Risk Factors Comparison 2024-03-15 to 2023-04-14 Form: 10-K

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You should carefully consider the following risks and uncertainties, together with all the other information in this Annual Report, including our consolidated financial statements and the related notes, in evaluating Enhabit and Enhabit common stock (“ our stock ” or “ our common stock ”). This section does not describe all risks that may be applicable to us, our industry, or our business, and it is intended only as a summary of material risk factors. Additional risks and uncertainties we have not or cannot foresee may also adversely affect us in the future. If any of the risks below or other risks or uncertainties discussed elsewhere in this Annual Report are ~~actually~~ realized, our business and financial condition, results of operations, and cash flows could be adversely affected. Risks Related to Our Business Reimbursement Risks Reductions or changes in reimbursement from government or third- party payors could adversely affect our Net service revenue and other operating results. We derive a substantial portion of our Net service revenue from the Medicare program ~~. See Item 1, “ Business — Sources of Revenue ” in this Annual Report for a table identifying the sources and relative payor mix of our revenues~~ . In addition to many ordinary course reimbursement rate changes that CMS adopts each year as part of its annual rulemaking ~~process~~ **processes** ~~for various healthcare provider categories~~ , Congress and certain state legislatures periodically propose significant changes in laws and regulations governing the healthcare system. ~~Many of these~~ **These** changes **may** result in limitations on increases and, in some cases, significant ~~roll- backs or~~ reductions in the levels of payments to healthcare providers. There can be no assurance that future governmental initiatives will not result in pricing freezes, reimbursement reductions, or ~~reduced~~ levels of reimbursement increases that are less than the increases we **may** experience in our costs of operations. There is also no assurance that our patient accounts receivable ~~, particularly during the business integration process, or when transitioning between systems associated with clinical data collection and submission,~~ will be collected in a timely fashion, or at all. ~~Because our percentage~~ **See Item 1, “ Business — Sources** of **Revenue, ” in this Annual Report for a table identifying the sources and relative payor mix of our** revenues ~~from Medicare exceeds that of many of our competitors, such changes could have a disproportionate impact on our revenues compared to the impact on the revenues of our competitors~~ . Many provisions within the ~~Patient Protection and Affordable Care Act (as amended, the “~~ 2010 Healthcare Reform Laws ~~”)~~ have impacted or could in the future impact our business, including Medicare reimbursement reductions and promotion of alternative payment models, such as ~~accountable care organizations (“~~ ACOs ~~”)~~ and bundled payment initiatives. For Medicare providers like us, the 2010 Healthcare Reform Laws ~~include~~ **included** reductions in CMS’ s annual adjustments to Medicare reimbursement rates, commonly known as a “ market basket update. ” The 2010 Healthcare Reform Laws also require market basket updates for home health and hospice providers to be reduced by a productivity adjustment on an annual basis. The productivity adjustment equals the trailing 10- year average of changes in annual economy- wide private nonfarm business multi- factor productivity. The **Fiscal Year** ~~2023~~ **2024** Hospice Payment Rate Update Final Rule finalized a 3. ~~8~~ **1** % hospice payment update percentage. This was ~~the~~ **a** result of a ~~4~~ **3** . ~~1~~ **3 % inpatient hospital market basket percentage increase reduced by a 0. 2 % productivity adjustment. The hospice payment update includes a statutory aggregate cap that limits the overall annual payments per patient made to hospices. The 2024 Home Health Final Rule reflects an estimated overall increase in Medicare home health reimbursement rates of 0. 8 % relative to 2023 levels. This payment update is the collective impact of a 3. 3** % market basket ~~increase~~ **positive adjustment** and a 0. **4 % fixed - dollar loss ratio positive adjustment, offset by a 0.** 3 ~~percentage point productivity adjustment. For home health, CMS finalized an aggregate 0. 7 % increase which reflects a 4. 1 % market basket increase, a 0. 1~~ % productivity **negative** adjustment ~~,~~ **and** a **2** ~~- 3~~ . ~~925~~ **6** % permanent behavioral **negative** adjustment ~~and an estimated 0~~ . ~~2 %~~ **There is no assurance that rates will** increase **in future years** ~~due to effects from updating the fixed- dollar loss ratio used for - or determining outlier payments~~ **that rate increases will be adequate to offset increases in operating costs** . Other federal legislation can also have a significant direct impact on our Medicare reimbursement. In 2011, President Obama signed into law the Budget Control Act of 2011, which provided for an automatic 2 % reduction of Medicare program payments. This automatic reduction, known as “ sequestration, ” began affecting payments received after April 1, 2013. Under current law, ~~for each year through fiscal year 2030,~~ the reimbursement we receive from Medicare ~~, after first considering all annual payment adjustments, including the market basket update,~~ will be reduced by **this** sequestration ~~. The CARES Act temporarily suspended sequestration for the period of May 1 through December 31, 2020. Subsequent legislation extended the