees in ~~2023~~ **2024** or be subject to an annual penalty. Risks Related to Ownership of Our Common Stock We may issue preferred stock whose terms could adversely affect the voting power or value of our common stock. Our second amended and restated certificate of incorporation (the " Amended Charter ") authorizes us to issue, without the approval of our stockholders, one or more classes or series of preferred stock having such designation, preferences, limitations and relative rights, including preferences over our common stock with respect to dividends and distributions, as our Board of Directors may determine. The terms of one or more classes or series of preferred stock could adversely impact the voting power or value of our common stock. For example, we might grant holders of preferred stock the right to elect some number of our directors in all events or on the happening of specified events or the right to veto specified transactions. Similarly, the repurchase or redemption rights or liquidation preferences we might assign to holders of preferred stock could affect the residual value of the common stock. We do not intend to pay dividends for the foreseeable future. We currently intend to retain all

available funds and any future earnings to fund the development and growth of our business, and therefore we do not anticipate paying any cash dividends in the foreseeable future. As a result of our current dividend policy, you may not receive any return on an investment in our common stock unless you sell our common stock for a price greater than that which you paid for it. Any future determination to declare and pay cash dividends, if any, will be entirely at the discretion of our Board of Directors and will depend upon then- existing conditions, including our earnings, capital requirements, results of operations, financial condition, business prospects and any other factors that our Board of Directors considers relevant. Our ability to pay dividends depends on our receipt of cash dividends from our operating subsidiaries, which may further restrict our ability to pay dividends as a result of the laws of their jurisdiction of organization or agreements of our subsidiaries, including agreements governing our current and future indebtedness. We take advantage of certain " controlled company " exemptions to the corporate governance rules for publicly listed companies, which could make our common stock less attractive to some investors or otherwise harm our stock price. Because we qualify as a " controlled company " under the corporate governance rules for publicly listed companies, we are not required to have a majority of our Board of Directors be independent under the applicable rules of Nasdaq, nor are we required to have a compensation committee or a corporate governance and nominating committee comprised entirely of independent directors. Our Board of Directors is permitted to not be composed of a majority of independent directors. We currently rely on the exemption to the requirement that our director nominations be made, or recommended to our full Board of Directors, by our independent directors or by a nominations committee that consists entirely of independent directors. Should the interests of **Bain Capital L. P.** ~~our~~ **or J. H. Whitney Capital Partners (collectively, our "** Sponsors **") or their respective affiliates (the " Sponsor Affiliates "), who collectively own 68. 3 % of our outstanding common stock,** differ from those of other stockholders, the other stockholders may not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance rules for publicly listed companies. Our status as a controlled company could make our common stock less attractive to some investors or otherwise harm our stock price. Our Sponsors can significantly influence our business and affairs and may have conflicts of interest with us in the future. The Sponsor Affiliates collectively own approximately ~~70~~ **68** . ~~5~~ **3** % of our common stock. Our Sponsors are in the business of making investments in companies and may from time to time acquire and hold interests in businesses that compete directly or indirectly with us. One or both of our Sponsors may also pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. So long as our Sponsors, or funds controlled by or associated with our Sponsors, continue to own a significant amount of the outstanding shares of our common stock, even if such amount is less than 50 %, our Sponsors will continue to be able to strongly influence us. Our Amended Charter provides that none of our Sponsors or any of their affiliates will have any duty to refrain from (i) engaging in a corporate opportunity in the same or similar lines of business in which we or our affiliates now engage or propose to engage or (ii) otherwise competing with us or our affiliates. As a public company, we incur significant increased expenses and administrative burdens, which could have an adverse effect on our business, financial condition and results of operations. We face increased insurance, legal, accounting, and other corporate related costs and expenses as a public company. For example, our director and officer liability insurance policy costs increased significantly upon becoming a public company. The Sarbanes- Oxley Act of 2002 (the " Sarbanes- Oxley Act "), including the requirements of Section 404, as well as rules and regulations subsequently implemented by the SEC, the Dodd- Frank Wall Street Reform and Consumer Protection Act of 2010 and the rules and regulations promulgated and to be promulgated thereunder, the Public Company Accounting Oversight Board (" PCAOB ") and the securities exchanges, impose additional reporting and other obligations on public companies. Compliance with public company requirements has increased costs and made certain activities more time- consuming. A number of those requirements require us