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

# FORM 10-K

**(Mark One)**

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

**For the fiscal year ended December 31, 2024**

**OR**

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

**For the transition period from to**

**Commission File Number 001-41938**

# BrightSpring Health Services, Inc.
**(Exact name of Registrant as specified in its Charter)**

| **Delaware** | **82-2956404** |
|---|---|
| **(State or other jurisdiction of incorporation or organization)** | **(I.R.S. Employer Identification No.)** |
| **805 N. Whittington Parkway Louisville, Kentucky** | **40222** |
| **(Address of principal executive offices)** | **(Zip Code)** |

**Registrant's telephone number, including area code: (502) 394-2100**

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

| Title of each class | Trading Symbol(s) | Name of each exchange on which registered |
|---|---|---|
| Common Stock, par value $0.01 per share | BTSG | The Nasdaq Stock Market LLC |
| 6.75% Tangible Equity Units | BTSGU | The Nasdaq Stock Market LLC |

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

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. YES ☒ NO ☐

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or 15(d) of the Act. YES ☐ NO ☒

Indicate by check mark whether the Registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the Registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. YES ☒ NO ☐

Indicate by check mark whether the Registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the Registrant was required to submit such files). YES ☒ NO ☐

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

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

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

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

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

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

Indicate by check mark whether the Registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). YES ☐ NO ☒

The aggregate market value of the common equity held by non-affiliates of the Registrant (assuming for these purposes, but without conceding, that all executive officers, directors and holders of more than 10% of Registrant's common stock are affiliates for the purpose of this calculation) as of June 28, 2024, the last business day of the registrant's most recently completed second fiscal quarter, was approximately $620 million (based on the closing sale price of the Registrant's common stock on that date as reported on the Nasdaq Stock Market).

The number of shares of Registrant's Common Stock outstanding as of March 3, 2025 was 174,973,806.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Registrant's Definitive Proxy Statement to be filed within 120 days of December 31, 2024 with the Securities and Exchange Commission in connection with its 2025 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report on Form 10-K.

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# GLOSSARY

As used in this Annual Report on Form 10-K (this "Form 10-K"), the terms identified below have the meanings specified below unless otherwise noted or the context indicates otherwise. BrightSpring Health Services, Inc. conducts its operations through its subsidiaries, including its indirect subsidiaries, BrightSpring Health Holdings Corp. and its wholly-owned subsidiary, ResCare, Inc., and PharMerica Corporation, or PharMerica. As used in this Annual Report on Form 10-K, unless otherwise stated or the context requires otherwise, the terms "BrightSpring," the "Company," "we," "us," and "our" refer to BrightSpring Health Services, Inc. and its consolidated subsidiaries.

- "ABA" means applied behavioral analysis, a type of therapy that focuses on improving specific behaviors;
- "ABI/TBI" means acquired/traumatic brain injury;
- "Abode" means Abode Healthcare, which we acquired in April 2021;
- "associated family satisfaction," for circumstances when a patient is unable to respond due to cognitive issues, is calculated by the percentage of such family member of a patient who would recommend the Company to another friend or family member based on the patient's experience in the Company's therapy, as reported in our outpatient therapy satisfaction survey from April 1, 2023 to June 30, 2023;
- "Behavioral" patients and populations mean individuals with intellectual and developmental disabilities including mental illness;
- "BHS Acquisition" means the acquisition of BrightSpring Health Holdings Corp. and its subsidiaries in March 2019;
- "BrightSpring," "BrightSpring Health Services," "Company," "we," "us," and "our" refer to BrightSpring Health Services, Inc. and its consolidated subsidiaries;
- "de novo" means new branch, agency, facility, clinic, and pharmacy locations;
- "First Lien Facilities" mean, collectively, the First Lien Term Loan Facility, the Revolving Credit Facility, and the LC Facility;
- "First Lien Term Loan Facility" means, collectively, the Initial Term Loans, the Tranche B-2 Term Loans, the Tranche B-3 Term Loans, the Tranche B-4 Term Loans, and the Tranche B-5 Term Loans, which are collectively described under "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Debt";
- "HCI" means Hospice Care Index, which captures care processes occurring throughout the hospice stay. The HCI is a single measure comprising ten indicators calculated from Medicare claims data. Each indicator equally affects the single HCI score, reflecting the equal importance of each aspect of care delivered from admission to discharge. The HCI score does not have a traditional numerator or denominator. Instead, a hospice, assuming 20 or more discharges in the two pooled years of data, is awarded a point for meeting each criterion for each of the ten claims-based indicators. The sum of the points earned from meeting the criterion of each individual indicator results in the hospice's HCI score. HCI scores can range from 0 to a perfect 10;
- "I/DD" means an intellectual/developmental or cognitive disability;
- "independent" when (i) describing independent provider of home and community-based health services means non-hospital providers that are not associated with a payor and (ii) describing independent platform of pharmacy services or independent specialty pharmacy means non-retail pharmacies that are not associated with a payor;
- "KKR Stockholder" means KKR Phoenix Aggregator L.P., an investment entity owned by investment funds and other entities affiliated with Kohlberg Kravis Roberts & Co. L.P.;
- "LC Facility" means our letter of credit facility, as described under "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Debt";
- "MPR" means Medication Possession Ratio, which is the most commonly used measure of adherence. MPR is calculated as the ratio of the number of days a patient is stocked for their medication to the number of days a patient should be stocked for their medication. We often use MPR to measure pharmacy performance. A performance measure over 80% is considered compliant under our contracts with a payor;
- "neuro" patients and populations mean individuals who have acquired a traumatic brain injury, spinal cord injury, pediatric autism, or other neurological condition;

- "NPS" represents Net Promoter Score, which is a metric used to gauge patient satisfaction based on how likely a patient or physician would be to recommend a company to a friend or colleague. The question is measured on a scale of 0 (not at all likely) to 10 (extremely likely). A designation of "Promoter" is assigned to respondents who provide a score of 9 or 10, a designation of "Passive" is assigned to respondents who provide a score of 7 or 8, and a designation of "Detractor" is assigned to respondents who provide a score of 0 to 6. NPS is calculated by subtracting the percentage of Detractors from Promoters. NPS ranges from -100 to +100, and scores that are closer to +100 indicate that there are more Promoters overall, and a score of +100 indicates that there are no Detractors or Passives. We utilize a third party consulting service, MMIT, to conduct our own NPS surveys of patients served by us and referring physicians in our network. MMIT, as well as other industry standards such as Qualtrics, have indicated that a score above 50 is "excellent" and a score above 80 is "world class." Throughout this Annual Report, we reference multiple NPS, as the underlying surveys are conducted by us or by third parties, including payers, across different constituents, both patients and referring physicians, as well as across various time periods, generally conducted quarterly;
- "overall rating of care" reflects the overall assessment of eight quality measures: communication with family, getting timely help, treating patient with respect, emotional and spiritual support, help for pain and symptoms, training family to care for patient, rating of hospice care, and willingness to recommend to others, as reported by the Agency for Healthcare Research and Quality;
- "patient satisfaction" is calculated (i) for purposes of Company's outpatient rehab services, by the percentage of patients who are satisfied or very satisfied with the progress they have made with the therapy treatment while on our services, as reported in our outpatient therapy satisfaction survey from April 1, 2023 to June 30, 2023; and (ii) for purposes of infusion scores, by averaging the results of seven quality measures, supplies, staff general communication, staff courtesy, staff helpfulness, staff instruction effectiveness, overall satisfaction, and willingness to recommend, as reported in our home infusion satisfaction survey from April 1, 2023 to June 30, 2023;
- "Revolving Credit Facility" means our senior secured revolving credit facility, as described under "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Debt";
- "Second Lien Facility" means our senior secured second lien term loan facility, as described under "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Debt";
- "Senior" patients and populations mean individuals who are aged 65 and older;
- "Specialty" patients and populations mean individuals who have unique, specialized and most often chronic/life-long health conditions and needs;
- "Walgreen Stockholder" means Walgreen Co., an affiliate of Walgreens Boots Alliance, Inc.; and
- "Workforce Solutions" means Arbor E&T, LLC, which we divested in November 2022.

## FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K includes forward-looking statements that reflect our current views with respect to, among other things, our operations, and financial performance. Forward-looking statements include all statements that are not historical facts. These forward-looking statements are included throughout this Annual Report on Form 10-K, including in the sections entitled "Summary," "Risk Factors," "Management's Discussion and Analysis of Financial Condition and Results of Operations" and "Business" and relate to matters such as our industries, business strategy, goals and expectations concerning our market position, future operations, margins, profitability, capital expenditures, liquidity and capital resources and other financial and operating information. We have used the words "anticipate," "assume," "believe," "continue," "could," "estimate," "expect," "intend," "may," "plan," "potential," "predict," "project," "future," "will," "seek," "foreseeable," the negative version of these words, or similar terms and phrases to identify forward-looking statements in this Annual Report on Form 10-K.

The forward-looking statements contained in this Annual Report on Form 10-K are based on management's current expectations and are not guarantees of future performance. The forward-looking statements are subject to various risks, uncertainties, assumptions, or changes in circumstances that are difficult to predict or quantify. Our expectations, beliefs, and projections are expressed in good faith and we believe there is a reasonable basis for them. However, there can be no assurance that management's expectations, beliefs, and projections will result or be achieved. Actual results may differ materially from these expectations due to changes in global, regional, or local economic, business, competitive, market, regulatory, and other factors, many of which are beyond our control.

Any forward-looking statement made by us in this Annual Report on Form 10-K speaks only as of the date of this Annual Report on Form 10-K and are expressly qualified in their entirety by the cautionary statements included in this Annual Report on Form 10-K. Factors or events that could cause our actual results to differ may emerge from time to time, and it is not possible for us to predict all of them. We may not actually achieve the plans, intentions, or expectations disclosed in our forward- looking statements and you should not place undue reliance on our forward-looking statements. Our forward- looking statements do not reflect the potential impact of any future acquisitions, mergers, dispositions, joint ventures, investments, or other strategic transactions we may make. We undertake no obligation to publicly update or revise any forward-looking statement, whether as a result of new information, future developments or otherwise, except as may be required by any applicable securities laws.

## SUMMARY RISK FACTORS

Our business is subject to numerous risks and uncertainties, including those described in Part I, Item 1A. "Risk Factors" in this Annual Report on Form 10-K. You should carefully consider these risks and uncertainties when investing in our common stock. The principal risks and uncertainties affecting our business include the following:

- we operate in a highly competitive industry;
- if we are unable to maintain relationships with existing patient referral sources or establish new referral sources, our business, financial condition and results of operations could be materially adversely affected;
- changes to Medicare and Medicaid rates or methods governing Medicare and Medicaid payments for our services could materially adversely affect our business;
- cost containment initiatives of third-party payors, including post-payment audits, could adversely impact our business, financial condition, and results of operations;
- the implementation of alternative payment models and the transition of Medicaid and Medicare beneficiaries to managed care organizations may limit our market share and could adversely affect our revenues;
- changes in the case mix of patients, as well as payor mix and payment methodologies, and decisions and operations of third-party organizations may have a material adverse effect on our business, financial condition, and results of operations;
- our business is reliant on federal and state spending, budget decisions, and continuous governmental operations which may fluctuate under different political conditions;
- changes in drug utilization and/or pricing, PBM contracts, and Medicare Part D/Medicaid reimbursement may negatively impact our profitability;
- changes in our relationships with pharmaceutical suppliers, including changes in drug availability or pricing, could adversely affect our business and financial results;

- our business relies on the continual recruitment and retention of nurses, pharmacists, therapists, caregivers, direct support professionals, and other qualified personnel, including senior management;
- we are subject to federal, state, and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time-off requirements; failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations;
- our results of operations fluctuate on a quarterly basis;
- our business may be harmed by labor relation matters;
- because we are limited in our ability to control reimbursement rates received for our services, our business could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services;
- delays in collection or non-collection of our accounts receivable, particularly during the business integration process, could adversely affect our business, financial condition, and results of operations;
- if we fail to manage our growth effectively, we may be unable to execute our business plan, maintain high levels of service and satisfaction, or adequately address competitive challenges;
- our growth strategy is partially dependent upon our ability to identify and successfully complete acquisitions, joint ventures, and other strategic initiatives; any failure by us to manage or integrate acquisitions, divestitures, and other significant transactions successfully may have a material adverse effect on our business, financial condition, and results of operations;
- if we are unable to provide consistently high quality of care, our business will be adversely impacted;
- if we are unable to maintain our corporate reputation, or there is adverse publicity, including negative information on social media, or changes in public perception of our services, our business may suffer;
- if our existing customers do not continue with or renew their contracts with us, renew at lower fee levels, decline to purchase additional services from us or reduce the services received from us pursuant to those contracts, it could have a material adverse effect on our business, financial condition, and results of operations;
- our business depends on our ability to effectively invest in, implement improvements to, and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems;
- security breaches, loss of data, and other disruptions could compromise sensitive business or patient information, cause a loss of confidential patient data, employee data, personal information, or prevent access to critical information and expose us to liability, litigation, and federal and state governmental inquiries and damage our reputation and brand;
- we are subject to risks related to credit card payments and other payment methods;
- we may be subject to substantial malpractice or other similar claims;
- we are exposed to various risks related to governmental inquiries, regulatory actions, and whistleblower and other lawsuits that could adversely affect our operating results. Our insurance may not cover all claims against us;
- our current insurance program may expose us to unexpected costs and negatively affect our business, financial condition, and results of operations, particularly if we incur losses not covered by our insurance or if claims or losses differ from our estimates;
- factors outside of our control, including those listed, have required, and could in the future require us to record an asset impairment of goodwill;
- a pandemic, epidemic, or outbreak of an infectious disease, including the ongoing effects of COVID-19, have had, and may continue to have, an adverse effect on our business;
- inclement weather, natural disasters, acts of terrorism, riots, civil insurrection or social unrest, looting, protests, strikes, or street demonstrations may impact our ability to provide services;
- we may be unable to adequately protect our intellectual property rights, which could harm our business;
- risks relating to our compliance with our regulatory framework;
- KKR Stockholder controls us and its interests may conflict with yours in the future;
- our substantial indebtedness of approximately $2.7 billion as of December 31, 2024; and

- we are a "controlled company" within the meaning of the rules of Nasdaq and the rules of the SEC and, as a result, qualify for, and rely on, exemptions from certain corporate governance requirements.

## MARKET AND INDUSTRY DATA

This Annual Report on Form 10-K contains estimates, projections and other information concerning our industry and our business, including data regarding the estimated size of the market, projected growth rates and perceptions and preferences of customers, that we have prepared based on industry publications, reports and other independent sources, each of which is either publicly available without charge or available on a subscription fee basis. None of such information was prepared specifically for us in connection with this filing. Some data also is based on our good faith estimates, which are derived from management's knowledge of the industry and from independent sources. These third-party publications and surveys generally state that the information included therein has been obtained from sources believed to be reliable, but that the publications and surveys can give no assurance as to the accuracy or completeness of such information. Market and industry data is subject to variations and cannot be verified due to limits on the availability and reliability of data inputs, the voluntary nature of the data gathering process and other limitations and uncertainties inherent in any statistical survey. Although we are responsible for all of the disclosures contained in this Annual Report on Form 10-K and we believe the industry and market data included in this Annual Report on Form 10-K is reliable, we have not independently verified any of the data from third-party sources nor have we ascertained the underlying economic assumptions on which such data is based. Similarly, we believe our internal research is reliable, even though such research has not been verified by any independent sources. The industry and market data included in this Annual Report on Form 10-K involve a number of assumptions and limitations, and you are cautioned not to give undue weight to such information.

Unless otherwise expressly stated, we obtained industry, business, market and other data from the reports, publications and other materials and sources listed below. In some cases, we do not expressly refer to the sources from which this data is derived. In that regard, when we refer to one or more sources of this type of data in any paragraph, you should assume that other data of this type appearing in the same paragraph is derived from the same sources, unless otherwise expressly stated or the context otherwise requires.

# PART I

## Item 1. Business

### Who We Are

We are a leading home and community-based healthcare services platform, focused on delivering complementary pharmacy and provider services to complex patients. We have a differentiated approach to care delivery, with an integrated and scaled model that addresses critical services that the highest-need and highest-cost patients require. With a focus on Senior and Specialty patients, which includes Behavioral populations, our platform provides pharmacy and provider services (both clinical and supportive care in nature) in lower-cost home and community settings largely to Medicare, Medicaid, and commercially-insured populations. We are an essential part of our nation's health delivery network as a front-line provider of high-quality and cost-effective care to a large and growing number of people, who increasingly require a combination of specialized solutions to enable holistic health care management. Our presence spans all 50 states, we serve over 450,000 patients daily through our approximately 11,000 clinical providers and pharmacists, and our services make a profound impact in the lives and communities of the people we serve.

Our model focuses on delivering high-touch and coordinated services to medically complex clients and patients, which is a large, growing, and underserved population in the U.S. healthcare system. These high-need and high-cost Senior and Specialty patients comprise a market of over $1.0 trillion across our business. The chronic conditions and long-term health needs of these patients not only represent an outsized share of health care spend today, according to RAND Health Care, but we believe that they are expected to also drive a disproportionate share of future expenditures. Americans with five or more chronic conditions make up over 10% of the population and account for 40% of total health care spending, on average spending 10 times more on health services than those without chronic conditions. These patients most often require both pharmacy and provider services to achieve the best outcomes, but must often navigate disjointed and separately-administered health services. This can result in uncoordinated care delivery with adverse medical consequences, as compared to receiving timely, proximal, and complete care support in the home and community that improves health and reduces cost.

We have built a significant presence and capability in delivering complementary and high-touch daily healthcare services and programs to complex patients in their homes and in communities in order to address their multiple health needs and requirements more completely. In pharmacy, we leverage our national infrastructure to provide daily medication therapy management to various customer and patient types wherever they reside in the community, including home and in-clinic infusion patients, oncology and other specialty patients in their homes, residents of independent and senior living communities, people receiving hospice care, neuro and Behavioral clients' and patients' homes, residents of skilled nursing and rehabilitation facilities, hospital patients, and the homes of Seniors who are on a significant number of medications. Within provider services, we address the clinical and supportive care needs of Senior and Specialty populations, including neuro and Behavioral patients, primarily in their homes, as well as some clinic and community settings. Our clinical services consist of home health and hospice and rehab therapy, and our supportive care services address activities of daily living and social determinants of health as well. We also provide home-based primary care for patients in senior living communities, long-term care, and individual homes to directly manage and optimize patient outcomes and to enable value-based care. By providing these complementary and necessary services for complex patients, our care model is designed to address multiple patient needs and better integrate health services delivery to improve quality and patient experiences, while reducing overall costs.

We believe that our Company addresses important needs today and is also well-positioned for the long-term, as it is underpinned by capabilities and characteristics that suggest continued differentiation and growth:

- **Complementary pharmacy and provider services that address multiple patient needs –** We have a healthcare platform that can combine pharmacy and provider care in order to address the spectrum of interrelated and chronic needs that Senior and Specialty patients possess. Through our comprehensive care capabilities, we are able to develop longitudinal relationships and views of our patients, which enables us to more closely manage daily medication requirements and adherence, provide primary care and other skilled nursing and therapy clinical services, and address social determinants of health and daily care needs. Moreover, we believe that this integrated model and capability set will increasingly be a more effective approach for providing high-need and high-cost Senior and Specialty populations the pharmacy and care services solutions they require.
- **Effectively serving complex patients in the home and community setting** – With over 40 years of experience caring for "must-serve" client and patient populations, we deliver care in preferred and lower-cost settings with strong quality results. Our services reduce cost by providing care for many of these individuals in non-institutional home and community settings and reducing hospitalizations. For example, across our pharmacies, we achieve 99.99% order accuracy and 98.63% order completeness, "excellent" and "world class" NPS, and a reduction in hospitalizations with CCRx, while also driving savings through medication adherence and therapeutic interchanges. We achieve 97% patient satisfaction in our outpatient rehab services, an 85% overall rating of care in hospice, and, as reported by the Agency for Healthcare

Research and Quality, hospitalizations that are 35% lower than the national average in our home-based primary care. Our complex Behavioral clients, often with three or more comorbidities and requiring eight or more medications, are still able to spend 359 days a year at home on average. We believe that we are positioned to identify potential medical problems and avoid adverse events due to our highly proximate position to patients.

- **Market-leading scale with a focus on operational excellence and coordinated front-line care –** We manage one of the nation's largest independent platforms of both pharmacy and provider services offered on a daily basis in home and community settings – to address the multiple needs of medically complex Senior and Specialty patients. Our leading scale across all 50 states has important benefits. Our scale provides complementary diversification and risk mitigation in payor sources, end markets, and geographies, while also creating exposure and access to a broader set of market growth opportunities. Further, we leverage economies of scale and best practices across the company, including in purchasing and all supplier contracting, quality, technology, human resources, and advocacy and payor relations. Scale from our pharmacy and provider businesses allow us to effectively deliver and coordinate integrated solutions to and across patient types and care settings, which we believe will be more important in the ongoing development of value-based care solutions. Ultimately, our track record of building market density, expanding core services to additional customer and patient types, and replicating this model across new geographies underpins both our historical results as well as our growth strategies.

We are one of the largest independent providers of home and community-based health services in the United States, offering skilled, complementary, integrated, and impactful health care solutions. Almost all of the clients and patients that we serve have chronic conditions and the vast majority of them receive their services on a recurring basis over long periods of time. In our pharmacy business, patients have an average of nine prescriptions at a given time and are supported by our local pharmacy model that delivers daily services, often within an hour or two, from over 180 pharmacies, infusion centers, and specialty oncology locations across all 50 states. We have specifically focused on and built a fast, local, and "white-glove" delivery model that is supported by expert clinical teams in the field, which fulfilled over 41 million prescriptions in 2024 across customer and patient settings and types. Patients who receive our provider services average six chronic conditions per patient, and we delivered approximately 19 million hours of quality and compassionate care in 2024 to home health, hospice, rehab, and home care patients and clients. Combined, our daily pharmacy and provider services are delivered from and to approximately 11,300 office, clinic, and customer locations across the country, with over 450,000 patients serviced at any one time, including approximately 300,000 patients served in their homes at any one time.

**Our Platform**

We believe our high-quality and complementary health services offerings address significant and important patient and stakeholder needs. In the home and community settings where we operate, patients with chronic conditions often require daily care, closely-managed medication regimens, and specialized clinical treatment, and our service model is defined by core pharmacy and provider services augmented by integrated care capabilities that are intended to maximize outcomes and minimize potential disruptions. The Company's quality outcomes achieved for Senior and Specialty patients and industry stakeholders are also mostly delivered in patient-preferred and lower-cost settings. We believe our breadth of service capabilities and proven outcomes position us as a provider of choice for patients, families, referral sources, customers, and payors.

Furthermore, scale is important in the industries and service areas that we participate in, for numerous reasons, including realizing economies of scale, for example in purchasing, technology, and related to fixed expenses, leveraging best practices and quality and operational oversight of the service lines, in payor contracting, being able to invest in attractive growth areas, and driving value through revenue, quality, and operational and cost synergies post acquisitions. Our service capabilities extend across all 50 states in the United States, with co-location of our pharmacy and provider services in 40 states. We deliver a higher proportion of services in select regions with favorable demographics and regulatory environments, with approximately 47% of our revenue in 10 states for the year ended December 31, 2024. Our services are organized and managed through two reportable segments: Pharmacy Solutions and Provider Services.

The Company's scale, complementary service offerings, and geographic footprint also enable integrated and value-based care opportunities. Many of our patients today receive both pharmacy and provider services from the Company, thus simplifying their experience and supporting positive outcomes. Our integrated care and value-based care model is based on three important service enablers and three primary strategies. For enablers, we view (i) home-based primary care capabilities, (ii) a customized transitional care management program, and (iii) a clinical care coordination hub as essential to drive optimized quality and reduced cost outcomes. The Company has spent the last several years building out these three integrated and value-based care capabilities. In turn, these enablers are required to execute three key integrated and value-based care strategies, including (i) the coordination of clinically integrated care for patients receiving multiple Company services across settings and over time, (ii) providing multiple integrated (or bundled) services to senior living communities, behavioral providers, skilled nursing and rehabilitation facility providers, hospitals,

and payors who all require our comprehensive offerings, and (iii) the execution of value-based care contracts, whether internal through the Company's own ACO shared savings arrangements and managed care plans or whether external through third-party government or managed care entities.

***Pharmacy Solutions***

We opportunistically provide pharmacy services when and where demanded and as required to customers and patients in their homes and communities, often in coordination with our provider services. The Company filled over 41 million prescriptions in 2024 from over 180 pharmacies across all 50 states, with services delivered to approximately 7,100 customer locations, more than 60,000 individual or group homes, and over 400,000 patients, all through over 4,700 unique customer and payor contracts. Our leading pharmacy support across customer and patient settings is achieved through a focus on medication availability and reliability, cost containment, customer staff and patient support programs, clinical and regulatory education and support, and leading customer service. Infusion and Specialty Pharmacy prescriptions and Home and Community Pharmacy prescriptions have grown at more than 22% and 11%, respectively, from December 2023 to December 2024. We have a unique opportunity to increasingly provide more pharmacy services in the future to provider patients and patients transitioning across settings of care. Almost every one of the Company's patients who receive provider services from us have a significant medication support need given their polypharmacy profile, which we have the opportunity to further address.

Pharmacy services are a universal need and ongoing connection point across medically complex populations. Our pharmacy services delivered into homes and community settings for complex patients are extremely different as compared to retail pharmacy, with more challenging customer and patient needs and service requirements. The average Senior fills approximately 52 medication prescriptions per year, while our average pharmacy patient is usually prescribed approximately nine medications at a given time, or at least two times more than the average Senior. As a result, medication appropriateness, accuracy, and adherence are critical points of emphasis for promoting the overall long-term health and well-being of patients. Non-adherence causes approximately 40% of chronic disease treatment failures and 125,000 deaths per year in the United States. Further, non-adherence costs $100 billion annually, according to the JAMDA study. We deliver on our goals with 99.99% order accuracy and 98.63% order completeness.

There are numerous success factors that we believe are important for long-term sustainability in the pharmacy industry. First, large scale, which our pharmacy platform has and is characterized by, is of critical importance. We are able to leverage our large pharmacy scale in purchasing and all supplier contracting, in operating and fixed expenses, in payor contracting, in technology and systems, in sales and marketing and with brand reputation, in being able to address customer and growth opportunities in more markets, in driving synergies post acquisitions, and in leveraging best practices, for example, in operational, quality, and compliance oversight and human resources and people management. Second, the Company has historically targeted and served home and community pharmacy customers, patients, and channels as different from a retail strategy. We believe that these service settings and channels are more challenging to serve and present the opportunity for greater customization of offerings, differentiation, and value-add to customers. Third, and related to the customer types and channels that we serve in pharmacy, we most often provide our services through a local pharmacy and delivery model. Many of our customers require same day pharmacy service or in-person administration, and this geographical requirement can only be met through local, physical pharmacies. Fourth, many of our customers and patients have different and more significant clinical, educational, and reimbursement needs as compared to the general population's retail medication profile, which must be addressed through particular expertise and high-touch customer and patient support vehicles and resources. Fifth, and also due to the different setting profile, heightened needs, and medication therapy profile of our patient base, there is an increased importance on service levels and quality measures in our specific pharmacy service types. Companies that outperform on service and quality in our pharmacy customer and patient channels have the opportunity to differentiate themselves in the market and with payors.

*Infusion and Specialty Pharmacy*

We provide infused, injectable, and oral medication services in the home and clinic focused on pharmaceutical therapies that require expert administration and high-touch clinical services to patients by our pharmacists, registered nursing staff, and patient support teams. Infusion therapy services are a specialty form of pharmaceuticals that involve the intravenous administration of higher-cost, specially-handled medications that treat a wide range of acute and chronic health conditions, including, for example, infections, auto-immune illnesses, oncology, multiple sclerosis, hemophilia, and nutritional deficiencies. Oral and injectable medication therapies for complex disease management treat oncology, neurology, dermatology, cardiology, immunology, inflammatory, rare and orphan, and other conditions. Within oncology, as one of the leading independent specialty pharmacies in the United States, our services encompass clinical coordination, patient education, protocol compliance, patient assistance with insurance access and outside funding, and timely delivery of medication. Our certified oncology pharmacists are available 24/7 to provide support for patients and caregivers while working in close coordination with their physicians.

Our customer service and quality metrics are in-line with, or better than, our peers, such as time-to-first-fill (3.6 day average turnaround time, which is significantly lower than the industry average of 9.7 day average turnaround time), overall MPR (93.3%, which is significantly higher than the generally accepted 80% threshold for compliance, which is also the threshold set forth in the Company's Blue Cross Blue Shield guarantee), and infusion patient satisfaction scores (94.5%, which is in-line with the 95.6% national average). We offer value-add services including technology integrations and real-time analytics for both suppliers and payors. As a result of our unique capabilities in serving pharmaceutical manufacturers and biotech companies, we have exclusive or preferred relationships in specialty oncology drugs, as manufacturers select our pharmacy – exclusively or as part of a group of a few other pharmacies – to distribute and support their therapies in the market. We currently have 125 limited distribution oncology drugs in the market with an additional 18 in the pipeline still to launch, including 4 exclusive and 14 ultra-narrow drugs with limited pharmacy access. In 2020, 2021, and 2022, as a testament to our leading quality and service, we achieved "world-class" NPS scores of over 90, which also triggered quality incentive payments. The Company receives incentive payments in connection with a payor contract, which includes incentive targets based on the Company's NPS scores achieved from surveys performed directly by the payor. During the year ended December 31, 2023, the incentive payment was approximately $30 million. The Company did not receive an incentive payment during the year ended December 31, 2024. The incentive program has reached its conclusion. Further, there are meaningful new opportunities, such as $90 billion expected by 2032 in pharmaceutical industry revenue from oncology drugs not yet launched, drugs that will become generic over the next five years, and approximately 400 drug therapies in Phase III in the Infusion and Specialty Pharmacy pipeline.

*Home and Community Pharmacy*

Our home and community-based pharmacy solutions ensure that medications are accessible and clinically supported for patients outside of retail pharmacies. The Company's footprint of pharmacies covers all 50 states with a localized model that features "white-glove" and customized programs and allows for faster response times and a better customer and patient experience. We service customer locations typically multiple times a day and 24/7 as needed, within a radius of approximately 100 miles of a pharmacy location. Our services focus on achieving leading medication availability, cost containment, and clinical and regulatory education and support for our customers, and they are designed to provide a consistent, best in-class experience for customers accompanied by local concierge support. Centralized intake and order entry drives consistency across operations and markets. Our pharmacy services are all customized to specific settings and patients among the Senior and Specialty populations served, for example whether a patient receiving our medications is in a senior living community, a behavioral group home, or a hospice patient in their own home.

In addition to our very strong service delivery metrics, our pharmacy services and proprietary programs reduce drug costs to customers and patients, for example with a 99.93% generic efficiency rate (the percent of drugs dispensed as generic, when both brand and generic versions of a drug are available) and saving customers an average of $58 per therapeutic interchange. Our customers, supported by several thousand pharmacists, pharmacist consultants, and nurses, perform better than the national average, with our patients consistently outperforming non-patients on overall CMS quality measures. Moreover, we believe we have certain comparative strengths in this large and fragmented pharmacy market due to our large pharmacy scale – and associated drug purchasing capabilities and distribution reach–and robustness of proprietary and customized customer and patient support programs.

In 2021, we launched CCRx, which is a longitudinal medication therapy and risk management program for home health patients, attempting to solve one of the biggest challenges and opportunities in healthcare, which is the ongoing management of complex patients in their homes to reduce adverse health events and hospitalizations. CCRx includes patient and home assessments, initial and ongoing medication review and reconciliation, user-friendly adherence packaging, direct patient engagement, and education by pharmacists and clinicians. The program was built for patients discharged from skilled nursing and rehabilitation facilities or hospitals, and/or patients going onto home health. Studies have shown that all-cause hospitalizations are higher in patients with poor medication adherence and that medication management associated issues are a leading cause of emergency room visits and hospitalizations. CCRx has been shown to reduce hospitalizations, and, as such, is a key enabler in managing patients in value-based care constructs. For example, the JAMDA study found that home health recipients who are enrolled in CCRx experience a 73.1% lower hospitalization rate than home health recipients who are not enrolled in CCRx.

***Provider Services***

We deliver a variety of impactful and valuable provider services to high-need, chronic, and complex patients in home and community settings. These services consist of clinical and supportive care to approximately 40,000 Senior and Specialty populations today, with both census for Home Health Care services specifically, and rehab hours served, having grown approximately 9% and 13% from December 2023 to December 2024, respectively. While the clinical services that we provide have demonstrated attractive volume growth over the past several years, supportive care services have also demonstrated stability and growth due to the valuable nature of these services that address activities of daily living and social determinants of health. Many of our provider patients also receive their pharmacy services through the Company, which helps to optimize their pharmacy and medication care and needs, simplify their experience, and improve their satisfaction. Our patient personal care satisfaction score for provider services patients was

4.54 out of 5.0, per an internal survey. We believe there is greater opportunity to provide integrated services to all of our patients in the future, as almost every one of the Company's patients who receive provider services from us have a significant medication support need given their polypharmacy profile, and, vice versa, many of the patients we serve in pharmacy have multiple provider service needs, including, for example, home-based primary care, home health, and rehab. To this end, the Company has endeavored to build out home-based primary care over the last several years to coordinate patient services.

There are numerous success factors that we believe are important for long-term sustainability in our provider services markets. First, we are able to leverage our investments in human resources and people management initiatives and best practices across the enterprise, including in recruiting scale and centralization, onboarding and training, and career paths. Second, quality and patient satisfaction are critical, and we are able to provide increased quality and compliance and operational oversight across all locations through additional regional and enterprise resources and functions. Third, we drive strong sales and marketing best practices across geographies to drive strong referral and volume growth rates. Fourth, we are able to drive economies of scale in supplier and payor contracting, in technology and systems, and in government affairs and advocacy. Fifth, the ability to address market opportunities and geographic coverage through de novo locations and tuck-in acquisitions that benefit from synergies adds value, which we have demonstrated. Moreover, provider services scale is perhaps the most important determinant of sustainability for a provider services business, as it enables a company to be able to execute on the aforementioned success factors. Complementary scale in the pharmacy business is additive to provider services quality and growth, as our pharmacy business' presence and footprint across geographies provide for a base of integrated care patient opportunities.

*Home Health Care*

We provide patient-centric, highly skilled, and compassionate clinical care to Seniors and others in their homes. For Seniors and other patients recovering from surgery or illness or living with chronic diseases, we provide clinical home health care in the home. These services help patients avoid unnecessary hospitalizations, speed up recovery time, and allow people to stay and feel secure in their own homes, which they prefer. Over $40 billion in annual U.S. health care spending is attributed to hospital readmissions, and home health care can reduce 365-day post-discharge costs by more than $6,000 per patient, each per the American Journal of Medicine. We also provide physical, emotional, and spiritual comfort and support primarily for Senior patients with terminal illnesses and their families through our hospice services. Our services have also been shown to help manage end-of-life healthcare spending. Like patients receiving home health care, our interdisciplinary hospice teams tailor individualized plans for patients and their families based on a comprehensive understanding of their needs. Our hospice patients require important daily pharmacy support, which we deliver through our pharmacy services. We have an 9.3 HCI score, calculated using data from CMS provider reports for each of our providers, and we believe that our nurse-to-patient visit frequency and staffing ratio is well above industry averages, as demonstrated by the fact that across our hospice services, our average total visits per patient is 17.1 visits per month as compared to the national average of 15.6 visits per month. Additionally, on average, nursing visits per patient per month was 8.2 as compared to the national average of 6.8 visits per patient per month, which monthly average was based on a MedPac report in 2024. Additionally, for Seniors and others who require supportive care and activities of daily living support that address social determinants of health, including dietary and nutrition management and cognitive and social engagement, among others, we offer these daily or weekly services. We estimate that the average cost per day of supportive home care services is 90% less than hospital care, and as Medicare spends an average of three times more on older adults with functional limitations, we also believe that supportive care services will continue to become a focus for payors to help improve outcomes and delay or prevent unnecessary facility placement.

We are continuing to build out specialized and different primary care capabilities through our home-based primary care medical home model and platform, which we view as central to the future of optimizing patient management, including patient experiences, outcomes, and cost. Many adverse health and/or medication events can be prevented through better understanding patients' health and risk factors by managing and treating them in the environment where they reside with primary care. In doing so, home-based primary care is more patient-centered and incorporates patients' specific objectives and goals. Home-based primary care pro-actively addresses gaps in care and triages health events in-place, when possible, thus mitigating avoidable emergency room visits and hospitalizations. Home-based primary care coordinates care and resources for patients in pulling together previously disparate information and contact points into one place for more coordinated and informed patient care. Our primary care clinicians, including physicians we directly employ in certain states, optimize clinical and care decisions as they see and manage both Seniors and Behavioral (including I/DD) patients in senior living communities, in individual homes and in group homes, in skilled nursing and rehabilitation facilities, as well as through transitional care visits after patients leave hospitals or skilled nursing facilities. By engaging with patients more frequently and where they live, the Company's home-based primary care can mitigate health issues before they escalate further and conduct many applicable treatments and procedures in a home or community setting. Our home-based primary care has delivered leading quality outcomes, including a hospital readmission rate 35% less than the national average and with acute, chronic, and complex patients served still able to spend 359 days per year at home, more than 7% than the Healthy Days at Home study of 6.6 million Medicare beneficiaries found, which reported that beneficiaries with three or more chronic conditions spent, on average 333.7 days at home. For I/DD patients, we have seen reductions in hospitalizations and readmissions of 44% and 84%, respectively, since beginning home-based primary care services.

In addition to many of our provider patients also receiving their pharmacy services from the Company, our patients often receive multiple in-home provider services from the Company to improve outcomes, including home-based primary care and home health or hospice and transitions from home health to hospice. In 2021, the Company implemented CCRx, which provides patients with a more coordinated experience and reduces risks through primary care expertise in the home soon after patient discharge and through optimized medication therapy management in an individual's home. Within the last two years, the Company has built a Clinical (Nursing) Hub to be the contact and coordination point for patients, families, and their pharmacy and provider services. As more of our patients utilize the multiple needed services that they require and we provide, we pro-actively monitor patients and deploy triage tools through our Clinical (Nursing) Hub to address risks and optimize quality outcomes in real-time, particularly for higher risk patients. Within the Clinical (Nursing) Hub, we centralize on-call and tele-triage, perform high-risk patient monitoring and intervention, conduct "Aftercare" patient calls, and manage care coordination opportunities across the enterprise. We see significant potential for additional integrated care opportunities by leveraging our Home-Based Primary Care, CCRx, and Clinical (Nursing) Hub capabilities to support senior living communities, payors, our hospital partners and their patient discharges, and our skilled nursing and rehabilitation facility customers who alone discharge approximately 360,000 patients a year back into the community and their homes.

*Community and Rehab Care*

Our Community and Rehab Care services provide both client-and patient-centric clinical care and supportive care to Senior and Specialty clients and patients living with age-related acute or chronic conditions, living with life-long indications (including I/DD and autism), or recovering from a catastrophic neuro event (ABI/TBI or stroke) requiring intensive therapy. These services support individuals of all ages who need various forms of expert clinical care and therapy in addition to assistance with daily skill building and living. The majority of these clients and patients receive daily pharmacy support, delivered through our pharmacy business, along with ongoing behavioral therapy consults and primary care medical care, which is increasingly being delivered through our home-based primary care practice.

We provide specialized, highly-skilled, and custom-designed rehabilitation services, including physical, speech and occupational therapy and ABA, for clients and patients of all ages with a range of injuries and conditions, including brain and spinal cord injuries, stroke, pediatric neuro conditions, and autism. Our services make a dramatic impact on the trajectory of a patient's independence, skills, and life and significantly lower longer-term costs. Rehab patients see profound improvements in their conditions, with the Company's outpatient rehab services receiving a 97% patient satisfaction score and approximately 97% of patients who would recommend our services. We also offer a variety of programs for individuals with I/DD through our community living services, including group homes, supported living and family living models (host homes), behavioral therapy, vocational therapy, and case management. Our programs are principally administered in individuals' homes and are predominantly based on individual support and clinical care plans designed to encourage greater independence and manage medical conditions, as the majority of I/DD individuals have multiple chronic conditions and require eight or more medications.

On January 17, 2025, we entered into a purchase agreement with National Mentor Holding, Inc. to divest the Company's community living services, home and community based waiver programs, and intermediate care facilities (the "Community Living business"), for $835 million, subject to typical adjustments for working capital and other customary items. The Company expects the divestiture to close in 2025, subject to customary closing conditions. This transaction provides for continuity of important intellectual and developmental disability services while BrightSpring focuses on a concentrated group of customers, patients and stakeholders in the future. We believe the Company's streamlined service offerings will result in increased strategic focus, operational efficiencies, a refined payor mix, and greater clinical integration and business synergy across the Provider Services segment. The divestiture will also augment the Company's expected Revenue and Adjusted EBITDA growth rates and maximize exposure to target growth markets that require BrightSpring's needed and valuable solutions, such as home health, rehab, primary care, and hospice. The Company expects to account for this sale as a strategic shift in fiscal year 2025.

**Our Team and Culture**

We believe an engaged, connected, and mission-driven team of employees across the Company is an essential component of our platform and growth strategy. Our dedicated clinicians, caregivers, field, corporate and other administrative support employees, managers, and leaders are the critical elements that have enabled us to build a differentiated healthcare platform of scale with strong quality outcomes and historical financial performance. We have a combination of long-standing employees at all levels who have worked together for years and talented newer employees that help to contribute best practices and innovation – all bringing a wealth of experience in healthcare.

Our leadership team has driven a clearly defined vision and mission through the organization. It has fostered and developed a focus on quality, operational excellence, and growth across our enterprise, underpinned by strong people, efficient processes, and robust technology and data systems and applications. The Company has consistently innovated its service models to drive results and augment our positioning as a valuable partner to industry stakeholders. Our culture is at the heart of all we do, enabling execution of

our strategies. Our commitment and passion for making a difference and helping people guides the way our care and services are delivered, one patient at a time.

As a leading mission-driven and quality-focused health services organization, our employees are fundamental to our ability to maximize our impact in serving clients, patients, families, customers, referrals sources and partners, and all healthcare stakeholders. Focusing on the interests and development of our employees is a top priority, and our ability to attract and retain compassionate and skilled caregivers and pharmacy professionals, as well as talented functional and managerial staff, is fundamental to our future.

Our LEGACY focus guides every member of our team to act as professionally and responsibly as possible with an attention to the following core behaviors:

- **Leadership:** Everyone is a leader. Establish purpose and coach to make others better.
- **Environment:** Work together among a trusting team, and reward good performance.
- **Get Going:** Think. Plan. Act. Take action to set and hit our goals.
- **Attitude:** Take a positive, can-do approach, because that is contagious.
- **Communication:** Connect, coordinate, and collaborate, so that everyone is in the know.
- **You:** Be an example. Stop and reflect. Set high standards, and note progress and wins.

These LEGACY standards show up in all areas of operations, including strategic planning, budgeting, quality and compliance, operations, sales and marketing, technology, management review systems, performance reviews, compensation, and promotions. We believe our culture supports our ability to operate at the highest levels to maximize our collective impact in fulfilling our mission and delivering critically needed care to our clients and patients in a high-quality way. If we do this, we believe that sound and responsible financial results will follow, which enable further investment in people, technology and continuous improvement efforts.

**Operational Excellence**

Operational excellence is a focus of our Company. It is a key aspect of our performance, and we believe it will be a driver of our continued growth. Our senior leadership's attention to how we operate and manage our services and enterprise support functions is reflected in continuous improvement efforts in both volume and cost efficiency related areas for improved results. In field operations, processes and teams are empowered with clear strategies and goals and managed from the local level up through regions, with key enterprise functions such as finance and accounting, revenue cycle, information technology, quality, compliance, human resources, legal, payroll, accounts payable, communications, sales and marketing, and government relations working to support front-line and field employees and managers to be as knowledgeable and impactful as possible. In addition to large finance and human resources organizations, dedicated PMO, IMO, and Procurement teams have been in place for the last eight years and serve as control functions, as they evaluate opportunities, drive continuous improvement projects, and support the execution of critical initiatives across all business and enterprise functions in the Company.

Working collaboratively, these teams have a broad mandate and are empowered from the CEO office to support further growth and realize savings through new strategies to drive volume, people and culture enhancements, process improvements and operational efficiencies, synergy capture from acquisitions, and improved purchasing that leverages our scale. The implementation of our PMO-led continuous improvement program over the past eight years at the enterprise level has resulted in approximately $67.5 million of annual savings in 2024 (in addition to annual efficiencies and savings work throughout field operations) from improved processes and working smarter, and these efficiencies have been used to reinvest in employees (both existing employees through wages and benefits and new employees to support key strategies, innovation and infrastructure needs to further scale), quality, technology, and growth initiatives. Our cost initiatives have included various projects such as formulary product focus which then can lead to pricing improvements, delivery route optimization, and vehicle and mileage optimization among many other initiatives focused on reducing waste and improving costs in our network.

We have continued to make investments to improve the overall efficiency and workflow of our business and position ourselves for continued future growth. For example, investments in technology and information systems to support our businesses in recent years have included new and improved EMR and ERP systems across different pharmacy and provider services for continued usability improvements, quality objectives, sales and marketing strategies, enabling mobile and electronic visit verification, implementation of daily pay and other employee support applications, and enhancements to financial, revenue cycle, recruiting and training systems. Our cloud-based data lake (storage) and business intelligence (analytics) capabilities are now a single digital platform and set up to feed real-time quality, operational, and financial metrics tracking across the Company.

In 2020, we also completed the implementation of a financial systems transformation, including the implementation of Oracle Fusion and a new budgeting and forecasting system. Continued enhancements in revenue cycle systems and processes have included a

new accounts receivable collections system to prioritize accounts and team activity and drive DSOs, implementation of our "One Touch" billing and collections program in pharmacy (to comparatively outperform for customers in a complicated industry billing environment using dedicated billing specialists assigned to facilities to proactively lower costs and optimize customer experiences), lockbox capability, and online bill pay. Employee and vendor initiatives have included payroll and accounts payable systems enhancements and conversions to automate field and people processes, a new enterprise recruiting, hiring and onboarding system, enhanced training systems and programs, introduction of an employee App, or OutReach, that also includes capability for employees to receive daily pay, and a new enterprise travel system to implement policy controls and bulk purchasing for better rates. In turn, we have continued to refine and leverage our scale with IT infrastructure consolidations and efficiencies and ongoing IT security investments in support of enterprise systems and data. Moreover, the Company is on a course to digitize as much information as possible and to automate all relevant processes and tasks possible, and we continue to identify opportunities to take advantage of robotic process automation, a discipline we introduced into the Company that has resulted in the automation of many wrote, manual processes, saving time and freeing up employees for higher value-add activities.

Quality and compliance are central to our strategies and mission. We have demonstrated leading and excellent service and customer/patient/family satisfaction scores across the organization, as referenced in prior and other sections of this Annual Report on Form 10-K. In addition to quality and compliance resources and programs in field operations, we invest over $200 million a year in people, training, auditing, signature programs, accreditations, advocacy, and technologies to support quality, compliance, and safety as part of our "Quality First" framework. We continue to invest in quality and compliance resources with 207 enterprise oversight quality and compliance team members, who conduct approximately 200 additional, deep, and next-level audits annually, in addition to ongoing audits at the field operations level. This team also completes monthly record reviews of patient charts, leveraging electronic health records. We have over 1,000 pharmacies, branches/agencies, and service locations are operated by agencies accredited by the leading, national, and third-party accreditation bodies, including ACHC, CHAP, Joint Commission, CARF, NABP, URAC, and DMEPOS. The strength of our quality outcomes has also been validated in over thirty peer-reviewed scientific publications and presentations, and our work has been cited by other authors 112 times.

Our continued build-out of Home-Based Primary Care, transitional care management programs, including CCRx, and Clinical (Nursing) Hub services should further optimize quality outcomes and help to reduce unnecessary ER visits and hospitalizations across all provider service lines, as they will increase transitional care and primary care visits in the homes of high-risk patients, centralize on-call and tele-triage, perform high-risk patient monitoring and intervention (utilizing telehealth), monitor home health and hospice utilization algorithms and bridging, conduct "Aftercare" patient calls, manage care coordination opportunities, and support CCRx with patient monitoring, touch points, and care services coordination as needed. These continued investments in innovation and quality resources should add capabilities to support evolved models of quality and payment initiatives with payors in value-based arrangements in the future.

**Our Competition**

The U.S. healthcare industry in which we operate is highly competitive. We compete with a broad and diverse set of businesses spanning both pharmacy and provider services. We operate in a highly competitive industry as well. Within our markets, we compete with businesses spanning both pharmacy and provider services markets. In our Pharmacy Solutions segment, we compete with local, regional, and national pharmacies. While no other company singularly competes with us across all of our pharmacy customers and patients, on a nationwide basis we compete with several companies depending on the patient type and related service offering. In our infusion and specialty pharmacy services, we compete in the large and fragmented home infusion and specialty pharmacy markets including Option Care Health, Inc., Coram CVS/specialty infusion services (a division of CVS Health), Accredo Health Group, Inc. (a unit of Cigna), Optum Specialty Pharmacy (a subsidiary of OptumRx, which is a unit of the UnitedHealth Group), and various regional and local providers. In our infusion and specialty pharmacy services, owners of senior living and skilled nursing and rehabilitation facilities may also provide pharmacy (and provider) services, and on a nationwide basis we compete with Omnicare, Inc., a division of CVS Health, and several others. In our Pharmacy Solutions segment, our continued success depends on our ability to attract and retain pharmacists and other pharmacy professionals. Competition for qualified pharmacists and other pharmacy professionals is robust. The inability to attract, retain, or motivate sufficient numbers of qualified pharmacy professionals could adversely affect our business. Although we have been able to meet our staffing requirements for pharmacists and other pharmacy professionals in the past, our inability to do so in the future would have a material adverse impact on us. In our Provider Services segment, we also compete for physicians, nurse practitioners, physician assistants, nurses, therapists, and other medical and non-medical personnel that we directly employ to provide healthcare services for our patients and to provide licensed medical services. We face significant competition in attracting and retaining these qualified providers.