sequestration suspension until April 1, 2022. Sequestration resumed on April 1, 2022 but with only a 1 % payment reduction through June 30, 2022, at which time the 2 % reduction resumed~~ . Additional Medicare payment reductions are also possible under Statutory PAYGO. Statutory PAYGO requires, among other things, that mandatory spending and revenue legislation not increase the federal budget deficit over a five- or ten- year period. If the Office of Management and Budget (the “ OMB ”) finds there is a deficit in the federal budget, Statutory PAYGO requires OMB to order sequestration of Medicare. In 2021, President Biden signed the American Rescue Plan Act of 2021 (the “ American Rescue Plan Act ”) ~~. The Congressional Budget Office estimated that the American Rescue Plan Act would result in budget deficits necessitating a 4 % reduction in Medicare program payments for 2022 under Statutory PAYGO unless Congress and the President take action to waive the Statutory PAYGO reductions~~ . The Protecting Medicare and American Farmers from Sequester Cuts Act also suspends until 2025 the Statutory PAYGO reductions that would have gone into effect **because** ~~as a result~~ of the American Rescue Plan Act. Concerns held by federal policymakers about the federal deficit, national debt levels, or healthcare spending specifically, including solvency of the Medicare trust fund, could result in enactment of further federal spending reductions **or limitations** , further entitlement reform legislation affecting the Medicare program, and further reductions to provider payments. Each year, MedPAC advises Congress on issues affecting

Medicare , including, among others, the HH- PPS and the Hospice **payment systems. MedPAC' s advice can affect the rates we are paid for our services. For example, CMS incorporated some of MedPAC' s recommendations into the PDGM system mandated by the 2018 Bipartisan Budget Act and set out in the final rule for the 2019 HH** - ~~PS~~ **PPS . Beginning in 2020, PDGM replaced the prior 60- day episode payment methodology with a 30- day payment period and eliminated therapy usage as a factor in setting payments. CMS was required to make assumptions about potential behavior changes caused by the implementation of the 30- day unit of payment and the PDGM. As a result, CMS must annually determine the impact of differences between assumed and actual behavior changes on estimated aggregate expenditures, beginning with 2020 and ending with 2026, and make permanent and temporary increases or decreases to the 30- day payment amount to account for such differences** . In **the 2023 Home Health PPS final rule, CMS finalized a methodology for analyzing the impact of differences between assumed versus actual behavior changes on estimated aggregate expenditures and calculated levels of actual and estimated aggregate expenditures using** 2020 **and 2021 claims. This resulted in the application of a 3. 925 % permanent adjustment reduction to the home health base rate for 2023. In the 2024 Home Health PPS final rule** , **CMS finalized an additional 2. 89 % permanent adjustment reduction to the home health base rate. CMS may make future permanent or temporary adjustments based on analysis of estimated aggregate expenditures through 2026, which could significantly impact our home health agencies. Changes to** MedPAC ~~called~~ **' s recommendations could also affect reimbursements** for **our services** ~~future research into Medicare hospice payments and expressed concerns that aggregate payments substantially exceed costs and that there are outlier utilization patterns in the industry . In~~ **For example, in** ~~2021~~ **2023** , MedPAC recommended ~~to~~ **that, for fiscal year 2024,** Congress **should** ~~, among other things, legislative changes to eliminate the~~ update ~~to~~ the **hospice** ~~2021 Medicare~~ base payment ~~rates -~~ **rate** ~~for~~ **and wage adjust and reduce the** hospice ~~, reduce the~~ aggregate ~~payment~~ cap by 20 % ~~, and reduce the base payment rate by 5 % under the HH- PPS~~ . **Similarly** ~~In 2018~~ , MedPAC ~~reiterated its recommendation~~ **has previously recommended** that Congress adopt a unified payment system for all post- acute care ~~(" PAC- PPS ") in lieu of separate systems for inpatient rehabilitation facilities~~ , **but has more recently concluded that due to the considerable resources this** ~~skilled nursing facilities, long- term acute care hospitals, and home health agencies. A PAC- PPS~~ would **require** ~~rely on " site neutral " reimbursement based on patients' medical conditions and other clinical factors rather than the care settings. MedPAC found a PAC- PPS to be feasible and desirable but also suggested many existing regulatory requirements should be waived or modified as part of implementing a PAC- PPS. MedPAC previously estimated , although we cannot verify the methodology or the accuracy of that estimate, a PAC- PPS would result in a 1 % decrease to home health reimbursements. MedPAC has also called for aligning Medicare regulatory requirements across post- acute providers, although the agency has acknowledged it could take years to complete this effort. Additionally, MedPAC previously has suggested that Medicare should ultimately move from fee- for- service reimbursement to more integrated delivery payment models. MedPAC also recommended significant changes to the HH- PPS, some of which CMS incorporated into the PDGM system mandated by the 2018 Budget Act and set out in the final rule for the 2019 HH- PPS. Beginning in 2020, PDGM replaced the prior 60- day episode of payment methodology with a 30- day payment period and eliminated therapy usage as a factor in setting payments (that is, more therapy visits led to higher reimbursement). CMS adopted a 4. 