to carry out activities we had not done previously. For example, we created new board committees and adopted new internal controls and disclosure controls and procedures. In addition, additional expenses associated with SEC reporting requirements have been and will continue to be incurred. Furthermore, if any issues in complying with those requirements are identified (for example, if we or our independent registered public accounting firm identify a material weakness or significant deficiency in our internal control over financial reporting), we could incur additional costs to remediate those issues, and the existence of those issues could adversely affect our reputation or investor perceptions of it. Risks associated with our status as a public company may make it more difficult to attract and retain qualified persons to serve on our Board of Directors or as executive officers. The additional reporting and other obligations imposed by these rules and regulations increase legal and financial compliance costs and the costs of related legal, accounting and administrative activities. These increased costs require us to divert a significant amount of money that could otherwise be used to expand our business and achieve certain strategic objectives. Advocacy efforts by stockholders and third parties may also prompt additional changes in governance and reporting requirements, which could further increase costs. If we fail to maintain an effective system of internal control over financial reporting, we may not be able to accurately report our financial results or prevent fraud. As a result, stockholders could lose confidence in our financial and other public reporting, which is likely to negatively affect our business and the market price of our common stock. Effective internal control over financial reporting is necessary for us to provide reliable financial reports and prevent fraud. Any failure to implement required new or improved controls, or difficulties encountered in our implementation could cause us to fail to meet our reporting obligations. In addition, any testing conducted by us, or any testing conducted by our independent registered public accounting firm, may reveal deficiencies in our internal control over financial reporting that are deemed to be material weaknesses or that may require prospective or retroactive changes to our financial statements or identify other areas for further attention or improvement. Inferior internal controls could also cause investors to lose confidence in our reported financial information, which is likely to negatively affect our business and the market price of our common stock. **We** ~~Beginning with this Annual Report on Form 10- K, we~~ are required to comply with Section 404 of the Sarbanes- Oxley Act, which requires annual management assessments of the effectiveness of our internal control over financial reporting and a report by our independent registered public accounting firm on the effectiveness of internal control over financial reporting as of year- end. In particular,

we are required to perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on the effectiveness of our internal controls over financial reporting, as required by Section 404 (a) of the Sarbanes- Oxley Act. We are also subject to the compliance requirements of Section 404 (b) of the Sarbanes- Oxley Act, which requires our independent registered public accounting firm to issue an annual report that addresses the effectiveness of internal control over financing reporting and has resulted in us incurring substantial expenses and expending significant management efforts to comply with the Sarbanes- Oxley Act, which we will continue. As of December ~~31~~ **30** , ~~2022~~ **2023** , we did not maintain effective internal control over financial reporting attributable to an identified material weakness. We describe this material weakness in Part II, Item 9A, of this Annual Report on Form 10- K. A material weakness is defined as a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected and corrected on a timely basis. The material weakness will not be considered remediated until the applicable new or enhanced controls operate for a sufficient period and management has concluded, through testing, that the related controls are operating effectively. As remediation has not yet been completed, the material weakness continued to exist with respect to our internal control over financial reporting as of December ~~31~~ **30** , ~~2022~~ **2023** . If our remedial measures are insufficient to address the material weakness, or if one or more additional material weaknesses or significant deficiencies in our internal control over financial reporting are discovered or occur in the future, our consolidated financial statements may contain material misstatements and we could be required to restate our financial results, which could, in turn, harm our reputation or otherwise cause a decline in investor confidence and in the market price of our stock. We cannot assure you that we will at all times in the future be able to report that our internal controls are effective. Material weaknesses in the design and operation of the internal control over financial reporting of businesses that we acquire could have a material adverse effect on our business and operating results. If we are not able to comply with the requirements of Section 404 of the Sarbanes- Oxley Act or if we identify or our independent registered public accounting firm identifies additional deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses, the market price of our common stock could decline and we could be subject to sanctions or investigations by Nasdaq, the SEC, or other regulatory authorities, which would require additional financial and management resources. Anti- takeover provisions in our governing documents and under Delaware law could make an acquisition of our