Our principal competitors in both of our segments vary considerably in type, identity, and size by market. Our business could be adversely affected if we are not able to continue to penetrate existing markets, successfully expand into new markets, maintain or establish new relationships with health plans and providers, recruit qualified employees, or if we experience significant customer attrition to our competitors. See "Risk Factors—Risks Related to Our Business."

***Sales and Marketing***

In our Pharmacy Solutions segment, potential referral sources and customers include physicians and specialists (prescribers), hospitals, senior living providers, behavioral (I/DD and other) providers, hospice providers, skilled nursing and rehabilitation providers, pharmaceutical manufacturers, and other health providers. We receive substantially all of our Provider Services clients and patients through third-party referrals, including from healthcare providers, such as physicians, hospitals, skilled nursing and rehabilitation facilities, assisted living facilities, state, county and city departments on aging, rehabilitation, mental health, behavioral health, and social services, MCOs, and other healthcare and social services providers, discharge planners, and case managers.

All of our referral sources are generally made aware of the Company's available in-home, clinic-based, or community-based pharmacy and provider services through our team of clinical/account liaisons, patient care coordinators, clinicians, and operators, as well as through traditional and digital marketing initiatives and inside inbound/outbounds call center teams. These individuals focus on initiating, building, and maintaining professional and trusting relationships underpinned by value-add and up-to-date education about client/patient conditions and needs, regulatory guidelines and client/patient eligibility, the benefit of relevant and authorized services, and our specific approach to care and outcomes. We also provide ongoing market development through education and outreach to the industries and in the communities we serve in order to inform referral sources and healthcare participants about federal, state and locally sponsored care options, the needs of different patient types, the benefits of our services, and to communicate our role in providing quality home and community-based health services. Our development teams work closely with referral source prescribers and providers to discuss their specific needs and our capabilities, including proprietary programs, clinical support, and performance measures.

We have continued to invest in the leadership and personnel of our development teams across the organization by growing the number of team resources and broadening its geographic coverage, rolling out new and updated training curriculum and programs, and optimizing the use of time through targeting analytics. We have a specialized team of trade professionals that work with pharmaceutical manufacturers to understand their needs and pipeline of limited distribution drugs and construct programs to optimize the distribution, support, and usage of their products. We augment these teams through marketing resources that provide optimized educational content and tools and develop and manage market-specific education events and digital content and lead generation. We utilize customer relationship management, or CRM, technology tools to plan, track, and manage initiatives, activities, and results across teams. We have built an inside team to outreach and educate our target industries and who works in close coordination with the development and marketing teams. Our centralized communications team catalogues and publishes important ongoing news and events, as well as client/patient testimonials, and quality results and white papers, which have been published in many peer-reviewed journals. We also have a dedicated function in the organization that educates and advocates with policymakers at a higher level in partnership with industry associations and advocates, as champions for our clients/patients and employees.

Over the past several years we have increasingly worked with key healthcare system stakeholders, such as health systems (hospitals) and payors, to develop new, direct, and value-add relationships that focus on patient experiences and quality, including ACOs and MCOs that contract with CMS and the states for the servicing of federal and state Medicare and Medicaid programs, respectively. We expect to work more directly with payors and at-risk providers in the future to mutually construct "win-win" programs and payment constructs that are based on quality and overall outcomes and driven by the Company's blend of service offerings and innovative care management programs that we continue to build.

**Our Payors**

We are reimbursed for substantially all of our services by federal, state, and local government programs, such as Medicare, including Medicare Part D, and Medicaid state programs, MCOs and other state agencies. In addition, we are reimbursed by commercial insurance, PBMs, and private pay consumers. Our pharmacy services are also reimbursed directly by some skilled nursing and rehabilitation facilities, hospice providers, Behavioral (including I/DD) providers, hospitals, and other provider customers. Depending on the type of service, coverage for services may be predicated on a case manager, physician or nurse determination that the care is necessary or on the development of a plan for care in the home.

***Medicare***

Medicare is a federal program that provides medical services to persons aged 65 or older and other qualified persons with disabilities or end-stage renal disease. Medicare Parts A (hospital insurance) and B (medical insurance) provide prescription drug coverage in certain circumstances, while the Part D prescription drug benefit covers many outpatient prescription drugs. For example, Medicare Part A may cover drugs for individuals in skilled nursing facilities that receive Medicare-covered skilled nursing care. Medicare Part B covers some outpatient prescription drugs and biologics provided through our pharmacy services in certain circumstances, such as injectable products administered incident to a physician service. Under the Managed Medicare program (also known as Medicare Part C, or Medicare Advantage), the federal government contracts with private health insurers to provide members with Medicare Part A, Part B and Part D benefits. All of our operations must comply with the extensive conditions of participation in the Medicare program in order to continue receiving Medicare reimbursement.

For our patients and clients that receive certain home health benefits, effective January 1, 2020, CMS transitioned to 30-day periods of care within each 60-day certification of patient eligibility period and implemented the Patient-Driven Groupings Model, or PDGM, as the payment model for services provided to Medicare patients with dates of service on or after January 1, 2020. The PDGM replaced the case-mix system, which used the number of visits to determine payment, and classified patients based on clinical characteristics. The intent of the PDGM is to shift toward a value-based payment system and remove the incentive to overprovide care. CMS updates the Home Health Prospective Payment System, or HH PPS, payment rates each calendar year. For calendar year 2024, HH PPS rates increased by 0.7%, which reflects a 4.1% market basket update, reduced by a multifactor productivity adjustment of 0.1% as well as permanent adjustments through authority CMS retains to achieve budget neutrality of the new PDGM system through calendar year 2026. Home health providers that do not comply with quality data reporting requirements are subject to a 2 percentage point reduction to their market basket update.

For our Medicare beneficiaries who have a terminal illness and a life expectancy of six months or less, these patients may elect to receive hospice benefits in lieu of standard Medicare coverage for treatment. Hospice services are paid by Medicare as a daily rate for each day a patient is enrolled in the hospice benefit. Hospice payment rates increased by 2.9% for federal fiscal year 2025, which reflects a 3.4% market basket update with a 0.5% productivity reduction. CMS requires various providers, including hospice providers, to submit quality reporting data each year. Hospices that do not satisfy quality reporting requirements are subject to a 2 percentage point reduction to the market basket percentage update. Additionally, hospice companies are subject to two specific payment limit caps under the Medicare program each federal fiscal year: the inpatient cap and the aggregate cap. The inpatient cap limits the number of inpatient care days provided to no more than 20% of the total days of hospice care provided to Medicare patients for the year. If a hospice exceeds the number of allowable inpatient care days, the hospice must refund any amounts received for inpatient care that exceed the total of: (i) the product of the total reimbursement paid to the hospice for inpatient care multiplied by the ratio of the maximum number of allowable inpatient days to the actual number of inpatient care days furnished by the hospice to Medicare patients; and (ii) the product of the number of actual inpatient days in excess of the limitation multiplied by the routine home care rate. The aggregate cap, which is calculated each federal fiscal year, limits the amount of Medicare reimbursement a hospice may receive based on an annual per-beneficiary cap amount and the number of Medicare patients served. If a hospice's Medicare payments exceed its aggregate cap, it must repay Medicare for the excess amount. In federal fiscal years 2024 and 2025, the aggregate caps are $33,494.01 and $34,465.34, respectively.

Our pharmacy services for eligible Medicare patients are reimbursed through the Medicare Part D program, which makes prescription drug coverage available to eligible Medicare beneficiaries. For our Medicare-eligible patients receiving pharmacy services, we primarily contract with PBMs, who contract with plan sponsors to administer and provide Medicare Part D prescription drug coverage. The Medicare Part D program regulates various aspects of the provision of Medicare drug coverage, including enrollment, formularies, pharmacy networks, marketing, and claims processing. CMS has imposed restrictions and consent requirements for automatic prescription delivery programs, and further limited the circumstances under which Medicare Part D plans may recoup payments to pharmacies for claims that are subsequently determined not payable under Medicare Part D. CMS sanctions for non-compliance may include suspension of enrollment and even termination from the program.

The Medicare Part D program has undergone significant legislative and regulatory changes since its inception, which have had varying impacts on utilization and margin rates. Medicare Part D continues to attract a high degree of legislative and regulatory scrutiny, and applicable government rules and regulations continue to evolve. Accordingly, it is possible that regulatory oversight and legislative and regulatory developments, including changes to Medicare Part D program requirements and reductions in funding, could materially affect our Medicare Part D business, results of operations, or profitability.

***Medicaid Programs***

Medicaid is a state-administered program that provides certain medical, pharmacy and social services to qualified low-income individuals and is jointly funded by the federal government and individual states. Reimbursement rates and methods vary by state and service type but are typically based on an hourly or unit-of-service basis. Rates are subject to adjustment based on statutory and regulatory changes, administrative rulings, government funding limitations and interpretations of policy by individual state agencies. Within guidelines established by federal statutes and regulations, and subject to federal oversight, each state establishes its own eligibility standards, determines the type, amount, duration and scope of services, sets the rate of payment for services and administers its own program. States typically cover Medicaid beneficiaries for intermittent home health services as well as continuous services for children and young adults with complicated medical conditions and home and community-based services for seniors and people with disabilities. Pharmacy coverage is an optional benefit under federal Medicaid laws and regulations, but states typically provide coverage for outpatient prescription drugs for eligible individuals under state Medicaid programs and may also pay pharmacies directly for the drugs and supplies of eligible Medicaid members.

Some states are moving the administration of their Medicaid personal care programs to MCOs. This transition is due to an overall desire to better manage the costs of the Medicaid long-term care programs. In addition, hospice and home health services are

also reimbursed by MCOs in some states. Reimbursement from the MCOs for personal care services is generally on an hourly, fee-for-service basis with rates consistent with or as a percentage of the individual state funded rates. The Company has been increasing its source of reimbursement and revenue from incentive and quality-based contracts with payors and through ACO arrangements and partnerships. In addition to personal care services, we derive reimbursement for our pharmacy services from Medicaid for those Medicaid-eligible and paid patients. Medicaid prescription drug coverage and reimbursement varies by state and is based on the ingredient cost of the drug, which may depend on factors such as a drug's acquisition cost and average sale price, and a professional dispensing fee, which may vary based on the type of medication (e.g., brand, generic, specialty, compounded medication) and other factors, such as annual prescription volume.

***Pharmacy Benefit Managers***

We have a large number of contracts with PBMs including Caremark, Optum, ESI, and Humana. PBMs are third-party administrators of prescription drug programs for commercial health plans, self-insured employer plans, Medicare Part D prescription drug plans, the Federal Employees Health Benefits Program, and state government employee plans. PBMs typically administer multiple prescription drug plans that provide for varying reimbursement rates. We contract directly with PBMs and other healthcare providers to provide our pharmacy services and derive a portion of our sales from prescription drug sales reimbursed through the prescription drug plans administered by PBMs. Our PBM contracts range from annual to multi-year contracts and expire at various times. If our contracts with one or more of these PBMs are terminated, restricted or subject to material adverse changes, such changes may have a material impact on the reimbursement we receive from the PBMs. PBM fees assessed to pharmacies by PBMs, which may be difficult to predict, may also adversely affect our profitability. There is also increased regulatory and legislative activity and scrutiny of PBMs and prescription drug costs at the federal and state levels that could lead to additional regulatory oversight, adverse legislative or regulatory developments or adverse impacts on our business, financial position, and results of operations.

***Other***

Healthcare provider pharmacy customers such as hospitals, skilled nursing and rehabilitation facilities, Behavioral (including I/DD) providers, hospice providers, and other healthcare services providers are direct payors for certain of our pharmacy services provided, and we have a large and diversified number of these contracts in place, which are either annual or multi-year and typically either fee-for-service or per diem in nature. Other sources of funding are available to support home and community-based healthcare services in different states and localities. In addition, many states appropriate general funds or special use funds through targeted taxes or lotteries to finance personal care services for senior citizens and individuals with disabilities. Depending on the state, these funds may be used to supplement existing Medicaid programs or for distinct programs that serve non-Medicaid eligible consumers. Any termination or material changes to these contracts or changes to the allocation of state funds or programs could affect our business, financial position, and results of operations.

***Commercial Insurance***

For patients receiving pharmacy services that are under commercial insurance coverage, we contract with many different commercial insurance plans and through PBMs for payment for their members' pharmacy services. For certain provider services, most long-term care insurance policies contain benefits for in-home services. Policies are generally subject to dollar limitations on the amount of daily, weekly or monthly coverage provided. Any termination or material changes to such contracts could have a material impact on the reimbursement that we receive and our financial position and results of operations.

***Private Pay***

Our private pay services are provided on an hourly or type of services basis. Our rates are competitive with those of other local providers. We bill our private pay consumers for services rendered weekly, bi-monthly or monthly. Other private payors include workers' compensation programs/insurance, preferred provider organizations, and employers.

**Supply**

Historically, in our Pharmacy Solutions segment, we have purchased most of the generic and brand pharmaceuticals that we dispense through wholesaler and GPO agreements. In certain situations, we also purchase branded pharmaceuticals directly from drug manufacturers. We have a sizable and experienced centralized procurement team that oversees inventory management and coordinates all purchasing across suppliers and vendors across the organization to leverage our scale and ensure optimal and cost-effective products.

**Intellectual Property**

We rely on a combination of intellectual property laws, internal procedures, and contractual provisions to protect our intellectual property and proprietary rights. We believe our trademarks are valuable assets, including various trademarks and service marks registered with the U.S. Patent and Trademark Office.

**Information Technology**

Our information technology systems are essential to our day-to-day operations as well as to our long-term growth strategies. Technology is integrated across all business functions throughout the organization, including in coding, eMARs/EHRs, clinical operations, pharmacy operations, billing and collections, compliance, human resources, payroll, accounts payable, purchasing, sales and marketing, management business reviews, and financial reporting and accounting functions. The focus of information technology for the Company is to provide for efficient workstreams and to strive to deliver real-time, accurate data and effective and secure solutions that enable our employees to perform their daily responsibilities of delivering services and care as best possible, while also determining new and innovative ways to improve both employee and patient experiences. We view information technology as a critical enabler of future results for the Company that must help support consistent, efficient processes and quality in a scaled organization with a large number of offices, customers, and patient service locations.

Our technology capabilities are delivered through a combination of services that utilize third-party software-as-a-service, or SaaS, cloud-based solutions, provider hosted colocation, and on-premises systems. The ability to leverage these different delivery methods allows our Company to customize solutions that meet customers' needs, support growth, leverage decision systems, and take advantage of evolving technology trends. Paramount in the delivery of all information technology services throughout the organization is a focus on data security and technology-based security solutions that protect the Company's data with responsible stewardship and efforts to safeguard of data. We have continued to invest greater amounts into technology resources and systems that we believe are required, drive continuous improvement, and reflect leading infrastructure and applications standards in our industries, including investments in automation, digitization, standardization, and modernization initiatives.

We will continue to drive new and innovative approaches to supporting our employees, clients, patients, customers, referral sources, payors, and all stakeholders through integrated technology solutions that help to optimize workflows, data/analytics sharing, and quality and cost outcomes. Over the past several years, we have deployed upgraded and new systems across clinical and compliance (e.g., eMARs/EHRs), pharmacy ERP, revenue cycle, finance, business intelligence, or BI, payroll, human resources, training, sales and marketing platforms, and employee connectivity applications. We are continuing to advance the integration of different systems across the enterprise, and by establishing an electronic lifecycle that supports a continuum of care for a patient. We are focused on continued improvements in the experience and quality of patient care, for example, in addressing healthcare industry challenges related to the navigation of multiple discharge/admissions processes, missing information from previous stages/sites of care, and connecting all patient care services. We believe we can provide a better patient and family experience during an individual's progression of care through more coordinated care enabled by user-friendly technology.

For more information regarding risks related to our information technology, see "Risk Factors—Risks Related to Our Business."

**Employees and Human Capital Resources**

As a leading mission-driven and quality-focused health services organization, our valued employees are fundamental to our ability to maximize the Company's impact in serving clients, patients, families, customers, referrals sources and partners, and all healthcare stakeholders. Focusing on the interests and development of our employees is a top priority, and our ability to attract and retain compassionate and skilled caregivers and pharmacy professionals, as well as talented functional and managerial staff, is fundamental to our future. We believe the team we have built across the Company, including managers and all of our dedicated clinicians, caregivers, employees, managers, and leaders, are the critical elements that have enabled us to build an industry leading and differentiated healthcare platform. We have approximately 600 human resources professionals in the Company supporting our businesses and enterprise functions, in groups and teams spanning recruiting, learning, training, and organizational development, compensation and benefits, leadership development, M&A integration, employee relations, HR compliance, HR information technology, and generalist HR activities and business partners.

A key strategy of the Company is effectively recruiting, attracting, onboarding, and retaining well-qualified and motivated employees. We use a comprehensive mix of initiatives and tactics to accomplish this, including traditional recruiting resources, traditional media, community events, open houses, job fairs, mailings, digital media candidate lead generation, targeted outreach, and partnerships with job boards, colleges, and non-profits. We continue to focus on the hiring, onboarding, and training process to make it as streamlined and meaningful as possible, while also evaluating and implementing the most up-to-date technology assisted solutions, including those driven by AI. Our LEGACY culture and core behaviors focus on fostering good environments for our employees, healthy communication through real time feedback and collaboration, and positive attitudes and actions that are routinely recognized and rewarded by peers and leaders. As a result, our retention rates across our Company have continued to improve year-over-year. For example, we have had approximately 68% retention of clinical positions in home health care, hospice care, and rehab care from December 31, 2023 to December 31, 2024.

Recognizing the importance of our employee base, we have consistently increased investments in compensation and benefits in support of our multi-faceted efforts to attract and retain people, as demonstrated by our compensation up over 50% in the last four years, and we offer innovative technology solutions to our employees that allow them the option to access their pay daily. We are continuing to broaden existing relationships that we have with nursing and other professional schools and build out more internal career pathways and talent pipeline programs (e.g., internships, high potential, and international programs) to each of our service lines to grow the pool of available, qualified candidates for rewarding professions and create higher-paying jobs for people through career paths. These career paths are designed to address many different roles in the Company, providing new skills, on-the-job training for employees to elevate their position and with opportunities for enhanced tuition programs to support our employees. We have developed an active affinity program for Veterans and families of Veterans, which connects with targeted individuals and provides employment opportunities and support during and after their service time. We are an active sponsor of Soldier's Angels and their Women of Valor program supporting active-duty females. We also invest in our employees through the Company's SHARE (Support Help Assistance Relief Effort) program, which is a non-profit 501(c)(3) charity helping employees during times of significant need. Since its inception in 1993, SHARE has contributed approximately $2 million and helped thousands of people when they needed it most and when faced with unexpected hardships. The SHARE program exemplifies what our culture is all about.

As of December 31, 2024, we had over 37,000 full-time equivalent employees at the Company. Approximately 7,200 full-time equivalent employees are represented by labor unions. We maintain strong working relationships with these organizations, and we have numerous collective bargaining agreements in place, which are renegotiated from time to time. See "Risk Factors—Risks Related to Our Business—Our business may be harmed by labor relation matters."

Overall, we believe that we have a strong employee relations culture and an inclusive work environment with policies and procedures to maintain safe working conditions for all of our employees. Our Company has received numerous human resources and many people-related awards from external companies over the years, and we remain committed to executing on our vision to be the leading provider of health services in the United States and doing so through an engaged and stable workforce.

**Regulation**

Our operations are subject to extensive federal, state, and local governmental laws and regulations. These laws and regulations require us to meet various standards relating to, among other things, arrangement and provision of covered healthcare services to our patients and customers, operation and management of provider and pharmacy solutions, dispensing of pharmaceuticals, the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payors, arrangements with physicians and other licensed healthcare professionals, manufacturers and referral sources, facility licensure, personnel qualifications, and maintenance of proper records and quality assurance programs. If any of our operations are found to violate applicable laws or regulations, we could suffer severe consequences that would have a material adverse effect on our business, financial condition, results of operations, cash flows, reputation, and stock price, including:

- suspension, termination or exclusion of our participation in government payor programs;
- loss of our licenses required to operate provider and pharmacy solutions in the states in which we operate;
- criminal or civil liability, fines, damages or monetary penalties relating to healthcare fraud and abuse, including the Stark Law, the Anti-Kickback Statute, the Civil Monetary Penalties Statute, the False Claims Act and/or state analogs to these federal enforcement authorities, or violations of other regulatory requirements, including state corporate practice of medicine and fee splitting laws;
- mandated changes to our practices or procedures that significantly increase selling, general, and administrative expenses or decrease our revenue;
- imposition of and compliance with corporate integrity agreements or other agreements that could subject us to ongoing audits, corrective actions, and reporting requirements as well as increased scrutiny of our business practices which could lead to potential fines, among other things;

- termination or restructuring of various relationships and/or contracts related to our business, including joint venture arrangements, contracts with government payors, and real estate leases;
- changes in and reinterpretation of rules and laws by a regulatory agency, legislature or court, such as state corporate practice of medicine laws, that could affect the structure and management of our business;
- negative adjustments to government payment models including, but not limited to, Medicare Parts A, B, C, and D and Medicaid;
- admissions bans, admissions holds, application denial periods, or reductions in census; and
- harm to our reputation, which could negatively impact our business relationships, the terms of government payor contracts, our ability to attract and retain patients, customers and referral sources, our ability to obtain financing, and our access to new business opportunities, among other things.

We expect that our industries will continue to be subject to substantial regulation, the scope and effect of which are difficult to predict. Our activities could be subject to investigations, audits, and inquiries by various government and regulatory agencies with whom we contract at any time in the future, including as a result of self-disclosures or self-reported non-compliance. In the past, government and regulatory agencies have taken measures against us and our facilities as a result of non-compliance with applicable laws and regulations. See "Risk Factors—Risks Related to Our Regulatory Framework."

***Anti-Kickback Statute***

The Anti-Kickback Statute prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made under federal and state healthcare programs such as Medicare and Medicaid. A person does not need to have actual knowledge of the Anti-Kickback Statute or have the specific intent to violate it.

Federal criminal penalties for the violation of the Anti-Kickback Statute include imprisonment, fines, and exclusion of the provider from future participation in federal healthcare programs, including Medicare and Medicaid. Violations of the Anti-Kickback Statute are punishable by imprisonment for up to ten years, fines of up to $100,000 per kickback or both. Larger fines can be imposed upon corporations under the provisions of the U.S. Sentencing Guidelines and the Alternate Fines Statute. Individuals and entities convicted of violating the Anti-Kickback Statute are subject to mandatory exclusion from participation in Medicare, Medicaid, and other federal healthcare programs for a minimum of five years in the case of criminal conviction. Civil penalties for violation of the Anti-Kickback Statute include up to $112,131 in monetary penalties per violation, repayments of up to three times the total payments between the parties to the arrangement and potential exclusion from participation in Medicare and Medicaid. Court decisions have held that the statute may be violated even if only one purpose of remuneration is to induce referrals.

The Anti-Kickback Statute includes statutory exceptions and regulatory safe harbors that protect certain arrangements. These exceptions and safe harbors are voluntary. Business transactions and arrangements that are structured to comply fully with an applicable safe harbor do not violate the Anti-Kickback Statute. However, transactions and arrangements that do not satisfy all elements of a relevant safe harbor do not necessarily violate the law. When an arrangement does not satisfy a safe harbor, the arrangement must be evaluated on a case-by-case basis in light of the parties' intent and the arrangement's potential for abuse. Arrangements that do not satisfy a safe harbor may be subject to greater scrutiny by enforcement agencies. For example, we have a dedicated recruiting team whose job functions include recruiting licensed professionals to provide quality care to our patients. From time to time, this team may award sign-on, retention, and other discretionary bonuses to attract, reward, or retain talent. We believe such bonuses and employment agreements are consistent with a safe harbor provision designed to protect payments made to employees, but a governmental or regulatory authority or private party may take a contrary position.

CMS and the HHS OIG published final regulations in 2020 that addressed concerns regarding compensation arrangements between parties that participate in alternative payment models and novel financial arrangements that potentially implicated the Anti-Kickback Statute and the Stark Law. These regulations modified existing Anti-Kickback Statute safe harbors and created new safe harbors and exceptions that may impact our business, results of operations, and financial condition.

***Stark Law***

The Stark Law generally prohibits a physician who has (or whose immediate family member has) a financial relationship with a provider from making referrals to that entity for "designated health services" if payment for the services may be made under Medicare or Medicaid. If such a financial relationship exists, referrals are prohibited unless a statutory or regulatory exception is available. "Designated health services" include clinical laboratory services, inpatient and outpatient hospital services, physical and occupational therapy services, outpatient speech-language pathology services, certain radiology services, radiation therapy services and supplies,

durable medical equipment and supplies, parenteral and enteral nutrients equipment and supplies, prosthetics, orthotics and prosthetic devices and supplies, home health services, and outpatient prescription drugs. The types of financial arrangements between a physician and an entity providing designated health services that trigger the self-referral prohibitions of the Stark Law are broad and include direct and indirect ownership and investment interests and compensation arrangements. The Stark Law prohibits any entity providing designated health services that has received a prohibited referral from presenting, or causing to be presented, a claim or billing for the services arising out of the prohibited referral. Similarly, the Stark Law prohibits an entity from "furnishing" a designated health service to another entity in which it has a financial relationship when that entity bills for the service. The prohibition applies regardless of the reasons for the financial relationship and the referral. Unlike the Anti-Kickback Statute, the Stark Law is a strict liability statute where unlawful intent need not be demonstrated.

If the Stark Law is implicated, the financial relationship must fully satisfy a Stark Law exception. If an exception is not satisfied, then the parties to the arrangement could be subject to sanctions. Sanctions for violation of the Stark Law include denial of payment for claims for services provided in violation of the prohibition, refunds of amounts collected in violation of the prohibition, a civil penalty of up to $27,750 for each service arising out of the prohibited referral, a civil penalty of up to $185,009 against parties that enter into a scheme to circumvent the Stark Law prohibition, civil assessment of up to three times the amount claimed and potential exclusion from the federal healthcare programs, including Medicare and Medicaid. Amounts collected on claims related to prohibited referrals must be reported and refunded generally within 60 days after the date on which the overpayment was identified. Furthermore, Stark Law violations and failure to return overpayments in a timely manner can form the basis for liability under the False Claims Act, as discussed below. If CMS or other regulatory or enforcement authorities determine that claims have been submitted for referrals by us that violate the Stark Law, we would be subject to the penalties described above.

CMS and the HHS OIG published final regulations that established exceptions to the Stark Law for certain value-based compensation arrangements between or among physicians, providers, and suppliers. The regulations also created a new exception for arrangements under which a physician receives limited remuneration for items or services actually provided by the physician, established a new exception for donations of cybersecurity technology and related services, and amended an exception for electronic health records items and services. These regulations may impact our business, results of operations and financial condition.

***Fraud and Abuse under State Law***

Some states have laws prohibiting physicians from having financial interests in or with healthcare facilities to which they refer patients. States also have laws similar to or stricter than the Anti-Kickback Statute that may affect our ability to enter into financial relationships with certain entities or individuals. Some state anti-kickback laws also include civil and criminal penalties. Some of these laws include exemptions that may be applicable to our physician relationships or for financial interests limited to shares of publicly traded stock. Some, however, may include no explicit exemption for certain types of agreements and/or relationships entered into with physicians. If these laws are interpreted to apply to physicians who hold equity interests in our pharmacies and/or centers or to physicians who hold our publicly traded stock, and for which no applicable exception exists, we may be required to terminate or restructure our relationships with these physicians and could be subject to criminal, civil, and administrative sanctions, refund requirements, and exclusions from government healthcare programs, including Medicare and Medicaid, which could have a material adverse effect on our business, results of operations, financial condition, cash flows, reputation, and stock price.

Similarly, states have beneficiary inducement prohibitions and consumer protection laws that may be triggered by the offering of inducements, incentives, and other forms of remuneration to patients and prospective patients. Violations range from civil to criminal and could have a material adverse effect on our business, results of operations, and financial condition.

***False Claims Act***

The False Claims Act is a means of policing false bills or false requests for payment in the healthcare delivery system. Among other things, the False Claims Act authorizes the imposition of up to three times the government's damages and significant per claim civil penalties on any "person" (including an individual, organization, or company) who, among other acts:

- knowingly presents or causes to be presented to the federal government a false or fraudulent claim for payment or approval;
- knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim;
- knowingly makes, uses, or causes to be made or used a false record, report or statement material to an obligation to pay the government, or knowingly conceals, or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the federal government; or
- conspires to commit the above acts.
- Under the False Claims Act, private parties can also bring *qui tam*, or "whistleblower," suits against healthcare facilities that submit false claims for payments to, or improperly retain overpayments from, governmental payors. In addition, the

government may assert that a claim including items or services resulting from a violation of the Anti-Kickback the Statute or Stark Law constitutes a false or fraudulent claim for purposes of the False Claims Act.

The federal government has used the False Claims Act to prosecute a wide variety of alleged false claims and fraud allegedly perpetrated against Medicare and state healthcare programs, including but not limited to coding errors, billing for services not rendered, the submission of false cost or other reports, billing for services at a higher payment rate than appropriate, billing under a comprehensive code as well as under one or more component codes included in the comprehensive code, billing for care that is not considered medically necessary and false reporting of risk-adjusted diagnostic codes. The ACA provides that claims for payment that are tainted by a violation of the Anti-Kickback Statute (which could include, for example, illegal incentives or remuneration in exchange for enrollment or referrals) are false for purposes of the False Claims Act. In addition, amendments to the False Claims Act and Social Security Act impose severe penalties for the knowing and improper retention of overpayments from government payors. Under these provisions, within 60 days of identifying and quantifying an overpayment, a healthcare provider is required to notify CMS or the Medicare Administrative Contractor of the overpayment and the reason for it and return the overpayment. An overpayment impermissibly retained could subject us to liability under the False Claims Act, exclusion from government healthcare programs and penalties under the Civil Monetary Penalties Statute. As a result of these provisions, our procedures for identifying and processing overpayments may be subject to greater scrutiny.

The penalties for a violation of the False Claims Act range from $5,500 to $11,000 (periodically adjusted for inflation) for each false claim, plus up to three times the amount of damages caused by each false claim, which can be as much as the amounts received directly or indirectly from the government for each such false claim. The Department of Justice has adjusted the per claim penalty range from $13,508 to $27,081 for penalties assessed after January 1, 2023, so long as the underlying conduct occurred after November 2, 2015. Healthcare providers often resolve allegations without admissions of liability for significant amounts to avoid the uncertainty of treble damages that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree, settlement agreement, or corporate integrity agreement. Given the significant size of actual and potential settlements for violations under the False Claims Act, it is expected that the government will continue to devote substantial resources to investigating healthcare providers' compliance with healthcare reimbursement rules and fraud and abuse laws.

In addition to civil enforcement under the False Claims Act, the federal government can use several criminal statutes to prosecute persons who are alleged to have submitted false or fraudulent claims for payment to the federal government. A determination that activities resulted in the submission of false claims could result in monetary liability, prison sentences, and/or exclusion from participation in any healthcare program funded in whole or in part by the U.S. government, including Medicare, Medicaid, TRICARE, and state healthcare programs. Any allegations or findings that we have violated the False Claims Act could have a material adverse impact on our reputation, business, results of operations, and financial condition.

In addition to the False Claims Act, the various states in which we operate have adopted their own analogs of the False Claims Act. States are becoming increasingly active in using their false claims laws to police the same activities listed above, particularly with regard to capitated government-sponsored healthcare programs, such as Medicaid fee-for-service and Managed Medicaid programs.

***Civil Monetary Penalties Statute***

The Civil Monetary Penalties Statute, 42 U.S.C. § 1320a-7a, authorizes the imposition of civil monetary penalties, assessments, and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to:

- presenting, or causing to be presented, claims, reports or records relating to payment by Medicare, Medicaid or other government payors that the individual or entity knows or should know are for an item or service that was not provided as claimed, is false or fraudulent or was presented for a physician's service by a person who knows or should know that the individual providing the service is not a licensed physician, obtained licensure through misrepresentation or represented certification in a medical specialty without in fact possessing such certification;
- offering remuneration to a federal healthcare program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive healthcare items or services from a particular provider;
- arranging contracts with or making payments to an entity or individual excluded from participation in the federal healthcare programs or included on CMS's preclusion list;
- violating the Anti-Kickback Statute;
- making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a federal healthcare program;

- making, using, or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a federal healthcare program; and
- failing to report and return an overpayment owed to the federal government.

We could be exposed to a wide range of allegations to which the Civil Monetary Penalties Statute would apply. Substantial civil monetary penalties may be imposed under the Civil Monetary Penalties Statute and may vary depending on the underlying violation. In addition, an assessment of not more than three times the total amount claimed for each item or service may also apply and a violator may be subject to exclusion from federal and state healthcare programs.

We perform checks on our providers and certain affiliates and vendors using government databases to confirm that these individuals have not been excluded from federal programs. However, should an individual become excluded and we fail to detect it, a federal agency could require us to refund amounts attributable to all claims or services performed or sufficiently linked to an excluded individual. Thus, we cannot foreclose the possibility that we will face allegations subject to the Civil Monetary Penalties Statute with the potential for a material adverse impact on our business, results of operations, and financial condition.

***Corporate Practice of Medicine and Fee-Splitting Laws***

Some of the states in which we currently operate have laws that prohibit business entities, such as us, from practicing medicine, employing physicians to practice medicine, exercising control over medical decisions by physicians or engaging in certain arrangements, such as fee-splitting, with physicians (such activities generally referred to as the corporate practice of medicine). These prohibitions on the corporate practice of medicine are intended to prevent unlicensed persons from interfering with the practice of medicine by licensed physicians or interfering with the independent professional judgment of physicians as it pertains to treatment and related clinical matters. Some states have similar doctrines with respect to other professional licensure categories, including behavioral health services. Fee-splitting, which describes the practice of professionals splitting their professional fees with a non-professional or other unlicensed person or an entity owned by an unlicensed person, is also prohibited in some jurisdictions. In some states, these prohibitions are expressly stated in a statute or regulation, while in other states the prohibitions are a matter of judicial or regulatory interpretation. Some of the relevant laws, regulations and agency guidance in states with corporate practice of medicine restrictions have been subject to limited judicial and regulatory interpretations, which are often sparse and not fully developed, complicating compliance efforts. While we endeavor to comply with state corporate practice of medicine laws and frequently engage outside counsel to conduct state analyses in each state in which we operate, the laws and regulations in these areas are complex, changing, and often subject to varying interpretations. For example, in states where the corporate practice of medicine is prohibited, we endeavor to comply with applicable state laws by entering into certain contractual relationships, such as management services agreements, whereby licensed medical practices employ licensed professionals to provide licensed services to our patients and residents.

The enforcement of these laws varies significantly from state to state, and state courts and regulatory authorities have broad discretion to enforce such laws. Penalties for violations of the corporate practice of medicine also vary by state and may result in physicians and licensed professionals being subject to disciplinary action, as well as to forfeiture of revenues from payors for services rendered. For business entities, such as us, violations may also bring both civil and, in more extreme cases, criminal liability for engaging in medical practice without a license.

State laws or regulations prohibiting the corporate practice of medicine may contemplate the employment of physicians and other licensed professionals by certain types of entities, but may not provide a specific exemption for the services we provide. Regulatory authorities and other parties may assert that our employment of licensed professionals in some states means that we are engaged in the prohibited corporate practice of medicine or that how such professionals are paid implicates fee-splitting prohibitions. If this were to occur, we could be subject to civil and/or criminal penalties, our agreements with physicians could be found legally invalid and unenforceable (in whole or in part) or we could be required to restructure our arrangements with licensed professionals, in each case in one or more of the jurisdictions in which we operate. Any of these outcomes may have a material adverse effect on our business, results of operations, financial condition, and reputation.

***Licensing Laws and State Directives***

Our facilities, healthcare professionals, and pharmacy and provider solutions are subject to various federal, state, and local licensure and certification requirements in connection with our provision of healthcare and other services. Certain states in which we operate have certificate of need or similar programs regulating the establishment or expansion of healthcare facilities, including our pharmacy and provider solutions. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, staff training, personnel, and the existence of adequate policies, procedures, and controls. Federal, state, and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory

operating and health standards and conditions for participating in government healthcare programs. In addition, physicians and other clinicians also must be licensed or certified, as applicable, in the states in which they are providing services.

Our healthcare facilities are also subject to federal, state, and commercial payor audits to validate the accuracy of claims submitted to government healthcare programs and commercial payors. If these audits identify overpayments, we could be required to make substantial repayments, subject to various appeal rights. Several of our facilities have undergone claims audits related to their receipt of payments during the last several years. Liability from audits could potentially exceed established reserves, and any excess could potentially be substantial. Further, Medicare and Medicaid regulations, as well as commercial payor contracts, also provide for withholding or suspending payments in certain circumstances, which could adversely affect our cash flow.

Any failure by us or our service providers to comply with federal, state, and local licensing and certification laws, regulations, and standards could result in a variety of consequences, including cessation of our services, loss of our contracts, prior payments by government payors being subject to recoupment, requirements to make significant changes to our operations, civil or criminal penalties, admissions bans, admissions holds, application denial periods, reductions in census, loss or revocation of licenses, loss of accreditation, administrative or other orders, adverse regulatory actions, settlements or other requirements to take corrective actions, harm to our reputation, or requirements to transfer our service users, to provide reports or other documentation, to demonstrate compliance with licensure or other requirements or to undergo revisit surveys or inspections. See "Risk Factors—Risks Related to Our Business—If we are unable to provide consistently high quality of care, our business will be adversely impacted."

Our operators, along with our compliance, quality, legal, and government affairs support teams, routinely interact with regulatory agencies and their representatives. In relation to such interactions, our quality and compliance rules require immediate reporting to regulatory bodies when we learn of a reportable event that may put the health and safety of our patients at risk. For example, in June 2020, we self-reported an employee in West Virginia who failed to meet our standards of care, and we communicated with regulators as part of their investigation and as part of licensure surveys. In July 2020, the West Virginia Department for Health and Human Resources issued a statewide admissions ban for all ResCare facilities that applied to new admissions and readmissions, and the state later issued separate admissions ban orders for other state operations. The ban was a result of the West Virginia Department of Health and Human Resources determination that certain of our entities in West Virginia were then operating in a manner that posed risks to the health, safety, welfare, and clinical treatment of consumers, in part as a result of our self-report. These admissions ban orders were subsequently cleared pursuant to a Settlement Agreement, entered into in June 2021, with the West Virginia Department of Health and Human Resources; that Settlement Agreement provided that certain facilities would have admissions bans, some of which stayed in effect until 2022, and the admission bans for some of such facilities were lifted earlier than the timing provided for in the Settlement Agreement when a West Virginia Office of Health Facility Licensure and Certification survey resulted in no citations related to consumer health, safety, welfare, or clinical treatment.

Further, failure to obtain CON approval of certain activities can result in our inability to complete an acquisition, expansion or replacement, the imposition of civil penalties, the inability to receive Medicare or Medicaid reimbursement, or the revocation of a facility's license, any of which could harm our business. We routinely take the steps we believe are necessary to retain or obtain all requisite licensure and operating authorities. While we endeavor to comply with federal, state, and local licensing and certification laws, regulations, and standards as we interpret them, the laws and regulations in these areas are complex, changing and often subject to varying interpretations.

***Data Privacy and Security***

Numerous state, federal, and foreign laws, including consumer protection laws and regulations, govern the processing, access to, confidentiality, and security of personal information, including health-related information. For example, HIPAA requires us to provide certain rights to individuals with respect to their health information. HIPAA extensively regulates the use and disclosure of PHI and requires covered entities, which include healthcare providers and their business associates, to implement and maintain administrative, physical, and technical safeguards to protect the security of such information. Additional security requirements apply to electronic PHI. HIPAA also provides individuals with substantive rights with respect to their health information.

HIPAA also requires us to enter into written agreements with certain contractors, known as business associates, to whom we disclose PHI. Covered entities may be subject to penalties for, among other activities, failing to enter into a business associate agreement where required by law or as a result of a business associate violating HIPAA, if the business associate is found to be an agent of the covered entity and acting within the scope of the agency. Business associates are also directly subject to liability under HIPAA. In instances where we act as a business associate to a covered entity, there is the potential for additional liability beyond our status as a covered entity. HIPAA violations may result in triggered settlement payments or civil monetary penalties.

Covered entities must notify affected individuals of breaches of unsecured PHI without unreasonable delay but no later than 60 days after discovery of the breach by a covered entity or its agents. Reporting must also be made to the HHS Office for Civil Rights and, for breaches of unsecured PHI involving more than 500 residents of a state or jurisdiction, to the media. All impermissible uses or

disclosures of unsecured PHI are presumed to be breaches unless an exception to the definition of breach applies or the covered entity or business associate establishes that there is a low probability the PHI has been compromised. Various state laws and regulations may also require us to notify affected individuals in the event of a data breach involving personal information without regard to the probability of the information being compromised.

Violations of HIPAA by providers like us, including, but not limited to, failing to implement appropriate administrative, physical and technical safeguards, have resulted in enforcement actions and in some cases significant civil or criminal penalties. Further, state attorneys general may bring civil actions seeking either injunction or damages in response to violations of the HIPAA privacy and security regulations that threaten the privacy of state residents. There can be no assurance that we will not be the subject of an investigation (arising out of a reportable breach incident, audit or otherwise) alleging non-compliance with HIPAA in our maintenance of PHI. States attorneys general may also negotiate settlements for related cases and on behalf of their respective residents.

HHS proposed revisions to HIPAA regulations in December 2020 that, if finalized as proposed, would modify existing provisions regarding individuals' rights to access health information, increase information sharing between healthcare organizations, including through direct sharing of electronic health records, and restrict certain fees that we may charge for medical record retrieval services. If certain of these proposed amendments are finalized as proposed, we will be required to establish and implement new policies and procedures to ensure compliance with such amendments. Additionally, HHS proposed revisions to HIPAA regulations in April 2023 that, if adopted as proposed, would modify privacy protections for reproductive health information, limit uses and disclosures of PHI for certain purposes, and establish new attestation requirements to protect sensitive PHI. If certain of these proposed amendments are adopted as proposed, we will be required to establish and implement new policies and procedures to ensure compliance with such amendments.

Any creation, use, or deployment of artificial intelligence, or AI, may also subject us to additional risks under HIPAA and other health privacy laws and regulations. To the extent we use PHI to train AI, we are required to follow laws, regulations, and contractual requirements on uses and disclosures of PHI, which may require us to obtain patient authorizations, or to de-identify PHI. In addition, the FTC has announced that they are taking a closer look at how AI is developed and used, including evaluating claims by companies regarding AI that could be false or misleading to take appropriate steps to reduce biases.

In addition to HIPAA, numerous state, federal, and foreign laws and regulations govern the processing of PHI and personal information, some of which are more stringent than HIPAA and many of which differ from each other in significant ways and may not have the same effect, thus complicating compliance efforts. Data privacy and security laws, regulations, and other obligations are constantly evolving, may conflict with each other to complicate compliance efforts, and can result in investigations, proceedings, or actions that lead to significant civil and/or criminal penalties and restrictions on data processing. For example, on July 15, 2020, the Substance Abuse and Mental Health Services Administration, or SAMHSA, issued a final rule on the protection of substance use disorder, or SUD, treatment records under 42 C.F.R. Part 2, or the Part 2 Rule. The Part 2 final rule aims to reduce delays and burdens in care coordination by more closely aligning Part 2 with the HIPAA privacy rule, while maintaining certain privacy protections specific to Part 2. This final rule became effective August 14, 2020. Under the CARES Act, Congress also made significant modifications to the authorizing statute for the Part 2 regulations and required greater alignment of the Part 2 laws with HIPAA. The law directs the Secretary of HHS to revise the Part 2 regulations such that the amendments would apply to uses and disclosures of SUD records on or after the date that is 12 months after the date of enactment of the CARES Act, which was enacted on March 27, 2020. On December 2, 2022, HHS issued a notice of proposed rulemaking on the Part 2 regulations.

Further, the CCPA went into effect on January 1, 2020, and limits how we may process personal information about California residents and may require us to modify our data processing practices and policies and incur substantial compliance-related costs and expenses. The CCPA imposes severe statutory damages and provides consumers with a private right of action for certain data breaches. Further, the CPRA, which went into effect on January 1, 2023, expands the CCPA with additional data privacy compliance requirements that may impact our business, and establishes a regulatory agency dedicated to enforcing those requirements. The requirements and effects of the CCPA and the CPRA are potentially far-reaching and may require us to modify certain policies and practices regarding the processing of certain personal information. Similar laws have been passed in other states, and are continuing to be proposed at the state and federal level, reflecting a trend toward more stringent privacy legislation in the United States.

Additionally, in Canada, PIPEDA and similar provincial laws may impose obligations with respect to processing personal information. PIPEDA requires companies to obtain an individual's consent when collecting, using, or disclosing that individual's personal information. Individuals have the right to access and challenge the accuracy of their personal information held by an organization, and personal information may only be used for the purposes for which it was collected. If an organization intends to use personal information for another purpose, it must again obtain that individual's consent. Failure to comply with PIPEDA could result in significant fines and penalties.

Data privacy and security laws and regulations are often contradictory and subject to change or differing and evolving interpretations. The complex, dynamic legal landscape regarding privacy, data protection, and information security creates significant compliance challenges for us, potentially restricts our ability to process data (including personal information), and exposes us to additional expense, and, if we cannot comply with applicable laws in a timely manner or at all, adverse publicity, harm to our reputation and liability. Although we make reasonable efforts to comply with all applicable laws and regulations and have invested and continue to invest in data privacy compliance efforts, there can be no assurance that we will not be subject to regulatory action, including fines, in the event of an incident or other claim. We or our third-party service providers could be adversely affected if legislation or regulations are expanded to require changes in our or our third-party service providers' business practices or if governing jurisdictions interpret or implement their legislation or regulations in ways that negatively affect our or our third-party service providers' business, results of operations or financial condition.

***Healthcare Reform Efforts***

The U.S. federal and state governments continue to enact and seriously consider many broad-based legislative and regulatory proposals that have had a material impact on or could materially impact various aspects of the healthcare system and our business, operating results, and/or cash flows. In addition, state and federal budgetary shortfalls and constraints pose potential risks for our revenue streams. We cannot predict how government payors or healthcare consumers might react to federal and state healthcare legislation and regulation, whether already enacted or enacted in the future, nor can we predict what form many of these regulations will take before implementation. Some examples of legislative and regulatory changes impacting our business include:

In March 2010, broad healthcare reform legislation was enacted in the United States through the ACA. There have since been numerous political and legal efforts to expand, repeal, replace, or modify the ACA, and there may be additional political, legislative, or other efforts to repeal, replace, or change the ACA. On June 17, 2021, the U.S. Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA. We anticipate continued changes with respect to the ACA, which may occur as a result of legislation, court challenges, or executive, administrative or other actions, which may significantly impact our business operations and results of operations.

In February 2018, Congress passed the Bipartisan Budget Act of 2018, which, among other things, adopted policies further integrating Medicare and Medicaid benefits for dual-eligible beneficiaries, repealed the Independent Payment Advisory Board that was established by the ACA and intended to reduce the rate of growth in Medicare spending, and extended sequestration cuts to Medicare payments through 2027. As a result of the CARES Act and subsequent legislation, the 2% aggregated reductions to Medicare payments will remain in effect through 2032.

In March 2020, ONC and CMS issued complementary new rules that are intended to clarify provisions of the Cures Act regarding interoperability and information blocking and create significant new requirements for healthcare industry participants. It is unclear at this time what the costs of compliance with the new rules will be, and what additional risks there may be to our business.

While there may be significant changes to the healthcare environment in the future, the specific changes and their timing are not yet apparent. Specifically, changes in Medicare and Medicaid could lower pharmacy and provider solutions rates or increase our expenses. Any failure to successfully implement strategic initiatives that respond to future legislative, regulatory, and executive changes could have a material adverse effect on our business, results of operations, and financial condition.

In December 2020, CMS and the HHS OIG final regulations established exceptions to the physician self-referral or the Stark Law for certain value-based compensation arrangements between or among physicians, providers, and suppliers. The regulations created a new exception for arrangements under which a physician receives limited remuneration for items or services actually provided by the physician, established a new exception for donations of cybersecurity technology and related services, and amended an exception for electronic health records items and services. These changes in federal regulations are anticipated to have a significant impact on healthcare providers and other stakeholders. In addition, we anticipate that additional changes will continue to be proposed in the future.

***Other Regulations***

Our operations are subject to various state hazardous waste and non-hazardous medical waste disposal laws. These laws do not classify as hazardous most of the waste produced from medical services. Occupational Safety and Health Administration regulations require employers to provide workers who are occupationally subject to blood or other potentially infectious materials with prescribed protections. These regulatory requirements apply to all healthcare facilities, including our pharmacy and provider solutions, and require employers to make a determination as to which employees may be exposed to blood or other potentially infectious materials and to have in effect a written exposure control plan. In addition, employers are required to provide or employ hepatitis B vaccinations, personal protective equipment and other safety devices, infection control training, post-exposure evaluation and follow-up, waste disposal techniques and procedures, and work practice controls. Employers are also required to comply with various record-keeping requirements.

Federal and state law also governs the dispensing of controlled substances by pharmacists and physicians. For example, the Prescription Drug Marketing Act governs the distribution of drug samples. Any allegations or findings that we or our providers have violated any of these laws or regulations could have a material adverse impact on our reputation, business, results of operations, and financial condition.

