Risk Factors Comparison 2025-03-06 to 2024-03-15 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 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 **rates** from government **programs,** or ~~third- party payors~~ **new government regulations,** 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. In addition to many ordinary course reimbursement rate changes that CMS adopts each year as part of its annual rulemaking processes, Congress and certain state legislatures periodically propose significant changes in laws and regulations governing the healthcare system ~~.~~ ~~These changes~~ **, which have resulted in, and** may result in **future,** limitations on increases and, in some cases, significant reductions in the levels of payments to healthcare providers. ~~There can be no assurance that~~ **For example: • 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. Applying this methodology, CMS implemented a 3. 925 %, 2. 89 % and 1. 975 % permanent adjustment reduction to the home health base rate for 2023, 2024 and 2025, respectively. CMS may make** future **permanent** ~~governmental initiatives will not result in pricing freezes, reimbursement reductions, or levels of reimbursement increases that are less than the increases we may experience in our~~ **or** ~~costs~~ **temporary adjustments based on analysis** of **estimated aggregate expenditures through 2026** ~~operations. There is also no assurance that our patient accounts receivable will be collected in a timely fashion~~ , **which** ~~or at all. See Item 1, " Business — Sources of Revenue, " in this Annual Report for a table identifying the sources and relative payor mix of our revenues. Many provisions within the 2010 Healthcare Reform Laws have impacted or~~ could **significantly** ~~in the future~~ impact our **home health agencies** ~~business, including Medicare reimbursement reductions and promotion of alternative payment models, such as ACOs and bundled payment initiatives~~ . **•** For Medicare providers like us, the 2010 Healthcare Reform Laws **provide that** ~~included reductions in~~ CMS ~~' s~~ **will make** annual adjustments to Medicare reimbursement rates, commonly known as a " market basket update ~~. ,~~ **"** ~~The 2010 Healthcare Reform Laws also require market basket updates for~~ **that in recent years has been largely offset by the permanent adjustment reduction to the** home health **base rate** ~~and hospice providers to be reduced by a productivity adjustment on an annual basis~~ . **For fiscal** ~~The productivity adjustment equals the trailing 10-~~ year ~~average of changes in annual economy- wide private nonfarm business multi- factor productivity. The Fiscal Year 2024~~ **2025 , for example, CMS implemented** ~~Hospice Payment Rate Update Final Rule finalized~~ a ~~3~~ **2** . ~~1~~ **7** % **net** ~~hospice payment update percentage. This was a result of a 3. 3 % inpatient hospital market basket percentage~~ increase **for** ~~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~~ **and a 2** . ~~8~~ **9** % ~~relative~~ **net increase** to **hospice reimbursement rates, each as compared to** ~~2023~~ **2024 reimbursement rates** ~~levels. This payment update is the collective impact of a 3. 3 % market basket positive adjustment and a 0. 4 % fixed - dollar loss ratio positive adjustment, offset by a 0. 3 % productivity negative adjustment and a 2. 6 % permanent behavioral negative adjustment~~ . There is no assurance that ~~rates~~ **future market basket updates** will **result in** ~~increase~~ **increases ,** ~~in future years~~ or that ~~rate increases~~ **such updates** will be ~~adequate~~ **sufficient** to offset increases in operating costs **or the effects of permanent adjustments to the home health or hospice base rates** . **•** Other federal legislation can also have a significant direct impact on our Medicare reimbursement. ~~In~~ **For example, 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, the reimbursement we receive from Medicare will be reduced by this sequestration. 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 Protecting Medicare and American Farmers from Sequester Cuts Act also suspends until 2025 the Statutory PAYGO reductions that would have gone into effect because 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 **, which** ~~. 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- PPS. **MedPAC** ~~Beginning in 2020, PDGM replaced the prior 60- day episode payment methodology with a 30- day payment period and eliminated therapy usage as~~ **has also recommended that** ~~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~~ , **for fiscal year** ~~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, **Congress should reduce** ~~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 **by 7** ~~for 2023. In the 2024 Home Health PPS final rule, CMS finalized an additional 2. 89~~ % **and eliminate** ~~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' s recommendations could also affect reimbursements for our services. For example, in 2023, MedPAC recommended that, for fiscal year 2024, Congress should update~~ the hospice base payment **update** ~~rate and wage adjust and reduce the hospice aggregate cap by 20 %. Similarly, MedPAC has previously recommended that Congress adopt a unified payment system for all post- acute care, but has more recently concluded that due to the considerable resources this would require, and other changes already made, policymakers should consider smaller- scale site- neutral policies~~ . There can be no assurance that ~~future~~ **the** ~~governmental~~ -- **government** ~~action~~ will not **enact future initiatives that result in pricing freezes, reimbursement reductions, or levels of reimbursement increases that are less than the increases we may experience in our costs of operations, which could** 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. **An** Our quality of care and CMS quality..... the penalty is 4 %. Increased - **increase** ~~scrutiny and oversight~~ in ~~these industries may pose a heightened risk to reimbursement. The IMPACT Act mandated that CMS adopt several new quality reporting measures for the various post- acute provider types. 