4 % reduction in the base payment rate for 2020 intended to offset the provider behavioral changes that CMS assumed PDGM would drive. The reimbursement~~ and other changes **already made** ~~associated with PDGM could have a significant impact on our home health agencies. Likewise , **policymakers should consider smaller** MedPAC' s previously recommended changes to the Hospice - **scale site- neutral policies** PS, including a wage adjustment and a reduction in the hospice aggregate cap by 20 %, could have a significant impact on our hospice agencies~~ . There can be no assurance that future governmental action will not result in substantial changes to, or material reduction in, our reimbursements. In any given year, the net effect of statutory and regulatory changes may result in a decrease in our reimbursement rate, and that decrease may occur at a time when our expenses are increasing. As a result, there could be a material adverse effect on our business, financial position, results of operations, and cash flows. For additional discussion of how we are reimbursed by Medicare, see Item 1, " Business — Sources of Revenue — Medicare Reimbursement — Regulation, " in this Annual Report. Our quality of care and CMS quality reporting requirements could adversely affect the Medicare reimbursement we receive. The focus on alternative payment models and value- based purchasing of healthcare services has ~~, in turn,~~ led to more extensive quality of care reporting requirements. In many cases, **our** ~~the new~~ reporting requirements are linked to reimbursement incentives. For example, home health and hospice agencies are required to submit quality of care data to CMS each year **.** ~~, and the failure~~ **Failure** to comply **with quality reporting requirements may** ~~results -~~ **result** in a **penalty on our reimbursement. For home health agencies that do not comply with quality reporting requirements, the penalty is** 2 % ~~reduction in~~ **; for hospices that do not comply,** ~~their -~~ **the** ~~market basket updates~~ **penalty is 4 %. Increased scrutiny and oversight in these industries may pose a heightened risk to reimbursement** . The IMPACT Act ~~has~~ mandated that CMS adopt several new quality reporting measures for the various post- acute provider types ~~, which we expect will be implemented over the next several years~~ . The adoption of additional quality reporting measures to track and report will require additional time and expense and could affect reimbursement in the future. In healthcare generally, the burdens associated with collecting, recording, and reporting quality data are increasing. Currently, CMS requires home health providers to track and submit patient assessment data to support the calculation of 20 quality of care reporting measures. In addition, CMS ~~has~~ instituted a Star rating methodology for home health agencies to meet the 2010 Healthcare Reform Laws' call for more transparent public information on provider quality. All Medicare- certified home health agencies are eligible to receive a Star rating (from 1 to 5 Stars) based on a number of quality of care measures, such as timely initiation of care, drug education provided to patients, fall risk assessment, depression assessments, improvements in bed transferring, and bathing, among others. Failing to maintain satisfactory Star rating scores could affect **some** ~~our rates~~ of **our** reimbursement and patient referrals and have a material adverse effect on our business and consolidated financial condition, results of operations, and cash flows. There can be no assurance that all of our agencies will meet quality reporting requirements

or quality performance **expectations** in the future, which may result in one or more of our agencies seeing a reduction in its Medicare reimbursements **or patient referral volume** . We, like other healthcare providers, are likely to incur additional expenses in an effort to comply with additional and changing quality reporting requirements. We face periodic and routine reviews, audits, and investigations under our contracts with federal and state government agencies and private payors, and these audits could have adverse findings that may negatively impact our business. As a result of our participation in the Medicare and Medicaid programs, we are subject to various governmental reviews, audits, and investigations to verify our compliance with these programs and applicable laws and regulations. We also are subject to audits under various federal and state government programs in which third **-** party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare program. For additional discussion of the reviews, audits, and investigations to which we are subject, see Item 1, " Business — **Regulation —** Governmental Review, Audits, and Investigations **,** " in this Annual Report. The HHS- OIG also conducts audits and has included various home health agency and hospice payment and quality issues in its current workplan. Additionally, private pay sources reserve the right to conduct audits. If billing errors are identified in the sample of reviewed claims, the billing error can be extrapolated to all claims filed which could result in a larger overpayment than originally identified in the sample of reviewed claims. Our costs to respond to and defend reviews, audits and investigations may be significant and could have a material adverse effect on our business and consolidated financial condition, results of operations **,** and cash flows. Moreover, an adverse review, audit or investigation could result in: • required refunding or retroactive adjustment of amounts