**Corporate and Available Information**

Through our predecessors, we commenced operations in 1974 and have grown organically and through acquisitions. We were incorporated in Delaware on July 19, 2017, as Phoenix Parent Holdings Inc., in connection with KKR Stockholder's and Walgreen Stockholder's acquisition of PharMerica Corporation, which was completed in December 2017. In March 2019, we acquired BrightSpring Health Holdings Corp. and its subsidiaries. We changed our name to BrightSpring Health Services, Inc. in May 2021. We completed our initial public offering ("IPO"), in January 2024 and our common stock is listed on the Nasdaq Global Select Market under the symbol "BTSG".

Our principal offices are located at 805 N. Whittington Parkway, Louisville, Kentucky 40222. Our telephone number is (502) 394-2100. We maintain a website at www.brightspringhealth.com.

Our Annual Report on Form 10-K, Quarterly Reports on Form 10-Q, Current Reports on Form 8-K and all amendments to those reports filed with or furnished to the SEC pursuant to Section 13(a) or 15(d) of the Securities Exchange Act are available free of charge on our website, under the "Investors - Financial Information - SEC Filings" caption, as soon as reasonably practicable after we electronically file them with, or furnish them to, the SEC. We also make available through the Investors section of our website other reports filed with or furnished to the SEC under the Exchange Act, including our proxy statements and reports filed by officers and directors under Section 16(a) of the Exchange Act, as well as our Code of Ethics and Business Conduct, Corporate Governance Guidelines and Board committee charters. The information on our website (or any webpages referenced in this Annual Report on Form 10-K) is not part of this or any other report that we file with, or furnish to, the SEC. The SEC also maintains a website (www.sec.gov) where you can search for annual, quarterly and current reports, proxy and information statements and other information regarding us and other public companies.

## Item 1A. Risk Factors

*Investing in our securities involves a high degree of risk. You should carefully consider the risks and uncertainties described below and the other information set forth in this Annual Report on Form 10-K before deciding to invest in our securities.*

### Risks Related to Our Business

***We operate in a highly competitive industry.***

The U.S. healthcare industry in which we operate is highly competitive. We compete with a broad and diverse set of services spanning both pharmacy and provider services. In our Pharmacy Solutions segment, the competition for the distribution of pharmaceuticals to patients and also to healthcare facilities is intense. In our Provider Services segment, we compete with local, regional, and national providers of home health, hospice, rehab therapy, personal, and behavioral health services in each of the geographical areas in which we operate. In each geographic market, there are national, regional, and local facility-based pharmacies that provide services comparable to those offered by our pharmacies. In addition, owners of skilled nursing facilities are also entering the facility-based pharmacy market, particularly in areas of their geographic concentration. We also compete in the large and highly fragmented hospice, infusion, and specialty pharmacy markets. Failure to compete effectively could have a material adverse effect on our market share, business, financial condition, and results of operations.

We compete based on the availability of personnel, the quality of services, expertise of clinicians, caregivers, pharmacists, and pharmacy professionals, and in certain instances, on the price of our services. Some of our competitors may have greater financial, technical, and marketing resources, name recognition, or a larger number of patients and payors than we do. Often our contracts with payors are not exclusive, and local competitors may develop strategic relationships with referral sources and payors, limiting our ability to retain referrals and payors in local markets. Some of our competitors may negotiate exclusivity provisions with managed care plans or otherwise interfere with the ability of managed care companies to contract with us. We may experience increased competition for managed care contracts due to state regulation and limitations. These competitive advantages could result in pricing pressures, loss of, or failure to gain market share, or loss of patients or payors, any of which could harm our business. In addition, our competitors may offer more services than we do in the markets in which we operate, introduce new or enhanced services that we do not provide, or be viewed by consumers as a more desirable local alternative. This, in combination with industry consolidation and the development of strategic relationships by our competitors (including mergers of competitors with each other and with insurers), could cause a decline in revenue, loss of market acceptance of our services or a negative impact on our results of operations. In addition, some of our competitors have vertically integrated business models with commercial payors, or are under common control with, or owned by, pharmaceutical wholesalers and distributors, Managed Care Organizations, or MCOs, PBMs, or retail pharmacy chains and may be better positioned with respect to the cost-effective distribution of pharmaceuticals. In addition, some of our competitors may have secured long-term supply or distribution arrangements for prescription pharmaceuticals necessary to treat certain chronic disease states on price terms substantially more favorable than the terms currently available to us. Consequently, we may be less price competitive than some of these competitors with respect to certain pharmaceutical products.

In our Provider Services segment, there are few barriers to entry in states that do not require a certificate of need, or CON, or permit of approval, or POA. Although state CON and POA laws may limit the ability of competitors to enter into certain markets, these laws are not uniform throughout the United States and are frequently the subject of efforts to limit or repeal such laws. If states remove existing CON or POA requirements, we could face increased competition in these states. There can be no assurances that other states will not seek to eliminate or limit their existing CON or POA programs, which could lead to increased competition in these states.

In our Pharmacy Solutions segment, we must maintain good working relationships with pharmaceutical manufacturers, wholesalers, and distributors. Any loss of a supplier relationship or other changes to these relationships could have an adverse effect on our business, financial condition, and results of operations. Additionally, access to limited distribution pharmaceuticals provides us with significant competitive advantages in developing relationships with payors and healthcare providers, and our failure to continue obtaining access to new limited distribution pharmaceuticals or the loss of our current access could have a material and adverse impact on our business. We also provide a significant amount of services to pharmaceutical manufacturers in exchange for a service fee related to patient access to specialty pharmaceuticals, and our failure to provide services at optimal levels could result in losing access to existing and future products. If pharmaceutical manufarcturers require significant additional services and products to obtain access to their products without a corresponding increase in service fees, our profitability could be adversely impacted.

***If we are unable to maintain relationships with existing patient referral sources or establish new referral sources, our business, financial condition, and results of operations could be materially adversely affected.***

Our success is heavily dependent on referrals from physicians, hospitals, long-term care facilities, other institutional healthcare providers, and other sources in the communities we serve, such as case managers and placement agencies, and on our ability to maintain good relationships with these referral sources. Our referral sources are not, and cannot be, obligated to refer patients to us and may refer their patients to other providers. Our growth and profitability depend, in part, on our ability to establish and maintain close working relationships with these patient referral sources, comply with applicable laws with respect to such relationships, and to increase awareness and acceptance of the benefits of our home and community health provider services and pharmaceutical solutions by our referral sources and their patients. Many of our referral sources are becoming increasingly focused on finding quality services. If we should fail to attain our goals regarding acute care hospitalization readmission rates and other quality metrics, we expect our ability to generate referrals would be adversely impacted. Our ability to attract and retain referral sources could also be adversely affected if we fail to provide or maintain a reputation for providing cost-effective care as compared to other providers in the same geographic area or if our reputation is affected by negative publicity, including adverse media related to staffing shortages, the quality of care, the failure to provide care, inadequate training, incidents at our facilities, employee misconduct, and inadequate conditions at our facilities. If we lose, or fail to maintain, existing relationships or fail to develop new referral relationships or if we are perceived by our referral sources for any reason as not providing high quality or cost-effective patient care and solutions, our patient volumes and the quality of our patient mix could suffer, and our revenue and profitability could decline.

***Changes to Medicare and Medicaid rates or methods governing Medicare and Medicaid payments for our services could materially adversely affect our business.***

We derive substantial revenue from government healthcare programs, primarily Medicare and Medicaid. Payments received from Medicare are subject to changes made through federal legislation and regulation. Payments received from Medicaid may vary from state to state. These payments are subject to statutory and regulatory changes, administrative rulings, interpretations, and determinations concerning patient eligibility requirements, funding levels, and the method of calculating payments or reimbursements. Changes in government healthcare programs may decrease the reimbursement we receive or limit access to, or utilization of, our services, and in turn, could cause our revenues and profitability to decline. When such changes are implemented, we must also modify our internal billing processes and procedures accordingly, which can require significant time and expense. As federal healthcare expenditures continue to increase and state governments may face budgetary shortfalls, federal and state governments have made, and may continue to make, significant changes to the Medicare and Medicaid programs and reimbursement received for services rendered to beneficiaries of such programs. The U.S. federal budget is subject to change, including reductions in federal spending, and the Medicare program is frequently mentioned as a target for spending cuts. Within the Medicare program, the hospice benefit is often specifically targeted for cuts. The full impact on our business of any future cuts in Medicare or other programs is uncertain. Changes that may occur at the federal or state level include:

- administrative or legislative changes to the base rates under the applicable prospective payment systems;
- the reduction or elimination of annual rate increases;
- redefining eligibility or enrollment standards or coverage criteria for government healthcare programs or the receipt of services under those programs or changes in documentation requirements;
- the imposition of prior authorization and concurrent utilization review programs that may further limit the services for which government healthcare programs will pay and shift patients to lower levels of care and reimbursement;
- the imposition or increase of mechanisms shifting more responsibility for a portion of payment to beneficiaries, such as co-payments;
- adjustments to the relative components of the wage index used in determining reimbursement rates;
- decreasing benefits, such as limiting the number of hours of personal care services that will be covered;
- changing reimbursement methodology;
- slowing payments to providers;
- increasing utilization of self-directed care alternatives or “all inclusive” programs;
- changes to cap limits and per diem rates;
- changes to case mix or therapy thresholds;

- the reclassification of home health resource groups; and
- the reclassification of long-term care diagnosis-related groups.

Additionally, regulators are increasing scrutiny of claims, which may require additional resources to respond to audits, and which may cause additional delays or denials in receiving payments. Medicare currently provides for an annual adjustment of the various payment rates based upon the increase or decrease of the medical care expenditure, which may be less than actual inflation, and if we do not manage the cost of providing services, such an annual adjustment may adversely impact our business, financial condition, and results of operations. This adjustment could be eliminated or reduced in any given year. Congress also passed legislation that resulted in aggregate reductions to Medicare payments to providers of 2% per fiscal year, which went into effect on April 1, 2013. Due to subsequent legislative amendments to the statute, the 2% aggregated reductions will remain in effect through 2032. Further, Medicare routinely reclassifies home health resource groups and long-term care diagnosis-related groups, and as a result, we could receive lower reimbursement rates depending on the case mix of the patients we service. If our cost of providing services increases by more than the annual Medicare price adjustment, or if these reclassifications result in lower reimbursement rates, our business, financial condition and results of operations could be adversely impacted. Certain of these measures have been implemented by, or are proposed in, states in which we operate.

Additionally, CMS changed the Home Health Prospective Payment System case-mix adjustment methodology through the use of a new Patient-Driven Groupings Model, or PDGM, for home health payments. This change was implemented on January 1, 2020, and also includes a change in the unit of payment from a 60-day payment period to a 30-day payment period and eliminates the use of therapy visits in the determination of payments. While the changes were intended to be implemented in a budget-neutral manner to the industry, the ultimate impact varied by provider based on factors including patient mix and admission source. Additionally, in arriving at the rate that is budget-neutral, CMS made assumptions about behavioral changes that resulted in a 4.36% reduction to reimbursement. Additionally, in the Calendar Year 2023 Home Health Final Rule, CMS finalized a 3.5% permanent reduction in reimbursement based on the difference between assumed and actual behavioral changes resulting from the implementation of PDGM.

The Patient Protection and Affordable Care Act and the Health Care Education and Reconciliation Act, or collectively, the ACA, added a new Medicare requirement for face-to-face encounters to support claims for home health services, which continues to be one of the most complex issues and can be the source of claims denials if not fulfilled, and extended the same requirements for face-to-face encounters to the case of physicians making certifications for home health services under Medicaid. For hospice patients receiving nursing center care under certain state Medicaid programs who elect hospice care under Medicare or Medicaid, the state must pay, in addition to the applicable Medicare or Medicaid hospice per diem rate, an amount equal to at least 95% of the Medicaid per diem nursing center rate for "room and board" furnished to the patient by the nursing center. The reduction or elimination of Medicare payments for hospice patients residing in nursing centers would significantly reduce our home and community health services revenues and profitability. In addition, changes in the way nursing centers are reimbursed for "room and board" services provided to hospice patients residing in nursing centers could adversely affect our ability to obtain referrals from nursing centers.

If changes in Medicare, Medicaid, or other state and local programs result in a reduction in available funds for the services we offer, a reduction in the number of beneficiaries eligible for our services or a reduction in the number of hours or amount of services that beneficiaries eligible for our services may receive, then our revenues and profitability could be negatively impacted. We cannot assure you that reimbursement payments under governmental payor programs, including supplemental insurance policies, will remain at levels comparable to present levels or will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. In some cases, commercial insurance companies and other private payors rely on government payment systems to determine payment rates. As a result, changes to government healthcare programs that reduce Medicare, Medicaid, or other payments may negatively impact payments from private payors, as well.

Any reduction in reimbursements from governmental or private payors, as well as the imposition of co-payments that dissuade the use of our services, could also materially adversely affect our profitability.

***Cost containment initiatives of third-party payors, including post-payment audits, could adversely impact our business, financial condition, and results of operations.***

During the past several years, third-party healthcare payors, such as federal and state governments, insurance companies and employers, have undertaken cost containment initiatives. As part of the efforts, such payors are increasingly demanding discounted fee structures or the assumption by healthcare providers of all or a portion of the financial risk relating to paying for care provided, often in exchange for exclusive or preferred participation in their benefit plans. We expect efforts to impose greater discounts and more stringent cost controls by government and other third-party payors to continue, potentially reducing the payments we receive for our services. For example, the Medicaid Integrity Program is increasing its scrutiny of Medicaid providers and reimbursements received through the program, which could result in recoupments of alleged overpayments. Similarly, private third-party payors also engage in

post-payment audits which can result in recoupments. Additionally, private third-party payors may be successful in negotiating reduced reimbursement schedules for our services. Fixed fee schedules, capitation payment arrangements, exclusion from participation in or inability to reach agreements with private insurance organizations or government funded programs, reduction, or elimination of payments or an increase in the payments at a rate that is less than the increase in our costs, or other factors affecting payments for healthcare services over which we have no control, could have a material adverse effect on our business, financial condition, results of operations, and prospects. Further, we cannot assure you that our services will be considered cost-effective by third-party payors, that third-party payor reimbursement will continue to be available or that changes to third-party payor reimbursement policies will not have a material adverse effect on our ability to provide our services on a profitable basis, if at all.

In addition, certain third parties, known as conveners, offer patient placement and care transition services to managed care companies, Medicare Advantage plans, bundled payment participants, ACOs, and other healthcare providers as part of an effort to manage costs. Given their focus on perceived financial savings, conveners customarily suggest that patients avoid higher cost settings altogether or move as soon as practicable to lower-cost settings. However, conveners are not healthcare providers and may suggest a setting or duration of care that may not be appropriate from a clinical perspective. Efforts by conveners to avoid our care settings or suggest shorter lengths of stay in our care settings could have a material adverse effect on our business, financial condition and results of operations.

***The implementation of alternative payment models and the transition of Medicaid and Medicare beneficiaries to managed care organizations may limit our market share and could adversely affect our revenues.***

Many government and commercial payors are transitioning providers to alternative payment models that are designed to promote cost-efficiency, quality, and coordination of care. For example, ACOs, incentivize hospitals, physician groups, and other providers to organize and coordinate patient care while reducing unnecessary costs. Conceptually, ACOs receive a portion of any savings generated above a certain threshold from care coordination as long as benchmarks for the quality of care are maintained. Providers are then paid based on the overall value and quality (as determined by outcomes) of the services they provide to a patient rather than the number of services they provide. Pursuant to the ACA, CMS has established several separate ACO programs, the largest of which is the Medicare Shared Savings Program, or MSSP, for care provided to Medicare fee-for-service beneficiaries. The ACO rules adopted by CMS are extremely complex and remain subject to further refinement by CMS. Several states have implemented, or plan to implement, accountable care models for their Medicaid populations. Eligible providers, hospitals, and suppliers may participate by creating, participating in or contracting with an ACO. If we are not included in these programs, or if ACOs establish programs that overlap with our services, we are at risk for losing market share, including a loss of our current business.

The trend in the healthcare industry toward value-based purchasing of healthcare services is growing among both government and commercial payors. Value-based purchasing programs emphasize quality of outcome and efficiency of care provided, rather than quantity of care provided. For example, Medicare requires home and community health services companies to report certain quality data in order to receive full reimbursement.

Failure to report quality data or poor performance may negatively impact the amount of reimbursement received. We may incur additional expenses in an effort to comply with additional and changing quality reporting requirements. The first performance year of the value-based purchasing program affecting home health providers began on January 1, 2023, and the model has been expanded to all 50 states. Under the expanded program, home health agencies receive payment bonuses or penalties based on their achievement of specified performance measures, relative to their peers' performance. Performance on these quality measures in a specified year (performance year) impacts payment adjustments in a later year. Additionally, commercial payors have expressed intent to shift toward value-based reimbursement arrangements. Government and commercial payors' implementation of value-based purchasing requirements could have a material adverse effect on our business, financial condition, and results of operations.

The ACA resulted in the establishment of various demonstration projects and Medicaid programs under which states may apply to test new or existing approaches to payment and delivery of Medicaid benefits. For example, CMS launched a home health agency pre-claim review demonstration project called the Review Choice Demonstration, or RCD, for Home Health Services. RCD is intended to assist in developing improved procedures to identify and prevent fraud and is limited to home health agencies in five states: Illinois, Ohio, North Carolina, Florida, and Texas. Home health agencies in these states have three options for initial review: pre-claim review of all claims, post-payment review of all claims, or minimal post-payment review with a 25% payment reduction for all home health services. Home health agencies that maintain pre-claim review affirmation rate or postpayment review approval rate of 90% or greater will be eligible for additional, less burdensome options for subsequent review. Compliance with this process has resulted in increased administrative costs and delays in reimbursement for home health services in the states subject to the demonstration. These delays could materially adversely affect our working capital and negatively affect our operations in these states.

Other alternative payment models, such as bundled payment arrangements, may be presented by the government and commercial payors to control costs that subject our Company to financial risk. We cannot predict at this time what effect alternative payment models may have on our Company. If we perform at a level below the outcomes demonstrated by our competitors, fail to satisfy quality data reporting requirements, are unable to meet or exceed quality performance standards under any applicable value-based purchasing program, or otherwise fail to effectively provide or coordinate the efficient delivery of quality healthcare services, our reputation in the industry may be negatively impacted, we may receive reduced reimbursement amounts and we may owe repayments to payors, which could materially adversely impact our business, financial condition, and results of operations. Additionally, our reputation may be affected by negative press, including adverse media related to staffing shortages, the quality of care, the failure to provide care, inadequate training, incidents at our facilities, and inadequate conditions at our facilities, which could materially adversely impact our business.

We may be similarly impacted by increased enrollment of Medicare and Medicaid beneficiaries in managed care plans, shifting away from traditional fee-for-service models. Under a managed Medicare plan, also known as Medicare Advantage, the federal government contracts with private health insurers to provide Medicare benefits and the insurers may choose to offer supplemental benefits. More than half of all Medicare beneficiaries were enrolled in a Medicare Advantage plan as of January 2023, a figure that continues to grow. CMS allows Medicare Advantage plans to offer certain personal care services as a supplemental benefit. Enrollment in managed Medicaid plans is also growing, as states are increasingly relying on MCOs to deliver Medicaid program services as a strategy to control costs and manage resources. Managed care contracts typically permit the payor to terminate the contract without cause, on very short notice, typically 60 days, which can provide payors leverage to reduce volume or obtain favorable pricing. We cannot assure you that we will be successful in our efforts to be included in managed plan networks, that we will be able to secure or maintain favorable contracts with all or some of the MCOs, that our reimbursement under these programs will remain at current levels, that the authorizations for services will remain at current levels or that our profitability will remain at levels consistent with past performance. In addition, operational processes may not be well-defined as a state transitions Medicaid recipients to managed care. For example, membership, new referrals, and the related authorization for services to be provided may be delayed, which may result in delays in service delivery to consumers or in payment for services rendered. Difficulties with operational processes associated with new managed care contracts may negatively affect our revenue, cash flow, and profitability for services provided.

***Changes in the case mix of patients, as well as payor mix and payment methodologies, and decisions and operations of third-party organizations may have a material adverse effect on our business, financial condition, and results of operations.***

The sources and amounts of our revenue are determined by a number of factors, including the mix of patients and third-party payors, the rates of reimbursement or payments among payors, and decisions and operations of third-party organizations. Changes in the case mix of the patients, payment methodologies, or payor mix among third-party payor, Medicare, and Medicaid may significantly affect our results of operations and cash flows. In particular, any significant decrease in our population of high-acuity patients could have a material adverse effect on our business, financial condition, and results of operations.

Our ability to provide services may also be impacted by actions of third-party organizations, such as assisted living facilities choosing to bring pharmacy services in-house or hospitals following CMS's guidelines for providing care outside of a traditional hospital setting. Increasing consolidation in the payor and supplier structure, including vertical integration efforts among insurers, providers, and suppliers, may limit our ability to negotiate favorable terms and conditions in our contracts and otherwise intensify competitive pressure. For example, MCOs and other third-party payors continue to consolidate, which enhances their ability to influence the delivery and cost structure of healthcare services. Consequently, the healthcare needs of patients in the United States are increasingly served by a smaller number of MCOs. These organizations generally enter into service agreements with a limited number of providers. Our business, financial condition, and results of operations could be materially adversely affected if these organizations terminate us as a provider, engage our competitors as a preferred or exclusive provider, and/or limit the patients eligible for our services.

***Our business is reliant on federal and state spending, budget decisions, and continuous governmental operations which may fluctuate under different political conditions.***

Adverse developments in the United States could lead to a reduction in federal government expenditures, including governmentally funded programs in which we participate. In addition, if at any time the federal government is not able to meet its debt payments unless the federal debt ceiling is raised, and legislation increasing the debt ceiling is not enacted, the federal government may stop or delay making payments on its obligations, including funding for government programs, such as Medicare and Medicaid. Further, any failure by the Congress to complete the federal budget process and fund government operations may result in a shutdown, potentially causing us to incur substantial costs without reimbursement under the Medicare program. For example, the failure of the

2011 Joint Select Committee to meet its Deficit Reduction goal resulted in an automatic reduction in Medicare home health and hospice payments of 2% beginning April 1, 2013. Due to subsequent legislative amendments to the statute, the 2% aggregated reductions will remain in effect through 2030. Congress continues to discuss deficit reduction measures, leading to a high degree of uncertainty regarding potential reforms to governmental healthcare programs. The Medicare program is frequently mentioned as a target for spending cuts and within the Medicare program, the home health and hospice benefits are often specifically targeted for cuts and a lowering of the Medicare caps. Historically, state budget pressures have resulted in reductions in state spending, and given that Medicaid outlays are a significant component of state budgets, we can expect continuing cost containment pressures on Medicaid outlays for our services. Weak economic conditions also could adversely affect the budgets of individual states and of the federal government. This could result in attempts to reduce or eliminate payments for federal and state healthcare programs, and could result in an increase in taxes and assessments on our activities.

Given competing national priorities, we are unable to predict the outcome and impact on our business of any changes in healthcare policy relating to the future funding of the Medicare and Medicaid programs. Further, Medicare, Medicaid, and/or private payor rates for home and community provider solutions and pharmacy services may not continue to be based on current methodologies or remain comparable to present levels. Any future healthcare legislation or regulation impacting these rates may materially adversely affect our business.

***Changes in drug utilization and/or pricing, PBM contracts, and Medicare Part D/Medicaid reimbursement may negatively impact our profitability.***

The profitability of our Pharmacy Solutions segment is dependent upon the utilization of prescription and non-prescription pharmaceuticals. Our revenues, operating results, and cash flows may decline if the utilization of drug and/or infusion therapies is reduced or physicians cease writing prescriptions for such therapies, including due to:

- increased safety risk profiles or regulatory restrictions;
- manufacturing or other supply issues;
- a reduction in drug manufacturers' participation in federal programs;
- certain products being withdrawn by their manufacturers or transitioned to over-the-counter products;
- FDA actions restricting the supply or increasing the cost of products;
- the introduction of new and successful prescription drugs or lower-priced generic alternatives to existing brand name products; or
- inflation in the price of drugs.

In addition, increased utilization of generic drugs has resulted in pressure to decrease reimbursement payments to facility-based, hospice, retail, and specialty pharmacies for generic drugs, causing a reduction in our margins on sales of generic drugs. Contracts and fee schedules in the prescription drug industry, including our contracts with various payors and fee schedules under state Medicaid programs, generally use certain published benchmarks, including Average Wholesale Price, or AWP, or Wholesale Acquisition Cost, or WAC, to establish pricing for prescription drugs. Future changes to the use of AWP, WAC or to other published pricing benchmarks used to establish drug pricing, including changes in the basis for calculating reimbursement by federal and state healthcare programs and/or other payors, could impact the reimbursement we receive from Medicare and Medicaid programs, the reimbursement we receive from our PBM, clients, and other payors, and/or our ability to negotiate rebates and/or discounts with drug manufacturers and wholesalers. A failure or inability to fully offset any increased prices or costs or to modify our operations to mitigate the impact of such increases could have a material adverse effect on our operating results. Additionally, any future changes in drug prices could be significantly different than our projections. We cannot predict the effect of these possible changes on our businesses.

Our reimbursement under Medicare Part D, as well as our reimbursement from certain private third-party payors, is determined pursuant to agreements that we negotiate with those payors or their PBM representatives or group purchasing organizations, or GPOs. Similarly, our reimbursement from skilled nursing and rehabilitation facilities for drugs is determined pursuant to our agreements with them. Certain of these agreements are terminable upon prior notice by the other party. We cannot provide assurance that we will be able to replace terminated or expired agreements on terms as favorable as our existing agreements or at all. The termination or modification of these agreements could adversely affect our reimbursement from these sources, which would have a material adverse effect on our results of operations. Additionally, the proportion of our Medicare Part D business serviced under specific agreements may change over time based upon beneficiary choice, reassignment of beneficiaries to different Medicare Part D Plans, Medicare Part D Plan consolidation or other factors, which could also adversely affect our revenue. Many payors seek to limit the number of

providers that supply pharmaceuticals to their enrollees in order to build volume that justifies their discounted pricing. From time to time, payors with whom we have relationships require that we bid against our competitors to keep their business. As a result of this bidding process, we may not be retained, and even if we are retained, the prices at which we are able to retain the business may be reduced. If we are not an approved provider selected by a GPO, affiliated hospitals and other members may be less likely to purchase our products. Should a GPO negotiate a sole source or bundling contract covering a future or current competitor, we may be precluded from making sales to members of that GPO for the duration of the contractual arrangement.

Furthermore, Medicare Part D has resulted in increased utilization of prescription medications and puts pressure on our gross margin rates in our Pharmacy Solutions segment due to regulatory and competitive pressures. As a result of the ACA and changes to the retiree drug subsidy rules, clients of our PBM business could decide to discontinue providing prescription drug benefits to their Medicare-eligible members. To the extent this occurs, the adverse effects of increasing customer migration into Medicare Part D may outweigh the benefits we realize from growth of our Medicare Part D products. For example, in October 2020, the U.S. Department of Health and Human Services, or the HHS, released a final rule requiring health insurers to disclose drug pricing and cost-sharing information. The public disclosure of insurer- or PBM-negotiated price concessions may result in drug manufacturers lowering discounts or rebates, impacting the ability to negotiate drug prices. In November 2020, the HHS released the Rebate Rule, which eliminates the regulatory safe harbor from prosecution under the Anti-Kickback Statute for rebates from pharmaceutical companies to PBMs in Medicare Part D and in Medicaid MCOs, replacing it with two far narrower safe harbors designed to directly benefit patients with high out-of-pocket costs and to change the way PBMs are compensated. The new safe harbors are (i) for rebates which are passed on to the patient at the point of sale and (ii) for flat service fee payments made to PBMs which cannot be tied to the list prices of drugs. The Pharmaceutical Care Management Association which represents PBMs, has filed a suit in an effort to block the Rebate Rule, claiming that the Rebate Rule would lead to higher premiums in Medicare Part D and was adopted in an unlawful manner. The Biden Administration has delayed the effective date of portions of the Rebate Rule to January 1, 2027, which would delay implementation until 2032. It is unclear whether the Rebate Rule will be modified by the current Administration, whether pharmaceutical companies will respond by reducing list prices, whether list prices in the private market may also be reduced, and what the resulting impact will be to PBMs or us.

There has also been increasing legislative and enforcement interest in the United States with respect to drug pricing practices. Specifically, there has been heightened governmental scrutiny over the manner in which manufacturers set prices for their marketed products, which has resulted in several congressional inquiries and proposed and enacted federal and state legislation designed to, among other things, bring more transparency to drug pricing, reduce the cost of prescription drugs under Medicare, and review the relationship between pricing and manufacturers' patient assistance programs. The Inflation Reduction Act of 2022, or IRA, includes several provisions that may impact our business to varying degrees, including provisions that reduce the out-of-pocket spending cap for Medicare Part D beneficiaries from $7,050 to $2,000 starting in 2025, thereby effectively eliminating the coverage gap; impose new manufacturer financial liability on certain drugs under Medicare Part D, allow the U.S. government to negotiate Medicare Part B and Part D price caps for certain high-cost drugs and biologics without generic or biosimilar competition; require companies to pay rebates to Medicare for certain drug prices that increase faster than inflation; and delay until January 1, 2032, the implementation of the HHS Rebate Rule that would have limited the fees that pharmacy benefit managers can charge. The implementation of the IRA is currently subject to ongoing litigation challenging the constitutionality of the IRA's Medicare drug price negotiation program. The effects of the IRA on our business and the healthcare industry in general are not yet known. See "—Risks Related to Our Regulatory Framework—If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting U.S. healthcare reform, our business may be harmed."

***Changes in our relationships with pharmaceutical suppliers, including changes in drug availability or pricing, could adversely affect our business and financial results.***

We have contractual relationships with pharmaceutical manufacturers, wholesalers, and distributors to purchase the pharmaceuticals that we dispense. In order to have access to these pharmaceuticals, and to be able to participate in the launch of new pharmaceuticals, we must maintain a good working relationship with these suppliers. Most of the manufacturers we contract directly with have the right to cancel their supply contracts with us without cause and after giving only minimal notice. In addition, these agreements may allow the manufacturers to distribute through channels other than us. Certain of these agreements also allow pricing and other terms to be adjusted periodically for changing market conditions or required service levels. We may be unable to renew contracts with our suppliers on favorable terms or at all. Any changes to these relationships, including, but not limited to, the loss of a supplier relationship or changes in pricing, could have an adverse effect on our business and financial results. Many products dispensed by our pharmacies are manufactured with ingredients that are susceptible to supply shortages. Our suppliers are independent entities subject to their own operational and financial risks that are outside our control. If our current suppliers were to stop selling drugs to us or delay delivery, including as a result of supply shortages, production disruptions, quality issues, closing, or bankruptcies of our suppliers, or for other reasons, we may be unable to procure alternatives from other suppliers in a timely and efficient manner

and on acceptable terms, or at all. Should a supply disruption result in the inability to obtain pharmaceutical solutions necessary for patient care, our business, financial condition, and results of operations could be negatively impacted.

Some pharmaceutical manufacturers, wholesalers, and/or distributors attempt to limit the number of preferred pharmacies that may market certain of their products. We cannot provide assurance that we will be selected and retained as a preferred pharmacy or can remain a preferred pharmacy to market these products. We cannot provide assurance that we will be able to compete effectively with other providers to dispense each of our core products. Consolidation within the drug manufacturing industry and other external factors may enhance the ability of suppliers to sustain or increase pricing of drugs and diminish our ability to negotiate reduced drug acquisition costs. Any inability to offset increased brand name or generic drug acquisition costs or to modify our activities to lessen the financial impact of such increased costs could have a significant adverse effect on our operating results. We receive certain discounts, rebates, and other price concessions from suppliers. For example, we have agreements with certain affiliates of Walgreen Stockholder pursuant to which we purchase both generic and non-generic pharmaceutical products and services at favorable prices and other payment terms. If one or both of such agreements were to terminate or if we were to otherwise lose our right to participate in such agreements, we may not be able to replace such arrangements to purchase pharmaceutical products and services at similarly favorable prices or at all. There can be no assurance that any changes in legislation or regulations, or the interpretation or application of current law, that would eliminate or significantly reduce the discounts, rebates, and other price concessions that we receive from suppliers or that would otherwise impact payment available for drugs under federal or state healthcare programs will not have a material adverse impact on our business, financial condition, and results of operations.

The pipeline of new drugs includes many products that over the long term may replace older, more expensive therapies. As a result of such older drugs losing patent protection and being replaced by generic substitutes, new and less expensive delivery methods (such as when an infusion or injectable drug is replaced with an oral drug) or additional products may be added to a therapeutic class, thereby increasing price competition in that therapeutic category. Much of the branded and generic drug product that we dispense is manufactured in whole or in substantial part outside of the United States and imported by our suppliers. As a result, significant changes in tax or trade policies, tariffs, or trade relations between the United States and other countries, such as the imposition of unilateral tariffs on imported products, could result in significant increases in our costs, restrict our access to suppliers, depress economic activity, and have a material adverse effect on our business, financial condition, and results of operations. In addition, other countries may change their business and trade policies and such changes, as well as any negative sentiments towards the United States in response to increased import tariffs and other changes in U.S. trade regulations, could adversely affect our businesses.

***Our business relies on the continual recruitment and retention of nurses, pharmacists, therapists, caregivers, direct support professionals, and other qualified personnel, including senior management.***

We compete with other healthcare providers for our employees, including but not limited to, clinicians, physicians, nurses, nurse practitioners, physician assistants, caregivers, direct care staff, counselors, therapists, pathologists, psychologists, pharmacists, other pharmacy professionals, and providers for our mobile network, as well as senior management. Competition for skilled personnel is intense, and the process of locating and recruiting qualified personnel with the combination of the skills, experience, and licenses necessary to meet the requirements of their job responsibilities can be difficult and lengthy. Various states in which we operate have established minimum staffing requirements or may establish minimum staffing requirements in the future. While we seek to comply with all applicable staffing and other requirements, such as state requirements related to compensation and benefits for direct care workers, the regulations in this area are complex and we may experience compliance issues from time to time.

Federal and state regulators have considered implementing requirements related to staffing ratios, pass-through payments to direct care workers, minimum compensation standards, and compensation and benefits for direct care workers, and we believe that regulators will continue to focus their attention and regulatory and legislative efforts on these matters. For example, in an effort to promote transparency, CMS has proposed requiring state Medicaid agencies to report on compensation for direct care workers and support staff as a percentage of Medicaid payments for services in intermediate care facilities for individuals with intellectual disabilities. Failure to comply with any new requirements may result in one or more facilities failing to meet the conditions of participation under relevant federal and state healthcare programs and the imposition of fines or other sanctions. The proposed rule would also require compensation reporting requirements to include individuals employed by or contracted or subcontracted with a Medicaid provider or state or local government agency, which would require compliance with new standards. In addition, private litigation involving these matters also has become more common. Moreover, a portion of the staffing costs we incur is funded by states through Medicaid program appropriations or otherwise. If states do not appropriate sufficient additional funds to pay for any additional operating costs resulting from new workforce, transparency, and reporting requirements, our profitability may be materially adversely affected.

Our ability to satisfy new workforce regulations will, among other things, depend upon our ability to attract and retain qualified healthcare professionals. If we are unable to attract and retain qualified personnel, we may be unable to provide our services, the quality of our services may decline, and we could lose patients and referral sources, which could have a material adverse effect on our business, financial condition, and results of operations. The loss of one or more of the members of the executive management team or the inability of a new management team to successfully execute our strategies may adversely affect our business. Our ability to attract

and retain qualified personnel depends on several factors, including our ability to provide these personnel with attractive assignments and competitive salaries and benefits. We cannot be assured we will succeed in any of these areas. From time to time and particularly in recent years, the lack of availability of medical personnel, including qualified nurses, has been a significant operating issue for us and other healthcare providers in certain local and regional markets. Further, because we generally recruit our personnel from the local area where the relevant facility is located, the availability in certain areas of suitably qualified personnel can be limited.

***We are subject to federal, state, and local laws and regulations that govern our employment practices, including minimum wage, living wage, and paid time-off requirements. Failure to comply with these laws and regulations, or changes to these laws and regulations that increase our employment-related expenses, could adversely impact our operations.***

We are subject to applicable rules and regulations relating to our relationship with our employees, including occupational safety and health requirements, wage and hour and other compensation requirements, break requirements, health benefits, unemployment, providing leave, sick pay and overtime, proper classification of workers as employees or independent contractors, immigration status, and equal employment opportunity laws. These laws and regulations can vary significantly among jurisdictions and can be highly technical. Notably, we are subject to the California Labor Code pursuant to which plaintiffs have filed representative actions under the California Private Attorney General Act seeking statutory penalties for alleged violations related to calculation of overtime pay, errors in wage statements, and meal and rest break violations, among other things. Costs and expenses related to these requirements are a significant operating expense and may increase as a result of, among other things, changes in federal, state, or local laws or regulations, or the interpretation thereof, requiring employers to provide specified benefits or rights to employees, increases in the minimum wage and local living wage ordinances, increases in the level of existing benefits, or the lengthening of periods for which unemployment benefits are available. We may not be able to offset any increased costs and expenses. We have a substantial number of hourly employees who are paid wage rates based on or approximating the applicable federal, state, or local minimum wage, and the high proportion of hourly employees makes our business sensitive to minimum wage laws at both the state and federal levels**.** Furthermore, any failure to comply with these laws requirements, including even a seemingly minor infraction, can result in significant penalties which could harm our reputation and have a material adverse effect on our business. In addition, federal, state, and local proposals to introduce a system of mandated health insurance and flexible work time, provide for higher minimum wages, paid time off and other similar initiatives could, if implemented, adversely affect our operations.

In addition, certain individuals and entities, known as excluded persons, are prohibited from receiving payment for their services rendered to Medicaid, Medicare, and other federal and state healthcare program beneficiaries. If we inadvertently hire or contract with an excluded person, or if any of our current employees or contractors becomes an excluded person in the future without our knowledge, we may be subject to substantial civil penalties, including up to $20,000 for each item or service furnished by the excluded person to a federal or state healthcare program beneficiary, an assessment of up to three times the amount claimed and exclusion from federal healthcare programs.

***Our results of operations fluctuate on a quarterly basis.***

Our financial condition and results of operations and other key metrics have fluctuated on a quarterly basis in the past and may continue to fluctuate in the future due to a variety of factors, including census, script volume, reimbursement rates, drug purchasing costs, labor availability and pricing, volume fluctuations in broader healthcare and provider markets that are upstream of our care settings and the potential timing of delayed or leading payor reimbursement rate changes based on budget seasons, as well as purchasing cost fluctuations depending on when core contracts renew or escalate. In addition, we have experienced and expect to continue to experience fluctuations in our quarterly results of operations due to the seasonal nature of our business. As a result, historical period-to-period comparisons of our results of operations are not necessarily indicative of future period-to-period results, impacting comparability of our quarterly results year-over-year.

***Our business may be harmed by labor relation matters.***

We are subject to a risk of work stoppages and other labor relations matters because our hourly workforce in some states is highly unionized. We have numerous agreements with various different unions, which are renegotiated from time to time. We may also negotiate Memoranda of Understanding to amend these collective bargaining agreements when we receive increases in our rates from various state agencies. Upon expiration of these collective bargaining agreements, we may not be able to negotiate labor agreements on satisfactory terms with these labor unions. A strike, work stoppage or other slowdown could result in a disruption of our operations and/or higher ongoing labor costs, which could adversely affect our business.

***Because we are limited in our ability to control reimbursement rates received for our services, our business could be materially adversely affected if we are not able to maintain or reduce our costs to provide such services.***

We receive fixed payments at predetermined reimbursement rates established through federal and state legislation from Medicare and Medicaid, our most significant payors, for our services. Consequently, our profitability largely depends upon our ability to manage the costs of providing these services. We cannot be assured that reimbursement payments under Medicare and Medicaid will be sufficient to cover the costs allocable to patients eligible for reimbursement pursuant to these programs. Commercial payors such as managed care organizations and private health insurance programs generally reimburse us for the services rendered to insured patients based upon contractually determined rates. Additionally, private payor rates are difficult for us to negotiate as such payors are under pressure to reduce their own costs. In addition, our profitability may be adversely affected by any efforts of our suppliers to shift healthcare costs by increasing the net prices on the products we obtain from them. Increases in operating costs, such as labor and supply costs, without a compensating increase in reimbursement rates, could have a material adverse effect on our business. In addition, cost pressures resulting from the use of more expensive forms of palliative care, including drugs and drug delivery systems, could negatively impact our profitability. As a result, we have sought to manage our costs in order to achieve a desired level of profitability including, but not limited to, centralization of various processes, the use of technology, and management of the number of employees utilized. If we are not able to continue to streamline our processes and reduce our costs, our business, financial condition, and results of operations could be materially adversely affected.

***Delays in collection or non-collection of our accounts receivable, particularly during the business integration process, could adversely affect our business, financial condition, and results of operations.***

Prompt billing and collection of receivables from patients and third-party payors are important factors in our liquidity, and our business is characterized by delays from the time we provide services to the time we receive reimbursement or payment for these services. Having a diversified payor mix requires expertise and compliance across multiple complex coding, billing, and revenue recognition functions. We bill numerous and varied payors, and they typically have different billing requirements that must be satisfied prior to receiving payment for services rendered. Reimbursement is typically conditioned on our documenting the level and the necessity of service provided and correctly applying administrative and billing codes. Coding of services can be complex. Incorrect or incomplete documentation and billing information could result in non-payment for services rendered and could lead to allegations of billing fraud. This could subsequently lead to civil and criminal penalties, including but not limited to exclusion from government healthcare programs. Reimbursement and procedural issues often require us to resubmit claims multiple times and respond to multiple administrative requests before payment is remitted, increasing the age of accounts receivable. Billing and collection of our accounts receivable are further subject to the complex regulations that govern Medicare and Medicaid reimbursement and rules imposed by third-party payors, which are continuously evolving. 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 condition, and results of operations. In addition, timing delays in billings and collections may cause working capital shortages. It is possible that Medicare, Medicaid, documentation support, system problems or other provider issues or industry trends, particularly with respect to newly acquired entities for which we have limited operational experience, may extend our collection period, which may materially adversely affect our working capital, and our working capital management procedures may not successfully mitigate this risk.

The timing of payments made under the Medicare and Medicaid programs is subject to governmental budgetary constraints, which may result in an increased period of time between submission of claims and subsequent payment under specific programs, most notably under the Medicare and Medicaid managed care programs, which in many cases pay claims significantly slower than traditional Medicare or state Medicaid programs. This delay is a result of more complicated authorization, billing, and collecting processes under Medicare and Medicaid managed care programs. In addition, we may experience delays in reimbursement as a result of the failure to receive prompt approvals related to change of ownership applications for acquired or other facilities. Further, our billing systems require significant technology investment and, as a result of marketplace demands, we need to continually invest in our billing systems. We may experience delays in reimbursement caused by our or other third parties' information system failures. Changes in laws and regulations could further complicate our billing and increase our billing expense.

A change in our estimates of collectability or a delay in collection of accounts receivable could adversely affect our results of operations and liquidity. The estimates are based on a variety of factors, including the length of time receivables are past due, significant one-time events, contractual rights, client funding and/or political pressures, discussions with clients, and historical experience. A delay in collecting our accounts receivable, or the non-collection of accounts receivable, including, without limitation, in connection with our transition and integration of acquired companies, could have a material negative impact on our results of operations and liquidity and could be required to record credit losses in our consolidated financial statements.

***If we fail to manage our growth effectively, we may be unable to execute our business plan, maintain high levels of service and satisfaction, or adequately address competitive challenges.***

We have experienced, and may continue to experience, rapid growth, and organizational change, which has placed, and may continue to place, significant demands on our management and our operational and financial resources. Additionally, our organizational structure may become more complex as we expand our operational, financial, and management controls, as well as our reporting systems and procedures as a public company. We may require significant capital expenditures and the allocation of valuable management resources to grow and evolve in these areas. We must effectively increase our headcount, ensure our personnel have the necessary licenses and competencies, and continue to effectively train and manage our employees. We will be unable to manage our business effectively if we are unable to alleviate the strain on resources caused by growth in a timely and successful manner. If we fail to effectively manage our anticipated growth and change or fail to ensure that the level of care and services provided by our employees complies with regulatory and contractual requirements, the quality of our services may suffer, which could negatively affect our brand and reputation, harm our ability to attract and retain patients, customers, referral sources, and employees, and lead to the need for corrective actions.

In addition, as we expand our business, it is important that we continue to maintain high levels of patient service and satisfaction. If we are unable to continue to provide high quality healthcare that meets the regulatory requirements and generates high levels of patient satisfaction, our reputation, as well as our business, results of operations and financial condition would be adversely affected.

***Our growth strategy is partially dependent upon our ability to identify and successfully complete acquisitions, joint ventures, and other strategic initiatives. Any failure by us to manage or integrate acquisitions, divestitures, and other significant transactions successfully may have a material adverse effect on our business, financial condition, and results of operations.***

Acquisitions are a key strategic advantage and value creation driver for us. We regularly evaluate opportunities to acquire other companies and have undertaken, and may in the future undertake, strategic, and accretive acquisitions. We face competition for acquisition and joint venture candidates, which may limit the number of acquisition and joint venture opportunities available to us or lead to the payment of higher prices for our acquisitions and joint ventures. In addition, changes in federal laws or regulations may materially adversely impact our ability to acquire businesses. For example, CMS has adopted a regulation known as the "36 Month Rule" that is applicable to home health agency acquisitions, which subject to certain exceptions, prohibits buyers of home health agencies that either enrolled in Medicare or underwent a change in ownership fewer than 36 months prior to the acquisition date, from assuming the Medicare billing privileges of the acquired home health agency. Instead, the acquired home health agencies must enroll as new providers with Medicare which may cause significant Medicare billing delays. As a result, the 36 Month Rule may further increase competition for acquisition targets that are not subject to the rule. We cannot assure you that we will successfully identify suitable acquisition candidates, obtain financing for such acquisitions, if necessary, consummate such potential acquisitions or efficiently integrate any acquired entities or successfully expand into new markets as a result of our acquisitions. If we are unable to successfully execute on such a strategy in the future, our future growth could be limited.

We believe that there are risks related to acquiring companies. Such risks include overpaying for acquisitions, losing key employees, strategic partnerships, or patients of acquired companies, failing to effectively integrate acquired companies, the assumption of liabilities and exposure to unforeseen liabilities of acquired operations, and failing to achieve potential synergies or remove transition, integration, or non-recurring costs. In addition, our due diligence review of acquired businesses may not successfully identify all potential issues. Further, following completion of an acquisition, we may not be able to maintain the growth rate, levels of revenue, earnings or operating efficiency that we and the acquired business have achieved or might achieve separately. Historically, we have funded acquisitions primarily through our credit facilities, the issuance of our common stock, and/or cash on hand, and there is no guarantee that we will be able to obtain financing for any future acquisition on favorable terms, if at all. These transactions may also cause us to significantly increase our interest expense, leverage and debt service requirements if we incur additional debt to pay for an acquisition or investment or dilute our current stockholders' percentage ownership if we issue common stock to pay for an acquisition or investment or subsequent capital infusion, or incur asset write-offs and restructuring costs and other related expenses that could have a material adverse impact on our operating results. Furthermore, in certain circumstances, we could be required to pay or be involved in disputes relating to termination fees or liquidated damages if an acquisition is not consummated, the payment of which could have a material adverse effect on our business, financial condition, or results of operations.

Upon consummation of an acquisition, the integration process could divert the attention of management, and any difficulties or problems encountered in the transition process could have a material adverse effect on our business, financial condition, or results of operations. In particular, the integration process may temporarily redirect resources previously focused on reducing cost of services, resulting in lower gross profits in relation to revenues. The process of combining companies could cause the interruption of, or a loss of momentum in, the activities of the respective businesses, which could have an adverse effect on their combined operations.

Additionally, in some acquisitions, we may have to renegotiate, or risk losing, one or more third-party payor contracts. We may also be unable to immediately collect the accounts receivable of an acquired entity while we align the payors' payment systems and accounts with our own systems, and may have difficulties in recouping partial episode payments and other types of misdirected payments for services from previous owners. Certain transactions can require licensure changes which, in turn, result in disruptions in payment for services.

We may also make strategic divestitures from time to time. With respect to any divestiture, we may encounter difficulty finding potential acquirers or other divestiture options on favorable terms. Any divestiture could affect our profitability as a result of the gains or losses on such sale of a business or service, the loss of the operating income resulting from such sale or the costs or liabilities that are not assumed by the acquirer that may negatively impact profitability subsequent to any divestiture. We may also recognize impairment charges as a result of a divesture.

***The sale of our Community Living business may not occur on the terms agreed to by the parties, in the expected time frame, or at all and, as a result, could adversely affect the Company's business and financial condition.***

As previously disclosed, on January 17, 2025, the Company entered into a purchase agreement with National Mentor Holding, Inc. to divest the Company's Community Living business for $835 million, subject to typical adjustments for working capital and other customary items. The Company expects the divestiture to close in 2025. The sale is subject to customary closing conditions, including the expiration or termination of the waiting periods under the Hart-Scott-Rodino Antitrust Improvements Act of 1976, as amended, and certain other antitrust laws. The Company may not receive the required approval and other clearances for the transaction, or they may not be received in a timely manner. If such approvals are received, they may impose terms, conditions or restrictions that may cause a failure of the closing conditions set forth in the purchase agreement or that could have a detrimental impact on the Company following completion of the transaction. A substantial delay in obtaining the required authorizations, approvals or consents or the imposition of unfavorable terms, conditions or restrictions could prevent the completion of the sale, and government authorities could seek to block or challenge the transaction as they deem necessary or desirable in the public interest.

While we believe the sale will result in increased strategic focus, operational efficiencies, a refined payer mix, and greater clinical integration and business synergy across the Provider Services segment, no assurances can be made that these impacts will occur. If the transaction fails to close, the Company's business and financial condition may be adversely affected and we may continue to be responsible for any transaction costs incurred.