company more difficult, limit attempts by our stockholders to replace or remove our current management and limit the market price of our common stock. Our Amended Charter, second amended and restated bylaws (the " Amended Bylaws ") and Delaware law contain provisions that could have the effect of rendering more difficult, delaying or preventing an acquisition deemed undesirable by our Board of Directors. Among other things, our Amended Charter and / or Amended Bylaws include the following provisions: • a staggered board, which means that our Board of Directors is classified into three classes of directors with staggered three- year terms and directors are only able to be removed from office for cause; • limitations on convening special stockholder meetings, which could make it difficult for our stockholders to adopt desired governance changes; • a prohibition on stockholder action by written consent from and after the date on which the Sponsors and each of their respective affiliates cease to beneficially own in the aggregate at least 50 % of the outstanding shares of common stock (the " Trigger Event "); • a forum selection clause, which means certain litigation against us can only be brought in Delaware; • from and after the Trigger Event, the removal of directors only for cause and only upon the affirmative vote of the holders of at least 66 2 / 3 % in voting power of all of the then- outstanding shares of our common stock entitled to vote thereon; • from and after the Trigger Event, requiring the affirmative vote of holders of at least 66 2 / 3 % of the voting power of all of the then outstanding shares of common stock to amend provisions of our Amended Charter relating to the management of our business, our Board of Directors, stockholder action by written consent, calling special meetings of stockholders, competition and corporate opportunities, Section 203 of the Delaware General Corporation Law (the " DGCL "), forum selection and the liability of our directors, or to amend, alter, rescind or repeal our Amended Bylaws; • the authorization of undesignated preferred stock, the terms of which may be established and shares of which may be issued without further action by our stockholders; and • advance notice procedures, which apply for stockholders to nominate candidates for election as directors or to bring matters before an annual meeting of stockholders. These provisions, alone or together, could delay or prevent hostile takeovers and changes in control or changes in our management. We have opted out of Section 203 of the DGCL. However, our Amended Charter contains similar provisions providing that we many not engage in certain " business combinations " with any " interested stockholder " for a three- year period following the time that the stockholder became an interested stockholder, unless (i) prior to the time such stockholder became an interested stockholder, the Board of Directors approved the transaction that resulted in such stockholder becoming an interested stockholder, (ii) upon consummation of the transaction that resulted in such stockholder becoming an interested stockholder, the interested stockholder owned at least 85 % of the common stock or (iii) following Board of Directors approval, the business combination receives the approval of the holders of at least two- thirds of our outstanding common stock not held by such interested stockholder at an annual or special meeting of stockholders. Our Amended Charter provides that the Sponsors and their respective affiliates, and any of their respective direct or indirect transferees and any group as to which such persons are a party, do not constitute " interested stockholders " for purposes of this provision. Any provision of our Amended Charter, Amended Bylaws or Delaware law that has the effect of delaying, preventing or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock and could also affect the price that some investors are willing to pay for our common stock. Our Amended Charter designates specific courts as the exclusive forum for certain litigation that may be initiated by our stockholders, which could limit our stockholders' abilities to obtain a favorable judicial forum for disputes with us or our directors, officers or employees. Our Amended Charter provides that, unless we consent in writing to the selection of an alternative forum, the sole and exclusive forum, to the fullest extent permitted by law, for (1) any derivative action or proceeding brought on our behalf, (2) any action asserting a claim of breach of a fiduciary duty owed by any of our current or former directors, officers or other employees or stockholders to us or our stockholders, creditors or other constituents, or a claim

of aiding and abetting any such breach of fiduciary duty, (3) any action asserting a claim against us or any of our directors or officers or other employees or stockholders arising pursuant to, or any action to interpret, apply, enforce any right, obligation or remedy under or determine the validity of, any provision of the DGCL or our Amended Charter or Amended Bylaws or as to which the DGCL confers jurisdiction on the Court of Chancery of the State of Delaware, (4) any action asserting a claim that is governed by the internal affairs doctrine, or (5) any other action asserting an " internal corporate claim " under the DGCL shall be the Court of Chancery of the State of Delaware (or, if and only if the Court of Chancery does not have subject matter jurisdiction, another state court sitting in the State of Delaware or, if and only if neither the Court of Chancery nor any state court sitting in the State of Delaware has subject matter jurisdiction, then the federal district court for the District of Delaware) (the " Delaware Forum Provision "). Notwithstanding the foregoing, our Amended Charter provides that the Delaware Forum Provision will not apply to any actions