we have been paid pursuant to the federal or state programs or from private payors; • state or federal agencies imposing fines, penalties, and other sanctions on us; • loss of our ~~right~~ **ability** to participate in the Medicare program, state programs or one or more private payor networks; or • damage to our business and reputation in various markets. Efforts to reduce payments to healthcare providers undertaken by third- party payors, conveners, and referral sources could adversely affect our revenues and profitability. Health insurers and managed care companies, including Medicare Advantage plans, may utilize certain third parties, known as conveners, to attempt to control costs. Conveners offer patient placement and care transition services to those payors as well as bundled payment participants, ACOs, and other healthcare providers with the intent of managing post ~~-~~ **-** acute utilization and associated costs. Conveners may influence referral source decisions on which post- acute setting to recommend, as well as how long to remain in a particular setting. Conveners are not healthcare providers and may suggest a post- acute setting or duration of care that may not be appropriate from a clinical perspective, potentially resulting in a costly acute care hospital readmission. We also depend on referrals from physicians, acute care hospitals, and other healthcare providers in the communities we serve. As a result of various alternative payment models, many referral sources are becoming increasingly focused on reducing post- acute costs by eliminating post- acute care referrals. Our ability to attract patients could be adversely affected if any of our home health agencies ~~fail~~ **fails** to provide or maintain a reputation for providing high- quality care on a cost ~~-~~ **-** effective basis as compared to other providers. In addition, there are increasing pressures, including as a result of the 2010 Healthcare Reform Laws, from many third ~~-~~ **-** party payors to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and nongovernmental third- party payors ~~, such as HMOs and PPOs,~~ are generally governed by negotiated agreements. These agreements set forth the amounts we are entitled to receive for our services ~~,~~ and can add administrative complexity to our billing and collection process. Our Net service revenue and our ability to grow our business with these payors could be adversely affected if we are unable to negotiate and maintain favorable agreements with third- party payors. Changes in our payor mix or the needs of our patients could adversely affect our Net service revenue or our profitability. ~~The~~ **Although the** reimbursement rates we receive from traditional Medicare Fee for Service are generally higher than those received from other payors **, an increasing percentage of Medicare eligible individuals are choosing to enroll in a Medicare Advantage plan** . We are attempting to grow the number of Medicare Advantage networks in which we participate, so we expect the payor mix to continue to shift with that growth. Not only do Medicare Advantage and managed care payors generally pay less than Medicare Fee for Service, **but** ~~we also expect~~ bad debt **and longer collection cycles also tend** to be ~~slightly~~ higher for patients covered by Medicare Advantage and managed care, as patients typically retain more payment responsibility under those arrangements. Further, it generally is more time and labor intensive to bill claims with Medicare Advantage, meaning our collection cycle will lengthen as we grow the number of Medicare Advantage networks in which we participate. The expansion and growth of Medicaid resulting from the 2010 Healthcare Reform Laws have increased the number of ~~those~~ **Medicaid** patients coming to us. Medicaid reimbursement rates are consistently the lowest among those of our payors, and frequently Medicaid patients come to us with other complicating conditions that make treatment more difficult and costly. ~~While we cannot predict the growth of, or changes to, Medicaid, President Biden has stated that he favors extending public health insurance coverage to low- income individuals currently ineligible for Medicaid, which could shift our payor mix to lower reimbursement rate payors.~~ The administration of billings and collections is complex, and our estimates of accounts receivable require us to exercise judgment. Delays in reimbursement due to administrative issues or inadequate reserve estimates may cause financial reporting issues or liquidity problems. The billing and collection of our accounts receivable ~~from payors~~ is subject to numerous and complex administrative processes and requires a significant amount of time and effort, including, but not limited to, the assessment of patient eligibility, the process of pre- authorization, the recording and collection of provider documentation, the timely and complete submission of claims for reimbursement, the application of cash receipts to patient accounts, the timely response to payor denials, and the conduct of collection activities. Additional administrative processes are also required when patients elect to change their third- party payors, **such as** ~~i. e.,~~ when patients switch from Medicare to Medicare Advantage **. If we incorrectly estimate our Accounts receivable, net of allowances, it may result in adjustments to our financial statements. For example, we previously identified a material weakness in our internal control over financial reporting which related to the design and maintenance of effective controls to monitor and review the estimated recoverability of accounts receivable, including the impact of changes to our third- party payor mix. This material**