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

Providing quality patient care is fundamental to our business. Clinical quality is becoming increasingly important within our industries. Medicare imposes a financial penalty upon hospitals that have excessive rates of patient readmissions within 30 days from hospital discharge. We believe this regulation provides a competitive advantage to home health providers who can differentiate themselves based upon quality, particularly by achieving low patient acute care hospitalization readmission rates and by implementing disease management programs designed to be responsive to the needs of patients served by referring hospitals. We are focused intently upon improving our patient outcomes, particularly our patient acute care hospitalization readmission rates. Additionally, Medicare has established consumer-facing websites, Home Health Compare and Hospice Compare, that present data regarding our performance on certain quality measures compared to state and national averages. If we should fail to achieve or exceed these averages, it may negatively affect our rates of reimbursement, our reputation, and our ability to generate referrals, which could have a material adverse effect upon our business, consolidated financial condition, and results of operations.

Many of our service users have complex medical conditions or special needs, are vulnerable, and often require a substantial level of care and supervision. There is a risk that one or more service users could be harmed by one or more of our employees, workforce members, or other service users, either intentionally, by accident, or through negligence, neglect, error, poor performance, mistreatment, failure to provide proper care or medication or carry out physician's orders, failure to properly document or monitor or report information, failure to address risks to service users' health or safety, failure to maintain appropriate staffing, failure to implement appropriate interventions or other actions or inaction. Employees and workforce members have engaged in conduct (including failing to take action) that has impacted, and may in the future engage in conduct that impacts, our service users or their health, safety, welfare, or clinical treatment. Further, individuals cared for by us have in the past engaged, and may in the future engage, in behavior that results in harm to themselves, our employees or workforce members or to one or more other individuals, including members of the public and other service users. In addition, we have experienced staff shortages and if we experience staff shortages, or are unable to meet any applicable regulatory staffing requirements, it could impact our quality of care. In the past, regulators have taken measures against certain of our facilities and locations as a result of non-compliance with applicable laws and regulations. For example, in July 2020, the West Virginia Department for Health and Human Resources issued a statewide admissions ban for all ResCare facilities that applied to new admissions and readmissions, and the state later issued separate admissions ban orders for other state operations. In addition, our facilities and locations have been subject to other regulatory inquiries and matters,

such as recoupments as a result of alleged insufficient documentation, overpayments, audits, removals of clients as a result of staffing and incidents identified during a monitoring visit, contract terminations, suspensions or revocations of licenses, home closures, vendor holds, which may occur as a result of our failure to submit an acceptable report under state law, and administrative penalties issued as a result of staffing issues and incidents found during monitoring visits.

If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care (including as a result of a staffing shortages or the actions or inactions of our employees or workforce members), governmental or regulatory authorities may take action against us or our employees or workforce members, including an admissions ban, admissions hold, reduction in census, loss of accreditation, license revocation, application denial period, administrative or other order, other adverse regulatory action, a settlement or other agreement requiring corrective actions or requiring us or a specific facility to demonstrate substantial compliance with licensure or other requirements, and the imposition of certain requirements, including requirements to transfer our service users, to provide reports or other documentation or to undergo revisit surveys or inspections. If such an action or a closure of a facility were to occur and result in the improper termination of patient care, we or our employees or workforce members may be exposed to governmental or regulatory inquiries, investigations, liability, and litigation, including claims of patient abandonment. Certain of our individual locations have been, and may continue to be, subject to findings of quality of care deficiencies or practices, incidents of patient abuse or neglect, and claims regarding services rendered that do not meet the standard of care, which have resulted, and in the future may result, in civil or criminal penalties; fines; the suspension, modification, termination, or revocation of a license of Medicare or Medicaid participation; the suspension of the operations of a facility; the suspension or denial of admissions of service users; a reduction in census; the removal of service users from properties; the denial of payments in full or in part; administrative orders; the implementation of state oversight, temporary management or receivership; and other actions. If an admissions hold, loss of accreditation, license revocation, or other action such as a closure of a facility occurs, states may interpret such an interruption to be "patient abandonment," which may lead to additional action by regulatory authorities or patients. In many states, patient abandonment includes abandoning or neglecting a patient needing professional care without making reasonable arrangements for the continuation of care. In addition to actions by state boards, patients may also pursue a private right of action claiming abandonment.

Any such patient incident, adverse regulatory action, self-disclosure, self-report, claim or other event, action or inaction has in the past, and could in the future, result in governmental investigations, judgments, or fines and have a material adverse effect on our business, financial condition, and results of operations. We have received inquiries and requests from various governmental and regulatory authorities and we have in the past and may in the future receive notices of potential sanctions based on violations of law or standards of care or alleged or actual failures to cure identified deficiencies or deficient practices. Further, claims of patient abuse, neglect, or medical malpractice have resulted in the past, and in the future may result, in law enforcement agencies investigating or arresting our employees and workforce members in order to investigate even unsubstantiated criminal or misdemeanor claims. While such enforcement actions are typically taken against individuals, we cannot predict how law enforcement or governmental or regulatory authorities will enforce the laws or whether governmental or regulatory authorities will assert that we or any of our employees or workforce members are responsible for such actions, or should have known about such actions. In addition, we have been and could become the subject of negative publicity or unfavorable media attention or governmental or regulatory scrutiny, regardless of whether the allegations are substantiated, that could have a significant, adverse effect on the trading price of our common stock or adversely impact our reputation, our relationships with referral sources and payors, whether service users and their family members choose us, and whether our referral sources choose other healthcare entities to provide healthcare.

If we fail to provide or maintain a reputation for providing high quality or cost-effective care or adequate staffing, training, monitoring, and facilities, or are perceived to provide lower quality or less cost-effective care or inferior staffing, training, monitoring, and facilities than our competitors within the same geographic area, or if patients of our home and community health services and/or pharmacy services perceive that they could receive higher quality or more cost-effective services from other providers, our ability to attract and retain patients, customers, and employees could be adversely affected, which could have a material adverse effect upon our business, consolidated financial condition and results of operations. We believe that the perception of our quality of care by potential patients or their families seeking our services is influenced by a variety of factors, including physician and other healthcare professional referrals, community information and referral services, electronic media, newspapers and other print, and results of patient surveys, recommendations from family and friends, and published quality care statistics compiled by CMS or other industry data.

***If we are unable to maintain our corporate reputation, or there is adverse publicity, including negative information on social media, or changes in public perception of our services, our business may suffer.***

Our success depends on our ability to maintain our corporate reputation, including our reputation for providing quality patient care and for compliance with applicable Medicare, Medicaid, or HIPAA requirements or other laws to which we are subject, among governmental authorities, physicians, hospitals, discharge planning departments, case managers, nursing homes, rehabilitation centers, advocacy groups, patients and their families, other referral sources, and the public. For example, while we believe that the services we

provide are of high quality, if our "quality measures," which are published annually online by CMS, are deemed to be not of the highest value, our reputation could be negatively affected. Adverse publicity surrounding any aspect of our business, including our failure to provide proper care, staffing, or training, incidents at our facilities, employee misconduct, conditions at our facilities, litigation, licensure actions, changes in public perception of our services or government investigations of our operations could negatively affect our overall reputation, the willingness of other providers and organizations to refer patients to us, of patients to use our services, and our ability to retain agreements or obtain new agreements. Increased government scrutiny may also contribute to an increase in compliance costs. Any of these events could have a negative effect on our business, financial condition, and operating results.

There has been a marked increase in the use of social media platforms and similar channels that provide individuals with access to a broad audience of consumers and other interested persons. The availability of information on social media platforms is virtually immediate, as is its effect. Many social media platforms immediately publish the content their subscribers and participants post, often without filters or checks on accuracy of the content posted. The opportunity for dissemination of information, including inaccurate information, is potentially limitless. Information about our business and/or services may be posted on such platforms at any time. Negative views regarding our services may continue to be posted in the future, and are out of our control. Regardless of their accuracy or authenticity, such information and views may be adverse to our interests and may harm our reputation and brand. The harm may be immediate without affording an opportunity for redress or correction. Such negative publicity also could adversely affect the size, engagement, activity, and loyalty of our customer base or the effectiveness of word-of-mouth marketing, and result in decreased revenue, or require us to expend additional funds for marketing efforts. Ultimately, the risks associated with any such negative publicity cannot be eliminated or completely mitigated and may materially adversely affect our business, financial condition, and results of operations.

***If our existing customers do not continue with or renew their contracts with us, renew at lower fee levels, decline to purchase additional services from us or reduce the services received from us pursuant to those contracts, it could have a material adverse effect on our business, financial condition, and results of operations.***

Our agreements with our customers are generally in effect for specific time periods. However, certain of our Pharmacy Solutions segment contracts are terminable without cause upon advance written notice, giving those customers leverage to demand more favorable pricing, or seek services from another provider. In all of our lines of business, our ability to renew or retain our agreements depends on our quality of service and reputation, but may also be affected by other factors over which we have little or no control, such as government appropriations and changes in provider eligibility requirements. Additionally, failure to satisfy any of the numerous technical renewal requirements in connections with our proposals for agreements could result in a proposal being rejected even if it contains favorable pricing terms. Failure to obtain, renew, or retain agreements with customers may negatively impact our business, financial condition, and results of operations. We can give no assurance that our existing agreements will be renewed on commercially reasonable terms or at all.

***Our business depends on our ability to effectively invest in, implement improvements to, and properly maintain the uninterrupted operation and data integrity of our information technology and other business systems.***

Our business is highly dependent on maintaining effective and secure information systems, including those maintained by us and those maintained and provided by third-party service providers (for example, "software-as-a-service" and cloud solutions), as well as the integrity and timeliness of the data we use to serve our patients, support employees and operate our business. Our business also supports the use of electronic visit verification, or EVV, to collect visit submission information such as service type, visit start time and end time, and care plan tasks for our home and community-based care services. We use mobile devices to capture time in and time out, mileage and travel time, as well as the completed care plan tasks with client verification. Our ability to effectively manage our business and coordinate the provision and billing of our services and prompt, accurate documentation of the care and services we provide depends significantly on the reliability and capacity of these systems. We rely on these providers to provide continual operation, as well as maintenance, enhancements, and security of any protected and/or confidential data (including personal information). To the extent that our EVV and other vendors fail to support these processes, our internal operations could be negatively affected. Our systems, and those of our third-party service providers, are vulnerable to damages, failures, malfunctions, outages or other interruptions which could be caused by a number of factors such as power outages or damages, telecommunications problems, data corruption, software errors, human error, computer viruses, defects and other errors, physical or electronic break-ins, theft, design defects, network failures, security breaches, cyberattacks, acts of war or terrorist attacks, fire, flood, and natural disasters. A system failure, outage or other interruption may also cause the corruption or loss of important, confidential, and/or protected data (including personal information). See "—Risks Related to Our Regulatory Framework—If we are found to have violated HIPAA, or any other applicable privacy and security laws and regulations, as well as contractual obligations, we could be subject to sanctions, fines, damages, and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation, and have a material

adverse effect on our business, financial condition, and results of operation." Furthermore, our third-party providers' existing safety systems, data backup, access protection, user management, information technology emergency planning, and other security measures may not be sufficient to prevent data loss or long-term network outages.

In addition, we may have to upgrade our existing information technology systems from time to time in order for such systems to withstand the increasing needs of our expanding business. We rely on certain hardware, telecommunications, and software vendors to maintain and periodically upgrade many of these systems so that we can continue to support our business. Costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems could disrupt or reduce the efficiency of our operations. Further, upgrading and expanding our information technology infrastructure could require significant investment of additional resources and capital, which may not always be available or available on favorable terms. We also depend on our information technology staff. If we cannot meet our staffing needs in this area, we may not be able to fulfill our technology initiatives while continuing to provide maintenance on existing systems. Any material disruption, outage or slowdown of our systems or those of our third-party providers, including those caused by our or their failure to successfully upgrade our or their systems, and our or their inability to convert to alternate systems in an efficient and timely manner could have a material adverse effect on our business, financial condition, and results of operations.

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

***Security breaches, loss of data, and other disruptions could compromise sensitive business or patient information, cause a loss of confidential patient data, employee data, personal information, or prevent access to critical information, and expose us to liability, litigation, and federal and state governmental inquiries and damage our reputation and brand.***

In the ordinary course of our business, we collect, process, use, transmit, share, disclose, create, receive, maintain, transmit, and store, or collectively, Process, personal information (which may also be referred to as personal data, personally identifiable information, and/or non-public personal information), including protected health information, or PHI, relating to our patients, employees, referral sources, payors, and others. We also Process, and contract with third-party service providers to Process, other sensitive, confidential, and/or proprietary information. We use third-party service providers for important aspects of the Processing of personal information and other confidential and sensitive data and information, and therefore rely on third parties to manage functions that have material cybersecurity risks. Because of the sensitivity of such personal information and other sensitive data and information that we and our service providers Process, the security of our technology platform and other aspects of our services, including those provided or facilitated by our third-party service providers, are critical to our operations and business strategy. Our patients, employees, payors, and referral sources have a high expectation that we will adequately protect their information, including personal information, from cyberattacks or other security breaches, and may have claims against us if we are unable to do so. We may also have exposure to regulatory investigations and other compliance risks in the event of a cyberattack or other security breach. We have been, and are currently, subject to HHS investigations with respect to data privacy and security incidents involving PHI. There can be no assurance that we will not be subject to such HHS investigations or investigations by other governmental or regulatory authorities in the future, including those that may have a material impact on our business. Any delay in identifying such breaches or incidents or in providing timely reports or notification of such incidents may lead to increased harm and increased penalties or other actions, such as measures required as part of any resolution or settlement agreement. Our patients, employees, payors, and referral sources may have contractual rights of indemnification against us in the event that their personal or proprietary business information is accessed, acquired, disclosed, lost, used or compromised as a result of a breach of our information systems. In such an event, these parties may also seek to terminate our contracts with them.

Our systems and those of our third-party service providers and business partners may be vulnerable to, and have experienced, data or security breaches, cyberattacks (including ransomware), acts of vandalism, computer viruses, misplaced or lost data, human errors, or other similar events. While we have safeguards in place designed to defend our systems against intrusions and attacks and to protect our data, we cannot be certain that these measures are sufficient to counter all current and emerging technology threats. If unauthorized parties gain access to our networks or data, or those of our employees, third-party service providers or business partners, they may be able to access, steal, publish, delete, use in an unauthorized manner or modify confidential and sensitive information, including personal information, PHI, trade secrets or other confidential information, intellectual property, and proprietary business information. In addition, employees may intentionally or inadvertently cause data or security breaches that result in destruction, loss, alteration, unauthorized disclosure of, or access to such information. Further, the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and are often difficult to detect. Threats to our systems and associated third-party systems can originate from human error, fraud, or malice on the part of employees or third parties or simply from accidental technological failure. Computer viruses and other malware can be distributed and could infiltrate our systems or those

of associated third parties. Because the techniques used to circumvent security systems can be highly sophisticated, change frequently, are often not detected until launched against a target and may originate from less regulated and remote areas around the world, we, and our third-party service providers, may be unable to effectively detect or proactively address all possible techniques, implement adequate preventive measures for all situations or respond to any breach or security incident. The administrative, physical, and technological safeguards we or our third-party service providers implement to address these risks may not address applicable laws and regulations or address situations that could lead to increased privacy or security risks. The businesses we have acquired, or may acquire in the future, may not have in place all of the required safeguards and may have experienced breaches or security incidents. It may take significant time and expense to integrate such businesses to our policies and procedures. To the extent we terminate contracts with our third-party service providers, we may not be able to ensure that the relevant personal information of our patients and employees is maintained in compliance with the required safeguards. In the normal course of business, we are and have been the target of malicious cyberattack attempts and have experienced ransomware attacks and other security incidents that have disrupted our operations. For example, in March 2023, we experienced a ransomware attack that resulted in a breach of more than 6 million individuals' personal information (including PHI). While we do not currently expect this incident to have a material impact on our business, we notified the impacted individuals and applicable regulators and are currently subject to a HHS Office for Civil Rights investigation, various state regulatory investigations, and various lawsuits in connection with this incident. There can be no assurance that any present or future cyberattacks will not be material or significant.

Any such cyberattack or threat, including those that result in data or security breaches, could result in costly investigations, litigation, government enforcement actions, civil or criminal penalties, fines, operational changes or other response measures, loss of patient and customer confidence in our security measures, loss of business partners, and negative publicity that could adversely affect our brand, reputation, business, financial condition, and results of operations. In particular, any such interruption in access, compromise, use, improper access, acquisition, disclosure or other loss of information, including personal information or PHI, could result in legal claims or proceedings and/or liability or penalties under laws and regulations that protect the privacy, confidentiality, or security of personal information, including the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 and other laws, and implementing regulations, or collectively, HIPAA, the FTCA, the California Consumer Privacy Act, or CCPA, as amended by the California Privacy Rights Act of 2020, or CPRA, and its implementing regulations, and other state data privacy, security, consumer health data, or consumer protection laws, including state breach notification laws. These laws often provide for civil penalties for violations, as well as a private right of action for data breaches that may increase data breach litigation. Any delay in identifying such breaches or incidents or in providing timely notification of such incidents may lead to increased harm and increased penalties. For further information, see "—Risks Related to Our Regulatory Framework—If we are found to have violated HIPAA, or any other applicable privacy and security laws and regulations, as well as contractual obligations, we could be subject to sanctions, fines, damages, and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation, and have a material adverse effect on our business, financial condition, and results of operation."

In addition, denial of service or other cyberattacks could be launched against us for a variety of purposes, including to interfere with our services or create a diversion for other malicious activities. Our defensive measures may not prevent unplanned downtime, or the unauthorized access, acquisition, disclosure, or use of confidential, sensitive data, and/or personal information. We may be required to expend significant capital and other resources to protect against security breaches, to safeguard the privacy, security, and confidentiality of personal information and other sensitive data and information, to investigate, contain, remediate, and mitigate actual or potential security breaches and security incidents, and/or to report security breaches and security incidents to patients, customers, employees, regulators, media, credit bureaus, and other third parties in accordance with applicable law and to offer complimentary credit monitoring, identity theft protection, and similar services where required by law or otherwise appropriate. While we maintain cyber errors and omissions insurance coverage that covers certain aspects of cyber risks, these losses may not be adequately covered by insurance or other contractual rights available to us. We may also be subject to potential increases in insurance premiums, resulting in increased costs or loss of revenue, and such insurance coverage may not continue to be available to us in adequate amounts or on satisfactory terms, if at all.

***We are subject to risks related to credit card payments and other payment methods.***

We currently accept credit cards and debit cards. As a result, we pay interchange and other related acceptance and transaction processing fees, which may increase over time and raise our operating costs and lower profitability.

We are also subject to evolving Payment Card Industry, or PCI, and network operating rules, including data security rules, certification requirements, and rules governing electronic funds transfers. For example, we are subject to the Payment Card Industry Data Security Standard, issued by the PCI Security Standards Council, that contains compliance guidelines and standards with regard to our security surrounding the physical and electronic storage, processing, and transmission of individual cardholder data, including regular audit to maintain compliance. As our business evolves and expands, and if we offer new payment options to consumers, we may be subject to additional regulations, compliance requirements, fraud, and other risks, in addition to new assessments that involve

costs above what we currently pay for compliance. By accepting debit cards for payment, we are also subject to compliance with American National Standards Institute data encryption standards and payment network security operating guidelines. Additionally, the Fair and Accurate Credit Transactions Act requires systems that print payment card receipts to employ personal account number truncation so that the customer's full account number is not viewable on the slip. Failure to be PCI compliant or to meet other payment card standards may result in the imposition of financial penalties or the allocation by the card brands of the costs of fraudulent charges to us. In addition, if we (or a third-party processing payment card transactions on our behalf) suffer a security breach affecting payment card information, we may have to pay onerous and significant fines, penalties, and assessments arising out of the major card brands' rules and regulations, contractual indemnifications, or liability contained in merchant agreements and similar contracts, and we may lose our ability to accept payment cards for payment for our services, which could materially impact our operations and financial performance.

In addition, we rely on third-party payment processors to process the payments made by our customers. If our third-party payment processors terminate their relationships with us or refuse to renew their agreements with us on commercially reasonable terms, we would need to find an alternate payment processor and may not be able to secure similar terms or replace such payment processors in an acceptable time frame. Further, the software and services provided by our third-party payment processors may contain errors or vulnerabilities, be compromised, experience outages, or not meet our expectations. If any of these events were to occur, our business, financial condition, and results of operations could be materially and adversely affected.

We occasionally receive payments made with fraudulent data which result in customer-initiated disputes (charge-backs). Under current credit and debit card practices, we may be liable for fraudulent transactions and be required by card issuers to pay charge-back fees. Charge-backs result not only in our loss of fees earned with respect to the payment, but also leave us liable for the underlying money transfer amount. If our charge-back rate becomes excessive, card brands and associations also may require us to pay fines or refuse to process our transactions. In addition, we may be subject to additional fraud risk if third-party service providers or our employees fraudulently use our customer information for their own gain or facilitate the fraudulent use of such information. As a result, we may suffer losses as a result of orders placed with fraudulent data even if the associated financial institution approved payment of the orders. If we are unable to detect or control credit and debit card fraud, our liability for these transactions could harm our business, financial condition, and results of operations.

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

The nature of our business subjects us to inherent risk of wrongful death, personal injury, product liability, professional malpractice and other potential claims, liabilities, and substantial damage awards. In addition, the pharmaceutical products we dispense could become subject to contamination, product tampering, mislabeling, recall or other damage. In addition, errors in the compounding, dispensing, and packaging of drugs and consuming drugs in a manner that is not prescribed could lead to serious injury or death. Healthcare providers have become subject to an increasing number of legal actions alleging malpractice or related legal theories in recent years, many of which involve large monetary claims and significant defense costs. In general, we coordinate care for high-need, medically complex individuals through employed clinicians, caregivers, and pharmacists, including registered nurses, limited practice nurses, licensed therapists, certified nursing assistants, home health aides, therapy assistants, direct care staff, and other similar professionals. From time to time, we are subject to claims alleging that we did not properly treat or care for a patient, that we failed to follow internal or external procedures that resulted in death or harm to a patient or that our employees mistreated our consumers, resulting in death or harm. We are also subject to claims arising out of accidents involving vehicle collisions brought by patients whom we are transporting, from employees driving to or from home visits or other affected individuals. We cannot be certain that a provider will not incur tort liability in treating one of our patients. The clinicians, caregivers, and other healthcare professionals we employ could be considered our agents and, as a result, we could be held liable for their acts, omissions, malpractice, and/or negligence and may be subject to mass tort actions and/or class actions. We cannot predict the effect that any claims of this nature, regardless of their ultimate outcome, could have on our business or reputation or on our ability to attract and retain patients and employees. We are self-insured for a substantial portion of our general and professional liability, automobile liability, workers' compensation risks, and (subject to certain stop loss coverage at a high level of losses) health benefits. Any claims against us in excess of insurance limits, or multiple claims requiring us to pay deductibles or self-insured retention amounts, as well as the potential impact on our brand or reputation as a result of being involved in any legal proceedings, could have a material adverse impact on our business, results of operations and financial condition.

***We are exposed to various risks related to governmental inquiries, regulatory actions, and whistleblower and other lawsuits that could adversely affect our operating results. Our insurance may not cover all claims against us.***

Regulatory agencies may initiate administrative proceedings alleging violations of statutes and regulations arising from our services, or reimbursement of those services, and seek to impose monetary penalties on us. We could be required to pay substantial

amounts to respond to and defend against regulatory investigations, and if we do not prevail, damages or penalties arising from these administrative proceedings. We are subject to lawsuits, civil investigative demands, and subpoenas under the False Claims Act, the Controlled Substances Act, the Anti-Kickback Statute, and other federal and state statutes designed to combat fraud and abuse in our industries, as well as civil investigative demands, subpoenas and other inquiries related to our operations, including several ongoing *qui tam* actions and the Silver matter, as discussed under Item 3 "Legal Proceedings" and Note 14 "Commitments and Contingencies" to our audited consolidated financial statements included elsewhere in this Annual Report on Form 10-K. Additionally, there can be no assurance that we will not be subject to claims or litigation related to the authorization or denial of claims for payment of benefits, or to allegations that we have engaged in fee splitting, which may be prohibited under state laws, or to allegations that we engage in the corporate practice of medicine or the delivery of medical services, where prohibited. Moreover, we could also be subject to potential litigation associated with compliance with various laws and governmental regulations at the federal or state levels, such as those relating to the protection of older adults and persons with disabilities or those related to employment, health, safety, security, and other regulations under which we operate. We are currently subject to class actions, employee-related claims, and other lawsuits and proceedings in connection with our operations, including, but not limited to, those related to alleged violations of federal and state wage and hour laws, wrongful discharge, retaliation, and illegal discrimination. We are also named as a defendant, along with a number of drug manufacturers, distributors, and pharmacies, in civil litigation instituted by certain Maryland municipalities, which allege claims generally concerning the impacts of widespread opioid abuse in their municipalities. We cannot predict with certainty the outcome of this litigation or how our role, including as a closed door long-term care pharmacy, may be viewed as compared to the role of a manufacturer, distributor or retail pharmacy. The litigation may remain unresolved for several years, and we could incur significant expense in order to resolve the matter, including through settlement agreements. These claims, lawsuits, and proceedings are in various stages of adjudication or investigation and involve a wide variety of claims and potential outcomes.

Responding to lawsuits brought against us and governmental inquiries can often be expensive, time-consuming, and disruptive to normal business operations. Moreover, complex legal proceedings and governmental inquiries may remain unresolved for several years, and the results are difficult to predict. Unfavorable outcomes from these claims, lawsuits, and governmental inquiries could adversely affect our business, financial condition, and results of operations and we could incur substantial monetary liability and/or be required to change our business practices. Any claims made against us, regardless of their merit or eventual outcome, could damage our reputation and business and our ability to attract and retain patients, customers, strategic partnerships, and employees.

We maintain general liability insurance to provide coverage to us and our subsidiaries against these litigation claims and potential litigation risks. However, we cannot assure you claims will not be made in the future in excess of the limits of our insurance, nor can we assure you that any such claims, if successful and in excess of such limits, will not have a material adverse effect on our business, financial condition, and results of operations. We cannot assure you that the insurance we maintain will satisfy claims made against us or that insurance coverage will continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms, if at all.

***Our current insurance program may expose us to unexpected costs and negatively affect our business, financial condition, and results of operations, particularly if we incur losses not covered by our insurance or if claims or losses differ from our estimates.***

Although our insurance coverage reflects deductibles, self-insured retentions, limits of liability, and similar provisions that we believe are reasonable based on our operations, the coverage under our insurance programs may not be adequate to protect us in all circumstances. Given the policy limits and high deductibles and/or self-insured retentions on many of the Company's insurance programs, the vast majority of claims may not be paid by third-party insurance. Our insurance policies contain exclusions and conditions that could have a materially adverse impact on our ability to receive indemnification thereunder, as well as customary sub-limits for particular types of losses. Additionally, insurance companies that currently insure companies in our industries may cease to do so, may change the coverage provided, or may substantially increase premiums in the future. Changes in our annual insurance costs and self-insured retention limits depend in large part on the insurance market, and insurance coverage may not continue to be available to us at commercially reasonable rates, in adequate amounts or on satisfactory terms, if at all. We self-insure for a substantial portion of our general and professional liability, automobile liability, workers' compensation risks, and (subject to certain stop loss coverage at a high level of losses) health benefits. We self-insure for various risks, including employment class actions, False Claims Act actions, adverse regulatory actions, commercial contractual or commercial tort actions, and intellectual property actions. The incurrences of losses and liabilities that exceed our available coverage, therefore, could have a material adverse effect on our business, financial condition, and results of operations.

We utilize historical data to estimate our reserves for our insurance programs. Unanticipated changes in any applicable actuarial assumptions and management estimates underlying our liabilities for these losses could result in materially different expenses than expected under these programs, which could have a material adverse effect on our financial condition and results of operations. In addition, if we experience a greater number of these losses than we anticipate, it could have a material adverse effect on our business, financial condition, and results of operations.

***Factors outside of our control, including those listed, have required, and could in the future require us to record an asset impairment of goodwill.***

Because we have grown in part through acquisitions, goodwill and intangible assets, net represent a significant portion of our assets. We monitor the recoverability of our indefinite-lived intangible assets, which include our licenses, and evaluate goodwill and indefinite-lived intangible assets annually, or more frequently if indicators of impairment exist in interim periods, to determine if impairment has occurred. We also review the carrying value of our goodwill and intangible assets, both indefinite- and definite-lived, for impairment whenever events or changes in circumstances indicate that the carrying value of such assets may not be fully recoverable. Such indicators are based on market conditions and the operational performance of our business. If the testing performed indicates that impairment has occurred, we are required to record a non-cash impairment charge for the difference between the carrying value of the intangible assets or goodwill and the fair value of the intangible assets or the goodwill, respectively, in the period the determination is made. The testing of goodwill and intangible assets for impairment requires us to make estimates that are subject to significant assumptions about our future revenues, profitability, cash flow, fair value of assets and liabilities, and weighted average cost of capital, as well as other assumptions. Changes in these estimates, or changes in actual performance compared with these estimates, may affect the fair value of intangible assets or goodwill, which may result in an impairment charge. We did not recognize any goodwill impairment charge for the years ended December 31, 2023 or 2024. See Note 1 "*Significant Accounting Policies*" and Note 4 "*Goodwill and Intangible Assets*" to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K. If as part of our review of goodwill and intangibles for impairment, we were required to write down all or a significant part of our goodwill and/or intangible assets, our financial condition and results of operations could be materially adversely affected.

***Inclement weather, natural disasters, acts of terrorism, riots, civil insurrection or social unrest, looting, protests, strikes, or street demonstrations may impact our ability to provide services.***

Inclement weather, natural disasters, acts of terrorism, riots, civil insurrection, social unrest or other acts of violence, looting, protests, strikes, or street demonstrations may prevent our employees from providing authorized services. We are not paid for authorized services that are not delivered due to these events. Furthermore, prolonged disruptions as a result of such events in the markets in which we operate, could disrupt our relationships with patients, caregivers and employees, and referral sources located in affected areas and, in the case of our corporate office, our ability to provide administrative support services, including billing and collection services. Future inclement weather, natural disasters, acts of terrorism, riots, civil insurrection, social unrest or other acts of violence, looting, protests, strikes or street demonstrations may adversely affect our reputation, business, financial condition, and results of operations.

***We may be unable to adequately protect our intellectual property rights, which could harm our business.***

We rely on a combination of intellectual property laws, internal procedures, and nondisclosure agreements to protect our intellectual property and proprietary rights. We believe our trademarks are valuable assets. However, our intellectual property rights may not be sufficient to distinguish our services from those of our competitors and to provide us with a competitive advantage. For example, from time to time, third parties may use names, logos, and slogans similar to ours, may apply to register trademarks or domain names similar to ours, and may infringe or otherwise violate our intellectual property rights. Our intellectual property rights may not be successfully asserted against such third parties or may be invalidated, circumvented, or challenged. Asserting or defending our intellectual property rights could be time consuming and costly and could distract management's attention and resources. If we are unable to prevent our competitors from using names, logos, slogans, and domain names similar to ours, consumer confusion could result, the perception of our brands and services could be negatively affected, and our revenue and profitability could suffer as a result. Failure to protect our intellectual property and proprietary rights could have an adverse effect on our business.

***KKR Stockholder controls us and its interests may conflict with yours in the future.***

KKR Stockholder beneficially owns approximately 54.2% of the voting power of our common stock. As a result, KKR Stockholder is able to control the election and removal of our directors and thereby determine our corporate and management policies, including potential mergers or acquisitions, payment of dividends, asset sales, amendment of our certificate of incorporation or bylaws and other significant corporate transactions for so long as KKR Stockholder and its affiliates retain significant ownership of us. KKR Stockholder and its affiliates may also direct us to make significant changes to our business operations and strategy, including with respect to, among other things, new service offerings, employee headcount levels, and initiatives to reduce costs and expenses. This concentration of our ownership may delay or deter possible changes in control of the Company, which may reduce the value of an investment in our common stock. So long as KKR Stockholder and its affiliates continue to own, directly or indirectly, a significant

amount of our voting power, even if such amount is less than 50%, it is able to strongly influence or effectively control our decisions, and KKR Stockholder has the right to nominate individuals to our board of directors under the existing stockholders agreement.

In the ordinary course of their business activities, KKR Stockholder and its affiliates may engage in activities where their interests conflict with our interests or those of our stockholders. Our second amended and restated certificate of incorporation provides that any of KKR Stockholder, any of its respective affiliates or any director who is not employed by us or his or her affiliates do not have any duty to refrain from engaging, directly or indirectly, in the same business activities or similar business activities or lines of business in which we operate. KKR Stockholder and its affiliates also may pursue acquisition opportunities that may be complementary to our business and, as a result, those acquisition opportunities may not be available to us. In addition, KKR Stockholder and its affiliates may have an interest in pursuing acquisitions, divestitures, and other transactions that, in their judgment, could enhance their investment, even though such transactions might involve risks to you.

In addition, KKR Stockholder and its affiliates are able to determine the outcome of all matters requiring stockholder approval and are able to cause or prevent a change of control of the Company or a change in the composition of our board of directors and could preclude any acquisition of the Company. This concentration of voting control could deprive you of an opportunity to receive a premium for your shares of common stock as part of a sale of the Company and ultimately might affect the market price of our common stock.

**Risks Related to Our Regulatory Framework**

***We conduct business in a heavily regulated industry, and changes in regulations, the enforcement of these regulations, or violations of regulations may result in increased costs or sanctions that reduce our revenues and profitability.***

The federal government and the states in which we operate regulate our industries extensively. The laws and regulations governing our operations, along with the conditions of participation and conditions of payment, in various government programs, impose certain requirements on the way in which we do business, the services we offer, and our interactions with providers and consumers. The extensive federal and state regulations affecting the healthcare industry include, but are not limited to, regulations relating to licensure, certification and enrollment, billing and coding, eligibility for, necessity of, and provision of services, conduct of operations, allowable costs, prices for services, adequacy and quality of services, facility staffing requirements, facility accreditation, qualifications and licensure of staff, environmental and occupational health and safety, and the confidentiality and security of health-related information. In particular, various fraud and abuse laws, including the Anti-Kickback Statute, the Stark Law, and the False Claims Act, prohibit certain business practices and relationships that might affect the provision and cost of healthcare services reimbursable under Medicare and Medicaid, including the payment or receipt of remuneration for the referral of patients whose care will be paid for by Medicare or other governmental programs. Additionally, in some states, our contractual relationships with physicians and professional corporations, which we do not own, may implicate certain state laws that generally prohibit non-professional entities, such as us, from practicing medicine, employing physicians to practice medicine, providing licensed medical services and exercising control over medical decisions by licensed physicians or other healthcare professionals (such activities are generally referred to as the corporate practice of medicine). Other states in which we may operate in the future may also prohibit the corporate practice of medicine. Our contractual relationships with physicians and professional corporations may be challenged by governmental and regulatory authorities, state boards of medicine, state attorneys general and other parties that assert or determine that our relationships with professional corporations violate state corporate practice of medicine, fee-splitting, and kickback prohibitions. We are also subject to laws requiring the registration and regulation of pharmacies; laws governing the dispensing of pharmaceuticals and controlled substances; laws regulating the protection of the environment and health and safety matters, including those governing exposure to, and the management and disposal of, hazardous substances; laws regarding food and drug safety, including those of the Food and Drug Administration, or FDA, and the Drug Enforcement Administration, or DEA. We are required to hold valid DEA and state-level licenses, meet various security and operating standards, and comply with the federal and various state controlled substance acts and related regulations governing the sale, dispensing, disposal, holding and distribution of controlled substances. Compliance with these regulations is expensive, and these costs may increase in the future.

Federal and state governments continue to pursue intensive enforcement policies resulting in a significant number of investigations, inspections, audits, citations of regulatory deficiencies, and other regulatory sanctions, including demands for refund of alleged overpayments, terminations from the Medicare and Medicaid programs, bans on Medicare and Medicaid payments for new admissions, admission moratoriums, and civil monetary penalties or criminal penalties. We expect audits under the CMS Recovery Audit Contractor, or RAC, program, the CMS Targeted Probe and Educate, or TPE, program, the Unified Program Integrity Contractors, or UPIC, program and other federal and state audits evaluating the medical necessity of services to further intensify the regulatory environment surrounding the healthcare industry, as third-party firms engaged by CMS and others conduct extensive pre and post-payment audits of claims data as well as medical and other records in order to identify improper payments to healthcare providers under the Medicare and Medicaid programs. The DEA, FDA, and state regulatory authorities have broad enforcement

powers, including the ability to seize or recall products. If we fail to comply with the extensive laws, regulations, and prohibitions applicable to our businesses, we could become ineligible or disqualified to provide services or receive government program reimbursement, suffer suspension or revocation of our licenses, cancellation of our agreements, civil or criminal penalties, and/or damage to our reputation, lose billing privileges, be barred from re-enrollment in governmental payor programs, or be required to repay amounts received or to make significant changes to our operations. We may also become subject to corporate integrity agreement(s) or monitoring by regulatory agencies. In addition, we could be forced to expend considerable resources responding to investigations, audits, or other enforcement actions related to these laws, regulations, or prohibitions. Failure of our staff to satisfy applicable licensure requirements, or of our home and community health services and pharmacy services operations or our service providers to satisfy applicable licensure and certification requirements, could have a material adverse effect on our business, financial condition, and results of operations.

In March 2020, the HHS Office of the National Coordinator for Health Information Technology, or ONC, and CMS promulgated final rules aimed at supporting seamless and secure access, exchange, and use of electronic health information, or EHI, by increasing innovation and competition by giving patients and their healthcare providers secure access to health information and new tools, allowing for more choice in care and treatment. The final rules were intended to clarify and operationalize provisions of the 21st Century Cures Act, or Cures Act, regarding interoperability and "information blocking." Information blocking is defined as any activity that is likely to interfere with, prevent, or materially discourage access, exchange, or use of EHI, where a health information technology developer, health information network or health information exchange knows or should know that such practice is likely to interfere with access to, exchange or use of EHI. The final rules created significant requirements for healthcare industry participants, and required certain electronic health record technology to incorporate standardized application programming interfaces, or APIs, to allow individuals to securely and easily access structured EHI using smartphone applications. The ONC also implemented provisions of the Cures Act requiring that patients can electronically access all of their EHI (structured and/or unstructured) at no cost. Finally, to further support access and exchange of EHI, the final ONC rule implemented the information blocking provisions of the Cures Act and identified eight "reasonable and necessary activities" as exceptions to information blocking activities, as long as specific conditions are met. On April 18, 2023, the ONC issued a notice of proposed rulemaking that would modify certain components of the final ONC rule, including modifying and expanding certain exceptions to the information blocking regulations, which are intended to support information sharing. The impact of these changes on our business is unclear at this time, due to, among other things, uncertainty regarding the interpretation of safe harbors and exceptions to the final ONC rule by industry participants and regulators. Additionally, on July 3, 2023, the HHS Office of Inspector General, or OIG, issued a final rule that amended the HHS OIG's civil money penalty regulations to add information blocking civil money penalty authority to the existing regulatory framework for the imposition and appeal of civil money penalties, assessments, and exclusions. The final rule also explained that OIG would focus its enforcement efforts on information blocking allegations that pose greater risk to patients, providers, and healthcare programs.

We are unable to predict the future course of federal and state regulation or legislation, including Medicare and Medicaid statutes and regulations, or the intensity of federal and state enforcement actions. Changes in the regulatory framework, including those associated with healthcare reform, and sanctions from various enforcement actions could have a material adverse effect on our business, financial condition, and results of operations.

***In the U.S., we conduct business in a heavily regulated industry and if we fail to comply with these laws and government regulations, we could incur fines and penalties or be required to make significant changes to our operations or experience adverse publicity, any or all of which could have a material adverse effect on our business, financial condition, and results of operations.***

The U.S. healthcare industry is heavily regulated and closely scrutinized by federal, state, and local governments. Comprehensive statutes and regulations govern our relationships with physicians and other healthcare providers, the manner in we provide and bill for services and collect reimbursement from governmental programs and private payors, our relationships with drug manufacturers, our marketing activities, and other aspects of our operations. Of particular importance are:

- the Anti-Kickback Statute, which prohibits the knowing and willful offer, payment, solicitation, or receipt of any bribe, kickback, rebate, or other remuneration for referring an individual, in return for ordering, leasing, purchasing or recommending or arranging for or to induce the referral of an individual, or the ordering, purchasing, or leasing of items or services covered, in whole or in part, by any federal healthcare program, such as Medicare and Medicaid. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;
- the federal physician self-referral law, commonly referred to as the Stark Law, which, subject to limited exceptions, prohibits physicians from referring Medicare or Medicaid patients to an entity for the provision of certain "designated health services" if the physician or a member of such physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity, and prohibit the entity from billing Medicare or Medicaid for such designated health services;

- the False Claims Act, which imposes civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment to the government or knowingly making, or causing to be made, a false statement in order to have a false claim paid, including *qui tam* or whistleblower suits. There are many potential bases for liability under the False Claims Act. The government has used the False Claims Act to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, and providing care that is not medically necessary or that is substandard in quality. In addition, the government may assert that a claim including items or services resulting from a violation of the Anti-Kickback Statute or the Stark Law constitutes a false or fraudulent claim for purposes of the False Claims Act;
- the criminal healthcare fraud provisions of HIPAA, and related rules that prohibit knowingly and willfully executing a scheme or artifice to defraud any healthcare benefit program or falsifying, concealing or covering up a material fact or making any material false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the Anti-Kickback Statute, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;
- reassignment of payment rules that prohibit certain types of billing and collection practices in connection with claims payable by the Medicare or Medicaid programs;
- similar state law provisions pertaining to anti-kickback, self-referral, and false claims issues, some of which may apply to items or services reimbursed by any payor, including patients and commercial insurers. These statutes and regulations generally prohibit the payment or receipt of remuneration to induce or in exchange for a referral, and prohibit physicians from referring patients to an entity with which the physicians have a financial relationship, thus limiting the types of payments that can be made between healthcare providers and other parties who may influence referrals to those providers. Many of these statutes and regulations have not been interpreted to the extent of their federal analogues, and therefore are not clear in their scope and application;
- state corporate practice of medicine and fee-splitting laws that prohibit general business corporations, such as us, from practicing medicine, controlling physicians' medical decisions or engaging in some practices such as splitting fees with physicians;
- laws that regulate debt collection practices;
- a provision of the Social Security Act that imposes criminal penalties on healthcare providers who fail to disclose, or refund known overpayments;
- federal and state laws that prohibit providers from billing and receiving payment from Medicare and Medicaid for services unless the services are medically necessary, adequately and accurately documented, and billed using codes that accurately reflect the type and level of services rendered;
- federal and state laws that require licenses to dispense pharmaceuticals, including state laws that restrict operations by non-resident pharmacies, which may affect our ability to operate in some states; and
- federal and state laws and policies that require healthcare providers to maintain licensure, certification or accreditation to enroll and participate in the Medicare and Medicaid programs, and to report certain changes in their operations to the agencies that administer these programs.

Because of the breadth of these laws and the narrowness of the statutory exceptions and safe harbors available, it is possible that some of our business activities could be subject to challenge under one or more of these laws. Achieving and sustaining compliance with these laws may prove costly. Although a well-designed and effective compliance program that detects and prevents wrongdoing may help identify and remediate misconduct and reduce the risk of investigation and prosecution for violations of these laws, the risks cannot be entirely eliminated, especially if our staff does not report compliance concerns or if our auditing and monitoring programs do not adequately identify and resolve compliance concerns. Failure to comply with these laws and other laws can result in civil and criminal penalties such as fines, damages, overpayment, recoupment, imprisonment, loss of enrollment status, and exclusion from the Medicare and Medicaid programs. Our failure to accurately anticipate the application of these laws and regulations to our business or any other failure to comply with regulatory requirements could create liability for us and negatively affect our business. Any action against us for violation of these laws or regulations, even if we successfully defend against it, could cause us to incur significant legal expenses, divert our management's attention from the operation of our business, and result in adverse publicity.

***Many states have CON laws or other regulatory provisions that may adversely impact our ability to expand into new markets and thereby limit our ability to grow and increase revenue.***

Many states, including Alabama, Tennessee, North Carolina, Arkansas, and Maryland, have enacted CON laws that require prior state approval to offer new or expanded healthcare services or open new healthcare facilities or expand services at existing facilities. In such states, expansion by existing providers or entry into the market by new providers is permitted only where a given amount of unmet need exists, resulting from population increases, a reduction in competing providers, or a lack of providers. These states ration the entry of new providers or services and the expansion of existing providers or services in their markets through a CON process, which is periodically evaluated and updated as required by applicable state law. The process is intended to promote comprehensive healthcare planning, assist in providing high-quality healthcare at the lowest possible cost and avoid unnecessary duplication by ensuring that only those healthcare facilities, services, and operations that are needed will be built and opened or expanded.

Our costs of obtaining a CON in any new CON state in which we seek to operate could be significant, and we cannot assure you that we will be able to obtain the CON or other required approvals in the future. We have applied for, and been approved for, CONs in states in which we currently operate. Our failure or inability to obtain a required CON, license, or any necessary approvals could adversely affect our ability to expand into new markets and to expand our services and facilities in existing markets. Furthermore, if a CON or other prior approval upon which we relied to invest in a facility were to be revoked or lost through an appeal process, we may not be able to recover the value of our investment. Failure to obtain a CON may result in a facility's ineligibility to receive reimbursement under the Medicare or Medicaid programs, the revocation of a facility's license or imposition of civil or criminal penalties, any of which could harm our business. Although we believe that CON laws have not had a material impact on our business to date, the repeal of CON laws in CON markets may have a material adverse effect on our business, financial condition, and results of operations.

CMS and state Medicaid agencies may, for a period of time, impose a moratorium against additional Medicaid enrollment for a particular type of service, upon a determination that a moratorium is necessary to prevent fraud, waste, or abuse, or to limit an over-abundance of a type of Medicaid provider within a state. In addition, states may impose moratoriums relating to state Medicaid program, licensure, and other matters, such as number of beds. A moratorium in any state in which we seek to, or currently, operate may prevent us from introducing, acquiring or disposing of, operations in that state, respectively, which may impair our future expansion, acquisition, or divestiture opportunities in some states. For example, Mississippi has imposed a moratorium on new home health and hospital licenses, and other states perform assessments to determine if there is a need for additional facilities or beds. As another example, West Virginia has imposed a moratorium on new intermediate care facilities, with limited exceptions, and has also imposed a moratorium on healthcare facilities' additions of intermediate care or skilled nursing beds to current licensed beds and the addition of beds in intermediate care facilities for individuals with intellectual disabilities. The imposition of additional CON laws may delay or otherwise affect our ability to accomplish our business objectives.

***If we are unable to effectively adapt to changes in the healthcare industry, including changes to laws and regulations regarding or affecting U.S. healthcare reform, our business may be harmed.***

In recent years, the Congress and certain state legislatures have considered and passed a large number of laws intended to result in significant changes to the healthcare industry, which could result in major changes in the healthcare delivery and reimbursement system on a national and state level, including changes directly impacting the reimbursement systems for our services. In March 2010, the ACA was signed into law and changed how healthcare services are delivered and reimbursed through the expansion of public and private health insurance coverage, reduction of growth in Medicare and Medicaid program spending, and the establishment and expansion of programs that tie reimbursement to quality and integration. Efforts to substantially modify provisions of the ACA have resulted in federal court reviews of such efforts, and the U.S. Supreme Court rejected the latest constitutional challenge to the ACA's requirement to obtain minimum essential health insurance coverage, or the individual mandate, on June 17, 2021. The ultimate outcomes of efforts to expand the ACA, substantially amend its provisions, or change funding for the ACA is unknown. Though we cannot predict what, if any, reform proposals will be adopted, healthcare reform and legislation may have a material adverse effect on our business, financial condition, and results of operations.

Moreover, healthcare reform initiatives have also resulted in changes to, or the adoption of, federal and state laws and regulations relating to the regulation of PBMs, drug pricing or purchasing, and purchase discount and rebate arrangements with drug manufacturers, which could reduce discounts or rebates and affect our relationships with drug manufacturers. In addition to the rules promulgated by HHS, there have also been judicial decisions impacting the pharmacies and PBMs. For example, in December 2020, the U.S. Supreme Court upheld an Arkansas law that, among other things, mandates a particular pricing methodology, establishes an appeals process for a pharmacy when the reimbursement is below the pharmacy's acquisition cost, permits a pharmacy to reverse and rebill if they cannot procure the drug from its wholesaler at a price equal to or less than the reimbursement rate, prohibits a PBM from reimbursing a pharmacy less than the amount it reimburses an affiliate on a per unit basis, and permits a pharmacy to decline to dispense if the reimbursement is lower than the pharmacy's acquisition cost. More recently, in June 2022, the Federal Trade

Commission, or FTC, announced an inquiry regarding the role of PBMs and stated its intent to closely scrutinize the impact of PBM rebates and fees on patients and payers. Several states have proposed separate PBM bills, and at least 18 states have adopted PBM oversight laws. A number of these proposed laws would require PBMs to submit annual transparency reports or otherwise disclose contractual arrangements with health benefit plans or health insurance issuers and would enable regulators to conduct audits of PBM operations. Congress has also considered legislation to reform PBMs and address PBM consolidation and power with respect to drug pricing. For example, in July 2023, the Senate Finance Committee voted to advance the Modernizing and Ensuring PBM Accountability Act. It is unclear how these laws, inquiries, rules, and decisions will impact pharmaceutical companies, pharmacies, and PBMs. In addition, CMS has indicated that it intends to increase flexibility in state Medicaid programs, including by expanding the scope of waivers under which states may implement Medicaid expansion provisions, impose different eligibility or enrollment restrictions, or otherwise implement programs that vary from federal standards. CMS administrators have also signaled interest in changing Medicaid payment models. Other industry participants, such as private payors, may also introduce financial or delivery system reforms. We are unable to predict the nature and success of such initiatives. We cannot predict with certainty what impact any federal and state healthcare reforms will have on us, but such changes could impose new and/or more stringent regulatory requirements on our activities, which could adversely affect our business, financial condition, and results of operations.