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 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 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 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 **and Medicaid** ~~plans, may utilize certain third parties, known as conveners, to attempt to control costs. Conveners offer patient~~ **patients** ~~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 **change** 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 fails to provide or~~ **our** ~~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 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~~ **payer** mix ~~or the needs of our patients~~ could adversely affect our Net service revenue or our profitability. Although the reimbursement rates we receive from traditional Medicare Fee for Service are generally higher than those received from other ~~payors~~ **payers** , an increasing percentage of Medicare eligible individuals are choosing to enroll in a Medicare Advantage plan. We are **therefore** attempting to grow the number of Medicare Advantage networks in which we participate **. Medicare Advantage presents a number of challenges** ~~, so we expect the payor mix to continue to shift~~ with ~~that growth~~ **respect to reimbursement rates and collection of fees, however** . Not only do Medicare Advantage and managed care ~~payors~~ **payers** generally pay less than Medicare Fee for Service, ~~but bad debt and longer collection cycles also tend to be 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~~ **we may experience increased bad debt and longer** collection ~~cycle~~ **cycles for services** ~~will lengthen as~~ we **provide under** ~~grow the number of~~ Medicare Advantage **compared to the Medicare Fee for Service payment cycle. As our payer mix shifts to a greater portion of Medicare Advantage and Medicaid patients, our ability to collect higher reimbursement rates will become increasingly difficult, and we may not be able to sufficiently increase the volume of patients to offset the impact, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Efforts to reduce payments to healthcare providers undertaken by third- party payers, conveners, and referral sources could adversely affect our revenues and profitability. Many third - party payers are exerting pressure on our industry to control healthcare costs and to reduce or limit increases in reimbursement rates for medical services. Our relationships with managed care and non- governmental third - party payers are generally governed by negotiated agreements. Our Net service revenue and our ability to grow our business with these payers could be adversely affected if we are unable to negotiate and maintain favorable agreements with them. In addition, 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. While the ACO rules are extremely complex and remain subject to further refinement by CMS, ACOs generally receive a portion of any savings generated from care coordination as long as benchmarks for the quality of care are maintained. It is possible, however, that ACOs may seek to reduce costs by discouraging referrals to post- acute care altogether. Health insurers and managed care companies, including Medicare Advantage plans, may also utilize certain third parties, known as conveners, to attempt to control costs. Conveners offer patient placement and care transition services to those payers 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. As a result of various alternative payment models, many referral sources — such as physicians, acute care hospitals, and other healthcare providers in the communities we serve — are 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 fails to provide or maintain a reputation for providing high- quality care on a cost - effective basis as compared to other providers. We face periodic and routine reviews, audits, and investigations under our contracts with federal and state government agencies and private payers, 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. 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 by federal or state programs or private payers; • state or federal agencies imposing fines, penalties, and other sanctions on us; • loss of our ability to participate in the Medicare program, state programs or one or more private payer** networks **; or • damage to our business and reputation** in **various markets. For additional discussion of the reviews, audits, and investigations to** which we ~~participate. The expansion and growth of Medicaid resulting from the 2010 Healthcare Reform Laws have increased the number of Medicaid patients coming to us.~~

~~Medicaid reimbursement rates~~ are **subject** ~~consistently the lowest among those of our payors~~ , **see Item 1, " Business — Regulation — Governmental Review, Audits, Surveys,** and **Investigations, " in this Annual Report** ~~frequently Medicaid patients come to us with other complicating conditions that make treatment more difficult and costly~~ . 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 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~~ **payer** denials, and the conduct of collection activities. Additional administrative processes are also required when patients elect to change their third- party ~~payors~~ **payers** , such as when patients switch from Medicare to Medicare Advantage. If we incorrectly estimate our Accounts receivable, net of allowances, **or the timing of those collections,** it may result in adjustments to our financial statements. **Future delays in reimbursement,** ~~For~~ **or** ~~example~~ **the future inability to collect aged accounts** , ~~we previously identified~~ **or inadequate reserve estimates could have** 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 **on** ~~of changes to~~ our **business and** ~~third- party payor mix. This material weakness resulted in adjustments to our~~ consolidated financial ~~statements as~~ **condition, results** of ~~and~~ **operations,** ~~for~~ **or cash flows** ~~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 **non-** ~~nongovernment~~ --- **government** ~~payors~~ **payers** , and a portion of our accounts receivable are typically under medical review by ~~payors~~ **payers** . 