weakness resulted in adjustments to our consolidated financial statements as of and for the year ended December 31, 2022 to Net service revenue, Accounts receivable, net of allowances, and Net loss. While this material weakness has been remediated as of December 31, 2023, there can be no assurance that similar internal control issues will not be identified in the future. See Item 9A, " Controls and Procedures, " in this Annual Report for additional information . In addition, our accounts receivable with Medicare and Medicaid are subject to the complex regulations that govern Medicare and Medicaid reimbursement and rules imposed by nongovernment payors, and a portion of our accounts receivable are typically under medical review by payors. The amount collected may materially differ from the amount billed. Our inability to bill and collect on a timely basis pursuant to these regulations and rules could subject us to payment delays that could have a material adverse effect on our business, financial position, results of operations **,** and liquidity. Further, if our reserve estimates are inadequate and we do not collect the amount of accounts receivable that we expect in a timely fashion, or at all, our financial position may materially differ from financial results that we have historically recorded. In addition, timing delays in, or unrealized levels of, 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. Medicare reimbursement of hospice services is subject to caps, which may result in our having to reimburse Medicare for certain amounts previously paid to us. Payments made by Medicare to each hospice provider are subject to an inpatient cap amount and an overall payment cap amount, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from October 1 through September 30. If payments made to our hospice providers exceed either of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations **,** and cash flows. Other Regulatory Risks The ongoing evolution of the healthcare delivery system, including alternative payment models and value- based purchasing initiatives, may significantly affect our business and results of operations. The healthcare industry faces regulatory uncertainty around attempts to improve outcomes and reduce costs, including coordinated care and integrated delivery payment models. In an integrated **payment** delivery ~~payment~~ model, hospitals, physicians, and other care providers are incentivized to coordinate healthcare on a more efficient, patient- centered basis. Providers are paid based on the overall value and quality, rather than the number, of services provided. While this is consistent with our goal and proven track record of being a high- quality, cost- effective provider, broad- based implementation of a new delivery payment model would disrupt the healthcare industry, which may have a significant impact on our business and results of operations. In recent years, HHS has been studying the feasibility of bundling, including conducting a voluntary, multi- year bundling pilot program to test and evaluate alternative payment methodologies. CMS' s voluntary BPCI Advanced initiative ~~runs~~ **ran** through December 31, 2023 and covers 29 types of inpatient and three types of outpatient clinical episodes, including stroke and hip fracture. Accordingly, reimbursement may be increased or decreased, compared to what would otherwise be due, based on whether the total Medicare expenditures and patient outcomes meet, exceed, or fall short of the targets. Similarly, CMS has established several ACO programs, the largest of which is the Medicare Shared Savings Program (" MSSP "), a voluntary ACO program in which hospitals, physicians, and other care providers pursue the delivery of coordinated healthcare on a more efficient, patient- centered basis. Conceptually, ACOs receive a portion of any savings generated from care coordination as long as benchmarks for the quality of care are maintained. The ACO rules are extremely complex and remain subject to further refinement by CMS. Additionally, as the number and types of bundling, direct contracting, and ACO models increase, the number of Medicare beneficiaries who are treated in these models increases. Our unwillingness or inability to participate in integrated delivery payment and other alternative payment models and the referral patterns of other providers participating in those models may limit our access to Medicare patients who would benefit from treatment by home health services. In an attempt to reduce costs, ACOs may seek to discourage referrals to post- acute care altogether. For further discussion of coordinated care and integrated delivery payment models and value- based purchasing initiatives, the associated challenges, and our efforts to respond to them, see Item 1, " Business — Our Industries and Opportunity — Emphasis on Value- Based Payment Models, " in this Annual Report. Other legislative and regulatory initiatives and changes affecting the industry could adversely affect our business and results of operations. In addition to the legislative and regulatory actions that directly affect our reimbursement rates or further the evolution of the current healthcare delivery system, other legislative and regulatory changes ~~, including as a result of ongoing healthcare reform,~~ affect healthcare providers like us from time to time. For example, the 2010 Healthcare Reform Laws provide for the expansion of the federal Anti- Kickback Law and the ~~False Claims Act (the "~~ FCA ~~")~~ , likely increasing investigation and enforcement efforts in the healthcare industry generally. Changes include increased resources for enforcement, lowered burden of