***If we are found to have violated HIPAA, or any other applicable privacy and security laws and regulations, as well as contractual obligations, we could be subject to sanctions, fines, damages and other additional civil or criminal penalties, which could increase our liabilities, harm our reputation and have a material adverse effect on our business, financial condition and results of operation.***

Numerous federal, state, and foreign laws, rules, and regulations, as well as contractual obligations, govern the Processing of confidential, sensitive, and personal information, including certain patient health information, such as patient records. Existing laws and regulations are constantly evolving, and new laws and regulations that apply to our business are being introduced at every level of government in the United States. In many cases, these laws and regulations apply not only to third-party transactions, but also to transfers of information between or among us, our affiliates, and other parties with whom we conduct business. These laws and regulations may be interpreted and applied differently over time and from jurisdiction to jurisdiction, and it is possible that they will be interpreted and applied in ways that may have a material adverse effect on our business. The regulatory framework for data privacy and security worldwide is continuously evolving and developing and, as a result, interpretation and implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future.

For example, HIPAA establishes a set of national privacy and security standards in the United States for the protection of PHI by health plans, healthcare clearinghouses, and certain healthcare providers, referred to as covered entities, and the business associates with whom such covered entities contract for services that involve the use or disclosure of PHI, including certain subcontractors of such business associates. HIPAA requires healthcare providers like us to develop and maintain policies and procedures with respect to PHI that is used or disclosed, including the adoption of administrative, physical, and technical safeguards to protect such information. In particular, HIPAA requires us to develop and maintain policies and procedures governing PHI that is used or disclosed, and to implement administrative, physical, and technical safeguards to protect PHI, including PHI maintained, used, and disclosed in electronic form. These safeguards include employee training, identifying business associates with whom covered entities need to enter into HIPAA-compliant contractual arrangements, called business associate agreements, and various other measures. Ongoing implementation and oversight of these measures involves significant time, effort, and expense and we may have to dedicate additional time and resources to ensure compliance with HIPAA requirements.

HIPAA further requires covered entities to notify affected individuals "without unreasonable delay and in no case later than 60 calendar days after discovery of the breach" if their unsecured PHI is subject to an unauthorized access, use or disclosure, though many states require shorter breach notification timeframes. If a breach affects 500 patients or more, covered entities must report it to HHS and local media without unreasonable delay (and in no case later than 60 days after discovery of the breach), and HHS will post the name of the entity on its public website. If a breach affects fewer than 500 individuals, the covered entity must log it and notify HHS at least annually. HIPAA also implemented the use of standard transaction code sets and standard identifiers that covered entities must use when submitting or receiving certain electronic healthcare transactions, including activities associated with the billing and collection of healthcare claims.

Penalties for failure to comply with a requirement of HIPAA vary significantly depending on the failure and could include requiring corrective actions, resolution agreements, and/or imposing civil monetary or criminal penalties. HIPAA also authorizes HHS to conduct audits of HIPAA compliance and state attorneys general to file suit under HIPAA on behalf of state residents. Courts can award damages, costs, and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for HIPAA violations, its standards have been used as the basis for a duty of care claim in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. Litigation with those affected

could increase our liabilities, harm our reputation, and have a material adverse effect on our business, financial condition, and results of operations.

Numerous other federal and state laws protect the confidentiality, privacy, availability, integrity, and security of PHI. For example, failing to take appropriate steps to keep consumers' personal information secure constitutes unfair acts or practices in or affecting commerce in violation of Section 5(a) of the Federal Trade Commission Act, or the FTCA. The FTC expects a company's data security measures to be reasonable and appropriate in light of the sensitivity and volume of consumer information it holds, the size and complexity of its business, and the cost of available tools to improve security and reduce vulnerabilities. Individually identifiable health information is considered sensitive data that merits stronger safeguards. The FTC's current guidance for appropriately securing consumers' personal information is similar to what is required by the HIPAA security regulations, but this guidance may change in the future, resulting in increased complexity and the need to expend additional resources to ensure we are complying with the FTCA. For information that is not subject to HIPAA and deemed to be "personal health records," the FTC may also impose penalties for violations of the Health Breach Notification Rule, or HBNR, to the extent we are considered a "personal health record-related entity" or "third party service provider." The FTC has taken several enforcement actions under HBNR this year and indicated that the FTC will continue to protect consumer privacy through greater use of the agency's enforcement authorities. As a result, our operations may be subject to greater scrutiny by federal and state regulators, partners, and consumers with respect to our collection, use, and disclosure of health information. Additionally, federal and state consumer protection laws are increasingly being applied by FTC and states' attorneys general to regulate the collection, use, storage, and disclosure of personal or personally identifiable information, through websites or otherwise, and to regulate the presentation of website content.

Further, various states, such as California and Massachusetts, have implemented privacy laws and regulations, such as the California Confidentiality of Medical Information Act, that impose restrictive requirements regulating the use and disclosure of personally identifiable information, including PHI. In many cases, these laws are more restrictive than, and may not be preempted by, HIPAA and may be subject to varying interpretations by courts and government agencies, creating complex compliance issues and potentially exposing us to additional expense, adverse publicity, and liability. We also expect that there will continue to be new laws, regulations, and industry standards concerning privacy, data protection, and information security proposed and enacted in various jurisdictions. For example, Washington State enacted a broadly applicable law to protect the privacy of personal health information known as the "My Health My Data Act," which generally requires affirmative consent for the collection, use, or sharing of any "consumer health data." Consumer health data is defined to include personal information that is linked or reasonably linkable to a consumer and that identifies a consumer's past, present, or future physical or mental health status; consumer health data also includes information that is derived or extrapolated from non-health information, such as algorithms and machine learning. Other states, including Connecticut and Nevada, have also passed consumer health data laws, and given the increased focus on the use of health data by entities that are not subject to HIPAA, additional states are expected to pass consumer health privacy laws. The CCPA originally went into effect on January 1, 2020, and established a new privacy framework for covered businesses such as ours. In November 2020, California voters passed the CPRA, which went into effect on January 1, 2023, and which further expanded the CCPA with additional data privacy compliance requirements that may impact our business, and established a regulatory agency dedicated to enforcing the CCPA. It remains unclear how various provisions of the CCPA (as amended by CPRA and its implementing regulations) will be interpreted and enforced. In addition, on March 2, 2021, Virginia enacted the Virginia Consumer Data Protection Act, or VCDPA, a comprehensive privacy statute that shares similarities with the CCPA and legislation proposed or enacted in other states. Additional states, including Colorado, Connecticut, Delaware, Indiana, Iowa, Montana, Oregon, Tennessee, Texas, and Utah have since passed or are considering passing comprehensive state privacy laws. In addition, laws such as the Illinois Biometric Information Privacy Act, which regulates the Processing of biometric information, provide for a private right of action and substantial penalties and statutory damages for violations that have generated significant class-action litigation and settlements. Such laws and regulations require us to continuously review our data Processing practices and policies, may cause us to incur substantial costs with respect to compliance, and could require us to adapt our products and solutions, which may reduce their utility to our customers.

Similar laws have been proposed in other states and at the federal level and if passed, such laws may have potentially conflicting requirements that would make compliance challenging. Such changes may also require us to modify our products and features, and may limit our ability to make use of the data that we collect, may require additional investment of resources in compliance programs, impact strategies, and the availability of previously useful data and could result in increased compliance costs and/or changes in business practices and policies. New legislation proposed or enacted in various other states will continue to shape the data privacy environment nationally.

Additionally, all 50 U.S. states and the District of Columbia have enacted breach notification laws that may require us to notify patients, employees, or regulators in the event of unauthorized access to or disclosure of personal or confidential information experienced by us or our service providers. These laws are not consistent, and compliance in the event of a widespread data breach is difficult and may be costly. Moreover, states have been frequently amending existing laws, requiring attention to changing regulatory requirements. We also may be contractually required to notify patients or other counterparties of a security breach. Although we may

have contractual protections with our service providers, any actual or perceived security breach could harm our reputation and brand, expose us to potential liability, or require us to expend significant resources on data security and in responding to any such actual or perceived breach. Any contractual protections we may have from our service providers may not be sufficient to adequately protect us from any such liabilities and losses, and we may be unable to enforce any such contractual protections. In addition to government regulation, privacy advocates and industry groups have and may in the future propose self-regulatory standards from time to time. These and other industry standards may legally or contractually apply to us, or we may elect to comply with such standards.

Further, in Canada, the Personal Information Protection and Electronic Documents Act, or PIPEDA, and similar provincial laws may impose obligations with respect to processing personal information. PIPEDA requires companies to obtain an individual's consent when collecting, using, or disclosing that individual's personal information. Individuals have the right to access and challenge the accuracy of their personal information held by an organization, and personal information may only be used for the purposes for which it was collected. If an organization intends to use personal information for another purpose, it must again obtain that individual's consent.

Additionally, we make public statements about our use and disclosure of personal information through our privacy policies, information provided on our website and press statements. Although we endeavor to comply with our public statements and documentation, we may at times fail to do so or be alleged to have failed to do so. The publication of our privacy policies and other statements that provide promises and assurances about data privacy and security can subject us to potential government or legal action if they are found to be deceptive, unfair, or misrepresentative of our actual practices. Moreover, from time to time, concerns may be expressed about whether our services compromise the privacy of patients and others. Any concerns about our data privacy and security practices, even if unfounded, could damage the reputation of our businesses, discourage potential patients from our services and have a material adverse effect on our business.

Complying with these various laws, rules, regulations, and standards, and with any new laws or regulations changes to existing laws, could cause us to incur substantial costs that are likely to increase over time, require us to change our business practices in a manner adverse to our business, divert resources from other initiatives and projects, and restrict the way products and services involving data are offered, all of which may have a material adverse effect on our business. For example, we have incurred and expect to continue to incur additional costs to comply with the CCPA and other similar U.S. state laws and regulations. However, in the future we may be unable to make such changes and modifications to our business practices in a commercially reasonable manner, or at all. Given the rapid development of data privacy laws and regulations, we expect to encounter inconsistent interpretation and enforcement of these laws and regulations, as well as frequent changes to these laws and regulations which may expose us to significant penalties or liability for non-compliance, the possibility of fines, lawsuits (including class action privacy litigation), regulatory investigations, criminal or civil sanctions, audits, adverse media coverage, public censure, other claims, significant costs for remediation and damage to our reputation, or otherwise have a material adverse effect on our business and operations. Any inability to adequately address data privacy or security-related concerns, even if unfounded, or to comply with applicable laws, regulations, standards, and other obligations relating to data privacy and security, could result in additional cost and liability to us, damage our relationships with patients, harm our reputation, and have a material adverse effect on our business.

***We face and are currently subject to reviews, audits, and investigations under our licenses and/or contracts with federal and state government agencies and other payors, and these reviews, audits, and investigations could have adverse findings that may negatively impact our business.***

As a result of our participation in the Medicare and Medicaid programs, we face and are currently subject to various governmental reviews, audits, and investigations to verify our compliance with these programs and applicable laws and regulations. An increasing level of governmental and private resources are being devoted to the investigation of allegations of fraud and abuse in the Medicare and Medicaid programs, and federal and state regulatory authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act, the Medicare and Medicaid programs, and other applicable laws. We are routinely subject to audits under various government programs, including the RAC program, the TPE program, and the UPIC program, in which CMS engages third-party firms to conduct extensive pre and post-payment reviews of claims data and medical and other records to identify potential improper payments to healthcare providers under the Medicare program.

In addition, each of our facilities and agencies must comply with required conditions of participation in the Medicare program. If we fail to meet the conditions of participation at a facility, we may receive a notice of deficiency from the applicable state surveyor. If that facility then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that care center could be terminated from the Medicare program or subjected to alternative sanctions. CMS may impose temporary management, direct a plan of correction, direct training, or impose payment suspensions and civil monetary penalties, in each case, upon providers who fail to comply with the conditions of participation. Termination of one or more of our facilities 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 reputation, business, financial condition, and results of operations.

In addition, we, like other healthcare providers, are subject to ongoing investigations by the U.S. Department of Health and Human Services Office of Inspector General, the United States Department of Justice, or DOJ, and State Attorneys General into the billing of services provided to Medicare and Medicaid patients, including whether such services were properly documented and billed, whether services provided were medically necessary, and general compliance with conditions of participation and conditions of payment in the Medicare and Medicaid programs. For example, a business we operate as Embrace Hospice is subject to an ongoing investigation, including by the DOJ and the DEA, of potential violations of the False Claims Act, Controlled Substances Act, and other laws, including allegations relating to hospice services that were not reasonable and medically necessary. While we believe our practices are compliant, the investigation continues to evolve and could become extensive and result in the government pursuing civil or criminal legal claims against us that may result in substantial liabilities. Private payors such as third-party insurance and managed care entities also often 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 any such reviews, audits, and investigations are significant and are likely to increase in the current enforcement environment. These audits and investigations may require us to refund or retroactively adjust amounts that have been paid under the relevant government program or from other payors, and, depending on the findings, the resolution of these audits and investigations could require payment of significant recoupments and other monetary penalties. For example, we have been, and may continue to be, subject to audits and recoupments related to the adequacy of clinical documentation supporting claims submitted to the Medicare and Medicaid programs or other third-party payors. Although we provide education and training to the members of our workforce regarding improvements to clinical documentation and we are working with our vendors regarding system improvements, such measures may not be effective or implemented within the desired timeframes or at all, and we may be subject to additional audits in the future. Further, an adverse review, audit, or investigation could result in other adverse consequences, particularly if the underlying conduct is found to be pervasive or systemic. These consequences include: (1) state or federal agencies imposing significant fines, penalties, and other sanctions on us; (2) loss of our right to participate in the Medicare or Medicaid programs or one or more third-party payor networks; (3) indemnity claims asserted by patients and others for which we provide services; and (4) damage to our reputation in various markets, which could adversely affect our ability to attract patients and employees. If they were to occur, these consequences could have a material adverse effect on our business, financial condition, and results of operations.

***Quality reporting requirements may negatively impact Medicare reimbursement.***

We are subject to certain reporting requirements, and if we fail to comply with those requirements, our future Medicare reimbursement could be impacted. In particular, the ACA directed the Secretary of HHS to establish quality reporting requirements for hospice programs. Failure to submit required quality data will result in a 2% reduction to the market basket percentage increase for that year. This quality reporting program is currently "pay-for-reporting," meaning it is the act of submitting data that determines compliance with program requirements. Similarly, in the Calendar Year 2015 Home Health Final Rule, CMS proposed to establish a new "Pay-for-Reporting Performance Requirement" with which provider compliance with quality reporting program requirements can be measured. Home health agencies that do not submit quality measure data to CMS are subject to a 2% reduction in their annual home health payment update percentage. Currently, home health agencies are required to report prescribed quality assessment data for a minimum of 90% of all patients. The Improving Medicare Post-Acute Care Transformation Act of 2014, or the IMPACT Act, requires the submission of standardized data by home health agencies and other providers. Specifically, the IMPACT Act requires, among other significant activities, the reporting of standardized patient assessment data with regard to quality measures, resource use, and other measures. Failure to report data as required will subject providers to a 2% reduction in market basket prices then in effect.

There can be no assurance that we will continue to meet quality reporting requirements in the future which may result in us seeing a reduction in its Medicare reimbursements. We could also incur meaningful additional expenses in an effort to comply with additional and changing quality reporting requirements.

**Risks Related to Our Indebtedness**

***Our high level of indebtedness requires that we dedicate a substantial portion of our cash flows to debt service payments and reduces the funds that would otherwise be available for other general corporate purposes and other business opportunities, which could adversely affect our operating performance, growth, profitability and financial condition, which in turn could make it more difficult for us to generate cash flow sufficient to satisfy all of our obligations under our indebtedness.***

As of December 31, 2024, we had approximately $2,546.8 million outstanding under the First Lien Term Loan Facility. As of December 31, 2024, we had $63.3 million outstanding under the Revolving Credit Facility, with an available borrowing capacity

under the Revolving Credit Facility of approximately $411.7 million, and $61.8 million of letters of credit outstanding under the LC Facility. On February 21, 2024, we used a portion of the net proceeds received from the IPO and the concurrent public offering by the Company of the 6.75% Tangible Equity Units ("TEUs") to repay $343.3 million of the borrowings under the First Lien Term Loan Facility, and established a new Tranche B-4 Term Loan to refinance the remaining $2,566.0 million of First Lien Term Loan Facility borrowings. We also used a portion of the IPO and concurrent offering proceeds to repay all borrowings under the Second Lien Facility. See Note 5 "Debt and Derivatives" within the audited consolidated financial statements and related notes, included elsewhere in this Annual Report on Form 10-K.

Our overall level of indebtedness requires that we dedicate a substantial portion of our cash flows to debt service payments. The First Lien Term Loan Facility requires quarterly principal and periodic cash interest payments through February 21, 2031. The Revolving Credit Facility requires periodic cash interest payments on outstanding amounts through June 30, 2028.

Our substantial indebtedness reduces the funds that would otherwise be available for operations, future business opportunities, and payments of our debt obligations and limits our ability to:

- obtain additional financing, if necessary, for working capital and operations, or such financing may not be available on favorable terms;
- make needed capital expenditures;
- make strategic acquisitions or investments or enter into joint ventures;
- react to changes or withstand a future downturn in our business, our industries or the economy in general;
- meet budget targets and forecasts of future results;
- engage in business activities, including future opportunities that may be in our interest; and
- react to competitive pressures or compete with competitors with less debt.

These limitations could adversely affect our operating performance, growth, profitability, and financial condition, which would make it more difficult for us to generate cash flow sufficient to satisfy our obligations under our indebtedness.

Our ability to make scheduled payments on our debt obligations also depends on our financial condition, results of operations, and capital resources, which are subject to, among other things: the business, financial, economic, industry, competitive, regulatory, and other factors discussed in these risk factors, and on other factors, some of which are beyond our control, including: the level of capital expenditures we make, including those for acquisitions, if any; our debt service requirements; fluctuations in our working capital needs; our ability to borrow funds and access capital markets; and restrictions on debt service payments and our ability to make working capital borrowings for debt service payments contained in our debt instruments.

If we are unable to generate sufficient cash flow to permit us to make scheduled service payments on our debt, then we will be in default and holders of that debt and potentially certain of our other debt could declare all outstanding principal and interest to be due and payable. If our existing indebtedness were to be accelerated, there can be no assurance that we would have, or be able to obtain, sufficient funds to repay such indebtedness in full. In addition, upon the occurrence and continuance of an event of a default, the lenders under the Revolving Credit Facility could terminate their further commitments to loan money and our secured lenders under the First Lien Facilities could foreclose against the assets securing their borrowings, and we could be forced into bankruptcy or liquidation.

***Despite our high level of indebtedness, we may still be able to incur substantially more debt, which could further increase the risks to our financial condition described above.***

Despite our high level of indebtedness, we may be able to incur significant additional indebtedness in the future, including off-balance sheet financings, trade credit, contractual obligations, and general and commercial liabilities. Although the credit agreements governing the First Lien Facilities contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness, and additionally we have further borrowing capacity under the Revolving Credit Facility. As of December 31, 2024, we had $63.3 million outstanding under the Revolving Credit Facility, with an available borrowing capacity under the Revolving Credit Facility of approximately $411.7 million, and $61.8 million of letters of credit outstanding under the LC Facility.

We may be able to increase the commitments under the Revolving Credit Facility, subject to certain conditions, which would be secured indebtedness. We may also be able to increase the capacity under the First Lien Term Loan Facility, subject to certain

conditions, which would be secured indebtedness. The addition of new debt to our current debt levels could further exacerbate the related risks to our financial condition that we now face.

***If we are unable to generate sufficient cash to service all of our indebtedness, we may be forced to take other actions to fund the satisfaction of our obligations under our indebtedness, which may not be successful.***

If our cash flow is insufficient to fund our debt service obligations, we could face substantial liquidity problems and could be forced to reduce or delay investments and capital expenditures or to dispose of material assets or operations, raise additional debt or equity capital or restructure or refinance our indebtedness. However, we may not be able to implement any such alternative measures on commercially reasonable terms or at all and, even if successful, those alternative actions may not allow us to meet our scheduled debt service obligations. Even if new financing were available, it may be on terms that are less attractive to us than our then existing indebtedness or it may not be on terms that are acceptable to us. In addition, the credit agreements governing the First Lien Facilities restrict our ability to dispose of assets and use the proceeds from those dispositions and may also restrict our ability to raise debt or equity capital to be used to repay other indebtedness when it becomes due. Thus, we may not be able to consummate those dispositions or to obtain proceeds in an amount sufficient to meet any debt service obligations then due.

If we cannot generate sufficient cash flow to permit us to make scheduled payments on our debt, then we will be in default and holders of that debt could declare all outstanding principal and interest to be due and payable. If our existing indebtedness were to be accelerated, there can be no assurance that we would have, or be able to obtain, sufficient funds to repay such indebtedness in full. In addition, in the event of a default, the lenders under the Revolving Credit Facility could terminate their further commitments to loan money and our secured lenders under the First Lien Facilities and the Second Lien Facility could foreclose against the assets securing their borrowings and we could be forced into bankruptcy or liquidation.

***The terms of our outstanding indebtedness may restrict our current and future operations, particularly our ability to respond to changes or to take certain actions.***

The credit agreements governing the First Lien Facilities contain restrictive covenants that impose significant operating and financial restrictions on us and may limit our ability to engage in acts that may be in our best interest, including restrictions on our ability to:

- incur additional indebtedness and guarantee indebtedness;
- pay dividends or make other distributions in respect of, or repurchase or redeem, capital stock;
- prepay, redeem, or repurchase certain debt;
- make loans, investments, and other restricted payments;
- sell or otherwise dispose of assets;
- incur liens;
- enter into transactions with affiliates;
- alter the businesses we conduct;
- enter into agreements restricting our subsidiaries' ability to pay dividends; and
- consolidate, merge, or sell all or substantially all of our assets.

Additionally, at certain times, the Revolving Credit Facility requires maintenance of a certain minimum fixed charge coverage ratio. Our ability to comply with the covenants and restrictions contained in our credit agreements may be affected by events beyond our control. If market or other economic conditions deteriorate, our ability to comply with these covenants and restrictions may be impaired.

A breach of the covenants under one of these agreements could result in an event of default under the applicable indebtedness, which, if not cured or waived, could have a material adverse effect on our business, results of operations, and financial condition. Such a default, if not cured or waived, may allow the creditors to accelerate the related debt principal and/or related interest payments and may result in the acceleration of any other debt to which a cross-acceleration or cross-default provision applies. If our existing indebtedness were to be accelerated, there can be no assurance that we would have, or be able to obtain, sufficient funds to repay such indebtedness in full. In addition, an event of default under the credit agreements governing the First Lien Facilities would permit the lenders under our Revolving Credit Facility to terminate all commitments to extend further credit under that facility. Furthermore, if

we were unable to repay the amounts due and payable under the First Lien Facilities, those lenders could proceed against the collateral granted to them to secure that indebtedness, and we could be forced into bankruptcy or liquidation.

***Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly. In addition, the phase-out of LIBOR and transition to SOFR as a benchmark interest rate will have uncertain and possibly adverse effects.***

Borrowings under the First Lien Facilities are at variable rates of interest and expose us to interest rate risk. As of December 31, 2024, while $2.0 billion notional amount of our outstanding debt was fixed through interest swap agreements, the other $0.7 billion of our outstanding debt remained subject to variable rates of interest and the related risk. If interest rates increase, our debt service obligations on the variable rate indebtedness will increase even though the amount borrowed will remain the same, and our net income and operating cash flows, including cash available for servicing our indebtedness, will correspondingly decrease.

The U.S. Federal Reserve Board significantly increased the federal funds rate in 2022 and 2023 and although it slightly reduced the federal funds rate in 2024, may make further rate increases to combat inflation in the United States, which increased the borrowing costs on our variable rate debt and may increase the cost of any new debt we incur. Any further additional federal fund rate increases could in turn make our financing activities, including those related to our acquisition activity, more costly and limit our ability to refinance existing debt when it matures or pay higher interest rates upon refinancing and increase interest expense on refinanced indebtedness.

On June 30, 2023, we entered into amendments to our First Lien Facilities, and as part of those amendments we transitioned from the use of London Interbank Offered Rate, or LIBOR, to Secured Overnight Financing Rate, or SOFR.

***If the financial institutions that are lenders under the Revolving Credit Facility fail to extend credit under the facility or reduce the borrowing base, our liquidity and results of operations may be adversely affected.***

One of our sources of liquidity is the Revolving Credit Facility. Each financial institution that is a lender under the Revolving Credit Facility is responsible on a several but not joint basis for providing a portion of the loans to be made under the facility. If any participant or group of participants with a significant portion of the commitments under the Revolving Credit Facility fails to satisfy its or their respective obligations to extend credit under the facility and we are unable to find a replacement for such participant or participants on a timely basis (if at all), our liquidity may be adversely affected.

In addition, the lenders under the Revolving Credit Facility may reduce the borrowing base under the facility in certain circumstances, which could adversely impact our liquidity and results of operations.

***Our high level of indebtedness may hinder our ability to negotiate favorable terms with our suppliers, which could negatively impact our operating performance and, thus, could make it more difficult for us to generate cash flow sufficient to satisfy all of our obligations under our indebtedness.***

Our high level of indebtedness may adversely affect our credit profile or rating, which may adversely affect our ability to negotiate favorable trade terms from our current or future suppliers, including pricing, payment, delivery, inventory, transportation, defective and marketing allowances, and other terms, and may increase our need to support merchandise purchases with letters of credit. We may also be unable to negotiate favorable trade terms for our current or future service and non-merchandise vendors, including vendors that assist us in critical aspects of the business such as transportation and logistics, supplies, professional services, insurance and risk management, procurement, marketing and advertising, online operations, and information technology. This could negatively impact the profitability of our business and our ability to effectively compete against competitors. Thus, our high level of indebtedness could adversely affect the profitability of our business, which could make it more difficult for us to generate cash flow sufficient to satisfy our obligations under our indebtedness.

**General Risk Factors**

***We are a "controlled company" within the meaning of the rules of Nasdaq and the rules of the SEC and, as a result, qualify for, and rely on, exemptions from certain corporate governance requirements. You do not have the same protections afforded to stockholders of other companies that are subject to such requirements.***

KKR Stockholder beneficially owns approximately 54.2% of the voting power of common stock. As a result, we are a "controlled company" within the meaning of the corporate governance standards of Nasdaq. Under these rules, a company of which more than 50% of the voting power is held by an individual, group or another company is a "controlled company" and may elect not to comply with certain corporate governance requirements, including the requirement that:

- a majority of our board of directors consist of "independent directors" as defined under the rules of Nasdaq;
- our director nominees be selected, or recommended for our board of directors' selection, by a nominating/governance committee comprised solely of independent directors; and
- the compensation of our executive officers be determined, or recommended to our board of directors for determination, by a compensation committee comprised solely of independent directors.

We currently utilize these exemptions. Accordingly, you do not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance requirements of Nasdaq. These exemptions do not modify the independence requirements for our audit committee, and we satisfy the member independence requirement for the audit committee.

***We incur additional costs associated with the requirements as a result of being a public company, and our management is required to devote substantial time to compliance adding complexity to running our business.***

As a public company, we incur significant legal, regulatory, finance, accounting, investor relations, insurance, and other expenses that we did not incur as a private company, including costs associated with public company governance and reporting requirements and costs of recruiting and retaining non-executive directors. We also incur costs associated with the Sarbanes-Oxley Act, and the Dodd-Frank Wall Street Reform and Consumer Protection Act, or the Dodd-Frank Act, and related rules implemented by the SEC and costs in connection with continued listing on Nasdaq. The expenses incurred by public companies generally for reporting and corporate governance purposes have been increasing. Our efforts to comply with these rules and regulations increase our legal and financial compliance costs and to make some activities more time-consuming and costly. Our management devotes a substantial amount of time to ensure that we comply with all of these requirements, diverting the attention of management away from revenue-producing activities. These laws and regulations also could make it more difficult or costly for us to obtain certain types of insurance, including director and officer liability insurance, and we may be forced to accept reduced policy limits and coverage or incur substantially higher costs to obtain the same or similar coverage. These laws and regulations could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees or as our executive officers. Furthermore, if we are unable to satisfy our obligations as a public company, we could be subject to delisting of our common stock and the Units, fines, sanctions and other regulatory action, and potentially civil litigation.

***Failure to comply with requirements to design, implement, and maintain effective internal controls could have a material adverse effect on our business and stock price.***

As a public company, we are subject to significant requirements for enhanced financial reporting and internal controls. We have made, and will continue to make, changes to our internal controls and procedures for financial reporting and accounting systems to meet our reporting obligations as a public company. The process of designing and implementing effective internal controls is a continuous effort that requires us to anticipate and react to changes in our business and the economic and regulatory environment, and to expend significant resources to maintain a system of internal controls that is adequate to satisfy our reporting obligations as a public company. The measures we take may not be sufficient to satisfy our obligations as a public company and if we are unable to establish or maintain appropriate internal financial reporting controls and procedures, it could cause us to fail to meet our reporting obligations on a timely basis, result in material misstatements in our consolidated financial statements, and harm our results of operations. In addition, we are required, pursuant to Section 404(a) of the Sarbanes-Oxley Act, or Section 404 to furnish a report by management on, among other things, the effectiveness of our internal control over financial reporting. This assessment will need to include disclosure of any material weaknesses identified by our management in our internal control over financial reporting. The rules governing the standards that must be met for our management to assess our internal control over financial reporting are complex and require

significant documentation, testing, and possible remediation. Testing and maintaining internal controls may divert our management's attention from other matters that are important to our business.

In connection with the implementation of the necessary procedures and practices related to internal control over financial reporting, we may identify deficiencies that we may not be able to remediate in time to meet the deadline imposed by the Sarbanes-Oxley Act for compliance with the requirements of Section 404. In addition, we may encounter problems or delays in completing the remediation of any deficiencies identified by us or our independent registered public accounting firm in connection with the issuance of their attestation report.

Our testing, or the subsequent testing (if required) by our independent registered public accounting firm, may reveal deficiencies in our internal control over financial reporting that are deemed to be material weaknesses. Any material weaknesses could result in a material misstatement of our annual or quarterly consolidated financial statements or disclosures that may not be prevented or detected. If we are unable to successfully remediate any future material weaknesses in our internal control over financial reporting, or if we identify any material weaknesses, the accuracy and timing of our financial reporting may be adversely affected, we may be unable to maintain compliance with securities law requirements regarding timely filing of periodic reports in addition to Nasdaq listing requirements.

We may not be able to conclude on an ongoing basis that we have effective internal control over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not issue an unqualified opinion. If either we are unable to conclude that we have effective internal control over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified report, investors could lose confidence in our reported financial information, which could have a material adverse effect on the trading price of our common stock.

***You may be diluted by the future issuance of additional common stock in connection with our incentive plans, acquisitions or otherwise.***

We have approximately 1.3 billion shares of common stock authorized but unissued. Our second amended and restated certificate of incorporation authorizes us to issue these shares of common stock, options, and other equity awards relating to common stock for the consideration and on the terms and conditions established by our board of directors in its sole discretion, whether in connection with acquisitions or otherwise. Issuances of common stock or voting preferred stock would reduce your influence over matters on which our stockholders vote, and, in the case of issuances of preferred stock, would likely result in your interest in us being subject to the prior rights of holders of that preferred stock, if any.

We have 7,968,779 Units outstanding, and each purchase contract that is a component of a Unit will settle automatically on the mandatory settlement date into between 3.2733 and 3.8461 shares of our common stock, subject to certain anti-dilution adjustments, which may result in dilution to investors.

We have reserved, or will reserve in the future, shares for issuance under our 2024 Incentive Plan. Any common stock that we issue, including under our 2024 Incentive Plan, including the issuance of the New Equity Awards, or other equity incentive plans that we may adopt in the future, would dilute the percentage ownership held by our then-current investors. In the future, we may also issue our securities in connection with investments or acquisitions. The number of shares of our common stock issued in connection with an investment or acquisition could constitute a material portion of our then-outstanding shares of our common stock. Any issuance of additional securities in connection with investments or acquisitions may result in additional dilution to investors.

***The Units may adversely affect the market price of our common stock.***

The market price of our common stock is likely to be influenced by the Units. For example, the market price of our common stock could become more volatile and could be depressed by:

- investors' anticipation of the potential resale in the market of a substantial number of additional shares of our common stock received upon settlement of the purchase contracts that are a component of the Units;
- possible sales of our common stock by investors who view the Units as a more attractive means of equity participation in us than owning shares of our common stock; and
- hedging or arbitrage trading activity that may develop involving the Units and our common stock.

***Our ability to raise capital in the future may be limited.***

Our business and operations may consume resources faster than we anticipate. In the future, we may need to raise additional funds through the issuance of new equity securities, debt, or a combination of both. Additional financing may not be available on favorable terms or at all. If adequate funds are not available on acceptable terms, we may be unable to fund our capital requirements. If we issue new debt securities, the debt holders would have rights senior to holders of our common stock to make claims on our assets and the terms of any debt could restrict our operations, including our ability to pay dividends on our common stock. If we issue additional equity securities or securities convertible into equity securities, existing stockholders will experience dilution and the new equity securities could have rights senior to those of our common stock. Because our decision to issue securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing, or nature of our future offerings. Thus, you bear the risk of our future securities offerings reducing the market price of our common stock and diluting their interest.

***Because we have no current plans to pay cash dividends on our common stock, you may not receive any return on investment unless you sell your common stock for a price greater than that which you paid for it.***

We have no current plans to pay cash dividends on our common stock. The declaration, amount and payment of any future dividends will be at the sole discretion of our board of directors, and will depend on, among other things, general and economic conditions, our results of operations and financial condition, our available cash and current and anticipated cash needs, capital requirements, contractual, legal, tax, and regulatory restrictions, and implications on the payment of dividends by us to our stockholders or by our subsidiaries to us, including restrictions under our credit agreements and other indebtedness we may incur, and such other factors as our board of directors may deem relevant. As a result, you may not receive any return on an investment in our common stock unless you sell our common stock for a price greater than your purchase price.

***BrightSpring Health Services, Inc. depends on its subsidiaries for cash to fund its operations and expenses, including future dividend payments, if any, and to meet its debt obligations.***

Our operations are conducted through our subsidiaries and our ability to generate cash to meet our debt service obligations (including the amortizing notes that are components of the Units) or to make future dividend payments, if any, is highly dependent on the earnings of, and the receipt of funds from, our subsidiaries via dividends or intercompany loans. We do not currently expect to declare or pay dividends on our common stock for the foreseeable future; however, to the extent that we determine in the future to pay dividends on our common stock, the agreements governing our indebtedness may restrict the ability of our subsidiaries to pay dividends or otherwise transfer assets to us. In addition, Delaware law may impose requirements that may restrict our ability to pay dividends to holders of our common stock.

***Future sales or issuances, or the perception of future sales or issuances, by us or our existing stockholders, or the settlement of the purchase contracts, could cause the market price for our common stock to decline.***

The sale or issuance of substantial amounts of shares of our common stock or other securities convertible or exchangeable into shares of our common stock in the public market, or the settlement of the purchase contracts that are a component of the Units, or the perception that such sales or issuances could occur, including sales by our existing stockholders, could harm the prevailing market price of shares of our common stock. These sales or issuances, or the possibility that these sales or issuances may occur, also might make it more difficult for us to sell equity securities in the future at a time and at a price that we deem appropriate.

***Anti-takeover provisions in our organizational documents could delay or prevent a change of control.***

Certain provisions of our second amended and restated certificate of incorporation and amended and restated bylaws may have an anti-takeover effect and may delay, defer or prevent a merger, acquisition, tender offer, takeover attempt, or other change of control transaction that a stockholder might consider in its best interest, including those attempts that might result in a premium over the market price for the shares held by our stockholders.

These provisions provide for, among other things:

- a classified board of directors, as a result of which our board of directors is divided into three classes, with each class serving for staggered three-year terms;

- the ability of our board of directors to issue one or more series of preferred stock;
- advance notice requirements for nominations of directors by stockholders and for stockholders to include matters to be considered at our annual meetings;
- certain limitations on convening special stockholder meetings;
- the removal of directors only for cause and only upon the affirmative vote of the holders of at least 66 2/3% of the shares of common stock entitled to vote generally in the election of directors if KKR Stockholder, Walgreen Stockholder and their respective affiliates cease to beneficially own, in the aggregate, at least 40% of shares of common stock entitled to vote generally in the election of directors; and
- that certain provisions may be amended only by the affirmative vote of at least 66 2/3% of shares of common stock entitled to vote generally in the election of directors if KKR Stockholder, Walgreen Stockholder and their respective affiliates cease to beneficially own, in the aggregate, at least 40% of shares of common stock entitled to vote generally in the election of directors.

These anti-takeover provisions could make it more difficult for a third party to acquire us, even if the third party's offer may be considered beneficial by many of our stockholders. These provisions also may have the effect of preventing changes in our board of directors and may make it more difficult to accomplish transactions that stockholders may otherwise deem to be in their best interests. As a result, our stockholders may be limited in their ability to obtain a premium for their shares.

***Our second amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware (or if such court does not have jurisdiction, another state or the federal courts (as appropriate) located within the State of Delaware) will be the exclusive forum for substantially all disputes between us and our stockholders and the federal district courts will be the exclusive forum for Securities Act and Exchange Act claims, which could limit our stockholders' ability to bring a suit in a different judicial forum than they may otherwise choose for disputes with us or our directors, officers, team members or stockholders.***

Our second amended and restated certificate of incorporation provides that unless we consent to the selection of an alternative forum, the Court of Chancery of the State of Delaware (or if such court does not have jurisdiction, another state or the federal courts (as appropriate) located within the State of Delaware) will, to the fullest extent permitted by law, be the sole and exclusive forum for any (i) derivative action or proceeding brought on behalf of our Company, (ii) action asserting a claim of breach of a fiduciary duty owed by any current or former director, officer, or other employee or stockholder of our Company to the Company or our stockholders, creditors, or other constituents, (iii) action asserting a claim against the Company or any current or former director or officer of the Company arising pursuant to any provision of the Delaware General Corporation Law, or the DGCL, or our second amended and restated certificate of incorporation or our amended and restated bylaws or as to which the DGCL confers jurisdiction on the Court of Chancery of the State of Delaware, or (iv) action asserting a claim governed by the internal affairs doctrine. Our second amended and restated certificate of incorporation also provides that, unless we consent in writing to the selection of an alternative forum, to the fullest extent permitted by law, the U.S. federal district courts will be the exclusive forum for the resolution of any complaint asserting a cause of action arising under the federal securities laws of the United States, including any claims under the Securities Act and the Securities Exchange Act of 1934, as amended, or the Exchange Act. However, Section 22 of the Securities Act creates concurrent jurisdiction for federal and state courts over all suits brought to enforce a duty or liability created by the Securities Act or the rules and regulations thereunder and accordingly, we cannot be certain that a court would enforce such provision.

***If tax laws change or we experience adverse outcomes resulting from examination of our tax returns or disagreements with taxing authorities, it could adversely affect our business, financial condition, and results of operations.***

We are subject to federal, state, and local tax laws and regulations in the United States. The application and interpretation of these laws in different jurisdictions affect our operations in complex ways and are subject to change, and some changes may be retroactively applied. Our future effective tax rates and the value of our deferred tax assets could be adversely affected by changes in tax laws, including impacts of the Tax Cuts and Jobs Act of Public Law No. 115-97, or the TCJA, and the Coronavirus Aid, Relief and Economic Security Act, or the CARES Act. In addition, in August 2022, the IRA was signed into law. The IRA, among other things, includes a new 15% corporate minimum tax as well as a 1% excise tax on corporate stock repurchases, subject to certain exceptions. The United States is also actively considering changes to existing U.S. tax laws that, if enacted, could increase our tax obligations or require us to change the manner in which we operate our business.

In addition, we are subject to the examination of our income and other tax returns by the Internal Revenue Service and other tax authorities. We regularly assess the likelihood of adverse outcomes resulting from such examinations to determine the adequacy of our

provision for income taxes. Although we believe we have made appropriate provisions for taxes in the jurisdictions in which we operate, changes in the tax laws, or challenges from tax authorities under existing tax laws could adversely affect our business, financial condition, and results of operations.

**Item 1B. Unresolved Staff Comments.**

None.

**Item 1C. Cybersecurity.**

*Risk Management and Strategy*

We recognize the importance of identifying, assessing, and managing material risks associated with cybersecurity threats, which include, among other things, operational risks, intellectual property theft, fraud, extortion, harm to employees or patients, and violation of data privacy or security laws. We incorporate cybersecurity practices into our Enterprise Risk Management (ERM) approach, which is subject to oversight by our Board of Directors. Our cybersecurity policies and practices are aligned with relevant industry standards and are designed to detect, prevent, contain, and respond to cybersecurity threats and incidents in a prompt and effective manner.

Our cybersecurity risk management program is informed by prevailing security standards and is designed to provide a framework for evaluating and responding to cybersecurity risks. Key aspects of this risk management program include, but are not limited to:

- Identifying the source of a cybersecurity threat;
- Assessing the severity of a cybersecurity threat;
- Implementing cybersecurity countermeasures and mitigation strategies;
- Providing our employees with regular training on cybersecurity and the protection of our information systems;
- Maintaining and testing a business continuity and disaster recovery program;
- Maintaining insurance coverage intended to address cybersecurity and data breach risks; and
- Informing and updating management and, as needed, the Audit Committee and our Board of Directors of cybersecurity incidents that may pose a significant risk for the business.

Security events and data incidents are evaluated, ranked by severity, and prioritized for response and remediation. Incidents are evaluated to determine materiality, as well as operational and business impact, and reviewed for privacy impact.

We deploy technical safeguards that are designed to protect our information systems, products, operations and sensitive information from cybersecurity threats. These include firewalls, intrusion prevention and detection systems, disaster recovery capabilities, malware and ransomware prevention, access controls, and data protection. We provide periodic training for all personnel regarding cybersecurity threats, with such training appropriate to the roles, responsibilities and access of the relevant Company personnel. Our policies require all workers to report any real or suspected cybersecurity events.

Recognizing the complexity and evolving nature of cybersecurity threats, incidents and risks, we engage third-party experts, including cybersecurity consultants, to evaluate and support our risk management systems. We also rely on software support from third-party vendors to assist with evaluating, monitoring, and testing our information technology systems. These relationships enable us to leverage specialized knowledge and insights, to help ensure our cybersecurity strategies and processes remain effective. Our collaboration with these third parties includes regular audits, routine system monitoring, threat assessments, and consultation on potential security enhancements. We require third-party service providers with access to personal, confidential, or proprietary information to implement and maintain comprehensive cybersecurity practices consistent with applicable legal standards and industry best practices.

As of the date of this Annual Report on Form 10-K, we are not aware of any cybersecurity incidents that have materially affected or are reasonably likely to materially affect the Company, including our business strategy, results of operations, or financial condition. For further discussion of the risks associated with cybersecurity incidents, as well as a description of an event that occurred in March 2023, see “Risk Factors—Risks Related to Our Business—Security breaches, loss of data, and other disruptions could compromise sensitive business or patient information, cause a loss of confidential patient data, employee data, personal information,

or prevent access to critical information, and expose us to liability, litigation, and federal and state governmental inquiries and damage our reputation and brand."

*Governance*

Our Board of Directors has overall oversight responsibility for our risk management, and delegates information security and related risk management oversight to the Audit Committee. The Audit Committee receives regular briefings on cybersecurity risks and risk management practices, including, for example, recent developments in the external cybersecurity threat landscape, evolving standards, vulnerability assessments, third-party and independent reviews, technological trends, as well as how management is addressing or mitigating those risks. The Audit Committee may also promptly receive information regarding any material cybersecurity incident that may occur, including any ongoing updates regarding the same. The Audit Committee periodically discusses our approach to cybersecurity risk management with our Chief Information Officer (CIO).

Our CIO is a member of our executive management team who is principally responsible for overseeing our cybersecurity risk management program, in partnership with other business leaders across the Company. Our CIO has over twenty-five years of extensive experience in information technology and security, and works in coordination with other members of the management team, including, among others, the Chief Financial Officer and Chief Compliance Officer and their designees. We believe our business leaders have the appropriate expertise, background, and depth of experience to manage risks arising from cybersecurity threats.

Our CIO, along with leaders from our privacy and corporate compliance functions, collaborate to implement a program designed to manage our exposure to cybersecurity risks and to promptly respond to cybersecurity incidents. Prompt response to incidents is delivered by multi-disciplinary teams in accordance with our incident response plan. Through ongoing communications with these teams during incidents, the CIO monitors the triage, mitigation and remediation of cybersecurity incidents, and reports such incidents to executive management, the Audit Committee and other colleagues in accordance with our cybersecurity policies and procedures, as is appropriate.

**Item 2. Properties.**

Our principal executive offices are located in Louisville, Kentucky, where we lease approximately 100,000 square feet. We also own 67 properties and lease 2,098 properties, with an additional 231 service sites, in the United States and lease one property in Canada. Of the leased properties, approximately 90% are provider service properties and 10% are pharmacy locations. We consider these facilities to be suitable and adequate for the management and operations of our business.

**Item 3. Legal Proceedings.**

**Legal Proceedings**

From time to time, we are involved in various legal and/or administrative proceedings and subject to claims that arise in the ordinary course of business. We do not believe the ultimate liability, if any, for outstanding proceedings or claims, individually or in the aggregate, in excess of amounts already provided in our consolidated financial statements, will have a material adverse effect on our business, financial condition or results of operations. It is reasonably possible that an adverse determination might have an impact on a particular period. Regardless of the outcome, litigation has the potential to have an adverse impact on us because of defense and settlement costs, diversion of management resources, and other factors.

On March 4, 2011, Relator Marc Silver, on behalf of the U.S. Government and various state governments, filed a complaint in the United States District Court for the District of New Jersey, or the District Court, against PharMerica, seeking relief, with respect to alleged violations of the federal False Claims Act and state false claims acts, including three times the amount of damages to the federal government plus civil penalties and no less than a certain amount for each alleged false claim, as well as any other recoveries or relief provided for by the federal False Claims Act; damages, fines, penalties, and other recoveries or relief permitted under state false claims acts; and other forms of relief, including attorneys' fees. The complaint alleged that, in violation of the Anti-Kickback Statute and the False Claims Act, PharMerica offered below-cost or below-fair-market-value prices on drugs in exchange for so-called preferred or exclusive provider status that would allow PharMerica to dispense drugs to patients for which PharMerica could bill federal healthcare program payers. The U.S. Government and state governments declined to intervene in the case.

The District Court issued an order dismissing the case in full in 2016. In 2018, however, the Third Circuit Court of Appeals issued an order reinstating the case. In April 2023, the District Court issued an order denying Relator's motion seeking to strike portions of the opinions of PharMerica's experts and granted in part PharMerica's motions to exclude Relator's experts. On June 28, 2023, the District Court issued an order setting a trial date of December 4, 2023. On November 6, 2023, the District Court denied our motion for summary judgment. On November 18, 2023, we agreed to settle the matter without admitting liability. On May 29, 2024, the parties entered into a final settlement agreement, which was approved by both the United States Department of Justice and the District Court. The total financial impact of the settlement is $120.0 million; $110.0 million of which was paid during the year ended

December 31, 2024, with the remaining $10.0 million in accrued expenses in the consolidated balance sheet as of December 31, 2024. As of December 31, 2023, the estimated financial impact of the settlement was $115.0 million, $105.0 million of which was included in accrued expenses and $10.0 million in long-term liabilities in the consolidated balance sheet. The District Court entered an order dismissing the Silver action in its entirety, with prejudice, on July 3, 2024.

The Company is also party to various legal and/or administrative proceedings arising out of the operation of our programs and arising in the ordinary course of business. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. We do not believe the ultimate liability, if any, for outstanding proceedings or claims, individually or in the aggregate, in excess of amounts already provided, will have a material adverse effect on our consolidated financial condition, results of operations, or cash flows. It is reasonably possible that an adverse determination might have an impact on a particular period. While we believe our provision for legal contingencies is adequate, the outcome of legal proceedings is difficult to predict, and we may settle legal claims or be subject to judgments for amounts that exceed our estimates.

**Item 4. Mine Safety Disclosures.**

Not applicable.

## PART II

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

***Market Information***

BrightSpring's common stock and 6.75% Tangible Equity Units began trading on the Nasdaq Global Select Market, (Nasdaq), under the ticker symbol "BTSG" and "BTSGU", respectively, on January 26, 2024. Prior to that date, there was no public market for our common stock or 6.75% Tangible Equity Units.

***Stockholders***

As of March 3, 2025, there were approximately 56 holders of our common stock. The actual number of stockholders of common stock is greater than this number of record holders and includes stockholders who are beneficial owners but whose shares are held in street name by brokers and other nominees. This number of holders of record also does not include stockholders whose shares may be held in trust by other entities.

***Dividends***

We have no current plans to pay cash dividends on our common stock. The declaration, amount and payment of any future dividends will be at the sole discretion of our board of directors, and will depend on, among other things, general and economic conditions, our results of operations and financial condition, our available cash and current and anticipated cash needs, capital requirements, contractual, legal, tax and regulatory restrictions and implications on the payment of dividends by us to our stockholders or by our subsidiaries to us, including restrictions under our credit agreements, our indenture governing the Notes and other indebtedness we may incur, and such other factors as our board of directors may deem relevant.

***Recent Sales of Unregistered Securities***

Except as set forth below, there were no sales of equity securities during the period covered by this Report that were not registered under the Securities Act and were not previously reported in a Quarterly Report on Form 10-Q or a Current Report on Form 8-K filed by the Company.