arising under the Securities Act or the Exchange Act. Section 27 of the Exchange Act creates exclusive federal jurisdiction over all suits brought to enforce any duty or liability created by the Exchange Act or the rules and regulations thereunder. Our Amended Charter further provides that unless we consent in writing to the selection of an alternative forum, the federal district court for the District of Delaware shall, to the fullest extent permitted by law, be the sole and exclusive forum for resolving any complaint asserting a cause of action arising under the Securities Act (the " Federal Forum Provision "). The Delaware Forum Provision and the Federal Forum Provision may limit a stockholder' s ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers or other employees, which may discourage lawsuits against us and our directors, officers and other employees. Alternatively, if a court were to find the Delaware Forum Provision or the Federal Forum Provision to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could harm our business, financial condition or results of operations. Any person or entity purchasing or otherwise acquiring any interest in our shares of capital stock shall be deemed to have notice of and consented to the Delaware Forum Provision and the Federal Forum Provision but will not be deemed to have waived our compliance with the federal securities laws and the rules and regulations thereunder. Our Amended Charter provides that the doctrine of " corporate opportunity " does not apply with respect to any officer, director or stockholder who is not employed by us or our subsidiaries. Our Amended Charter provides that the doctrine of " corporate opportunity " does not apply with respect to the Sponsors or any of their respective officers, directors, agents, stockholders, members, partners, affiliates and subsidiaries (other than us and our subsidiaries). The doctrine of corporate opportunity generally provides that a corporate fiduciary may not develop an opportunity using corporate resources or information obtained in their corporate capacity for their personal advantage, acquire an interest adverse to that of the corporation or acquire property that is reasonably incident to the present or prospective business of the corporation or in which the corporation has a present or expectancy interest, unless that opportunity is first presented to the corporation and the corporation chooses not to pursue that opportunity. The doctrine of corporate opportunity is intended to preclude officers, directors or other fiduciaries from personally benefiting from opportunities that belong to the corporation. Our Amended Charter does, to the extent permitted by Delaware law, renounce any interest or expectancy that we have in, or right to be offered an opportunity to participate in, specified business opportunities that are from time to time presented to the Sponsors or any of their respective officers, directors, agents, stockholders, members, partners, affiliates and subsidiaries (other than us and our subsidiaries), including any of the foregoing who serves as a director or officer of the Company. Such person will therefore have no duty to communicate or present corporate opportunities to us, and will have the right to either hold any corporate opportunity for their (and their affiliates') own account and benefit or to recommend, assign or otherwise transfer such corporate opportunity to persons other than us, including to any officers, directors or stockholders or their respective affiliates (other than those who are employees of the Company or its subsidiaries). As a result, the Sponsors or any of their respective officers, directors, agents, stockholders, members, partners, affiliates and subsidiaries (other than us and our subsidiaries) are not prohibited from operating or investing in competing businesses. We therefore may find ourselves in competition with such person, and we may not have knowledge of, or be able to pursue, transactions that could potentially be beneficial to us. Accordingly, we may lose a corporate opportunity or suffer competitive harm, which could negatively impact our business or prospects. If securities analysts do not publish research or reports about our company, or if they issue unfavorable commentary about us or our industry or downgrade our common stock, the price of our common stock could decline. The market for our common stock depends in part on the research and reports that securities or industry analysts publish about us, our business or our industry. If one or more of the analysts who cover us downgrade their opinions about our common stock, publish inaccurate or unfavorable research about us, or cease publishing about us regularly, demand for our common stock could decrease, which might cause our share price and trading volume to decline significantly. Additionally, if securities or industry analysts publish negative information regarding the industry generally or certain competitors of ours, this may affect the market price of all stocks in our sector, even if unrelated to our performance. If our operating and financial performance in any given period does not meet or exceed the guidance that we provide to the public, the market price of our common stock may decline. We have provided public guidance on our expected operating and financial results for future periods, which is composed of forward- looking statements subject to the risks and uncertainties described elsewhere in this Annual Report on Form 10- K. Our actual results may not always be in line with or exceed any guidance we have provided, especially in times of economic uncertainty. If, in the future, our operating or financial results for a particular period do not meet any guidance we provide or the expectations of investment analysts, or if we reduce our guidance for future periods, the market price of our common stock may decline.