proof for the government in healthcare fraud matters, expanded definition of claims under the FCA, enhanced penalties, and increased rewards for relators in successful prosecutions. CMS may also suspend payment for claims prospectively if, in its opinion, credible allegations of fraud exist. The initial suspension period may be up to 180 days. However, the payment suspension period can be extended almost indefinitely if the matter is under investigation by the HHS- OIG or the DOJ. Any such suspension would adversely affect our financial position, results of operations, and cash flows. Some states in which we operate have also undertaken, or are considering, healthcare reform initiatives that address similar issues. While many of the stated goals of other federal and state reform initiatives are consistent with our own goal to provide high- quality and cost- effective care, legislation and regulatory proposals may lower reimbursements, increase the cost of compliance, decrease patient volumes, promote frivolous or baseless litigation, and otherwise adversely affect our business ~~. We cannot predict what healthcare initiatives, if any, will be enacted, implemented, or amended, or the effect any future legislation or regulation will have on us. In 2019, CMS adopted a new rule as called for by the IMPACT Act that revises the discharge~~

~~planning requirements applicable to our home health agencies. This rule requires hospitals to institute standardized procedures to identify those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and to provide a discharge planning evaluation for such patients to ensure that appropriate arrangements for post- hospital care are made before discharge. The rule requires that home health agencies develop and implement an effective discharge planning process. Home health agencies must also send certain medical and other information to the post- discharge facility or health care practitioner and comply with requests for additional information as necessary for treatment of the patient. The rule will likely require implementation of new processes and modification of existing discharge forms and reports, and patient visits may need to be extended in order to accommodate patient education. We expect to incur additional one- time and recurring expenses to comply with the new requirements, but at this time we cannot predict what the final impact will be. In areas where we are not part of a managed care network with significant enrollment, this discharge planning rule may negatively affect the number of patients choosing us~~ . We cannot predict what legislative or regulatory reforms or changes, if any, will ultimately be enacted or the timing or effect any of those changes or reforms will have on us. If enacted, they may be challenging for all providers, and have the effect of limiting Medicare beneficiaries' access to healthcare services, which could have a material adverse impact on our Net service revenue, financial position, results of operations, and cash flows. For additional discussion of healthcare reform and other factors affecting reimbursement for our services, see Item 1, " Business — Regulation — Sources of Revenue — Medicare Reimbursement, " in this Annual Report. Compliance with the extensive laws and government regulations applicable to healthcare providers requires substantial time, effort, and expense, and if we fail to comply with them, we could suffer penalties or be required to make significant changes to our operations. Healthcare providers are required to comply with extensive and complex laws and regulations at the federal, state, and local government levels. These laws and regulations relate to, among other things: • licensure, certification, enrollments, and accreditation; • policies, at either the national or local level, delineating what conditions must be met to qualify for reimbursement under Medicare (also referred to as coverage requirements); • coding and billing for services; • relationships with physicians and other referral sources, including physician self- referral and anti- kickback laws; • quality of medical care; • use and maintenance of medical supplies and equipment; • maintenance, security and privacy of patient information and medical records, including electronic health data and health system interoperability; • minimum staffing; • acquisition and dispensing of pharmaceuticals and controlled substances; and • disposal of medical and hazardous waste. In the future, changes in these laws or regulations or the manner in which they are enforced could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our equipment, personnel, services, capital expenditure programs, operating procedures, and contractual arrangements, as well as the way in which we deliver home health and hospice services. Those changes could also affect reimbursements as well as future compliance, training, and staffing costs. Examples of regulatory changes that can affect our business, beyond direct changes to Medicare reimbursement rates, can be found from time to time in CMS' s annual rulemaking. For example, to implement the 2018 Budget Act, the final rule for the 2019 Hospice- PS amended the hospice regulations to permit physician assistants to serve as " attending physicians " for patients in addition to physicians and nurse practitioners. In addition, the use of sub- regulatory guidance, statistical sampling, and extrapolation by CMS, Medicare contractors, HHS- OIG, and DOJ to deny claims, expand enforcement claims, and advocate for changes in reimbursement policy increases the risk that we could experience reduced revenue, suffer penalties, or be required to make significant changes to our operations. Because Medicare **payments** ~~comprises~~ **comprise** a significant portion of our Net service revenue, failure to comply with the laws and regulations governing the Medicare program and related matters, including anti- kickback and anti- fraud requirements, could materially and adversely affect us. Settlements of alleged violations or imposed reductions in reimbursements, substantial damages and other remedies assessed against us could have a material adverse effect on our business, financial position, results of operations, and cash flows. Even the assertion of a violation, depending on its nature, could have a material adverse effect upon our stock price or reputation and could cost us significant time and expense to defend. If any of our home health or hospice agencies ~~fail~~ **fails** to comply with the Medicare enrollment requirements or conditions of participation, that agency could be subject to sanctions or terminated from the Medicare program. Each of our home health and hospice agencies must comply with extensive enrollment requirements and conditions of participation for the Medicare program. Failure to comply with applicable certification requirements may make our agencies ineligible for Medicare or Medicaid reimbursement. A determination by a regulatory authority that an agency is not in compliance with applicable requirements could also lead to the assessment of fines or other penalties, loss of licensure, exclusion from participation in Medicare and Medicaid, and the imposition of requirements that the offending agency must take corrective action. In addition, Medicare or Medicaid may seek retroactive reimbursement from noncompliant providers or otherwise impose sanctions for noncompliance. Non- governmental payors often have the right to terminate provider contracts if the provider loses its Medicare or Medicaid certification. Termination of one or more of our care centers from the Medicare program for failure to satisfy the program' s conditions of participation, or the imposition of alternative sanctions, could disrupt operations, require significant attention by management, or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations, and cash flows. Federal regulation may impair our ability to ~~consummate acquisitions or~~ open new agencies **or consummate acquisitions** . Changes in federal laws or regulations may materially adversely impact our ability to ~~acquire~~ **open de novo** home health agencies or **acquire** ~~open de novo~~ home health agencies. For example, CMS has adopted a regulation known as the " 36 Month Rule " that is applicable to home health agency acquisitions. Subject to certain exceptions, the 36 Month Rule prohibits buyers of certain home health agencies ~~—~~ **,** those that either enrolled in Medicare or underwent a change in ownership within 36 months before the acquisitions ~~—~~ **,** from assuming the Medicare billing privileges of the acquired agency. Instead, the acquired home health agencies must enroll as new providers with Medicare **. CMS has recently extended the 36 Month Rule to Medicare - enrolled hospices as well** . As a result, the 36 Month Rule may further increase competition for acquisition targets that are not subject to the rule and may cause significant Medicare billing delays for the purchases of home health **and hospice** agencies that are subject to the rule. Other

Operational and Financial Risks The proper function, availability, and security of our information systems are critical to our business, and failure to maintain them or to protect our data against unauthorized access could have a material adverse effect on our business, financial position, results of operations, and cash flows. We are required to comply with HIPAA regulations regarding the privacy and security of protected health information, as well as state laws that focus on privacy, security, and notification requirements with regard to personal information. The HIPAA regulations impose significant requirements on providers and our third **-** party vendors with regard to how such protected health information may be used and disclosed. Further, the regulations include extensive and complex requirements for providers to establish reasonable and appropriate administrative, technical, and physical safeguards to ensure the confidentiality, integrity, and availability of protected health information. HIPAA directs the Secretary of HHS to periodically audit compliance by covered entities. We are and will remain dependent on the proper function, availability, and security of our (and third parties **'’**) information systems, including our electronic clinical information system. We expend ~~significant~~ capital to protect our information systems and the data maintained within those systems from security breaches, including cyber- attacks, email phishing schemes, malware, and ransomware, and we periodically test the adequacy of our security and disaster recovery measures. We have implemented administrative, technical, and physical controls to prevent unauthorized access to that data, which includes patient information and other sensitive information, but we routinely identify attempts to gain unauthorized access to our systems **. We are likely to face attempted attacks in the future** . Given the rapidly evolving nature and proliferation of cyber threats, there can be no assurance our training and network security measures or other controls will detect, prevent, or remediate security or data breaches in a timely manner or otherwise prevent unauthorized access to, damage to, or interruption of our systems and operations. In recent years, several hospitals have reported being victims of ransomware attacks in which they lost access to their systems, including clinical systems, during the course of the attacks. There have been other recent significant incidents of software vendor compromises. Threat actors continue to attempt to exploit commonly used software and services to gain remote access to a large number of their customers' information systems. For example, in August 2021, Microsoft, our email exchange service provider, reported a vulnerability within its email exchange services which attackers can use to remotely bypass the access control list then elevate privileges. ~~We are likely to face attempted attacks in the future.