On April 30, 2024, we issued 99,252 shares of common stock at $10.89 per share to Rodney A. Thomason Revocable Trust shareholders (the "Trust") as partial consideration for our acquisition of certain assets and equity interests from the Trust, ICP Holdings, LLC and ICP Management, LLC (together with ICP Holdings, LLC, the "Sellers") pursuant to an Asset Purchase Agreement by and among the Company, the Trust, and the Sellers (the "ICP Purchase Agreement"). We also issued 30,533 shares of common stock at $10.89 per share to the Trust to be held by the Company subject to a one year lock-up post-closing adjustment feature based on stock price performance. This post-closing adjustment resulted in the number of holdback shares being reduced to zero and cancelled. We issued these shares of common stock pursuant to the exemption from registration provided by Section 4(a)(2) of the Securities Act of 1933, as amended (the "Act"), in that such issuance did not constitute a public offering.

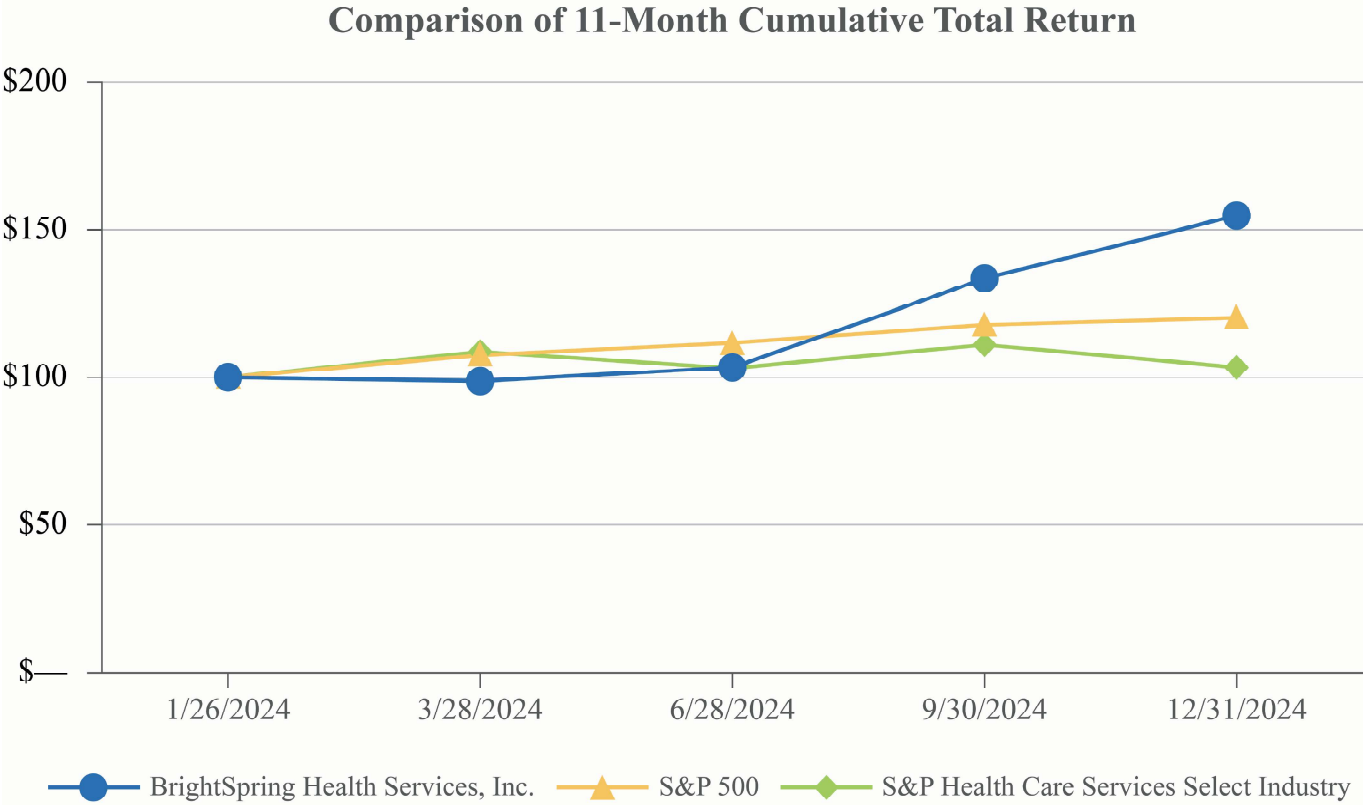
***Issuer Purchases of Equity Securities***

None.

***Stock Performance Graph***

The following performance graph compares the cumulative total return to shareholders on our common stock relative to the cumulative total returns of the S&P 500 Index and S&P 500 Health Care Services Select Industry Index, the Dow Jones US Industrial

Average Index and the S&P 500 Index for the period beginning with our IPO and ended December 31, 2024. The comparisons assume the investment of $100 on January 26, 2024 in our common stock and in each index, and the reinvestment of dividends when paid.




| | 1/26/2024 | 3/28/2024 | 6/28/2024 | 9/30/2024 | 12/31/2024 |
|---|---|---|---|---|---|
| BrightSpring Health Services, Inc. | $ 100.00 | $ 98.82 | $ 103.27 | $ 133.45 | $ 154.82 |
| S&P 500 Index | $ 100.00 | $ 107.43 | $ 111.64 | $ 117.82 | $ 120.25 |
| S&P 500 Health Care Services Select Industry Index | $ 100.00 | $ 108.58 | $ 103.05 | $ 110.98 | $ 103.33 |

The stock performance graph above shall not be deemed to be "soliciting material" or to be "filed" with the U.S. Securities and Exchange Commission or subject to the liabilities of Section 18 under the Securities Exchange Act of 1934, as amended (the "Exchange Act"). In addition, it shall not be deemed incorporated by reference by any statement that incorporates this Annual Report on Form 10-K by reference into any filing under the Securities Act of 1933 (the "Securities Act") or the Exchange Act, except to the extent that we specifically incorporate this information by reference.

**Item 6. [Reserved]**

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

*The following discussion analyzes our financial condition and results of operations and should be read in conjunction with our consolidated financial statements and related notes included elsewhere in this Annual Report Form 10-K. This discussion contains forward-looking statements that involve risks and uncertainties. See "Forward-Looking Statements." When reviewing the discussion below, you should keep in mind the substantial risks and uncertainties that characterize our business. Known material factors that could affect our financial performance and actual results, and could cause actual results to differ materially from those expressed or implied in any forward-looking statements included in this discussion or otherwise made by our management, are described in "Risk Factors." Factors that could cause or contribute to such difference are not limited to those identified in "Risk Factors."*

### Overview

We are a leading home and community-based healthcare services platform, focused on delivering complementary pharmacy and provider services to complex patients. We have a differentiated approach to care delivery, with an integrated and scaled model that addresses critical services that the highest-need and highest-cost patients require. With a focus on Senior and Specialty patients, our platform provides pharmacy and provider services (both clinical and supportive care in nature) in lower-cost home and community settings largely to Medicare, Medicaid, and commercially-insured populations. Our presence spans all 50 states, we serve over 450,000 patients daily through our approximately 11,000 clinical providers and pharmacists, and our services make a profound impact in the lives and communities of the people we serve.

We have built a significant presence and capability in delivering complementary and high-touch daily healthcare services and programs to complex patients in their homes and in communities in order to address their multiple health needs and requirements more completely, through two reportable segments: Pharmacy Solutions and Provider Services. In pharmacy, we leverage our national infrastructure to provide daily medication therapy management to various customer and patient types wherever they reside in the community, including home and in-clinic infusion patients, oncology and other specialty patients in their homes, residents of independent and senior living communities, people receiving hospice care, neuro and Behavioral clients' and patients' homes, residents of skilled nursing and rehabilitation facilities, hospital patients, and the homes of Seniors who are on a significant number of medications. Within provider services, we address the clinical and supportive care needs of Senior and Specialty populations, including neuro patients, primarily in their homes, as well as some clinic and community settings. Our clinical services consist of home health and hospice and rehab therapy, and our supportive care services address activities of daily living and social determinants of health as well. We also provide home-based primary care for patients in senior living communities, long-term care, and individual homes to directly manage and optimize patient outcomes and to enable value-based care. By providing these complementary and necessary services for complex patients, our care model is designed to address multiple patient needs and better integrate health services delivery to improve quality and patient experiences, while reducing overall costs.

### 2024 Key Highlights

- *Completion of our Initial Public Offering (*"IPO") *on January 30, 2024*
- *Extinguishment of our Second Lien Facility*
- *Paydown and modification of our First Lien Facility, including interest rate refinancings that resulted in interest savings*
- *$63.3 million of equity awards granted to management and certain other full-time employees at the time of our IPO*
- *7.7 million restricted stock units granted to certain full-time employees in the second fiscal quarter of 2024, as disclosed in connection with our IPO*
- *Completed eight acquisitions within our Pharmacy Solutions and Provider Services segments*

*Announcement of the pending divestiture of our Community Living business on January 20, 2025*

**Financial Performance Highlights: Fiscal Year 2024 Compared to Fiscal Year 2023**

- *Revenue grew by $2.4 billion, or 27.6%, to $11.3 billion*
- *Pharmacy Solutions segment revenue grew by $2.2 billion, or 34.2%, to $8.8 billion*
- *Provider Services segment revenue grew by $208.5 million, or 9.0%, to $2.5 billion*
- *Net loss decreased by $136.3 million from $156.8 million to $20.5 million; when excluding the approximately $30 million quality incentive payment ("QIP") received in 2023, net loss decreased by $166.5 million*
- *Adjusted EBITDA[(1)] increased by $50.3 million, or 9.3%, to $588.1 million; when excluding the approximately $30 million QIP received in 2023, Adjusted EBITDA increased by $80.5 million or 15.9%*
- *Pharmacy Solutions segment EBITDA grew by $23.7 million, or 6.4%, to $394.7 million; when excluding the approximately $30 million QIP received in 2023, Pharmacy Solutions segment EBITDA increased by $53.9 million or 15.8%*
- *Provider Services segment EBITDA grew by $53.9 million, or 17.6%, to $360.6 million*
- *Loss per share decreased by $1.22 from $(1.31) to $(0.09)*
- *Adjusted EPS [(1)] increased by $0.49 from $0.07 to $0.56*

[(1)] Reconciliation of GAAP to non-GAAP results is provided in the section "Non-GAAP Financial Measures" in Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations"

**Our Service Offerings**

We are one of the largest independent providers of home and community-based health services in the United States, delivering both pharmacy and provider services. We believe our high-quality and complementary health services offerings address significant and important patient and stakeholder needs. We enhance patient outcomes through the delivery and coordination of high-quality services that high-need, high-cost patients require. Our services are principally delivered in patient-preferred and lower-cost settings and often over longer periods of time, given the chronic nature of the patient conditions that we address. We believe our breadth of service capabilities and proven outcomes position us as a provider of choice for patients, families, referral sources, customers, and payors. We deliver services through two reportable segments: Pharmacy Solutions and Provider Services.

The following table summarizes the revenues generated by each of our reportable segments for the most recent two years:

| *($ in millions)* | For the Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2024 | | 2023 | |
| | Revenue | % of Revenue | Revenue | % of Revenue |
| Pharmacy Solutions | $ 8,754.3 | 77.7% | $ 6,522.5 | 73.9% |
| Provider Services | 2,512.2 | 22.3% | 2,303.7 | 26.1% |
| Consolidated | $ 11,266.5 | 100.0% | $ 8,826.2 | 100.0% |

***Pharmacy Solutions***

We opportunistically provide pharmacy services when and where demanded and as required to customers and patients in their homes and communities, often in coordination with our provider services. The Company filled over 41 million prescriptions in 2024 from over 180 pharmacies across all 50 states, with services delivered to approximately 7,100 customer locations, more than 60,000 individual or group homes, and over 400,000 patients, all through over 4,700 unique customer and payor contracts. Our leading pharmacy support across customer and patient settings is achieved through a focus on medication availability and reliability, cost containment, customer staff and patient support programs, clinical and regulatory education and support, and leading customer service. Infusion and Specialty Pharmacy prescriptions and Home and Community Pharmacy prescriptions have grown at more than 22% and 11%, respectively, from December 2023 to December 2024. We have a unique opportunity to increasingly provide more pharmacy services in the future to provider patients and patients transitioning across settings of care. Almost every one of the Company's patients who receive provider services from us have a significant medication support need given their polypharmacy profile, which we have the opportunity to further address.

*Infusion and Specialty Pharmacy*

We provide infused, injectable, and oral medication services in the home and clinic focused on pharmaceutical therapies that require expert administration and high-touch clinical services to patients by our pharmacists, registered nursing staff, and patient support teams. Infusion therapy services are a specialty form of pharmaceuticals that involve the intravenous administration of higher-cost, specially-handled medications that treat a wide range of acute and chronic health conditions, including, for example, infections, auto-immune illnesses, oncology, multiple sclerosis, hemophilia, and nutritional deficiencies. Oral and injectable medication therapies for complex disease management treat oncology, neurology, dermatology, cardiology, immunology, inflammatory, rare and orphan, and other conditions. Within oncology, as one of the leading independent specialty pharmacies in the United States, our services encompass clinical coordination, patient education, protocol compliance, patient assistance with insurance access and outside funding, and timely delivery of medication. Our certified oncology pharmacists are available 24/7 to provide support for patients and caregivers while working in close coordination with their physicians.

As a result of our unique capabilities in serving pharmaceutical manufacturers and biotech companies, we have exclusive or preferred relationships in specialty oncology drugs, as manufacturers select our pharmacy – exclusively or as part of a group of a few other pharmacies – to distribute and support their therapies in the market. We currently have 125 limited distribution oncology drugs in the market, with an additional 16 in the pipeline still to launch over the next 12 to 18 months.

*Home and Community Pharmacy*

Our home and community-based pharmacy solutions ensure that medications are accessible and clinically supported for patients outside of retail pharmacies. The Company's footprint of pharmacies covers all 50 states with a localized model that features "white-glove" and customized programs and allows for faster response times and a better customer and patient experience. We service customer locations typically multiple times a day and 24/7 as needed, within a radius of approximately 100 miles of a pharmacy location. Our pharmacy services are all customized to specific settings and patients among the Senior and Specialty populations served, for example whether a patient receiving our medications is in a senior living community, a behavioral group home, or a hospice patient in their own home.

***Provider Services***

We deliver a variety of impactful and valuable provider services to high-need, chronic, and complex patients in home and community settings. These services consist of clinical and supportive care to approximately 40,000 Senior and Specialty populations, with both census for Home Health Care services specifically, and rehab hours served, having grown approximately 9% and 13% from December 2023 to December 2024, respectively. While the clinical services that we provide have demonstrated attractive volume growth over the past several years, supportive care services have also demonstrated stability and growth due to the valuable nature of these services that address activities of daily living and social determinants of health. Many of our provider patients also receive their pharmacy services through the Company, which helps to optimize their pharmacy and medication care and needs, simplify their experience, and improve their satisfaction.

On January 17, 2025, the Company entered into a purchase agreement with National Mentor Holding, Inc. to divest the Company's community living services, home and community based waiver programs, and intermediate care facilities (the "Community Living business"), for $835 million, subject to typical adjustments for working capital and other customary items. The Company expects the divestiture to close in 2025, subject to customary closing conditions. This transaction provides for continuity of important intellectual and developmental disability services while BrightSpring focuses on a concentrated group of customers, patients and stakeholders in the future. We believe the Company's streamlined service offerings will result in increased strategic focus, operational efficiencies, a refined payer mix, and greater clinical integration and business synergy across the Provider Services segment. The divestiture will also augment the Company's expected Revenue and Adjusted EBITDA growth rates and maximize exposure to target growth markets that require BrightSpring's needed and valuable solutions, such as home health, rehab, primary care, and hospice. The Company expects to account for this sale as a strategic shift in fiscal year 2025. As of December 31, 2024, the Community Living business did not meet the definition of held for sale or discontinued operations. The results of operations of Community Living are consolidated in the Company's results of operations for the years ended December 31, 2023 and 2024.

*Home Health Care*

We provide patient-centric, highly skilled, and compassionate clinical care to Seniors and others in their homes. For Seniors and other patients recovering from surgery or illness or living with chronic diseases, we provide clinical home health care in the home. We also provide physical, emotional, and spiritual comfort and support primarily for Senior patients with terminal illnesses and their families through our hospice services. Like patients receiving home health care, our interdisciplinary hospice teams tailor individualized plans for patients and their families based on a comprehensive understanding of their needs. Our hospice patients require important daily pharmacy support, which we deliver through our pharmacy services. Additionally, for Seniors and others who require supportive care and activities of daily living support that address social determinants of health, including dietary and nutrition management and cognitive and social engagement, among others, we offer these daily or weekly services.

We are continuing to build out specialized and different primary care capabilities through our home-based primary care medical home model and platform, which we view as central to the future of optimizing patient management, including patient experiences, outcomes, and cost. Home-based primary care is more patient-centered and incorporates patients' specific objectives and goals by pro-actively addressing gaps in care and triaging health events in-place when possible, thus mitigating avoidable emergency room visits and hospitalizations. Home-based primary care coordinates care and resources for patients in pulling together previously disparate information and contact points into one place for more coordinated and informed patient care.

In addition to many of our provider patients also receiving their pharmacy services from the Company, our patients often receive multiple in-home provider services from the Company to improve outcomes, including home-based primary care and home health or hospice and transitions from home health to hospice. As more of our patients utilize the multiple needed services that they require and we provide, we pro-actively monitor patients and deploy triage tools through our Clinical (Nursing) Hub to address risks and optimize quality outcomes in real-time, particularly for higher risk patients. Within the Clinical (Nursing) Hub, we centralize on-call and tele-triage, perform high-risk patient monitoring and intervention, conduct "Aftercare" patient calls, and manage care coordination opportunities across the enterprise.

*Community and Rehab Care*

Our Community and Rehab Care services provide both client- and patient-centric clinical care and supportive care to Senior and Specialty clients and patients living with age-related acute or chronic conditions, living with life-long indications (including I/DD and autism), or recovering from a catastrophic neuro event (ABI/TBI or stroke) requiring intensive therapy. These services support individuals of all ages who need various forms of expert clinical care and therapy in addition to assistance with daily skill building and living. The majority of these clients and patients receive daily pharmacy support, delivered through our pharmacy business, along with ongoing behavioral therapy consults and primary care medical care, which is increasingly being delivered through our home-based primary care practice.

We provide specialized, highly-skilled, and custom-designed rehabilitation services, including physical, speech and occupational therapy and ABA, for clients and patients of all ages with a range of injuries and conditions, including brain and spinal cord injuries, stroke, pediatric neuro conditions, and autism. We also offer a variety of programs for individuals with I/DD through our community living services, including group homes, supported living and family living models (host homes), behavioral therapy, vocational therapy, and case management. Our programs are principally administered in individuals' homes and are predominantly based on individual support and clinical care plans designed to encourage greater independence and manage medical conditions, as the majority of I/DD individuals have multiple chronic conditions and require eight or more medications.

As noted earlier, the Company announced the entry into a purchase agreement in January 2025 with respect to the expected sale of our Community Living business, which is expected to close in 2025, subject to customary closing conditions, and will represent a strategic shift in fiscal year 2025.

**Locations of Operations**

We are headquartered in Louisville, Kentucky with operations in all 50 states, Puerto Rico, and Canada. We deliver a higher proportion of services in select regions with favorable demographics and regulatory environments.

We serve patients from and across approximately 11,300 offices, customer locations and group homes, as well as serving approximately 300,000 patients in their own homes, every day with co-location of our pharmacy and provider services in 40 states.

**Payor Mix**

We are characterized by payor diversification across our platform. Our payors are principally federal, state, and local governmental agencies, commercial insurance, private, and other payors. No payor represents more than 30% of our revenue in the aggregate for the years ended December 31, 2024 and 2023. Additionally, our Medicaid payors can be further broken down across each individual state with our top 10 Medicaid states representing 12% and 14% of total Company revenue for the year ended December 31, 2024 and 2023, respectively. The federal, state, and local programs under which we operate are subject to legislative and budgetary changes that can influence reimbursement rates.

| ($ in millions) | For the Years Ended December 31, | | | |
|---|---|---|---|---|
| | 2024 | | 2023 | |
| | Revenue | % of Revenue | Revenue | % of Revenue |
| Commercial insurance | $ 2,557.9 | 22.8% | $ 1,811.6 | 20.5% |
| Medicaid | 2,196.1 | 19.5% | 1,974.2 | 22.3% |
| Medicare A | 999.6 | 8.8% | 958.6 | 10.8% |
| Medicare B | 96.0 | 0.8% | 82.8 | 1.0% |
| Medicare C | 1,665.0 | 14.8% | 1,450.4 | 16.5% |
| Medicare D | 3,202.0 | 28.4% | 2,031.9 | 23.0% |
| Private & other | 549.9 | 4.9% | 516.7 | 5.9% |
| | $ 11,266.5 | 100.0% | $ 8,826.2 | 100.0% |

We provide our services across all 50 states, Puerto Rico and Canada, with our top 10 states of operations comprising 47% and 49% of total Company revenue for the years ended December 31, 2024, and 2023 respectively.

The following tables summarize the percentage of revenue generated by each payor type for each of our service offerings and reportable segments:

| | For the Year Ended December 31, 2024 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Commercial insurance | Medicaid | Medicare Part A | Medicare Part B | Medicare Part C | Medicare Part D | Private & other | Total |
| Infusion and Specialty Pharmacy | 18.4% | 5.3% | 0.0% | 0.6% | 13.7% | 19.1% | 0.8% | 57.9% |
| Home and Community Pharmacy | 2.6% | 2.1% | 4.8% | 0.0% | 0.0% | 9.3% | 1.0% | 19.8% |
| **Pharmacy Solutions** | **21.0%** | **7.4%** | **4.8%** | **0.6%** | **13.7%** | **28.4%** | **1.8%** | **77.7%** |
| Home Health Care | 0.3% | 2.5% | 4.0% | 0.2% | 1.1% | — | 1.2% | 9.3% |
| Community and Rehab Care | 1.5% | 9.6% | 0.0% | 0.0% | 0.0% | — | 1.9% | 13.0% |
| **Provider Services** | **1.8%** | **12.1%** | **4.0%** | **0.2%** | **1.1%** | — | **3.1%** | **22.3%** |
| **Consolidated BrightSpring** | **22.8%** | **19.5%** | **8.8%** | **0.8%** | **14.8%** | **28.4%** | **4.9%** | **100.0%** |

| | For the Year Ended December 31, 2023 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Commercial insurance | Medicaid | Medicare Part A | Medicare Part B | Medicare Part C | Medicare Part D | Private & other | Total |
| Infusion and Specialty Pharmacy | 17.0% | 5.0% | 0.0% | 0.7% | 15.7% | 12.6% | 1.0% | 52.0% |
| Home and Community Pharmacy | 1.8% | 2.4% | 6.2% | 0.0% | 0.0% | 10.4% | 1.1% | 21.9% |
| **Pharmacy Solutions** | **18.8%** | **7.4%** | **6.2%** | **0.7%** | **15.7%** | **23.0%** | **2.1%** | **73.9%** |
| Home Health Care | 0.4% | 3.1% | 4.6% | 0.2% | 0.7% | — | 1.4% | 10.4% |
| Community and Rehab Care | 1.3% | 11.8% | 0.0% | 0.1% | 0.1% | — | 2.4% | 15.7% |
| **Provider Services** | **1.7%** | **14.9%** | **4.6%** | **0.3%** | **0.8%** | — | **3.8%** | **26.1%** |
| **Consolidated BrightSpring** | **20.5%** | **22.3%** | **10.8%** | **1.0%** | **16.5%** | **23.0%** | **5.9%** | **100.0%** |

See Note 2 of the audited consolidated financial statements and related notes in this Form 10-K for information regarding revenue by payor type for each reportable segment for the years ended December 31, 2024 and 2023.

## Trends and Other Factors Affecting Business

### *Continued Growth of our Pharmacy Solutions Patient Populations*

We focus on providing health-dependent medications in a timely and well-supported manner to our patients receiving pharmacy solutions in their home and community-based settings. Our pharmacy services are primarily delivered directly to patients in their place of residence, home, or stay, and sometimes in a clinic setting. Our high-need Senior and Specialty patients depend on closely and expertly managed daily medication regimens that are supported by pharmacist and nurse consultants whom are available in a timely and 24/7 manner. According to industry reports, pharmacy solutions delivered to and tailored for the home environment, such as home infusion services, oncology services, and daily medication management services in the home, will continue to grow faster than the overall and general pharmacy market. Each of the end markets that these home and community-based pharmacy services supply and support are growing at attractive rates, and the lack of appropriate pharmacy medication management and resulting non-adherence among complex and polypharmacy patients in homes are significant contributors to ER visits, hospitalizations and increased costs.

We have continued to expand our pharmacy capabilities to serve this need. Overall, our pharmacy has grown patient census and prescriptions by 12% over the past year. We are a leading independent pharmacy provider in our respective pharmacy patient markets,

and we expect to continue to increase our share. Our growth in serving numerous patient types has been well into the double digits, including home infusion patients, specialty oncology patients, behavioral patients, in-home Seniors, and hospice patients.

***Continued Growth of our Provider Services Patient Populations***

Our Provider Services segment focuses on delivering high-touch and coordinated services to medically complex Senior and Specialty patients in the home and community-based settings where they live. As the baby boomer population ages, Seniors, who comprise a significant majority of our patients, will represent a higher percentage of the overall population. The U.S. Census Bureau projects that the U.S. population aged 65 and over will grow substantially from 15% of the population in 2016 to 21% of the population by 2030, and the population size of people over age 85 is expected to double by 2040, according to the Administration for Community Living. Given the proven value proposition of home-based health services, we believe patients will increasingly seek treatment and referral sources and payors will increasingly support treatment in homes more often than in higher cost, less convenient, higher acuity institutional settings. Home health care can reduce 365-day post-discharge costs by more than $6,000 per patient, and as healthcare spending rises, home health care can improve the continuity of care while reducing overall costs. In addition, advancements in medical technology have allowed providers to expand access points and the breadth of services available in the home.

The vast majority of patients we serve in our provider businesses are served in the home, and we have purposefully continued to expand our service offering and footprint to serve patients in this lower cost setting. Over the past five years we built upon supportive care services to patients, as we have meaningfully expanded our footprint of highly clinical and expert services to home health, rehabilitation, and hospice patients to address a large national healthcare need and more completely and better serve Senior and Specialty patients in the home as evidenced by continued census growth within the Provider Services segment. Our complementary services that address the multiple needs of these patient populations will increasingly provide integrated care opportunities to provide more complete and better coordinated services to patients across health settings and stages.

As noted earlier, the Company announced the entry into a purchase agreement in January 2025 with respect to the expected sale of our Community Living business, which is expected to close in 2025, subject to customary closing conditions. The sale of this business will represent a strategic shift, in fiscal year 2025, from our services to Behavioral populations. After closing, our focus will be primarily on Seniors and Specialty patients receiving neuro rehab.

***Stable Reimbursement Environment Across our Portfolio of Businesses***

Our revenue is dependent upon our contracts and relationships with payors for our "must-serve" patient populations. We partner with a large and diverse set of payor groups nationally and in each of our markets to form provider networks and to lower the overall cost of care. We structure our payor contracts to help both providers and payors achieve their objectives in a mutually aligned manner. Maintaining, supporting, and both deepening and increasing the number of these contracts and relationships, particularly as we continue to grow market share and enter new markets, is important for our long-term success.

We have observed relatively stable reimbursement rates from government and commercial payors in our pharmacy and provider services over a number of years, particularly for services provided to high-need, medically complex populations. Due to the medical necessity of our services, which are lower cost than healthcare services provided in other settings and reduce ER, hospital and institutional facility utilization, we have a history of reimbursement stability characterized by low-to-mid single digit rate increases across our lines of business from 2014 to 2022. Our average reimbursement rate increases based on revenue during this time period included 4.2% for personal care services associated with activity of daily living services for Seniors, 4.5% for Behavioral services, 2.2% for hospice services, and 1.6% associated with long term care pharmacy services.

***Culture of Quality and Compliance and Consistent Operations Execution***

Quality and compliance are central to our strategies and mission. We have demonstrated leading and excellent service and customer/patient/family satisfaction scores across the organization, as referenced in prior and other sections of this Annual Report on Form 10-K. In addition to quality and compliance resources and programs in field operations, we invest over $200 million a year in people, training, auditing, signature programs, accreditations, advocacy, and technologies to support quality, compliance, and safety as part of our "Quality First" framework. We have demonstrated consistently high and often leading marks for service levels, satisfaction scores, and quality metrics in our industries.

For example, across our pharmacies we achieve 99.99% order accuracy and 98.63% order completeness, "excellent" and "world class" NPS, a 94% satisfaction rating from infusion patients, and a reduction in hospitalizations with CCRx, while also driving savings through medication adherence and therapeutic interchanges. We achieve 97% patient satisfaction in our outpatient rehab services, and we achieve an 85% overall rating of care in hospice (compared to the national average of 81%), hospitalizations 35% lower than the national average in our home-based primary care, and four stars (out of five) in the CAHPS home health patient survey ratings. 84% of our home health branches have a STAR rating of 4 or higher. Our complex Behavioral clients, often with three or more comorbidities and requiring eight or more medications, are still able to spend 359 days a year at home on average. We believe that we

are positioned to identify potential medical problems and avoid adverse events due to our highly proximate position to patients and attentive care protocols, as evidenced by these quality metrics.

Operational excellence is also an ongoing focus at the Company, including how we collect and share key metrics, hold operational reviews, audit, conduct training, deploy expert support resources, execute on corrective and preventative actions, and implement continuous improvement initiatives across the organization. We have continued to make investments in automation, data, and technology systems to support enhanced workflows, further scale, and future growth across service lines.

***Ability to Build De Novo Locations***

We have a proven ability to augment growth of existing operations by expanding our presence and opening new locations – in both of our operating segments in Pharmacy Solutions and Provider Services – across geographies with consistent ramp-up in performance after site opening. We believe our platform can continue to build further scale nationally, adding density to additional and targeted key markets as a lever to facilitate maximum pharmacy and provider services overlap, integrated and value-based care, and growth. The Company's geographic and operations scale and platform of complementary segments and service lines provides us with access to more de novo opportunities to consider and prioritize.

Since January 1, 2018, we have opened 164 de novo offices (branches/agencies) and clinics in new locations across our pharmacy and provider services. In 2024, we opened 21 de novo offices. We typically identify and open new locations within proximity of an existing location as we leverage existing market knowledge and presence to expand in target markets, regions, and states. Our internal support resources in real estate, purchasing, IT, credentialing, payor contracting, HR, and sales and marketing, along with our PMO, help to support and manage de novos from start to opening. We expect to continue to selectively and strategically expand our footprint within the United States and extend our service offerings to our patients and for customers, referral sources, and payors, and we believe de novo investments facilitate more integrated care capability and are a meaningful organic growth driver for the Company.

***Ability to Facilitate Integrated Care***

Our operating model consists of complementary pharmacy and provider services that high-need Senior and Specialty populations require, and it is designed to increasingly coordinate, manage, and serve patients across our various needs and settings over time, leading to improved patient, family, physician, and referral source satisfaction, improved payor experiences, and better outcomes. Our performance and potential to drive increased service volume for increased patient and health outcomes impact is driven partly by our appeal with our patients, families, customers, referral sources, and payors to provide multiple integrated care services – either in the same setting at the same time or across settings and stages of health – within our collection of pharmacy solutions and provider services and differentiated overall capabilities.

We provide multiple pharmacy and provider services to approximately 20,000 patients today, and we believe that there are substantially more opportunities to deliver more integrated care, given the hundreds of thousands of patients we serve and a similar number of patients discharging from customers annually. Value-add, beneficial, and multiple integrated care opportunities exist for our customer base and all Senior and Specialty patient populations and not only across pharmacy and provider services, but also within each segment. Within the pharmacy services, CCRx is aimed at providing medication risk and therapy management continuously and longitudinally post discharge from hospitals and skilled nursing customers. Within the provider services, patients often transition from home health to hospice services and can receive therapy and supportive care services concurrent with each other and with home health and hospice.

***Aligning to Value-Based Care Reimbursement Models with Innovative Solutions***

The scale and depth of our complimentary platform of diverse yet related customer and patient services – that complex patients require – positions us at the forefront with governmental and commercial payors who are increasingly seeking ways to expand value-based reimbursement models. Our high-quality services that are delivered in home and community-based and patient and family-preferred settings at lower comparable costs are well-positioned for the long-term, and we continue to add wraparound care management capabilities and offerings to our core services. In addition to our large Medicare and Medicaid beneficiary populations, we have a large number of non-governmental payor contracts across the organization today, which both diversifies our payor mix, and provides for additional value-based opportunities and partnerships.

The Company's focused build out of its (i) Home-Based Primary Care, transitional care programs, and in-home medication therapy management (CCRx), and (ii) Clinical (Nursing) Hub, are key enablers to coordinate base pharmacy and provider services and drive improved quality and lower costs for value-based care constructs.

In addition to numerous payor contracts that feature reimbursement incentives, in the past year the Company has entered into several ACO arrangements to participate in shared savings from its attributed primary care patients and other ACO partnerships and contract as a preferred provider.

***Initial Public Offering***

On January 30, 2024, we completed our IPO of 53,333,334 shares of common stock at a price of $13.00 per share and a concurrent offering of 8,000,000 6.75% tangible equity units ("TEUs") with a stated amount of $50.00 per Unit (collectively, the "IPO Offerings"). The net proceeds from the IPO Offerings amounted to $656.5 million and $389.0 million for the common stock and TEUs, respectively, after deducting underwriting discounts, commissions, and offering-related expenses. The shares of common stock and TEUs began trading on the Nasdaq Global Select Market on January 26, 2024 under the ticker symbols "BTSG" and "BTSGU," respectively.

We used a portion of the net proceeds received from the IPO Offerings to (i) repay all indebtedness outstanding under the Second Lien Facility, (ii) repay all indebtedness outstanding under the Revolving Credit Facility, (iii) repay $343.3 million outstanding aggregate amount under the First Lien Facility, and (iv) pay certain expenses in the offering. We retained the remaining proceeds for general corporate purposes. Additionally, we paid $22.7 million of termination fees in connection with the termination of our monitoring agreement with Kohlberg Kravis Roberts & Co. L.P. ("KKR") and Walgreens Boots Alliance, Inc. (together with KKR, the "Managers") (the "Monitoring Agreement").

***New Equity Awards***

We granted approximately $63.3 million in non-cash share-based compensation with equity awards to our management and certain other full-time employees in January 2024 at the time of the IPO Offerings. Additionally, as previously disclosed in connection with the IPO, we granted approximately $100.0 million in non-cash share-based compensation equity awards, which equates to approximately 7.7 million restricted stock units, to certain full-time employees in the second quarter of fiscal year 2024.

**Factors Affecting Results of Operations and Comparability**

***Acquisitions and Divestitures***

During the years ended December 31, 2023 and 2024, we completed five and eight acquisitions, respectively, within the Pharmacy Solutions and Provider Services segments. Aggregate consideration, net of cash acquired, for these acquisitions was approximately $73.1 million and $110.9 million, respectively.

As noted earlier, the Company announced the entry into a purchase agreement in January 2025 with respect to the expected sale of our Community Living business, which is expected to close in 2025, subject to customary closing conditions. The Company's Community Living business was not accounted for as held for sale or discontinued operations as of December 31, 2023 or 2024. Thus, the Community Living business' results of operations are consolidated in the Company's results of operations. We intend to use the proceeds from the sale to reduce debt resulting in accelerated deleveraging while also increasing capital availability. We believe the divestiture will result in enhanced operational efficiency across the organization by optimizing resource allocation to further strengthen our position in our service offerings within the Pharmacy Solutions and remaining Provider Services segments by focusing on seniors and specialty populations with similar business and delivery models.

***Quality Incentive Payment***

As discussed under Part I, Item 1. "Business", the Company was eligible to receive incentive payments in connection with a payor contract based on the Company's Net Promoter Score ("NPS") achieved from surveys performed directly by the payor. During the second fiscal quarter of 2023, our Infusion and Specialty Pharmacy services earned a quality incentive payment ("QIP") of approximately $30 million. The Company did not receive a QIP during the year ended December 31, 2024. The QIP program has reached its conclusion.

***Legal Costs and Settlements Accrual***

In November 2023, the Company agreed to settle the Silver matter without admitting liability, as discussed under Part I, Item 3. "Legal Proceedings". On May 29, 2024, the parties entered into a final settlement agreement, which was approved by both the United States Department of Justice and the District Court. The total financial impact of the settlement is $120.0 million; $115.0 million of which was recorded during the year ended December 31, 2023 as an estimate, and an incremental $5.0 million was recorded in the year ended December 31, 2024 once the settlement agreement was finalized. We paid $110.0 million of the settlement in 2024, and the remainder will be paid in 2025.The District Court entered an order dismissing the Silver action in its entirety, with prejudice, on July 3, 2024. See Note 14 "Commitments and Contingencies" within the audited consolidated financial statements and related notes, included elsewhere in this Annual Report on Form 10-K.

***Update on the Impact of the COVID-19 Pandemic***

On May 11, 2023, the Department of Health and Human Services declared the COVID-19 pandemic is no longer a public health emergency. New variants could affect our operations for an extended period; however, at this time we cannot confidently forecast the duration or the ultimate financial impact on our operations, should such an impact occur. In the year ended December 31, 2024, the Company received no funds from the Provider Relief Fund ("PRF") and recognized no income related to the program. The Company received and recognized into income $18.8 million from the PRF for the year ended December 31, 2023. The income recognized was offset directly by the expenses incurred within selling, general, and administrative expenses in our audited consolidated statement of operations, which resulted in no net financial impact to the Company.

**Components of Results of Operations**

*Revenues*. The Company recognizes the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. For transactions involving the transfer of goods, revenues are primarily recognized when the customer obtains control of the products sold, which is generally upon shipment or delivery, depending on the delivery terms specified in the sales agreement. For transactions exclusively involving provision of services, revenues are recognized over time based on an appropriate measure of progress.

*Cost of Goods and Cost of Services*. We classify expenses directly related to providing goods and services, including depreciation and amortization, as cost of goods and cost of services. Direct costs and expenses primarily include cost of drugs, net of rebates, salaries and benefits for direct care and service professionals, contracted labor costs, insurance costs, transportation costs for clients requiring services, certain client expenses such as food, supplies and medicine, residential occupancy expenses, which primarily comprise rent and utilities, and other miscellaneous direct goods or service-related expenses.

*Selling, General, and Administrative Expenses*. Selling, general, and administrative expenses consist of expenses incurred in support of our operations and administrative functions and include labor costs, such as salaries, bonuses, commissions, benefits, and travel-related expenses, distribution expenses, facilities rental costs, third-party revenue cycle management costs, and corporate support costs including finance, information technology, legal costs and settlements, human resources, procurement, and other administrative costs.

*Loss on Extinguishment of Debt.* Loss on extinguishment of debt reflects the write-off of unamortized debt issuance costs upon the early repayment of our Second Lien Facility.

*Interest Expense, net*. Interest expense, net includes interest paid on and debt service costs associated with our various debt instruments, including our First Lien Facilities and Second Lien Facility, and the amortization of related deferred financing fees, which are amortized over the term of the respective credit agreement. Interest expense, net also includes the portion of the gain or loss on our interest rate swap agreements that is reclassified into earnings.

*Income Tax Benefit*. Our provision for income taxes is based on permanent book/tax differences and statutory tax rates in the various jurisdictions in which we operate. Significant estimates and judgments are required in determining the provision for income taxes.

**Results of Operations**

This section of this Annual Report on Form 10-K generally discusses the years ended December 31, 2024 and 2023 and year-over-year comparisons between the years ended December 31, 2024 and 2023. For information of our results of operations for the year ended December 31, 2023 compared to the year ended December 31, 2022, refer to Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations in our previously filed Annual Report on Form 10-K.

**Consolidated Results of Operations**

| *($ in thousands)* | For the Years Ended December 31, | | | |
|---|---|---|---|---|
| | | | Change | |
| | 2024 | 2023 | Amount | % |
| Revenues: | | | | |
| Products | $ 8,754,282 | $ 6,522,450 | $ 2,231,832 | 34.2% |
| Services | 2,512,190 | 2,303,725 | 208,465 | 9.0% |
| Total revenues | 11,266,472 | 8,826,175 | 2,440,297 | 27.6% |
| Cost of goods | 8,008,501 | 5,840,716 | 2,167,785 | 37.1% |
| Cost of services | 1,669,536 | 1,551,665 | 117,871 | 7.6% |
| Gross profit | 1,588,435 | 1,433,794 | 154,641 | 10.8% |
| Selling, general, and administrative expenses | 1,382,061 | 1,286,614 | 95,447 | 7.4% |
| Operating income | 206,374 | 147,180 | 59,194 | 40.2% |
| Loss on extinguishment of debt | 12,726 | — | 12,726 | n.m. |
| Interest expense, net | 228,386 | 324,593 | (96,207) | (29.6)% |
| Loss before income taxes | (34,738) | (177,413) | 142,675 | n.m. |
| Income tax benefit | (14,217) | (20,578) | 6,361 | n.m. |
| Net loss | $ (20,521) | $ (156,835) | $ 136,314 | n.m. |
| Adjusted EBITDA [(1)] | $ 588,075 | $ 537,808 | $ 50,267 | 9.3% |

** n.m.: not meaningful*

[(1)] Reconciliation of GAAP to non-GAAP results is provided in the section "Non-GAAP Financial Measures" in Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations"

The following discussion of our results of operations should be read in conjunction with the foregoing table summarizing our consolidated results of operations.

*Revenues*

Revenues were $11,266.5 million for the year ended December 31, 2024, as compared with $8,826.2 million for the year ended December 31, 2023, an increase of $2,440.3 million or 27.6%. The increase resulted from growth in our Pharmacy Solutions and Provider Services segments. See additional discussion in "—Segment Results of Operations" below. Revenues for the Company's Community Living business were $1,194.3 million for the year ended December 31, 2024, as compared with $1,135.2 million for the year ended December 31, 2023. When excluding the Community Living business revenues, consolidated revenues increased by $2,381.2 million or 31.0%.

*Cost of Goods*

Cost of goods was $8,008.5 million for the year ended December 31, 2024, as compared with $5,840.7 million for the year ended December 31, 2023, an increase of $2,167.8 million or 37.1%. The increase resulted from an increase in Pharmacy Solutions cost of goods. See additional discussion in "—Segment Results of Operations" below.

*Cost of Services*

Cost of services was $1,669.5 million for the year ended December 31, 2024, as compared with $1,551.7 million for the year ended December 31, 2023, an increase of $117.9 million or 7.6%. The increase resulted from an increase in Provider Services cost of services. See additional discussion in "—Segment Results of Operations" below.

*Selling, General, and Administrative Expenses*

Selling, general, and administrative expenses were $1,382.1 million for the year ended December 31, 2024, as compared with $1,286.6 million for the year ended December 31, 2023, an increase of $95.4 million or 7.4%. The increase primarily resulted from the following segment activity and factors:

- an increase of $66.4 million, or 5.2% growth on consolidated 2023 selling, general, and administrative expenses, as a result of growth in our Pharmacy Solutions and Provider Services segments. See additional discussion in "—Segment Results of Operations" below;
- an increase of $44.1 million, or 3.4% growth on consolidated 2023 selling, general, and administrative expenses, as a result of our IPO Offerings and are therefore not expected to reoccur. These expenses include $22.7 million of termination

fees paid to the Managers in connection with the termination of our Monitoring Agreement; $15.0 million of previously unrecognized non-cash share-based compensation expense related to performance-vesting options, a portion of which vested upon the IPO; and $6.4 million of non-capitalizable offering costs;

- an increase of $49.2 million, or 3.8% growth on consolidated 2023 selling, general, and administrative expenses, due to non-cash share-based compensation related to the new equity awards granted to management and certain full-time employees in conjunction with the IPO;
- an increase of $41.5 million, or 3.2% growth on consolidated 2023 selling, general, and administrative expenses, as a result of an increase in other operational expenses year-over-year; offset by,
- a decrease of $105.8 million, or 8.2%, decline on consolidated 2023 selling, general, and administrative expenses, due to the settlement and changes in estimate of legal settlements and defense costs related to certain historical PharMerica litigation matters, which includes the Silver matter. See Note 14 “Commitments and Contingencies” within the audited consolidated financial statements and related notes.

*Interest Expense, net*

Interest expense, net was $228.4 million for the year ended December 31, 2024, as compared with $324.6 million for the year ended December 31, 2023, a decrease of $96.2 million or 29.6%. The decrease primarily resulted from lower outstanding term debt as compared to the prior period and a $3.9 million increase in interest income related to cash flow hedges of interest rate risk. The Company's outstanding term debt decreased in the first fiscal quarter of 2024 as a result of the paydowns on our term debt using proceeds from the IPO Offerings. The Company also refinanced the First Lien facility in the first fiscal quarter of 2024 and, again, in the fourth fiscal quarter of 2024 resulting in a reduction of the applicable interest rate margin to 3.25% and 2.50%, respectively.

*Income Tax Benefit*

Income tax benefit was $14.2 million for the year ended December 31, 2024, as compared with $20.6 million for the year ended December 31, 2023, a change of $6.4 million which corresponds with a change in the effective tax rate from 11.6% for the year ended December 31, 2023 to 40.9% for the year ended December 31, 2024. The increase in the effective tax rate is primarily due to limitations on the deductibility of certain executive compensation that now apply to the Company upon completion of its IPO in January 2024, partially offset by the tax benefit related to the Silver legal settlement. The terms of the settlement agreement, including partial deductibility for tax purposes, were finalized in 2024 and resulted in favorable treatment for tax purposes. See Note 14 “Commitments and Contingencies” within the consolidated financial statements and related notes, included elsewhere in this Annual Report on Form 10-K.

*Net Loss*

Net loss was $20.5 million for the year ended December 31, 2024, as compared with $156.8 million for the year ended December 31, 2023, a decrease of $136.3 million. Net loss for 2024 includes the aforementioned $44.1 million of expense related to non-recurring costs directly associated with the IPO Offerings. Additionally, the Company incurred a write-off of $12.7 million of unamortized debt issuance costs upon the extinguishment of the Second Lien and $49.2 million of non-cash share-based compensation expense related to new equity awards granted to management and certain full-time employees in connection with the IPO Offerings. The increase in expenses is offset by the aforementioned decrease in interest expense, net, income tax benefit, and legal settlement and defense costs, and increase in revenues. When excluding the approximately $30 million QIP received in 2023, net loss decreased by $166.5 million compared to a net loss of $187.0 million in 2023.

*Adjusted EBITDA* [(1)]

Adjusted EBITDA was $588.1 million for the year ended December 31, 2024, as compared with $537.8 million for the year ended December 31, 2023, an increase of $50.3 million or 9.3%. When excluding the approximately $30 million QIP received in 2023, Adjusted EBITDA increased $80.5 million or 15.9%. The increase of $50.3 million primarily resulted from the following segment activity and factors:

- an increase of $77.6 million, or 14.4% growth on consolidated 2023 Adjusted EBITDA, as a result of growth in our Pharmacy Solutions and Provider Services segments. See additional discussion in "—Segment Results of Operations" below; offset by,
    - When excluding the approximately $30 million QIP received in 2023, consolidated Adjusted EBITDA related to the Pharmacy Solutions segment increased 10.6% compared to consolidated Adjusted EBITDA of $507.6 million in 2023.
- a decrease of $27.3 million, or 5.1% decline on consolidated 2023 Adjusted EBITDA, as a result of increased corporate expenses incurred primarily due to investments in information technology and positions to support growth within the business.

[(1)] Reconciliation of GAAP to non-GAAP results is provided in the section "Non-GAAP Financial Measures" in Part II, Item 7 "Management's Discussion and Analysis of Financial Condition and Results of Operations"

## Segment Results of Operations

### Pharmacy Solutions Segment

The following table sets forth, for the years indicated, our segment results of operations.

| *($ in thousands, except Business Metrics)* | Pharmacy Solutions For the Years Ended December 31, | | | |
|---|---|---|---|---|
| | | | Change | |
| | 2024 | 2023 | Amount | % |
| Revenues | $ 8,754,282 | $ 6,522,450 | $ 2,231,832 | 34.2% |
| Cost of goods | 8,008,501 | 5,840,716 | 2,167,785 | 37.1% |
| Gross profit | 745,781 | 681,734 | 64,047 | 9.4% |
| Selling, general, and administrative expenses | 462,219 | 426,521 | 35,698 | 8.4% |
| Segment operating income | $ 283,562 | $ 255,213 | $ 28,349 | 11.1% |
| Segment EBITDA | $ 394,665 | $ 370,962 | $ 23,703 | 6.4% |
| | | | | |
| Business Metrics: | | | | |
| Prescriptions dispensed | 41,816,584 | 37,390,655 | 4,425,929 | 11.8% |
| Revenue per script | $ 209.35 | $ 174.44 | $ 34.91 | 20.0% |
| Gross profit per script | $ 17.83 | $ 18.23 | $ (0.40) | (2.2)% |

*Revenues*

Revenues were $8,754.3 million for the year ended December 31, 2024, as compared with $6,522.5 million for the year ended December 31, 2023, an increase of $2,231.8 million or 34.2%. The increase primarily resulted from volume growth in prescriptions dispensed across and within the Pharmacy Solutions segment. Revenue attributable to Infusion and Specialty Pharmacy was $6,526.0 million for the year ended December 31, 2024, as compared with $4,600.9 million for the year ended December 31, 2023, an increase of $1,925.1 million or 41.8% attributable to an increase in prescriptions dispensed on certain specialty branded drugs. Revenue attributable to Home and Community Pharmacy was $2,228.3 million for the year ended December 31, 2024, as compared with $1,921.6 million for the year ended December 31, 2023, an increase of $306.7 million or 16.0% attributable to volume growth.