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, results of operations, and in maintaining liquidity. It is possible that Medicare, Medicaid, documentation support, system problems or other provider issues or industry trends may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk. 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 **. See Item 1** , ~~which could~~ **" Business — Sources of Revenues — Hospice, " in this Annual Report. For example, we accrued approximately $ 1. 4 million, zero and $ 0. 2 million for hospice cap exposure in the fiscal years ended December 31, 2024, 2023, and 2022, respectively. There can be no assurance that future hospice cap exposure will not** 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. **Government and private payers are increasingly looking to alternative payment models and value-based purchasing to contain costs.** 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 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~~ **could** disrupt the healthcare industry, ~~which~~ **and** 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 ~~ran~~ **runs** through December 31, ~~2023~~ **2025** 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 **patients** ~~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~~ **Government** ~~an~~ **and private payers' implementation** ~~attempt to reduce~~

~~costs, ACOs may seek to discourage referrals to post- acute care altogether. For further discussion~~ of **alternative** ~~coordinated care and integrated delivery~~ payment models and value- based purchasing **requirements could have a material adverse effect** ~~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~~ **our business. We may not be able to effectively adapt to such changes** ~~, " in this Annual Report~~ **or our competitors may be able to adapt more quickly, which would harm our ability to increase our volume of patients and revenue and harm our Net service revenue, financial position, results of operations, and cash flows** . 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~~ **Other** legislative and regulatory changes **may** affect healthcare providers like us from time to time **by lowering reimbursements, increasing the cost of compliance, decreasing patient volumes, promoting frivolous or baseless litigation, and otherwise adversely affecting our business** . For example, the 2010 Healthcare Reform Laws provide for the expansion of the federal Anti- Kickback Law and 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~~ **While the** initial suspension period may be up to 180 days ~~. However~~ , **it** ~~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~~ **The results** of ~~the stated goals of other~~ -- **the 2024** federal **elections further increase legislative** and **regulatory uncertainty. For example, changes in agency structure and staffing of government subsidized healthcare programs, including Medicare, could affect these programs by changing the number of persons enrolled in or eligible for these programs, reducing or delaying funding, changing reimbursement rules or increasing our administrative and compliance costs. Further, legislation and administrative actions at the federal level may impact funding for, or the structure of, the Medicaid program at the** state **level** ~~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 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 **federal programs** ~~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; • **implementation,** 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. **Any** ~~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 **costs related to** 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~~ **See Item 1A** , ~~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~~ **Risk Factors — Risks Related to Our Business — Reimbursement Risks,** " ~~for patients~~ in **this Annual Report** ~~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~~ **our** risk **of** ~~that we could experience~~ **experiencing** reduced revenue, ~~suffer~~ **financial** penalties, or ~~be~~ **significant** required ~~to make significant~~ changes to our operations. Because ~~Medicare~~ **our business is both highly regulated and dependent on** ~~payments~~ **payment from federal programs** ~~comprise a significant portion of our Net service revenue~~ , failure to comply with ~~the~~ **applicable** laws and regulations **could materially** ~~governing the Medicare program~~ and ~~related matters~~ **adversely affect us. As stated in Item 1** , ~~including anti- kickback and~~ **" Business — Regulation, " we are required to comply with various federal** anti- fraud ~~requirements, could materially~~ and ~~adversely affect us~~ **abuse laws, including the False Claims Act, the federal Anti - Kickback Statute, the Stark or Physician Self- Referral Law, and Civil Monetary Penalties Law, as well as state laws and regulations** . Settlements of alleged violations **of applicable regulations** 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 **agencies** or hospice ~~agencies~~ **provider locations** 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 **agencies** and hospice ~~agencies~~ **provider locations** 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~~ **payers** 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. **Pressures relating to downturns in the economy, including increased inflation, could adversely affect our business and consolidated