~~ A compromise of our network security measures or other controls, or ~~of~~ those **of** businesses or vendors with whom we interact, which results in confidential information being accessed, obtained, damaged or used by unauthorized persons or unavailability of systems necessary to the operation of our business, could impact patient care, harm our reputation, and ~~exposes~~ **expose** us to significant remedial costs as well as regulatory actions (fines and penalties) and claims from patients, financial institutions, regulatory and law enforcement agencies, and other persons, any of which could have a material adverse effect on our business, financial position, results of operations **,** and cash flows. A security breach, or threat thereof, could require that we expend significant resources to repair or improve our information systems and infrastructure and could distract management and other key personnel from performing their primary operational duties. In the case of a material breach or cyber- attack, the associated expenses and losses may exceed our current insurance coverage for such events. Some adverse consequences may not be insured, such as reputational harm and third- party business interruption. Failure to maintain proper function, security, or availability of our information systems or **to** protect our data against unauthorized access, or the failure of one or more of our key partners, vendors, or other counterparties to do these things, could have a material adverse effect on our business, financial position, results of operations, and cash flows. If we are unable to provide a consistently high quality of care, our business will be adversely impacted. Providing quality patient care is fundamental to our business. We believe 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. For example, Medicare imposes a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this regulation provides a competitive advantage to home health providers who can differentiate themselves based upon quality, particularly by achieving low patient acute care hospital readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. If we fail to attain our goals regarding acute care hospital readmission rates and other quality metrics, we expect our ability to generate referrals to be adversely impacted, which could have a material adverse effect upon our business and consolidated financial condition, results of operations **,** and cash flows. Additionally, Medicare has established consumer- facing websites, Home Health Compare and Hospice Compare, that present data regarding our performance on certain quality measures compared to state and national averages. Failure to achieve or exceed these averages may 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. We face intense competition for patients from other healthcare providers. We operate in the highly competitive and fragmented home health and hospice industries. Our primary competitors in home health services are two large insurance companies, a large public home health company, privately owned home health and hospice companies, and acute care hospitals with adjunct home health services. ~~We compete with a variety of companies in both home~~ **Some** ~~health and hospice, some~~ of ~~which~~ **these competitors** have greater financial and other resources, advantages of scale and more established presences in their respective communities. Competing companies may offer newer or different services from those we offer or have better relationships with referring physicians and may thereby attract patients who are presently, or would be candidates for, receiving our services. Other companies, including hospitals and other healthcare organizations that are not currently providing competing services, may expand their services to include home health, hospice care, or similar services. In several states in which we operate, a majority of the Medicare Advantage patients within the state are insured by two large managed care companies that either currently offer home health services or are actively pursuing the acquisition of a business that offers home health services. The managed care companies have substantial resources and existing relationships with customers, which may serve as a large patient base for their current or future home health services. Competition by these managed care companies in home health services may adversely affect our growth strategy of capturing

greater Medicare Advantage volumes. In addition, from time to time, there are efforts in states with certificate of need laws to weaken those laws, which could potentially increase competition in those states. Conversely, competition and statutory procedural requirements in some CON states may inhibit our ability to expand our operations in those states. For a breakdown of the CON status of the states and territories in which we have operations, see Item 2, " Properties, " in this Annual Report. There can be no ~~assurance current or future competition will not adversely affect our business, financial position, results of operations or cash flows.~~