The increase in revenue per prescription dispensed is due to mix changes year-over-year and a greater relative increase in volume growth in certain specialty brand drugs, which carry a higher revenue per prescription dispensed.

*Cost of Goods*

Cost of goods was $8,008.5 million for the year ended December 31, 2024, as compared with $5,840.7 million for the year ended December 31, 2023, an increase of $2,167.8 million or 37.1%. The increase primarily resulted from the aforementioned revenue growth in the period as well as an increase in cost per prescription dispensed as a result of mix shift.

Gross profit was $745.8 million for the year ended December 31, 2024, as compared with $681.7 million for the year ended December 31, 2023, an increase of $64.0 million or 9.4%. The increase primarily resulted from the aforementioned revenue growth in the period, primarily the result of outsized volume growth as well as mix in certain specialty branded drugs, which have lower margins, partially offset by the QIP received in 2023 for which there was no comparable in 2024. When excluding the approximately $30 million QIP received in 2023, gross profit increased 14.5% compared to gross profit of $651.5 million in 2023.

Gross profit margin for the year ended December 31, 2024 was 8.5% compared to 10.5% for the year ended December 31, 2023. The decrease in gross profit margin is due to mix shift in the Pharmacy Solutions segment with greater relative volume growth in Infusion and Specialty Pharmacy, along with product-level mix shifts, rate changes, an increase in the fulfillment cost per script in Home and Community Pharmacy, and the QIP received in 2023 for which there was no comparable in 2024. When excluding the aforementioned QIP, gross profit margin was 10.0% for the year ended December 31, 2023.

*Selling, General, and Administrative Expenses*

Selling, general, and administrative expenses were $462.2 million for the year ended December 31, 2024, as compared with $426.5 million for the year ended December 31, 2023, an increase of $35.7 million or 8.4%. The increase primarily resulted from the aforementioned revenue growth in the period with selling, general, and administrative expenses growing less than the volume growth rate and demonstrating economies of scale.

*Segment EBITDA*

Segment EBITDA was $394.7 million for the year ended December 31, 2024, as compared with $371.0 million for the year ended December 31, 2023, an increase of $23.7 million or 6.4%. The increase primarily resulted from the aforementioned revenue and gross profit growth in the period, partially offset by the QIP received in 2023 for which there was no comparable in 2024. When excluding the approximately $30 million QIP received in 2023, segment EBITDA increased 15.8% compared to segment EBITDA of $340.8 million in 2023. See Note 17 “Segment Information” to our audited consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K for further discussion.

**Provider Services Segment**

The following table sets forth, for the years indicated, our segment results of operations.

| *($ in thousands, except Business Metrics)* | Provider Services For the Years Ended December 31, | | | |
|---|---|---|---|---|
| | | | Change | |
| | 2024 | 2023 | Amount | % |
| Revenues | $ 2,512,190 | $ 2,303,725 | $ 208,465 | 9.0% |
| Cost of services | 1,669,536 | 1,551,665 | 117,871 | 7.6% |
| Gross profit | 842,654 | 752,060 | 90,594 | 12.0% |
| Selling, general, and administrative expenses | 549,026 | 518,297 | 30,729 | 5.9% |
| Segment operating income | $ 293,628 | $ 233,763 | $ 59,865 | 25.6% |
| Segment EBITDA | $ 360,642 | $ 306,776 | $ 53,866 | 17.6% |
| | | | | |
| Business Metrics: | | | | |
| Home Health Care average daily census | 44,920 | 40,068 | 4,852 | 12.1% |
| Community and Rehab Care persons served | 16,684 | 16,655 | 29 | 0.2% |

*Revenues*

Revenues were $2,512.2 million for the year ended December 31, 2024, as compared with $2,303.7 million for the year ended December 31, 2023, an increase of $208.5 million or 9.0%. The increase primarily resulted from volume growth as well as rate increases received during the period. Revenue attributable to Home Health Care was $1,041.3 million for the year ended December 31, 2024, as compared with $921.4 million for the year ended December 31, 2023, an increase of $119.9 million or 13.0%. Revenue attributable to Community and Rehab Care was $1,470.9 million for the year ended December 31, 2024, as compared with $1,382.3 million for the year ended December 31, 2023, an increase of $88.6 million or 6.4%.

Revenues for the Company's Community Living business were $1,194.3 million for the year ended December 31, 2024, as compared with $1,135.2 million for the year ended December 31, 2023. When excluding the Community Living business revenues, Provider Services revenues increased by $149.4 million or 12.8%.

*Cost of Services*

Cost of services was $1,669.5 million for the year ended December 31, 2024, as compared with $1,551.7 million for the year ended December 31, 2023, an increase of $117.9 million or 7.6%. The increase primarily resulted from the aforementioned revenue growth and included operational improvements resulting in lower costs of services increases compared to revenue growth.

Gross profit was $842.7 million for the year ended December 31, 2024, as compared with $752.1 million for the year ended December 31, 2023, an increase of $90.6 million or 12.0%. The increase primarily resulted from the aforementioned revenue growth and costs of services improvements in the period.

*Selling, General, and Administrative Expenses*

Selling, general, and administrative expenses were $549.0 million for the year ended December 31, 2024, as compared with $518.3 million for the year ended December 31, 2023, an increase of $30.7 million or 5.9%. The increase primarily resulted from the aforementioned revenue growth in the period with selling, general, and administrative expenses growing less than the volume growth rate and demonstrating economies of scale.

*Segment EBITDA*

Segment EBITDA was $360.6 million for the year ended December 31, 2024, as compared with $306.8 million for the year ended December 31, 2023, an increase of $53.9 million or 17.6%. The increase primarily resulted from the aforementioned revenue growth and operational improvements impacting cost of services. See Note 17 “Segment Information” to our audited consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K for further discussion.

**Non-GAAP Financial Measures**

In addition to our results of operations prepared in accordance with U.S. GAAP, which we have discussed above, we also evaluate our financial performance using EBITDA, Adjusted EBITDA, and Adjusted EPS. These non-GAAP financial measures are not intended to replace financial performance measures determined in accordance with U.S. GAAP, such as net loss and diluted EPS. Rather, we present EBITDA, Adjusted EBITDA, and Adjusted EPS as supplemental measures of our performance.

*EBITDA, Adjusted EBITDA, and Adjusted EPS*

The following are key financial metrics and, when used in conjunction with U.S. GAAP measures, we believe they provide useful information for evaluating our core business performance, enable comparison of financial results across periods, and allow for greater transparency with respect to key metrics used by management for financial and operational decision-making. We define EBITDA as net loss before income tax benefit, interest expense, net, and depreciation and amortization. Adjusted EBITDA and Adjusted EPS exclude certain other items that are either non-recurring, infrequent, non-cash, unusual, or items deemed by management to not be indicative of the performance of our core operations, including non-cash, share-based compensation; acquisition, integration, and transaction-related costs; restructuring and divestiture-related and other costs; legal and settlement costs associated with certain historical matters for PharMerica; significant projects; management fees; and unreimbursed COVID-19 related costs. In determining which adjustments are made to arrive at Adjusted EBITDA and Adjusted EPS, management considers both (1) certain non-recurring, infrequent, non-cash, or unusual items, which can vary significantly from year to year, as well as (2) certain other items that may be recurring, frequent, or settled in cash but which management does not believe are indicative of our core operating performance. The financial measure calculated under U.S. GAAP which is most directly comparable to Adjusted EBITDA is net loss. The financial measure calculated under U.S. GAAP which is most directly comparable to Adjusted EPS is diluted EPS.

We have historically incurred substantial acquisition, integration, and transaction-related costs. The underlying acquisition activities take place over a defined timeframe, have distinct project timelines, and are incremental to activities and costs that arise in the ordinary course of our business. Therefore, we have excluded these costs from our Adjusted EBITDA and Adjusted EPS because it provides management a normalized view of our core, ongoing operations after integrating our acquired companies.

The legal costs and settlements adjustment represents defense costs associated with certain PharMerica litigation matters, all of which have been finalized as of December 31, 2024, that commenced prior to KKR Stockholder’s and Walgreen Stockholder’s acquisition of PharMerica in December 2017, as well as settlement costs associated with the Silver matter, which settled in November 2023. We have excluded defense costs associated with these PharMerica litigation matters from our Adjusted EBITDA and Adjusted EPS due to the magnitude of these cases and the costs attributable to them, the timing of the commencement of the cases and the fact that no similar cases have been brought against the Company since the acquisition of PharMerica, and the fact that these cases are

unlike our routine legal and regulatory proceedings that we see in the normal course of business. Further, we have excluded settlement costs associated with the Silver matter from our Adjusted EBITDA and Adjusted EPS due to the magnitude of the case and the costs attributable to it, as well as the fact that the Silver matter is unlike our routine legal and regulatory proceedings that we see in the normal course of business.

The significant projects adjustment represents costs associated with certain transformational projects, which are not considered to be a part of our normal and recurring business operations and are not expected to recur in our future business plans. As of December 31, 2024, all significant projects have been finalized. Moreover, the costs associated with significant projects, which are incurred on an infrequent and limited basis, are not reflective of our operating performance. Due to the aforementioned reasons, we have excluded the costs related to significant projects from our Adjusted EBITDA and Adjusted EPS, as such adjustment provides a more meaningful understanding to investors and others of our ongoing results.

The management fees adjustment represents fees paid historically under the Monitoring Agreement related to either (i) activities that are expected to be performed by our existing personnel upon the termination of the Monitoring Agreement, and thus not expected to result in incremental costs subsequent to the IPO Offerings, or (ii) acquisitions, divestitures, and external financing activities, which costs would otherwise be excluded from our Adjusted EBITDA and Adjusted EPS. Therefore, we have excluded management fees from our Adjusted EBITDA and Adjusted EPS, as such fees are no longer applicable and representative of our ordinary operating performance as a result of the completion of the IPO Offerings.

EBITDA, Adjusted EBITDA, and Adjusted EPS are not measures of financial performance under U.S. GAAP and should be considered in addition to, and not as a substitute for, net loss, diluted EPS or other financial measures performed in accordance with U.S. GAAP. Our method of determining non-GAAP financial measures may differ from other companies' financial measures and therefore may not be comparable to methods used by other companies.

Given our determination of adjustments in arriving at our computations of EBITDA, Adjusted EBITDA, and Adjusted EPS, these non-GAAP measures have limitations as analytical tools and should not be considered in isolation or as substitutes or alternatives to net loss, operating income, loss per diluted share, cash flows from operating activities, total indebtedness, or any other financial measures calculated in accordance with U.S. GAAP.

The following table reconciles net loss to EBITDA and Adjusted EBITDA:

| *($ in thousands)* | For the Years Ended December 31, | |
|---|---|---|
| | 2024 | 2023 |
| Net loss | $ (20,521) | $ (156,835) |
| Income tax benefit | (14,217) | (20,578) |
| Interest expense, net | 228,386 | 324,593 |
| Depreciation and amortization | 204,482 | 202,336 |
| EBITDA | $ 398,130 | $ 349,516 |
| Non-cash share-based compensation [(1)] | 69,174 | 3,917 |
| Acquisition, integration, and transaction-related costs [(2)] | 34,869 | 20,734 |
| Restructuring and divestiture-related and other costs [(3)] | 38,031 | 21,848 |
| Legal costs and settlements [(4)] | 21,886 | 127,695 |
| Significant projects [(5)] | 2,604 | 8,379 |
| Management fees [(6)] | 23,381 | 5,631 |
| Unreimbursed COVID-19 related costs | — | 88 |
| Total adjustments | $ 189,945 | $ 188,292 |
| Adjusted EBITDA | $ 588,075 | $ 537,808 |

(1) Represents non-cash share-based compensation to certain members of our management and other full-time employees. The year ended December 31, 2024 includes $49.2 million of costs related to new equity awards granted upon the completion of our IPO under the 2024 Equity Incentive Plan and $15.0 million of previously unrecognized share-based compensation expense related to performance-vesting options under the 2017 Stock Plan, a portion of which vested upon completion of the IPO.

(2) Represents transaction costs incurred in connection with planned, completed, or terminated acquisitions, which include investment banking fees, legal diligence and related documentation costs, finance and accounting diligence and documentation; costs associated with the integration of acquisitions, including any facility consolidation, integration travel, or severance; and costs associated with other planned, completed, or terminated non-routine transactions. The year ended December 31, 2024 includes acquisition and integration related costs of $17.4 million, earn-out adjustments from previous acquisitions of $2.4 million, and other non-routine transaction costs of $8.7 million, as compared to acquisition and integration related costs of $3.7

million for the year ended December 31, 2023. These costs also included $6.4 million and $4.7 million of costs related to the IPO Offerings which were not capitalizable for the years ended December 31, 2024 and 2023, respectively.

(3) Represents costs associated with restructuring-related activities, including closure costs, and related license impairment, and severance expenses associated with certain enterprise-wide or significant business line cost-savings measures. These costs included $12.7 million of unamortized debt issuance costs associated with the extinguishment of our Second Lien Facility in the year ended December 31, 2024. These costs also included $7.3 million and $10.6 million of intangible asset and other non-cash investment impairment for the years ended December 31, 2024 and 2023, respectively.

(4) Represents settlement and defense costs associated with certain historical PharMerica litigation matters, including the Silver matter, all of which were finalized in 2024. See Note 14 “Commitments and Contingencies” within the audited consolidated financial statements and related notes, included elsewhere in this Annual Report on Form 10-K, for additional information.

(5) Represents costs associated with certain transformational projects and for the periods presented primarily included general ledger system implementation, pharmacy billing system implementation, and ransomware attack response costs, all of which were finalized in 2024. General ledger system migration and related business intelligence system implementation costs, which were capitalized as development costs and are subsequently amortized in accordance with ASC 350-40, *Internal Use Software*, were $0.7 million and $2.0 million for the years ended December 31, 2024, and 2023, respectively. Pharmacy billing system implementation costs were $0.7 million and $2.2 million for the year ended December 31, 2024 and 2023, respectively. Ransomware attack response costs were $1.0 million and $3.4 million for the years ended December 31, 2024 and 2023.

(6) Represents annual management fees payable to the Managers under the Monitoring Agreement through the date of the IPO, and $22.7 million of termination fees resulting from the Monitoring Agreement being terminated upon completion of the IPO Offerings. All management fees have ceased following the completion of the IPO.

The following table reconciles diluted EPS to Adjusted EPS:

| *(shares in thousands)* | For the Years Ended December 31, | |
|---|---|---|
| | 2024 | 2023 |
| Diluted EPS | $ (0.09) | $ (1.31) |
| Non-cash share-based compensation [1] | 0.34 | 0.03 |
| Acquisition, integration, and transaction-related costs [1] | 0.17 | 0.16 |
| Restructuring and divestiture-related and other costs [1] | 0.19 | 0.17 |
| Legal costs and settlements [1] | 0.11 | 1.01 |
| Significant projects [1] | 0.01 | 0.07 |
| Management fee [1] | 0.12 | 0.04 |
| Unreimbursed COVID-19 related costs [1] | — | 0.00 |
| Income tax impact on adjustments [2][3] | (0.29) | (0.10) |
| Adjusted EPS | $ 0.56 | $ 0.07 |
| | | |
| Weighted average common shares outstanding used in calculating diluted U.S. GAAP net loss per share | 192,997 | 117,868 |
| Weighted average common shares outstanding used in calculating diluted Non-GAAP earnings per share | 202,106 | 126,355 |

(1) This adjustment reflects the per share impact of the adjustment reflected within the definition of Adjusted EBITDA.

(2) The income tax impact of non-GAAP adjustments is calculated using the estimated tax rate for the respective non-GAAP adjustment.

(3) For the year ended December 31, 2024, the income tax impact on adjustments is inclusive of a discrete tax benefit related to the Silver matter that was finalized in connection with the signing of the settlement agreement during the second fiscal quarter of 2024.

**Liquidity and Capital Resources**

Our principal sources of cash have historically been from operating activities. Our principal source of liquidity in excess of cash from operating activities has historically been from proceeds from our debt facilities and issuances of common stock. Our principal uses of cash and liquidity have historically been for acquisitions, debt service requirements, and financing of working capital. We believe that our operating cash flows, available cash on hand, and availability under our Revolving Credit Facility and the LC Facility will be sufficient to meet our cash requirements for the next twelve months and beyond. Our future capital requirements will depend on many factors that are difficult to predict, including the size, timing, and structure of any future acquisitions, future

capital investments, and future results of operations. We cannot assure you that cash provided by operating activities or cash and cash equivalents will be sufficient to meet our future needs. If we are unable to generate sufficient cash flows from operations in the future, we may have to obtain additional financing. If we obtain additional capital by issuing equity, the interests of our existing stockholders will be diluted. If we incur additional indebtedness, that indebtedness may contain significant financial and other covenants that may significantly restrict our operations. We cannot assure you that we could obtain refinancing or additional financing on favorable terms or at all.

We evaluate our liquidity based upon the availability we have under our First Lien Facilities, as applicable, in addition to the net cash provided by (used in) operating, investing, and financing activities. Specifically, we review the activity under the Revolving Credit Facility and the LC Facility and consider period end balances outstanding under the Revolving Credit Facility and the LC Facility. Based upon the outstanding borrowings and letters of credit under the Revolving Credit Facility and the LC Facility, we calculate the availability for incremental borrowings under the Revolving Credit Facility and the LC Facility. Such amount, in addition to cash on our balance sheet, is what we consider to be our "Total Liquidity."

The following table provides a calculation of our Total Liquidity:

| *($ in thousands)* | For the Years Ended December 31, | |
|---|---|---|
| | 2024 | 2023 |
| *Revolving Credit Facility Rollforward* | | |
| Beginning Revolving Credit Facility balance | $ 50,700 | $ 74,800 |
| Borrowings (repayments) of swingline debt, net | 12,600 | (24,100) |
| Ending Revolving Credit Facility balance | $ 63,300 | $ 50,700 |
| | | |
| *Calculation of Revolving Credit Facility and LC Facility availability* | | |
| Revolving Credit Facility and LC Facility limit | $ 540,000 | $ 530,000 |
| Less: outstanding Revolving Credit Facility balance | 63,300 | 50,700 |
| Less: outstanding letters of credit subject to LC Sublimit | — | 6,632 |
| Less: outstanding letters of credit under the LC Facility | 61,821 | 54,279 |
| End of period Revolving Credit Facility and LC Facility availability | 414,879 | 418,389 |
| End of period cash balance | 61,253 | 13,071 |
| Total Liquidity, end of period | $ 476,132 | $ 431,460 |

**Cash Flow Activity**

The following table sets forth a summary of our cash flows provided by (used in) operating, investing, and financing activities for the periods presented:

| *($ in thousands)* | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | Variance |
| Net cash provided by operating activities | $ 23,774 | $ 210,783 | $ (187,009) |
| Net cash used in investing activities | $ (140,237) | $ (134,433) | $ (5,804) |
| Net cash provided by (used in) financing activities | $ 164,645 | $ (76,907) | $ 241,552 |

*Operating Activities*

Net cash provided by operating activities decreased by $187.0 million, from $210.8 million for 2023, to $23.8 million for 2024. The decrease was primarily due to the following:

- a $114.0 million increase in cash outflows for the payments of legal settlements including the Silver matter in 2024;
- a $55.0 million increase in cash outflows due to an increase in strategic inventory purchases from 2023;
- a $35.5 million increase in one-time cash outflows for direct and indirect remuneration ("DIR") fees paid in connection with the conclusion of the DIR program;
- an approximately $30 million decrease in cash inflows related to the QIP received in 2023 that was not received in 2024;
- a $18.8 million decrease in cash inflows related to the PRF general distribution received in 2023 that was not received in 2024;
- a $17.6 million increase in cash outflows attributable to acquisition and restructuring activities;

- a $17.3 million increase in cash outflows directly attributable to management fees paid in 2024 as a result of the termination of the Monitoring Agreement in connection with the IPO Offerings; offset by
- a decrease of $92.1 million in cash outflows for interest, net primarily as a result of paydowns, extinguishments and modifications of debt utilizing proceeds from the IPO Offerings; and
- a decrease of $12.5 million in cash outflows for income taxes.

*Investing Activities*

Net cash used in investing activities increased by $5.8 million, from $134.4 million in 2023, to $140.2 million in 2024. The increase was primarily due to a $7.4 million increase in purchases of property and equipment and a decrease of $3.3 million cash paid for acquisitions.

*Financing Activities*

Net cash provided by financing activities was $164.6 million for the year ended December 31, 2024, primarily attributable to net proceeds received from the IPO Offerings of $1,045.5 million, net borrowings on our Revolving Credit Facility of $12.6 million, partially offset by extinguishment of and net repayments on our long-term debt of $830.3 million, payment of debt issuance costs of $47.0 million, payment of finance lease obligations of $11.6 million, and other financing activities.

Net cash used in financing activities was $76.9 million for the year ended December 31, 2023, primarily attributable to repayments on our long-term debt of $30.4 million, net repayments on our Revolving Credit Facility of $24.1 million, payment of finance lease obligations of $11.6 million, and other financing activities.

**Debt**

We typically incur debt to finance mergers and acquisitions, and we borrow under our Revolving Credit Facility for working capital purposes, as well as to finance acquisitions, as needed.

On March 5, 2019, the Company entered into the First Lien Credit Agreement with Morgan Stanley Senior Funding, Inc., as the Administrative Agent and Collateral Agent. The Company also entered into a $450.0 million Second Lien Facility with certain Lenders and Wilmington Trust, National Association as the Administrative Agent and Collateral Agent, on the same date. The First Lien Credit Agreement, as amended, also extends credit in the form of a Revolving Credit Facility, or the Revolver, which is comprised of Revolving Credit Loans and Swingline Loans. The total borrowing capacity of the Revolver as of December 31, 2024 was $475.0 million. Additionally, the Letter of Credit Issuer may issue standby Letters of Credit at any time and the Swingline Lender may issue Swingline Loans in an aggregated amount outstanding not in excess of $65.0 million.

Following our IPO Offerings in January 2024, we used a portion of the net proceeds received to repay all outstanding borrowings under the Second Lien Facility and repay $343.3 million of borrowings under the First Lien Facility. No remaining obligation exists related to the Second Lien Facility and the transaction was accounted for as a debt extinguishment resulting in a $12.7 million related to the write-off of unamortized debt issuance costs. At that time, we also established a new Tranche B-4 under the First Lien to refinance the equivalent amount of the remaining First Lien Tranche B-1, B-2 and B-3 borrowings. On December 11, 2024, we again amended the First Lien to establish a new Tranche B-5 Term Loan ("Tranche B-5") in an aggregate principal amount of $2,553.2 million to refinance the equivalent amount of the remaining Tranche B-4 borrowings at a rate equal to SOFR plus 2.50% or ABR plus 1.50% with a maturity date of February 21, 2031.

Concurrently with the IPO, we issued 8,000,000 TEUs, which have a stated amount of $50.00 per unit. Each TEU is comprised of a prepaid stock purchase contract ("Purchase Contract") and a senior amortizing note ("Amortizing Note") due February 1, 2027, each issued by the Company. Refer to Note 6 within our consolidated financial statements and related notes in this Annual Report on Form 10-K for further discussion.

Our outstanding debt as of December 31, 2024 was $2,683.3 million, which is primarily comprised of $2,546.8 million outstanding under the First Lien Facility, $63.3 million outstanding under the Revolver, and $53.8 million outstanding related to Amortizing Notes.

The First Lien Credit Agreement described above contain customary negative covenants, including, but not limited to, restrictions on the Company and its restricted subsidiaries' ability to merge and consolidate with other companies, incur indebtedness, grant liens or security interests on assets, make acquisitions, loans, advances, or investments, pay dividends, sell or otherwise transfer assets, prepay or modify terms of certain junior indebtedness, enter into transactions with affiliates, or change their lines of business or fiscal year. In addition, under the Revolving Credit Facility, the Company will not permit the consolidated first lien secured debt to consolidated EBITDA (as defined in the First Lien Credit Agreement) ratio to be greater than 6.90 to 1.00, which shall be tested as of

the end of the most recent quarter at any time when the aggregate revolving credit loans exceed 35% of the total revolving credit commitments. We were in compliance with all applicable financial covenants under the First Lien Facilities as of December 31, 2024.

*Interest Rate Swap Agreements*

To manage fluctuations in cash flows resulting from changes in the variable rates, the Company entered into three receive-variable, pay-fixed interest rate swap agreements, with a combined notional value of $2.0 billion, all effective September 30, 2022 with a maturity date of September 30, 2025. The refinancings of existing term debt in 2024, did not result in a change to the terms of the interest rate swap agreements. For years ended December 31, 2024 and 2023, interest expense, net includes interest income related to cash flow hedges of interest rate risk of $35.3 million and $31.4 million, respectively.

The table below summarizes the total outstanding debt of the Company:

| *($ in thousands)* | Rate | | Long-term obligation and note payable | | Interest Expense | |
|---|---|---|---|---|---|---|
| | December 31, 2024 | December 31, 2023 | December 31, 2024 | December 31, 2023 | Fiscal Year 2024 | Fiscal Year 2023 |
| First Lien - payable to lenders at SOFR plus applicable margin | — | 8.72% | $ — | $ 1,719,360 | $ 21,217 | $ 146,167 |
| First Lien Tranche B-2 and B-3 - payable to lenders at SOFR plus applicable margin | — | 8.97% | — | 1,189,975 | 15,106 | 104,190 |
| First Lien Incremental Term Loan Tranche B-4 - payable to lenders at SOFR plus applicable margin | — | — | — | — | 176,223 | — |
| First Lien Incremental Term Loan Tranche B-5 - payable to lenders at SOFR plus applicable margin | 6.86% | — | 2,546,787 | — | 10,353 | — |
| Second Lien - payable to lenders at SOFR plus applicable margin | — | 13.97% | — | 450,000 | 5,239 | 62,012 |
| Revolving Credit Loans - payable to lenders at SOFR plus applicable margin | 7.61% | 9.59% | — | 50,000 | 387 | 3,988 |
| Swingline Loans and Base Rate Loans - payable to lenders at ABR plus applicable margin | 9.75% | 11.75% | 63,300 | 700 | 12,392 | 12,243 |
| Amortizing Notes | | | 53,804 | — | 5,726 | — |
| Notes payable and other | | | 19,428 | 4,356 | 316 | 2 |
| Amortization of deferred financing costs & other, net of interest income from cash flow hedges | | | — | — | (18,573) | (4,009) |
| Total debt | | | $ 2,683,319 | $ 3,414,391 | $ 228,386 | $ 324,593 |
| Less: debt issuance costs, net | | | 72,736 | 50,177 | | |
| Total debt, net of debt issuance costs | | | 2,610,583 | 3,364,214 | | |
| Less: Current portion of long-term debt | | | 48,725 | 32,273 | | |
| Total long-term debt, net of current portion | | | $ 2,561,858 | $ 3,331,941 | | |

Our Company leverage, as calculated under our First Lien Credit Facilities, was 4.16x at December 31, 2024. Our Company leverage, as calculated under our First Lien Facilities and the Second Lien Credit Agreement, was 5.86x at December 31, 2023.

**Off-Balance Sheet Arrangements**

As of December 31, 2024 and 2023, we did not have any material off-balance sheet arrangements. As part of our ongoing business, we do not participate in transactions that generate relationships with unconsolidated entities or financial partnerships, such as entities often referred to as structured finance or special purpose entities, or SPEs, which would have been established for the purpose of facilitating off-balance sheet arrangements or other contractually narrow or limited purposes. As of December 31, 2024 and 2023, we were not involved in any unconsolidated SPE transactions. We do enter into letters of credit in the normal course of our operations.

**Critical Accounting Policies and Use of Estimates**

In preparing our consolidated financial statements in conformity with U.S. GAAP, we must use estimates and assumptions that affect the reported amounts of assets and liabilities and related disclosures and the reported amounts of revenue and expenses. In general, our estimates are based on historical experience and various other assumptions we believe are reasonable under the circumstances. We evaluate our estimates on an ongoing basis and make changes to the estimates and related disclosures as experience develops or new information becomes known. Actual results could differ from those estimates.

We consider our critical accounting policies and estimates to be those that involve significant judgments and uncertainties and may potentially result in materially different results under different assumptions and conditions. See Note 1 “Significant Accounting Policies” to our audited consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K for a summary of all of our significant accounting policies.

**Revenue Recognition**

The Company recognizes the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. For transactions involving the transfer of goods, revenues are primarily recognized when the customer obtains control of the products sold, which is generally upon shipment or delivery, depending on the delivery terms specified in the sales agreement. For transactions exclusively involving provision of services, revenues are recognized over time based on an appropriate measure of progress. Additionally, as a policy, where we are required to collect sales taxes from our customers, revenue is recognized net of any taxes collected, and the sales tax amounts are recorded as a liability until remitted to the governmental taxing authorities.

Revenues and the associated receivables are based upon the actual reimbursements to be received and include contractual allowances based upon historical trends, contractual reimbursement terms, and other factors which may impact ultimate reimbursement. Amounts are adjusted to actual reimbursed amounts based upon cash receipts.

*Pharmacy Solutions*

Pharmacy Solutions revenues are generated from the products and services provided in association with the distribution of prescription drugs to consumers primarily under contracts with Prescription Drug Plans, or PDPs, under Medicare Part D, state Medicaid programs, long-term care institutions, third party insurance companies, and private payors. Services provided include individualized medication management and support, staff and patient support programs and solutions, regulatory support, and product delivery. When an order for a prescription is placed with the Company, it creates the performance obligation to deliver a prescription and related services. The performance obligation is satisfied at a point in time upon shipment for specialty pharmacies and upon delivery for other pharmacies. Revenues are recognized at a point in time when the associated performance obligations are satisfied at the contractual rate established at or before the time the performance obligation is satisfied.

*Provider Services*

Provider Services revenues are generated from providing care services directly to consumers under contracts with state, local, and other governmental agencies, as well as commercial insurance companies, long-term care insurance policies, private pay customers, and management contracts with private operators. Generally, these contracts, which are negotiated based on current contract practices as appropriate for the payor, establish the terms of a customer relationship, and set the broad range of terms for services to be performed at a stated rate. The contracts do not give rise to rights and obligations until a service request is placed with the Company. Contract terms vary but generally are for one year or less with available renewal options and a 30 – 60-day reimbursement period. When a service request is placed with the Company, it creates the performance obligation to provide a defined quantity of service hours per patient. Performance obligations to deliver patient care services are satisfied over time and revenue is recognized using a time-based input method to measure progress against the contract between the Company and the customer, given that consumers simultaneously receive and consume the benefits provided by the Company as the services are performed. Revenues are recognized over a period of time as the services are rendered at the contractual rate established at or before the time services are rendered; thus, there are no forms of variable consideration associated with the various revenue streams.

**Accounts Receivable and Allowance for Credit Losses**

Accounts receivable primarily consist of amounts due from PDPs under Medicare Part D, institutional healthcare providers, state Medicaid programs, other government agencies, third-party insurance companies, and private payors. The Company performs a periodic analysis to review the valuation of accounts receivable and collectability of outstanding balances. Management's evaluation takes into consideration factors such as historical bad debt experience, business and economic conditions, trends in healthcare coverage, other collection indicators, and information about specific receivables. The Company's evaluation also considers the age and composition of the outstanding amounts in determining their estimated net realizable value. The Company's ability to collect outstanding receivables is critical to its results of operations and cash flows. To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for credit losses to reduce the carrying value of such receivables to the extent it is probable that a portion or all of a particular account will not be collected, with the related expense recorded as a component of selling, general, and administrative expenses.

**Goodwill and Intangible Assets**

Goodwill represents the amount of the purchase price in excess of the fair values assigned to the underlying identifiable net assets of acquired businesses. Goodwill is not amortized, but is subject to an annual impairment test. Tests are performed more frequently if events occur or circumstances change, that would more-likely- than-not reduce the fair value of the reporting unit below its carrying amount.

The Company performs an annual goodwill impairment test on October 1st of each year for each reporting unit. The Company first assesses certain qualitative factors to determine whether the existence of events or circumstances would indicate that it

is more-likely-than-not that the fair value of a reporting unit was less than its carrying amount. If after assessing the totality of events and circumstances, we were to determine that it is more-likely-than-not that the fair value of a reporting unit is less than its carrying amount, then we would perform quantitative impairment testing. The quantitative impairment test is a single-step process. The process requires the Company to estimate and compare the fair value of a reporting unit to its carrying amount, including goodwill. If the fair value exceeds the carrying amount, the goodwill is not considered impaired. To the extent a reporting unit's carrying amount exceeds its fair value, the reporting unit's goodwill is deemed impaired, and an impairment charge is recognized based on the excess of a reporting unit's carrying amount over its fair value.

A reporting unit is either an operating segment or one level below the operating segment. The Company has six reporting units. Through November 1, 2022, the Company had a seventh reporting unit, Workforce Solutions, which was sold effective November 1, 2022.

In each of 2024, 2023, and 2022, we performed a quantitative assessment of all reporting units as of October 1. We engaged a third-party valuation firm to assist in calculating each reporting unit's fair value, which is derived using a combination of both income and market approaches. The material assumptions underlying the estimate of fair value of each reporting unit included the following:

- Future cash flow assumptions—the projections for future cash flows utilized in the model were derived from historical experience and assumptions regarding future growth and profitability of each reporting unit. These projections are consistent with our operating budget and strategic plan. Beyond the forecasted period, a long-term growth rate was utilized to determine a terminal value that reflects our estimate of stable and perpetual growth.
- Weighted average cost of capital (WACC)—the WACC is the rate used to discount each reporting unit's estimated future cash flows. The WACC is calculated based on a proportionate weighting of the cost of debt and equity. The cost of equity is based on a capital asset pricing model and includes a company-specific risk premium to capture the perceived risks and uncertainties associated with each reporting unit's projected cash flows.
- Market approach—the market approach measures the value of an asset through the analysis of publicly traded companies or present sales of similar businesses. The analysis entails measuring the multiple of sales and/or EBITDA at which the comparables are currently trading or were purchased.
- Equal weighting was applied to the discounted cash flow analysis or income approach (50%) and the market approach (50%).

*2024 Goodwill Impairment Analysis*

As of October 1, 2024, our six reporting units had an aggregate carrying amount of $4.3 billion. Our Behavioral Health, Specialty Solutions, and Hospice Pharmacy reporting units had fair values that substantially exceeded their respective carrying amounts and an aggregate goodwill balance of $559.2 million.

Our Home Infusion, Home Health and Therapies, and Institutional Pharmacy reporting units had fair values that exceeded their carrying amounts by less than 25%, carrying amounts of $334.3 million, $1.8 billion, and $1.1 billion and goodwill balances of $192.5 million, $1.4 billion, and $454.0 million, respectively.

Notwithstanding our belief that the assumptions we used for WACC and long-term growth rates in our impairment testing were reasonable, we performed sensitivity analyses for the Home Infusion, Home Health and Therapies and Institutional Pharmacy reporting units. The results of these sensitivity analyses on our impairment tests revealed that if there was a hypothetical 1% increase in the WACC or a hypothetical 1% decrease in the long-term growth rate, the fair value of the Home Infusion, Home Health and Therapies, and Institutional Pharmacy reporting units each would continue to be in excess of its carrying amount. We believe that our estimates and assumptions used in the 2024 goodwill impairment tests are reasonable but are subject to change from period to period. Actual results of operations and other factors may differ from the estimates used and it is possible that differences could be significant. A change in the estimates we use could result in a decline in the estimated fair values derived in the 2024 impairment testing.

We then conducted an analysis of market data inputs and risk considerations in the period since the 2024 impairment test date and do not believe that market or risk considerations changed materially. Further, we had no substantial changes in our long-term projections between those used in the 2024 impairment test. Therefore, we do not believe there were any material changes to the conclusions reached with no impairment of goodwill and indefinite-lived intangible assets.

*2023 and 2022 Goodwill Impairment Analyses*

Our 2023 goodwill impairment analysis concluded that the fair value of the Behavioral Health, Specialty Solutions, Hospice Pharmacy, and Home Infusion reporting units were each substantially in excess of carrying value. Our Home Health and Therapies and Institutional Pharmacy reporting units had fair values that exceeded their carrying amounts by less than 10%, carrying amounts of $1.6 billion and $1.2 billion, and goodwill balances of $1.4 billion, and $447.0 million, respectively.

Our 2022 goodwill impairment analysis concluded that the fair value of the Home Health and Therapies, Behavioral Health, Institutional Pharmacy, Specialty Pharmacy and Home Infusion reporting units were each substantially in excess of carrying value. Our Hospice Pharmacy and Workforce Solutions reporting units had carrying amounts that exceeded their respective fair values, and an aggregate carrying amount of $332.1 million. We recognized non-cash goodwill impairment charges of $25.5 million and $15.4 million related to the Hospice Pharmacy and Workforce Solutions reporting units, respectively, during the year ended December 31, 2022. Following the goodwill impairment charges, the Hospice Pharmacy and Workforce Solutions reporting units had goodwill balances of $92.1 million and $77.4 million, respectively.

The Company's intangible assets are comprised primarily of trade names, customer contracts and relationships, and licenses, which are amortized on a straight-line basis over their estimated useful lives, which is generally two to twenty years. The Company's indefinite-lived intangible assets are comprised of indefinite lived licenses, which are reviewed for impairment annually or more frequently if events occur or circumstances change that would more-likely-than-not reduce the fair value of the intangible asset below its carrying amount. We elected to perform a qualitative assessment for our intangible assets for our annual impairment test in the fourth quarter of 2024, 2023 and 2022. As a result of our qualitative analyses, we determined that it was more-likely-than-not that the fair values of our indefinite-lived intangible assets were greater than their carrying values. We recorded intangible impairment of $6.6 million and $8.3 million related to definite-lived intangible licenses for the years ended December 31, 2024 and 2023, respectively. During the year ended December 31, 2022, we recorded no impairment related to intangible assets.

The estimates and assumptions we use to estimate fair values when performing quantitative assessments are highly subjective judgments based on our experience and knowledge of our operations. Significant changes in the assumptions used in our analysis could result in an impairment charge related to goodwill or the indefinite-lived intangible assets. Circumstances that could result in changes to future estimates and assumptions include, but are not limited to, expectations of lower revenue growth, which can be caused by a variety of factors, fluctuations in comparable company and acquisition market multiples, increases in income tax rates, and increases in discount rates.

**Self-insurance**

The Company is self-insured for a substantial portion of the Company's general and professional liability, automobile liability, workers' compensation risks, and health benefits, subject to certain stop loss coverage at a high level of losses. Given the policy limits and high deductibles and/or self-insured retentions on many of the Company's insurance programs, the vast majority of claims may not be paid by third-party insurance.

The Company's self-insured liabilities contain uncertainties because management must make assumptions and apply judgment to estimate the ultimate cost of reported claims and claims incurred but not reported as of the balance sheet date. The Company's provisions for losses for workers' compensation and health benefit risks are based upon actuarially determined estimates and include an amount determined from reported claims and an amount based on past experiences for losses incurred but not reported. The Company's provisions for general and professional and automobile liabilities are recorded on a claims-made basis, which includes estimates of fully developed losses for both reported and unreported claims. Accruals for general and professional and automobile liabilities are based on analyses performed internally by management.

On a quarterly basis, the Company evaluates the assumptions and the valuations to determine the adequacy of the self-insurance liabilities. The following are certain of the key assumptions and other factors that significantly influence the Company's estimate of self-insurance liabilities: historical claims experience; trending of loss development factors; trends in the frequency and severity of claims; coverage limits of third-party insurance; demographic information; medical cost inflation; and payroll dollars. Any adjustments to the liabilities are reflected in earnings in the period identified.

The time period to resolve claims can vary depending upon the jurisdiction, the nature, and the form of resolution of the claims. The estimation of the timing of payments beyond a year can vary significantly. In addition, if current and future claims differ from historical trends, our estimated liabilities for self-insured claims may be significantly affected. The Company's self-insurance liabilities for workers' compensation are discounted based on actuarial estimates of claim payment patterns.

The Company believes the provision for loss is adequate for claims that have been reported but not paid and for claims that have been incurred but not reported. Due to the considerable variability that is inherent in such estimates, there can be no assurance the ultimate liability will not exceed management's estimates. If actual results are not consistent with the assumptions and judgments, the Company may be exposed to gains or losses that could be material.

**Recent Accounting Pronouncements**

Refer to Note 1 "Significant Accounting Policies" within our audited consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K for further discussion.

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

### *Impact of Inflation*

Wages and other expenses increase during periods of inflation and when labor shortages occur in the marketplace. The impact of inflation on the Company is primarily in the area of labor costs. The healthcare industry is labor intensive. There can be no guarantee we will not experience increases in the cost of labor, particularly given the shortage of qualified caregivers in our markets, and the demand for homecare services is expected to grow.

In addition, increases in healthcare costs are typically higher than inflation and impact our costs under our employee benefit plans. Managing these costs remains a significant challenge and priority for us. While we believe the effects of inflation, if any, and labor shortages on our results of operations and financial condition have not been significant, there can be no guarantee we will not experience the effect of inflation in the future.

In addition, suppliers pass along rising costs to us in the form of higher prices, which impacts us primarily in the area of pharmaceutical drug costs in our Pharmacy Solutions segment. Changes in costs of drugs can be accompanied by a change in rate that we pass along to our customers. Additionally, our supply chain efforts have enabled us to effectively manage and mitigate any inflationary impacts in our supply chain over recent years. However, we cannot predict our ability to cover future cost increases.

We have little or no ability to pass on certain of these increased costs associated with providing services to Medicare and Medicaid patients due to federal and state laws that establish fixed reimbursement rates.

### *Interest Rate Risk*

Our Company is exposed to interest rate risk related to changes in interest rates for borrowings under our First Lien Facilities. Although we hedge a portion of our interest rate risk through interest rate swaps, any borrowings under our First Lien in excess of the notional amount of the swaps are subject to variable interest rates.

As of December 31, 2024, we had three interest rate swaps with a combined notional value of $2.0 billion that were designated as cash flow hedges of interest rate risk. See Note 5 “Debt and Derivatives” within the audited consolidated financial statements and related notes, included elsewhere in the Annual Report on Form 10-K.

The changes in fair value of derivatives designated and that qualify as cash flow hedges are recorded in accumulated other comprehensive income, or AOCI, and are subsequently reclassified into earnings in the period that the hedged forecasted transaction impacts earnings. Amounts reported in AOCI related to derivatives will be reclassified to interest expense, net as interest payments are made on the Company’s variable-rate debt. The Company expects approximately $10.6 million of pre-tax gains to be reclassified out of AOCI into earnings within the next twelve months.

As of December 31, 2024, our debt outstanding was $2.7 billion, of which $2.0 billion is fixed through interest rate swap agreements. A hypothetical 1% increase in interest rates would increase our net loss and decrease our cash flows by $6.1 million on an annual basis based upon our borrowing level at December 31, 2024.

**Item 8. Financial Statements and Supplementary Data**

## INDEX TO CONSOLIDATED FINANCIAL STATEMENTS

## Report of Independent Registered Public Accounting Firm

To the Shareholders and Board of Directors
BrightSpring Health Services, Inc.:

*Opinion on the Consolidated Financial Statements*

We have audited the accompanying consolidated balance sheets of BrightSpring Health Services, Inc. and subsidiaries (the Company) as of December 31, 2024 and 2023, the related consolidated statements of operations, comprehensive loss, shareholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2024, and the related notes (collectively, the consolidated financial statements). In our opinion, the consolidated financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2024 and 2023, and the results of its operations and its cash flows for each of the years in the three-year period ended December 31, 2024, in conformity with U.S. generally accepted accounting principles.

*Basis for Opinion*

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

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud. The Company is not required to have, nor were we engaged to perform, an audit of its internal control over financial reporting. As part of our audits, we are required to obtain an understanding of internal control over financial reporting but not for the purpose of expressing an opinion on the effectiveness of the Company's internal control over financial reporting. Accordingly, we express no such opinion.

Our audits included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. We believe that our audits provide a reasonable basis for our opinion.

*Critical Audit Matter*

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

*Valuation of self-insurance liabilities*

As discussed in Note 1 to the consolidated financial statements, the Company is self-insured for a substantial portion of its general and professional liabilities, automobile liabilities, and workers' compensation liabilities. As discussed in Note 8 to the consolidated financial statements, accrued expenses include workers' compensation insurance reserves, general and professional liability insurance reserves, and automobile insurance reserves of $19,966 thousand, $8,328 thousand, and $21,353 thousand, respectively, and long-term liabilities include workers' compensation insurance reserves, general and professional liability insurance reserves, and automobile insurance reserves of $25,360 thousand, $21,182 thousand, and $9,034 thousand, respectively, as of December 31, 2024.The liabilities recognized for workers' compensation are actuarially determined estimates, while the other reserves are based on analyses performed by management.

We identified the evaluation of the self-insurance liabilities noted above as a critical audit matter. Specifically, evaluation of the Company's determination of the claims incurred but not reported for workers' compensation liabilities involved auditor judgment due to significant measurement uncertainty. In addition, evaluation of the Company's estimates of the ultimate cost of reported claims related to general and professional liabilities, automobile liabilities, and workers' compensation liabilities involved actuarial professionals with specialized skills and knowledge.

The following are the primary procedures we performed to address this critical audit matter. We evaluated the Company's ability to estimate self-insurance reserves, and assessed potential management bias, by comparing the prior year estimated reserves to subsequent adjustments to those reserves recorded in the current year. We involved actuarial professionals with specialized skills and knowledge, who assisted in:

- evaluating the Company's expected loss rates used to determine claims incurred but not reported for workers' compensation liabilities by developing an independent expectation of the loss rates using actuarial methodologies and independent assumptions and comparing them to the Company's expected loss rates
- evaluating the Company's determination of the ultimate cost of reported claims by developing an independent estimate of the Company's loss development factors and comparing them to the Company's loss development factors used to determine the ultimate cost of reported claims.

/s/ KPMG LLP

We have served as the Company's auditor since 2019.

Louisville, Kentucky
March 6, 2025

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Balance Sheets**
*(In thousands, except share and per share data)*

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| **Assets** | | |
| **Current assets:** | | |
| Cash and cash equivalents | $ 61,253 | $ 13,071 |
| Accounts receivable, net of allowance for credit losses | 1,028,654 | 881,627 |
| Inventories | 640,568 | 402,776 |
| Prepaid expenses and other current assets | 162,579 | 159,167 |
| **Total current assets** | 1,893,054 | 1,456,641 |
| Property and equipment, net of accumulated depreciation of $450,309 and $368,089 at December 31, 2024 and 2023, respectively | 250,286 | 245,908 |
| Goodwill | 2,671,524 | 2,608,412 |
| Intangible assets, net of accumulated amortization | 811,482 | 881,476 |
| Operating lease right-of-use assets, net | 249,748 | 267,446 |
| Deferred income taxes, net | 5,575 | — |
| Other assets | 44,471 | 72,838 |
| **Total assets** | $ 5,926,140 | $ 5,532,721 |
| **Liabilities, Redeemable Noncontrolling Interests, and Equity** | | |
| **Current liabilities:** | | |
| Trade accounts payable | $ 941,292 | $ 641,607 |
| Accrued expenses | 356,538 | 492,363 |
| Current portion of obligations under operating leases | 69,665 | 71,053 |
| Current portion of obligations under financing leases | 12,113 | 11,141 |
| Current portion of long-term debt | 48,725 | 32,273 |
| **Total current liabilities** | 1,428,333 | 1,248,437 |
| Obligations under operating leases, net of current portion | 187,614 | 201,655 |
| Obligations under financing leases, net of current portion | 24,991 | 22,528 |
| Long-term debt, net of current portion | 2,561,858 | 3,331,941 |
| Deferred income taxes, net | — | 23,668 |
| Long-term liabilities | 71,759 | 91,943 |
| **Total liabilities** | 4,274,555 | 4,920,172 |
| Redeemable noncontrolling interests | 3,730 | 27,139 |
| **Shareholders' equity:** | | |
| Common stock, $0.01 par value, 1,500,000,000 and 137,398,625 shares authorized, 174,245,990 and 117,857,055 shares issued and outstanding at December 31, 2024 and 2023, respectively | $ 1,742 | $ 1,179 |
| Preferred stock, $0.01 par value, 250,000,000 authorized; no shares issued and outstanding at December 31, 2024; no shares authorized, issued or outstanding at December 31, 2023 | — | — |
| Additional paid-in capital | 1,866,850 | 771,336 |
| Accumulated deficit | (222,155) | (200,319) |
| Accumulated other comprehensive income | 1,418 | 12,544 |
| Total shareholders' equity | 1,647,855 | 584,740 |
| Noncontrolling interest | — | 670 |
| **Total equity** | 1,647,855 | 585,410 |
| **Total liabilities, redeemable noncontrolling interests, and equity** | $ 5,926,140 | $ 5,532,721 |

See accompanying notes to the consolidated financial statements.

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Statements of Operations**
*(In thousands, except per share amounts)*

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Revenues: | | | |
| Products | $ 8,754,282 | $ 6,522,450 | $ 5,264,423 |
| Services | 2,512,190 | 2,303,725 | 2,456,137 |
| Total revenues | 11,266,472 | 8,826,175 | 7,720,560 |
| Cost of goods | 8,008,501 | 5,840,716 | 4,635,404 |
| Cost of services | 1,669,536 | 1,551,665 | 1,730,912 |
| Gross profit | 1,588,435 | 1,433,794 | 1,354,244 |
| Selling, general, and administrative expenses | 1,382,061 | 1,286,614 | 1,125,558 |
| Goodwill impairment loss | — | — | 40,856 |
| Operating income | 206,374 | 147,180 | 187,830 |
| Loss on extinguishment of debt | 12,726 | — | — |
| Interest expense, net | 228,386 | 324,593 | 233,584 |
| Loss before income taxes | (34,738) | (177,413) | (45,754) |
| Income tax (benefit) expense | (14,217) | (20,578) | 8,465 |
| Net loss | (20,521) | (156,835) | (54,219) |
| Net loss attributable to noncontrolling interests | (2,459) | (2,232) | (312) |
| Net loss attributable to BrightSpring Health Services, Inc. and subsidiaries | $ (18,062) | $ (154,603) | $ (53,907) |
| | | | |
| Net loss per common share (Note 9): | | | |
| Loss per share - basic | $ (0.09) | $ (1.31) | $ (0.46) |
| Loss per share - diluted | $ (0.09) | $ (1.31) | $ (0.46) |
| Weighted average shares outstanding: | | | |
| Basic | 192,997 | 117,868 | 117,840 |
| Diluted | 192,997 | 117,868 | 117,840 |

See accompanying notes to the consolidated financial statements.