financial statements. Adverse developments in the United States could lead to a reduction in** ~~Federal~~ **federal 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** ~~regulation~~ **legislation increasing the debt ceiling is not enacted, the federal government** may ~~impair~~ **stop** ~~our~~ **or** ~~ability to open new agencies~~ **delay making payments on its obligations, including funding** ~~or~~ **for government programs** ~~consummate acquisitions. Changes~~ in **which we participate, such as Medicare and Medicaid. Failure of the government to make payments under these programs could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Further, any failure by Congress to complete the** federal ~~laws or regulations~~ **budget process and fund government operations** may **result in a federal government shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program, which could have a** ~~materially~~ -- **material adverse effect on our business and consolidated financial condition, results of operations and cash flows. Sustained unfavorable economic conditions could also 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. For example, general levels of inflation and specific inflationary pressures that we have experienced in areas such as labor, transportation and medical supplies may continue to persist due to events outside of our control, such as, potential pandemic events, supply chain disruptions, and the broader macro- economic environment. In 2023 and 2024, for example, inflation increased throughout the U. S. economy. The sustained or continued rise of inflation may** adversely impact our **business operations** ~~ability to open de novo home health agencies or acquire home health agencies. For example~~ , **financial condition and** ~~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~~ **results** ~~, 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 **operations** ~~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. **Third-party vendors or " business associates, " in the event the vendor creates, receives, transmits or maintains protected health information on our behalf, are required to comply with substantially the same HIPAA requirements as the healthcare provider. This is accomplished using " Business Associate Agreements " with vendors.** 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 ~~(~~ **information systems, including systems provided by or hosted by business associates, external contractors, vendors and other businesses with whom we interact. For example, we depend upon our,** and third parties' ~~)~~ **,** information systems **and software for patient care, coding, accounting, billing, collections, quality assurance, human resources, payroll and other information considered to be sensitive and / or confidential** , including **protected health** ~~our electronic clinical~~ information ~~system~~ . We expend 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. **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.** 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. **The occurrence of any information system failure, breach** ~~For~~ **or** ~~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. A compromise of our network~~ security ~~measures~~ **incident, or those of business associates** or other **vendors and** ~~controls, or those of~~ businesses ~~or vendors~~ with whom we interact, which results in confidential **, protected health or personal** 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 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, **operations,** financial position, results of operations, and cash flows. ~~A security breach, or threat thereof,~~ **Our quality of care expectations and reporting requirements** could ~~require that~~ **adversely affect our business, our referrals, and the Medicare reimbursement** we **receive** ~~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~~ **In addition, value- based purchasing under HHVBP may negatively impact Medicare reimbursement for** home health providers ~~who~~ **Our quality of care and** ~~impacts payment adjustments in a later year (payment year).~~ CMS **quality reporting requirements could adversely affect** ~~may also create a similar plan for hospices in~~ the ~~future~~ **Medicare reimbursement we receive** .The focus on alternative payment models and value- based purchasing of healthcare services has led to more extensive quality of care reporting requirements.In many cases,our ~~reimbursement is conditioned upon,or qualified by,our satisfaction of CMS quality of care~~ reporting requirements **are linked to reimbursement incentives** .For example,home health ~~agencies~~ and hospice **agencies** ~~provider locations~~ are required to submit quality of care data to CMS each year **. ,and failure Failure** to comply with ~~these~~ **quality reporting** requirements may result in a ~~2 %~~ penalty ~~to~~ **on** our **reimbursement.For** home health agencies ~~reimbursement and~~ **that do not comply with quality reporting requirements,the penalty is 2 %;for hospices that do not comply,the penalty is** 4 % ~~for hospices reimbursement~~ . **Increased** ~~In addition~~ can ~~differentiate themselves based upon~~ **be no assurance that all our agencies will meet** quality **performance expectations (including Star ratings) or quality reporting requirements in the future** , ~~particularly by achieving low~~ **which may result in one or more of our agencies seeing a reduction in its Medicare reimbursements or** patient **referral volume** ~~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 **and our Medicare reimbursements** 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 **and hospice** company, privately owned home health and hospice companies, and acute care hospitals with adjunct home health services **. See Item 1, " Business — Our Industry and Opportunity, " in this Annual Report** . Some of 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.**