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Statements of Comprehensive Loss**
*(In thousands)*

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Net loss | $ (20,521) | $ (156,835) | $ (54,219) |
| Other comprehensive (loss) income, net of tax: | | | |
| Foreign currency translation adjustments | (309) | 131 | (353) |
| Cash flow hedges: | | | |
| Net change in fair value, net of tax [1] | 15,826 | 14,948 | 28,128 |
| Amounts reclassified to earnings, net of tax [2] | (26,643) | (23,727) | (503) |
| Total other comprehensive (loss) income | (11,126) | (8,648) | 27,272 |
| Total comprehensive loss | (31,647) | (165,483) | (26,947) |
| Comprehensive loss attributable to redeemable noncontrolling interests | (1,789) | (2,167) | (312) |
| Comprehensive loss attributable to noncontrolling interest | (670) | (65) | — |
| Comprehensive loss attributable to BrightSpring Health Services, Inc. and subsidiaries | $ (29,188) | $ (163,251) | $ (26,635) |

[1] The income tax effects of the net change in fair value were $(5,149), $(4,591), and $(9,026) for the years ended December 31, 2024, 2023, and 2022, respectively.
[2] The income tax effects of amounts reclassified to earnings were $8,646, $7,683, and $167 for the years ended December 31, 2024, 2023, and 2022, respectively.

See accompanying notes to the consolidated financial statements.

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Statements of Shareholders' Equity**
*(In thousands, except share data or otherwise indicated)*

| | Common Stock | | Additional Paid-In Capital | (Accumulated Deficit) Retained Earnings | Accumulated Other Comprehensive Income | Noncontrolling Interest | Total |
|---|---|---|---|---|---|---|---|
| | Shares | Amount | | | | | |
| Balances at January 1, 2022 | 117,824,173 | $ 1,178 | $ 772,451 | $ 971 | $ 217 | $ — | $ 774,817 |
| Net loss [1] | — | — | — | (53,907) | — | — | (53,907) |
| Other comprehensive income, net of tax | — | — | — | — | 27,272 | — | 27,272 |
| Share-based compensation | — | — | 3,547 | — | — | — | 3,547 |
| Acquisition of noncontrolling interest | — | — | 1,890 | | — | — | 1,890 |
| Adjustments to redemption value of redeemable noncontrolling interest | | — | | 923 | — | — | 923 |
| Shares issued under share-based compensation plan, including tax effects | 36,666 | 1 | 233 | — | — | — | 234 |
| Other | — | — | — | 6,297 | (6,297) | — | — |
| Balances at December 31, 2022 | 117,860,839 | $ 1,179 | $ 778,121 | $ (45,716) | $ 21,192 | $ — | $ 754,776 |
| Net loss [1] | — | — | — | (154,538) | — | (65) | (154,603) |
| Other comprehensive loss, net of tax | — | — | — | — | (8,648) | — | (8,648) |
| Share-based compensation | — | — | 3,917 | — | — | — | 3,917 |
| Repurchase of shares of common stock | (81,654) | (1) | (1,299) | — | — | — | (1,300) |
| Shares issued under share-based compensation plan, including tax effects | 77,870 | 1 | 597 | | — | — | 598 |
| Repurchase of stock options | — | — | (10,000) | — | — | — | (10,000) |
| Investment in noncontrolling interest | — | — | — | (65) | — | 735 | 670 |
| Balances at December 31, 2023 | 117,857,055 | $ 1,179 | $ 771,336 | $ (200,319) | $ 12,544 | $ 670 | $ 585,410 |
| Net loss [1] | — | — | — | (18,062) | — | (670) | (18,732) |
| Other comprehensive loss, net of tax | — | — | — | — | (11,126) | — | (11,126) |
| Share-based compensation | — | — | 69,174 | — | — | — | 69,174 |
| Exercise of stock options | 234,608 | 2 | 1,533 | — | — | — | 1,535 |
| Issuance of common stock for settlement of RSUs | 241,971 | 2 | (2) | — | — | — | — |
| Shares withheld related to net share settlement | (93,678) | (1) | (1,195) | — | — | — | (1,196) |
| Shares issued for payment of acquisition | 2,570,503 | 26 | 31,055 | — | — | — | 31,081 |
| Derecognition of redeemable noncontrolling interest, net of tax | — | — | 12,439 | (3,774) | — | — | 8,665 |
| Issuance of common stock on initial public offering, net [2] | 53,333,334 | 533 | 661,244 | — | — | — | 661,777 |
| Proceeds from stock purchase contract issued under tangible equity units, net [3] | — | — | 321,611 | — | — | — | 321,611 |
| Other | 102,197 | 1 | (345) | — | — | — | (344) |
| Balances at December 31, 2024 | 174,245,990 | $ 1,742 | $ 1,866,850 | $ (222,155) | $ 1,418 | $ — | $ 1,647,855 |

[1] Net loss to the Company for the years ended December 31, 2024, 2023, and 2022 excludes $(1,789), $(2,167), and $(312), respectively, allocable to the redeemable noncontrolling interests for our joint venture arrangements.
[2] Issuance of common stock on initial public offering is presented net of underwriting discounts and commissions, and offering-related expenses of $36.8 million and tax benefit of $5.3 million
[3] Proceeds from stock purchase contract issued under tangible equity units is presented net of underwriting discounts and commissions of $9.1 million

See accompanying notes to the consolidated financial statements.

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Statements of Cash Flows**
*(In thousands)*

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| **Operating activities:** | | | |
| Net loss | $ (20,521) | $ (156,835) | $ (54,219) |
| Adjustments to reconcile net loss to cash provided by (used in) operating activities: | | | |
| Depreciation and amortization | 204,482 | 202,336 | 203,970 |
| Impairment of long-lived assets | 10,235 | 10,631 | 10,821 |
| Change in fair value of contingent consideration, net | 2,261 | — | — |
| Payment of contingent consideration in excess of acquisition date fair value | (2,351) | — | — |
| Goodwill impairment | — | — | 40,856 |
| Provision for credit losses | 33,998 | 23,237 | 15,065 |
| Amortization of deferred debt issuance costs | 12,108 | 20,916 | 20,439 |
| Share-based compensation | 69,174 | 3,917 | 3,547 |
| Deferred income taxes, net | (25,914) | (52,632) | (27,962) |
| Loss on divestiture | — | — | 5,502 |
| Loss on extinguishment of debt | 12,726 | — | — |
| Loss (gain) on disposition of fixed assets | 101 | 349 | (903) |
| Other | (2,451) | (572) | 2,696 |
| Change in operating assets and liabilities, net of acquisitions and dispositions: | | | |
| Accounts receivable | (179,040) | (127,246) | (150,466) |
| Prepaid expenses and other current assets | 7,595 | (34,899) | (24,280) |
| Inventories | (236,514) | 28,660 | (131,833) |
| Trade accounts payable | 303,209 | 105,649 | 133,466 |
| Accrued expenses | (144,580) | 193,633 | (46,035) |
| Other assets and liabilities | (20,744) | (6,361) | (5,317) |
| Net cash provided by (used in) operating activities | $ 23,774 | $ 210,783 | $ (4,653) |

**BrightSpring Health Services, Inc. and Subsidiaries**
**Consolidated Statements of Cash Flows (continued)**
*(In thousands)*

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| **Investing activities:** | | | |
| Purchases of property and equipment | $ (80,913) | $ (73,527) | $ (70,113) |
| Acquisitions of businesses, net of cash acquired | (59,797) | (63,058) | (42,459) |
| Proceeds from sale of business, net of cash divested | — | — | 155,793 |
| Other | 473 | 2,152 | 2,135 |
| Net cash (used in) provided by investing activities | $ (140,237) | $ (134,433) | $ 45,356 |
| **Financing activities:** | | | |
| Long-term debt borrowings | $ 2,566,000 | $ — | $ — |
| Long-term debt repayments | (3,396,334) | (30,441) | (40,721) |
| Proceeds from issuance of common stock on initial public offering, net | 656,485 | — | — |
| Proceeds from issuance of tangible equity units, net | 389,000 | — | — |
| Borrowings (repayments) of the Revolving Credit Facility, net | 12,600 | (24,100) | (17,300) |
| Payment of debt issuance costs | (47,045) | — | — |
| Repurchase of shares of common stock | (650) | (650) | — |
| Proceeds from shares issued under share-based compensation plan | 1,535 | 598 | 234 |
| Taxes paid related to net share settlement of equity awards | (1,196) | — | — |
| Repurchase of stock options | — | (10,000) | — |
| Payment of contingent consideration up to acquisition date fair value | (1,805) | (1,453) | (4,364) |
| Distributions to redeemable noncontrolling interests | — | — | (750) |
| Purchase of redeemable noncontrolling interest | (2,316) | — | — |
| Investment in noncontrolling interests | — | 735 | — |
| Payment of financing lease obligations | (11,629) | (11,596) | (10,909) |
| Net cash provided by (used in) financing activities | $ 164,645 | $ (76,907) | $ (73,810) |
| Net increase (decrease) in cash and cash equivalents | 48,182 | (557) | (33,107) |
| Cash and cash equivalents at beginning of year | 13,071 | 13,628 | 46,735 |
| Cash and cash equivalents at end of year | $ 61,253 | $ 13,071 | $ 13,628 |
| Supplemental disclosures of cash flow information: | | | |
| Cash paid for: | | | |
| Interest, net | $ 211,387 | $ 303,530 | $ 213,308 |
| Income taxes, net of refunds | $ 24,953 | $ 37,499 | $ 28,851 |
| Supplemental schedule of non-cash investing and financing activities: | | | |
| Notes issued and contingent liabilities assumed in connection with acquisitions | $ 22,302 | $ 7,519 | $ 5,134 |
| Financing lease obligations (Note 12) | $ 13,095 | $ 11,562 | $ 10,652 |
| Repurchases of common stock in accounts payable | $ — | $ 650 | $ — |
| Purchases of property and equipment in accounts payable | $ 12,136 | $ 12,981 | $ 4,597 |
| Acquisition consideration in accounts payable | $ — | $ 2,500 | $ — |
| Consideration for purchase of redeemable noncontrolling interest in accounts payable | $ 5,100 | $ — | $ — |
| Shares issued in connection with acquisitions | $ 31,081 | $ — | $ — |

See accompanying notes to the consolidated financial statements.

**BrightSpring Health Services, Inc. and Subsidiaries**
**Notes to Consolidated Financial Statements**

## 1. Significant Accounting Policies

*Description of Business*

BrightSpring Health Services, Inc. and its subsidiaries ("BrightSpring," the "Company," "we," "us," or "our") is a leading home and community-based healthcare services platform, focused on delivering complementary pharmacy and provider services to complex patients. Our platform delivers clinical services and pharmacy solutions across Medicare, Medicaid, and commercially-insured populations.

On December 7, 2017, affiliates of Kohlberg Kravis Roberts & Co. L.P. ("KKR") and Walgreens Boots Alliance, Inc. ("WBA") purchased PharMerica Corporation ("PharMerica") and on March 5, 2019, expanded with the acquisition of BrightSpring Health Holdings Corp. ("BrightSpring Corp. Acquisition"). The surviving entity was renamed BrightSpring Health Services, Inc.

BrightSpring Health Services, Inc. completed its initial public offering ("IPO") of 53,333,334 shares of its common stock at a price of $13.00 per share and its concurrent offering of 8,000,000 6.75% tangible equity units ("TEUs") with a stated amount of $50.00 per unit in January 2024 (collectively, "the IPO Offerings"). The net proceeds from the IPO Offerings amounted to $656.5 million and $389.0 million for the common stock and TEUs, respectively, after deducting underwriting discounts, commissions, and offering-related expenses. The common stock and TEUs began trading on the Nasdaq Global Select Market on January 26, 2024 under the ticker symbols "BTSG" and "BTSGU," respectively. BrightSpring Health Services, Inc. used a portion of the net proceeds received from the IPO Offerings to repay certain indebtedness (see Note 5) and pay termination fees in connection with the termination of our monitoring agreement with KKR and WBA (the "Monitoring Agreement") (see Note 16). The remaining proceeds were retained for general corporate purposes.

*Principles of Consolidation*

The accompanying consolidated financial statements include the accounts of BrightSpring Health Services, Inc. and its subsidiaries. The Company consolidates its majority-owned and controlled entities, including variable interest entities ("VIEs") for which the Company is the primary beneficiary. All intercompany balances and transactions have been eliminated.

We record a noncontrolling interest for the allocable portion of income or loss and comprehensive income or loss to which the noncontrolling interest holders are entitled based upon their ownership share of the affiliate. The Company determined noncontrolling interests for certain of these VIEs to be redeemable noncontrolling interests, which are presented on the consolidated balance sheets as redeemable noncontrolling interests (see Note 15).

*Basis of Presentation*

The accompanying consolidated financial statements have been prepared in accordance with U.S. generally accepted accounting principles ("U.S. GAAP").

*Use of Estimates*

The preparation of consolidated financial statements in conformity with U.S. GAAP requires us to make estimates and assumptions that affect the reported amounts and related disclosures. We rely on historical experience and on various other assumptions that we believe to be reasonable under the circumstances to make judgments about the carrying values of assets and liabilities that are not readily apparent from other sources. Significant estimates are involved in the valuation of accounts receivable, inventory, long-lived assets, intangible assets, derivatives, contingent consideration, taxes, insurance reserves, share-based compensation, and goodwill. Actual amounts may differ from these estimates.

*Revenue Recognition*

The Company recognizes the amount of revenue to which it expects to be entitled for the transfer of promised goods or services to customers. For transactions involving the transfer of goods, revenues are primarily recognized when the customer obtains control of the products sold, which is generally upon shipment or delivery, depending on the delivery terms specified in the sales agreement. For transactions exclusively involving provision of services, revenues are recognized over time based on an appropriate measure of progress. Additionally, where we are required to collect sales taxes from our customers, revenue is recognized net of any taxes collected, and the sales tax amounts are recorded as a liability until remitted to the governmental taxing authorities. The Company's revenue recognition policy by reportable segment is as follows:

*Provider Services*

Provider Services revenues are generated from providing care services directly to consumers under contracts with state, local and other governmental agencies, as well as commercial insurance companies, long-term care insurance policies, private pay customers, and management contracts with private operators. Generally, these contracts, which are negotiated based on current contract practices as appropriate for the payor, establish the terms of a customer relationship and set the broad range of terms for services to be performed at stated rates. The contracts do not give rise to rights and obligations until a service request is placed with the Company. Contract terms vary but generally are for one year or less with available renewal options and a thirty-to-sixty-day reimbursement period. When a service request is placed with the Company, it creates the performance obligation to provide a defined quantity of service hours per patient. Performance obligations to deliver patient care services are satisfied over time and revenue is recognized using a time-based input method to measure progress against the contract between the Company and the customer, given that consumers simultaneously receive and consume the benefits provided by the Company as the services are performed. Revenues are recognized over a period of time as the services are rendered at the contractual rate established at or before the time services are rendered; thus, there are no forms of variable consideration associated with the various revenue streams.

*Pharmacy Solutions*

Pharmacy Solutions revenues are generated from the products and services provided in association with the distribution of prescription drugs to consumers primarily under contracts with Prescription Drug Plans ("PDPs") under Medicare Part D, state Medicaid programs, long-term care institutions, third party insurance companies and private payors. Services provided include individualized medication management and support, staff and patient support programs and solutions, regulatory support, and product delivery. When an order for a prescription is placed with the Company, it creates the performance obligation to deliver a prescription and related services. The performance obligation is satisfied at a point in time upon shipment for specialty pharmacies and upon delivery for home and community-based pharmacies and facility-based pharmacies. Revenues are recognized at a point in time when the associated performance obligations are satisfied at the contractual rate established at or before the time the performance obligation is satisfied.

*Contractual Allowances*

Revenues and the associated receivables are based upon the actual reimbursements expected to be received and include contractual allowances based upon historical trends, contractual reimbursement terms, and other factors which may impact ultimate reimbursement. Amounts are adjusted to actual reimbursed amounts based upon cash receipts.

*Cost of Goods and Cost of Services*

We classify expenses directly related to providing goods and services, including associated depreciation and amortization expense, as cost of goods and cost of services, respectively. Direct costs and expenses primarily include cost of drugs, salaries and benefits for direct care and service professionals, contracted labor costs, insurance costs, transportation costs for clients requiring services, certain client expenses such as food, supplies and medicine, residential occupancy expenses, which primarily comprise rent and utilities, and other miscellaneous direct goods or service-related expenses.

*Supplier Rebates*

Pharmacy Solutions receives rebates on purchases from select vendors and suppliers for achieving purchase volumes, primarily through agreements with or between WBA, certain of its affiliates, and AmerisourceBergen Drug Corporation ("ABDC"). Rebates for brand name products are generally based on purchasing volumes or actual prescriptions dispensed. Rebates for generic products are primarily based on achieving purchasing volume requirements or other contractually based requirements. The Company considers these rebates product discounts, and as a result, the rebates are recorded as a reduction of product cost and relieved through cost of goods upon the sale of the related inventory or as a reduction of inventory for drugs which have not yet been sold. The rebate recorded is adjusted, if necessary, after the third party validates the appropriate data and notifies the Company of its agreement under the terms of the contract.

*Cash and Cash Equivalents*

Cash and cash equivalents consist of cash on hand and cash equivalents with original maturities of three months or less. The Company places its cash in financial institutions that are federally insured. The majority of the Company's bank accounts are zero balance accounts where cash needs are funded as checks are presented for payment by the holder. Checks issued pending clearance that result in overdraft balances for accounting purposes are included in accrued expenses in our consolidated balance sheets, and the change in the related balances are reflected in operating activities in the Company's consolidated statements of cash flows.

*Accounts Receivable*

Accounts receivable primarily consist of amounts due from PDPs under Medicare Part D, institutional healthcare providers, state Medicaid programs, other government agencies, third party insurance companies, and private payors. To provide for accounts receivable that could become uncollectible in the future, the Company establishes an allowance for credit losses to reduce the carrying value of such receivables to the extent it is probable that a portion or all of a particular account will not be collected, with the related expense recorded as a component of selling, general, and administrative expenses. The allowance for credit losses totaled $45.0 million, $45.9 million and $47.4 million as of December 31, 2024, 2023, and 2022, respectively, and is reflected in accounts receivable, net of allowance for credit losses in our consolidated balance sheets.

We regularly monitor past due accounts and establish appropriate reserves to cover potential losses and consider historical experience, pricing discrepancies, the current economic environment, customer credit ratings and/or bankruptcies to develop our allowance for credit losses. We review these factors quarterly to determine if any adjustments are needed to the allowance and write off any amounts deemed uncollectible against the established allowance for credit losses. Activity in the allowance for credit losses for the years ended December 31, 2024 and 2023 included provisions of credit losses of $34.0 million and $23.3 million, respectively; write offs of $40.7 million and $26.3 million, respectively; and recoveries and other changes of $5.8 million and $1.5 million, respectively.

*Inventories*

Inventory is primarily located at the Company's pharmacy locations. Inventory consists solely of finished products (primarily prescription drugs) and is valued at the lower of first-in, first-out ("FIFO") cost or net realizable value. Physical inventory counts are performed, at a minimum, on a quarterly basis at all pharmacy sites. Inventory and cost of goods are adjusted based upon the results of the physical inventory counts.

*Investments*

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

We account for investments in entities in which we have the ability to exercise significant influence under the equity method if we hold 50% or less of the voting stock and the entity is not a VIE in which we are the primary beneficiary. The book value of investments that we account for under the equity method of accounting totaled $0.7 million as of December 31, 2024 and 2023, and is reflected in other assets within our consolidated balance sheets.

*Goodwill and Intangible Assets*

The Company tests goodwill for impairment annually as of October 1, or more frequently if impairment indicators arise. The Company had six reporting units for the purpose of goodwill testing in 2024 and 2023: Institutional Pharmacy, Home Infusion, Specialty Solutions, Hospice Pharmacy, Behavioral Health, and Home Health and Therapies. In 2022, the Company had a seventh reporting unit, Workforce Solutions, which was sold effective November 1, 2022. In 2024, 2023 and 2022, the Company performed a quantitative assessment of all reporting units as of October 1. Refer to Note 4 for discussion of results.

Our intangible assets consist primarily of customer relationships, trade names, and definite-lived licenses, which are amortized over two to twenty years, based on their estimated useful lives. We also have indefinite-lived intangible licenses. The Company tests all intangible assets for impairment at least annually, and more frequently if impairment indicators arise. If the carrying amount of an intangible asset exceeds its fair value, an impairment loss is recognized. We elected to perform a qualitative assessment for all intangible assets for our annual impairment test in the fourth quarter of 2024, 2023 and 2022. As a result of our qualitative analyses, we determined that it was more-likely-than-not that the fair values of our indefinite-lived intangible assets were greater than their carrying values. We recorded impairment related to definite-lived intangible licenses of $6.6 million, $8.3 million, and $8.3 million for the years ended December 31, 2024, 2023 and 2022, respectively.

*Debt Issuance Costs*

The Company capitalizes financing fees related to acquiring or issuing new debt instruments. These expenditures include bank fees and premiums, legal costs, and filing fees. Debt issuance costs are capitalized and amortized as interest expense over the terms of the related debt using the effective interest rate method. Debt issuance costs related to term loans and specified maturity borrowings are presented as a direct reduction of the carrying value of the debt. Debt issuance costs related to revolving credit facilities and lines of credit are presented as other assets in our consolidated balance sheets.

*Deferred Offering Costs*

Deferred offering costs of $5.6 million, which consist of legal, accounting, filing, and other fees and costs directly attributable to the Company's IPO, were capitalized, and upon completion of the IPO in January 2024, were subsequently recorded in shareholders' equity as a reduction of proceeds during the first fiscal quarter. As of December 31, 2023, deferred offering costs of $3.9 million were capitalized and included in other assets in our consolidated balance sheets. There were no deferred offering costs as of December 31, 2024.

*Derivative Financial Instruments*

The Company has interest rate swap agreements to manage its interest rate exposure. The Company does not use financial instruments for trading or other speculative purposes.

The interest rate swap agreements are designated as qualifying cash flow hedging relationships and changes in the fair values that are included in the assessment of effectiveness are recognized in accumulated other comprehensive income (“AOCI”) until the hedged items affect earnings. The Company formally assesses, both at the inception of the hedging relationship and on an ongoing basis, whether the derivatives that are used in hedging relationships are highly effective in offsetting changes in cash flows of hedged transactions. The gain or loss on the derivative included in the assessment of effectiveness is reported as a component of other comprehensive income (“OCI”) and reclassified into earnings in the same period or periods during which the hedged transaction affects earnings.

The Company’s policy for treatment of discontinued derivative instruments states that the Company will discontinue hedge accounting prospectively when it determines that the derivative is no longer effective in offsetting cash flows attributable to the hedged risk, the derivative expires or is sold, terminated, or exercised, the cash flow hedge is de-designated because a forecasted transaction is not probable of occurring, or management determines to remove the designation of the cash flow hedge. Additionally, if it becomes probable that a forecasted transaction will not occur, the Company will recognize immediately in earnings gains and losses that were accumulated in OCI related to the hedging relationship. In all situations in which hedge accounting is discontinued and the derivative remains outstanding, the Company would continue to carry the derivative at its fair value on the consolidated balance sheets and recognize any subsequent changes in its fair value in earnings.

*Income Taxes*

Our provision for income taxes is based on expected book income, permanent book/tax differences, discrete items, and statutory tax rates in the various jurisdictions in which we operate. Income tax (benefit) expense includes the recognized portion of current and deferred income taxes at a federal, state, and local level. Significant estimates and judgments are required in determining the provision for income taxes.

Deferred tax assets and liabilities are recognized for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect of a change in tax rates on deferred tax assets and liabilities is recognized in income in the period that includes the enactment date. A valuation allowance is provided for deferred assets if it is more-likely-than-not that some portion or all of the net deferred tax assets will not be realized.

The Company recognizes tax benefits that are considered more-likely-than-not to be sustained. Recognized income tax positions are measured at the largest amount that is more-likely-than-not of being realized. Changes in recognition or measurement are reflected in the period in which the change in judgment occurs.

Our policy is to recognize interest related to unrecognized tax benefits as interest expense, and penalties as selling, general, and administrative expenses in the consolidated statements of operations.

*Legal Contingencies*

We are a party to numerous claims and lawsuits with respect to various matters. Liabilities for loss contingencies arising from claims, assessments, litigation, fines and penalties, and other sources are recorded when it is probable that a liability has been incurred and the amount can be reasonably estimated. Legal costs incurred in connection with loss contingencies are expensed as incurred. See Note 14.

*Insurance Losses*

We self-insure a substantial portion of our general and professional liability, automobile liability, workers’ compensation risks, and health benefits, subject to certain stop loss coverage at a high level of losses. Provisions for losses for workers’ compensation risks and health benefits are based upon actuarially determined estimates and include an amount determined from reported claims and an amount based on past experiences for losses incurred but not reported. Estimates of workers’ compensation claims reserves have been

discounted using a discount rate of 4.5% and 4.0% at December 31, 2024 and 2023, respectively. Provisions for general and professional and automobile liabilities are recorded on a claims-made basis, which includes estimates of fully developed losses for both reported and unreported claims. Accruals for general and professional and automobile liabilities are based on analyses performed internally by management. The liabilities are evaluated quarterly, and any adjustments are reflected in earnings in the period identified. These liabilities are necessarily based on estimates and, while we believe that the provision for loss is adequate, the ultimate liability may differ than the amounts recorded.

*Transition Services Agreement ("TSA")*

In conjunction with the divestiture of Workforce Solutions on November 1, 2022, BrightSpring entered into a TSA with the buyer to provide certain transition services in exchange for service fees totaling $15.0 million over the 36 months following the close of the transaction. Services provided primarily include business development, finance and accounting, human resources, IT, facilities management, and compliance. For the years ended December 31, 2024 and 2023, the Company recognized $5.0 million and $7.1 million of other income within selling, general, and administrative expenses in our consolidated statements of operations related to services rendered under the TSA. For the year ended December 31, 2022, other income related to the TSA was not significant.

*Fair Value of Financial Instruments*

The Company uses valuation approaches that maximize the use of observable inputs and minimize the use of unobservable inputs to the extent possible. The Company determines fair value based on assumptions that market participants would use in pricing an asset or liability in the principal or most advantageous market. When considering market participant assumptions in fair value measurements, the following fair value hierarchy distinguishes between observable and unobservable inputs, which are categorized in one of the following levels:

(a) Level 1 Quoted prices in active markets for identified assets or liabilities.

(b) Level 2 Inputs other than quoted prices included within Level 1 that are observable for the asset or liability.

(c) Level 3 Unobservable inputs used in valuations in which there is little market activity for the asset or liability at the measurement date.

At December 31, 2024 and 2023, the fair value of cash and cash equivalents, accounts receivable, trade accounts payable, and accrued expenses approximated their carrying values because of the short-term nature of these instruments. The carrying amounts of the Company's long-term debt approximated fair value as interest rates and negotiated terms and conditions are consistent with current market rates due to the close proximity of recent refinancing transactions to the dates of these consolidated financial statements. All debt classifications and interest rate swaps represent Level 2 fair value measurements. Contingent consideration, which is comprised of future earn-outs and a post-closing equity adjustment feature associated with an acquisition, represents a Level 3 fair value measurement as there is little or no market data available. Refer to Note 13.

*Leases*

We determine if an arrangement is, or contains, a lease at contract inception and recognize a right-of-use asset and a lease liability at the lease commencement date. Leases with an initial term of 12 months or less are not recorded on the consolidated balance sheet for select asset classes. The lease liability is measured at the present value of future lease payments as of the lease commencement date. The right-of-use asset recognized is based on the lease liability adjusted for prepaid and deferred rent and unamortized lease incentives. Amortization of the right-of-use asset and accretion of the lease liability for an operating lease are recognized as a single lease cost, on a straight-line basis, over the lease term and included in cost of goods, cost of services, or selling, general, and administrative expenses on our consolidated statements of operations. A finance lease right-of-use asset is amortized on a straight-line basis over the lesser of the useful life of the leased asset or lease term, with interest costs reported separately. Variable common area maintenance and property tax expenses are expensed as incurred. Reductions of the right-of-use asset and the change in the lease liability are included within the changes in other assets and liabilities within operating activities on our consolidated statements of cash flows.

As our leases do not provide an implicit discount rate, we use our incremental borrowing rate as the discount rate for our leases, which is equal to the rate of interest the Company would have to pay on a collateralized basis to borrow an amount equal to the lease payments under similar terms. We determine the incremental borrowing rate applicable to each lease by reference to our outstanding secured borrowings. We then obtain a corporate yield curve with the same rating from an external source to adjust for differing tenors to reflect differing lease terms. We have elected to use the portfolio approach in determining our incremental borrowing rate. The incremental borrowing rate for all new or amended leases is based upon the lease terms. The lease terms for all the Company's leases include the contractually obligated period of the leases, plus any additional periods covered by Company options to extend the leases that the Company is reasonably certain to exercise.

Certain leases provide that the lease payments may be increased annually based on the fixed rate terms or adjustable terms such as the Consumer Price Index. Future base rent escalations that are not contractually quantifiable as of the lease commencement date are not included in our lease liability.

We regularly review the carrying value of our right-of-use assets with respect to any events or circumstances that indicate a possible inability to recover their carrying amount. Indicators of impairment include, but are not limited to, loss of contracts, significant census declines, reductions in reimbursement levels, significant litigation, and impact of economic conditions on service demands and levels. Our evaluation is based on undiscounted cash flows, operating results, as well as significant events or changes in the reimbursement or regulatory environment. If the undiscounted cash flows suggest the recorded amounts cannot be recovered, the carrying values of such assets are reduced to fair value. We recorded a right-of-use asset impairment of $3.6 million, $2.3 million and $2.5 million for the years ended December 31, 2024, 2023 and 2022, respectively, included within selling, general, and administrative expenses on the consolidated statements of operations.

*Property and Equipment*

Property and equipment are recorded at cost. Depreciation is recorded using the straight-line method over the estimated useful lives of the assets (generally, three to ten years for equipment and software and twenty years for buildings). Leasehold improvements are depreciated over the shorter of their estimated useful lives or the terms of their respective leases (generally, one to fifteen years).

We regularly review the carrying value of long-lived assets, with respect to any events or circumstances that indicate a possible inability to recover their carrying amount. Indicators of impairment include, but are not limited to, loss of contracts, significant census declines, reductions in reimbursement levels, significant litigation, and impact of economic conditions on service demands and levels. Our evaluation is based on undiscounted cash flows, operating results, as well as significant events or changes in the reimbursement or regulatory environment. If the undiscounted cash flows suggest the recorded amounts cannot be recovered, the carrying values of such assets are reduced to fair value. There was no impairment for the years ended December 31, 2024, 2023 and 2022.

*Segments*

Operating segments are defined as components of a company that engage in business activities from which it may earn revenues and incur expenses, and for which separate financial information is available and is regularly reviewed by the Company's chief operating decision maker ("CODM") to assess the performance of the individual segments and make decisions about resources to be allocated to the segments. The Company's operating segments have been identified based upon similar economic characteristics, nature of services, types of customers, and how the CODM manages the business and allocates resources in accordance with Financial Accounting Standards Board ("FASB") Accounting Standards Codification ("ASC") 280, *Segment Reporting*. The Company has identified three operating segments and has aggregated two of these operating segments into the Provider Services reportable segment. The Pharmacy Solutions operating segment is also a reportable segment.

In our Provider Services reportable segment, we provide a variety of services to help manage the whole-person health of our patients in their homes and communities through services such as home health care and hospice care and long-term specialty care. This includes providing services to support individuals who need assistance with daily living due to an intellectual, developmental or cognitive disability.

Our Pharmacy Solutions segment operates long-term institutional pharmacies, hospice pharmacies, specialty oncology pharmacies, and home infusion centers. Our service offerings are impacted by medication availability and reliability, cost containment, staff and patient support solutions, and regulatory support. Our Pharmacy Solutions segment is designed to drive medication adherence, patient outcomes, process efficiency, and compliance in a number of areas.

Substantially all of the Company's revenues are generated inside the United States, with the Provider Services segment generating insignificant amounts of revenue in Canada. Refer to Note 17 for additional information on the Company's segments.

*Share-Based Compensation*

The Company measures and recognizes compensation expense for share-based compensation awards based on the fair value of each award at its grant date and recognizes expense over the related service period on a straight-line basis. The Company accounts for forfeitures of share-based compensation awards as they occur. Compensation expense for share-based payments is included in cost of goods, cost of services, and selling, general, and administrative expenses in our consolidated statements of operations.

*Foreign Currency Translation*

BrightSpring's Canadian subsidiary designates its local currency as its functional currency. Operating results are translated into U.S. dollars using monthly average exchange rates, while balance sheet accounts are translated using period-end exchange rates. The resulting translation adjustments are included as a component of AOCI in shareholders' equity. Operating results from foreign operations are not material to our consolidated financial statements.

*Government Actions to Mitigate COVID-19's Impact*

On May 11, 2023, the Department of Health and Human Services declared that the COVID-19 pandemic is no longer a public health emergency. Through the Coronavirus Aid, Relief, and Economic Security Act, the Paycheck Protection Program and Health Care Enhancement Act, and the Consolidated Appropriations Act, $178 billion of funding was authorized to be distributed to health care providers through the Provider Relief Fund ("PRF") in response to COVID-19. The Company did not receive or recognize into income any funds from the PRF during the year ended December 31, 2024. The Company received and recognized into income $18.8 million in the year ended December 31, 2023, as compared with receiving no funds and recognizing $29.8 million into income during the year ended December 31, 2022. The income recognized in each period was offset directly by expenses incurred within selling, general, and administrative expenses in our consolidated statements of operations, resulting in no net financial impact to the Company.

*Recently Adopted Accounting Standards*

In November 2023, the FASB issued Accounting Standards Update ("ASU") 2023-07, *Segment Reporting*. This ASU requires the following disclosures on an annual and interim basis:

- Significant segment expenses that are regularly provided to the CODM and included with each reported measure of segment profit/loss;
- Other segment items by reportable segment, consisting of differences between segment revenue and segment profit/loss not already disclosed above;
- Other information by reportable segment, including total assets, depreciation and amortization, and capital expenditures; and
- The title of the CODM and an explanation of how the CODM uses the reported measures of segment profit/loss in assessing segment performance and deciding how to allocate resources.

The amendments in this ASU are effective for fiscal years beginning after December 15, 2023, and interim periods within fiscal years beginning after December 15, 2024, with early adoption permitted, and should be applied on a retrospective basis. The Company adopted the ASU for the year ended December 31, 2024. This ASU had no impact on the Company's consolidated financial condition or results of operations. Refer to Note 17 for the related segment disclosures.

*Recently Issued Accounting Standards*

In December 2023, the FASB issued ASU 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures*. This ASU requires the following disclosures on an annual basis:

- A tabular rate reconciliation using both percentages and amounts, broken out into specific categories with certain reconciling items at or above 5% of the statutory tax further broken out by nature and/or jurisdiction;
- Qualitative disclosure of the nature and effect of significant reconciling items by specific categories and individual jurisdictions; and
- Income taxes paid (net of refunds received), broken out between federal, state/local and foreign, and amounts paid to an individual jurisdiction when 5% or more of the total income taxes paid.

The amendments in this ASU are effective for annual periods beginning after December 15, 2024, with early adoption permitted, and should be applied on a prospective basis. This ASU will have no impact on the Company's consolidated financial condition or results of operations. The Company is currently evaluating the impact to the income tax disclosures.

In November 2024, the FASB issued ASU 2024-03, *Income Statement - Reporting Comprehensive Income - Expense Disaggregation Disclosures (Subtopic 220-40): Disaggregation of Income Statement Expenses*, which was further clarified in January 2025 through the issuance of ASU 2025-01. These ASUs require new financial statement disclosures to provide disaggregated information for certain types of expenses, including purchases of inventory, employee compensation, depreciation, and amortization in commonly presented expense captions such as cost of goods and services and selling, general and administrative expenses. The amendments in this ASU are effective for annual periods beginning after December 15, 2026, with early adoption permitted. The adoption of this guidance will have no impact on the Company's consolidated financial condition or results of operations. The Company is currently evaluating the impact to the related disclosures.

## 2. Revenues

The Company is substantially dependent on revenues received under contracts with federal, state, and local government agencies. Operating funding sources are generally earned from Medicaid, Medicare, commercial insurance reimbursement, and private and other payors. There is no single customer whose revenue was 10% or more of our consolidated revenue. The following tables set forth revenue by payor type for the years ended December 31, 2024, 2023 and 2022 (in millions):

| | Pharmacy Solutions | | | | | |
|---|---|---|---|---|---|---|
| | For the Years Ended December 31, | | | | | |
| | 2024 | | 2023 | | 2022 | |
| | Revenue | % of Revenue | Revenue | % of Revenue | Revenue | % of Revenue |
| Commercial insurance | $ 2,360.0 | 21.0% | $ 1,657.7 | 18.8% | $ 1,339.4 | 17.3% |
| Medicaid | 829.1 | 7.4% | 656.1 | 7.4% | 517.1 | 6.7% |
| Medicare A | 546.4 | 4.8% | 549.3 | 6.2% | 481.2 | 6.2% |
| Medicare B | 70.3 | 0.6% | 61.2 | 0.7% | 42.1 | 0.6% |
| Medicare C | 1,547.1 | 13.7% | 1,384.3 | 15.7% | 1,243.5 | 16.2% |
| Medicare D | 3,202.0 | 28.4% | 2,031.9 | 23.0% | 1,482.4 | 19.2% |
| Private & other | 199.4 | 1.8% | 182.0 | 2.1% | 158.7 | 2.1% |
| | $ 8,754.3 | 77.7% | $ 6,522.5 | 73.9% | $ 5,264.4 | 68.3% |

| | Provider Services | | | | | |
|---|---|---|---|---|---|---|
| | For the Years Ended December 31, | | | | | |
| | 2024 | | 2023 | | 2022 | |
| | Revenue | % of Revenue | Revenue | % of Revenue | Revenue | % of Revenue |
| Commercial insurance | $ 197.9 | 1.8% | $ 153.9 | 1.7% | $ 131.2 | 1.7% |
| Medicaid | 1,367.0 | 12.1% | 1,318.1 | 14.9% | 1,254.6 | 16.3% |
| Medicare A | 453.2 | 4.0% | 409.3 | 4.6% | 456.9 | 5.9% |
| Medicare B | 25.7 | 0.2% | 21.6 | 0.3% | 15.4 | 0.1% |
| Medicare C | 117.9 | 1.1% | 66.1 | 0.8% | 9.0 | 0.1% |
| Private & other | 350.5 | 3.1% | 334.7 | 3.8% | 314.4 | 4.1% |
| | $ 2,512.2 | 22.3% | $ 2,303.7 | 26.1% | $ 2,181.5 | 28.2% |

| | Other | | | | | |
|---|---|---|---|---|---|---|
| | For the Years Ended December 31, | | | | | |
| | 2024 | | 2023 | | 2022 | |
| | Revenue | % of Revenue | Revenue | % of Revenue | Revenue | % of Revenue |
| Department of Labor | $ — | — | $ — | — | $ 273.4 | 3.5% |
| Private & other | — | — | — | — | 1.3 | 0.0% |
| | $ — | — | $ — | — | $ 274.7 | 3.5% |

| | Consolidated | | | | | |
|---|---|---|---|---|---|---|
| | For the Years Ended December 31, | | | | | |
| | 2024 | | 2023 | | 2022 | |
| | Revenue | % of Revenue | Revenue | % of Revenue | Revenue | % of Revenue |
| Commercial insurance | $ 2,557.9 | 22.8% | $ 1,811.6 | 20.5% | $ 1,470.6 | 19.0% |
| Medicaid | 2,196.1 | 19.5% | 1,974.2 | 22.3% | 1,771.7 | 23.0% |
| Medicare A | 999.6 | 8.8% | 958.6 | 10.8% | 938.1 | 12.1% |
| Medicare B | 96.0 | 0.8% | 82.8 | 1.0% | 57.5 | 0.7% |
| Medicare C | 1,665.0 | 14.8% | 1,450.4 | 16.5% | 1,252.5 | 16.3% |
| Medicare D | 3,202.0 | 28.4% | 2,031.9 | 23.0% | 1,482.4 | 19.2% |
| Department of Labor | — | — | — | — | 273.4 | 3.5% |
| Private & other | 549.9 | 4.9% | 516.7 | 5.9% | 474.4 | 6.2% |
| | $ 11,266.5 | 100.0% | $ 8,826.2 | 100.0% | $ 7,720.6 | 100.0% |

Refer to Note 17 for the disaggregation of revenues by segment.

**3. Acquisitions**

*2024 Acquisitions*

During the year ended December 31, 2024, we completed eight acquisitions within the Pharmacy Solutions and Provider Services segments. We entered these transactions in order to expand our services and geographic offerings. Aggregate consideration net of cash acquired for these acquisitions was approximately $110.9 million. The operating results of these acquisitions are included in our consolidated financial statements from the respective dates of the acquisition.

*Haven Hospice*

The following table summarizes the consideration paid (in thousands) for the September 1, 2024 acquisition of North Central Florida Hospice, Inc. ("Haven Hospice") and the fair value of the assets acquired and the liabilities assumed at the acquisition date, which has been adjusted for immaterial measurement-period adjustments through December 31, 2024. Haven Hospice provides hospice and palliative care services in the state of Florida. Its results are consolidated within the Provider Services segment.

| | | |
|---|---|---|
| Inventories | $ | 45 |
| Property and equipment | | 495 |
| Goodwill | | 45,114 |
| Intangible assets | | 19,860 |
| Operating lease right-of-use assets | | 7,157 |
| Trade accounts payable | | 764 |
| Current portion of obligations under operating leases | | 2,235 |
| Obligations under operating leases, net of current portion | | 4,922 |
| Aggregate purchase price | $ | 64,750 |

The Company is in the process of reviewing the fair value of the assets acquired and liabilities assumed. We have estimated the fair value of acquired intangible assets based upon a third-party valuation. Based on the Company's preliminary valuations, the total estimated consideration has been allocated to assets acquired and liabilities assumed as of the acquisition date.

Consideration for the Haven Hospice acquisition included a $15.0 million cash payment, $15.0 million seller note payable in 2028, and $30.0 million of the Company's common stock equal to 2,471,251 shares. The number of shares was calculated by dividing $30.0 million by a price per share equal to the average of the volume weighted average trading price of the Company's common stock on each of the fifteen consecutive trading days ending on and including the trading day that is three trading days prior to the closing date, as required by the asset purchase agreement. The sellers are restricted from trading during a 180-day lock-up period from closing with agreed-upon sale volume limitations for four years thereafter. The asset purchase agreement also includes a post-closing adjustment feature to the extent any losses are incurred by the sellers in the sale of their common stock for four years following closing with a final equity adjustment feature (see Note 13).

The estimated intangible assets consist of $14.8 million in indefinite-lived licenses and $5.1 million of trade name. The trade name has an estimated useful life of 10.0 years. We expect all of the goodwill will be deductible for tax purposes. The Company believes the resulting amount of goodwill reflects its expectation of synergistic benefits of the acquisition.

Haven Hospice contributed $19.8 million in revenue and $1.0 million of operating income during the year ended December 31, 2024. Pro forma financial data for the Haven Hospice acquisition has not been included as the results of the operations are not material to our consolidated financial statements.

*Others*

The following table summarizes the consideration paid (in thousands) for 2024 acquisitions, excluding Haven Hospice, and the estimated fair value of the assets acquired and the liabilities assumed at the acquisition dates, which are adjusted for immaterial measurement-period adjustments through December 31, 2024. Consideration for acquisitions by the Pharmacy Solutions and Provider Services segments was $27.0 million and $19.2 million, respectively.

| | | |
|---|---|---|
| Accounts receivable | $ | 3,749 |
| Inventories | | 1,234 |
| Prepaid expenses and other current assets | | 174 |
| Property and equipment | | 398 |
| Goodwill | | 18,093 |
| Intangible assets | | 31,233 |
| Operating lease right-of-use assets | | 364 |
| Other assets | | 1,438 |
| Trade accounts payable | | 650 |
| Accrued expenses | | 7,742 |
| Current portion of obligations under operating leases | | 56 |
| Current portion of obligations under financing leases | | 53 |
| Obligations under operating leases, net of current portion | | 308 |
| Obligations under financing leases, net of current portion | | 8 |
| Deferred income taxes, net | | 1,686 |
| Aggregate purchase price, net of cash acquired | $ | 46,180 |

The Company is in the process of reviewing the fair value of the assets acquired and liabilities assumed. We have estimated the fair value of acquired intangible assets based upon third-party valuations and/or the values assigned in prior acquisitions that were deemed comparable in nature. Based on the Company's preliminary valuations, the total estimated consideration has been allocated to assets acquired and liabilities assumed as of the acquisition dates.

The estimated intangible assets consist primarily of $22.3 million in customer relationships, $5.7 million in definite-lived licenses, $2.1 million in indefinite-lived licenses, $0.6 million in covenants not to compete, and $0.5 million in trade names. Definite-lived intangible assets have an estimated weighted average useful life of 14.9 years. We expect $12.3 million of the goodwill will be deductible for tax purposes. The Company believes the resulting amount of goodwill reflects its expectation of synergistic benefits of the acquisitions.

The above acquisitions contributed approximately $59.9 million in revenue and $5.0 million in operating income during the year ended December 31, 2024. Pro forma financial data for the 2024 acquisitions has not been included as the results of the operations are not material to our consolidated financial statements.

During the year ended December 31, 2024, the Company incurred approximately $3.4 million in transaction costs related to all aforementioned acquisitions completed in 2024. These costs are included in selling, general, and administrative expenses in our consolidated statements of operations.

The Company also purchased the remaining 30% noncontrolling interest in Gateway Pediatric Therapy, LLC during the first fiscal quarter of 2024 and the remaining 45% noncontrolling interest in Harvest Grove LTC, LLC during the third fiscal quarter of 2024. These transactions did not meet the definition of a business combination in accordance with ASC 805*, Business Combinations* (refer to Note 15).

*2023 Acquisitions*

During the year ended December 31, 2023, we completed five acquisitions within the Pharmacy Solutions and Provider Services segments. We entered these transactions in order to expand our services and geographic offerings. Aggregate consideration for these acquisitions was approximately $73.1 million. No cash was acquired as a part of these transactions. The operating results of these acquisitions are included in our consolidated financial statements from the respective dates of the acquisition.

The following table summarizes the consideration paid (in thousands) for 2023 acquisitions, and the estimated fair value of the assets acquired and the liabilities assumed at the acquisition dates, which are adjusted for immaterial measurement-period adjustments through December 31, 2023. Consideration for acquisitions by the Pharmacy Solutions and Provider Services segments was $29.8 million and $43.3 million, respectively.

| | | |
|---|---|---|
| Accounts receivable | $ | 2,500 |
| Inventories | | 919 |
| Property and equipment | | 13 |
| Intangible assets | | 37,914 |
| Goodwill | | 31,931 |
| Operating lease right-of-use assets | | 530 |
| Accrued expenses | | 200 |
| Current portion of obligations under operating leases | | 207 |
| Obligations under operating leases, net of current portion | | 323 |
| Aggregate purchase price | $ | 73,077 |

The intangible assets consist primarily of $18.9 million in indefinite-lived licenses, $14.0 million in customer relationships, $3.9 million in trade names, and $1.1 million in covenants not to compete. Definite-lived intangible assets have an estimated weighted average useful life of 11.2 years. We expect all of the goodwill will be deductible for tax purposes. The Company believes the resulting amount of goodwill reflects its expectation of synergistic benefits of the acquisitions.

Measurement period adjustments for 2023 acquisitions recorded in the year ended December 31, 2024 were not material to the consolidated financial statements. The Company finalized the purchase price allocation for the 2023 acquisitions prior to the one-year anniversary date of each acquisition.

The above acquisitions contributed approximately $119.3 million and $55.1 million in revenue and approximately $5.7 million and $4.5 million in operating income during the years ended December 31, 2024 and 2023, respectively. Pro forma financial data for 2023 acquisitions has not been included as the results of the operations are not material to our consolidated financial statements.

During the year ended December 31, 2023, the Company incurred approximately $2.5 million in transaction costs related to completed 2023 acquisitions. These costs are included in selling, general, and administrative expenses in our consolidated statements of operations.

**4. Goodwill and Intangible Assets**

In 2024, 2023 and 2022, the Company performed a quantitative assessment of all reporting units as of October 1. We utilized a combination of the discounted cash flow analysis or “income approach” (50%) and the “market approach” (50%).

Our 2024 and 2023 goodwill impairment analyses concluded that the fair values of all reporting units were in excess of their carrying amounts. Subsequent to completing our goodwill impairment tests, no further indicators of impairment were identified. Based on these analyses, we recorded no goodwill impairment for the years ended December 31, 2024 and 2023.

Our 2022 goodwill impairment analysis concluded that the fair values of the Institutional Pharmacy, Specialty Solutions, Home Infusion, Home Health and Therapies, and Behavioral Health reporting units were in excess of their carrying amounts, and that the fair values of the Hospice Pharmacy and Workforce Solutions reporting units were less than their carrying amounts. We recognized non-cash goodwill impairment charges of $25.5 million related to the Hospice Pharmacy reporting unit and $15.4 million related to the Workforce Solutions reporting unit during 2022, which represent the excess of the reporting units’ carrying values over their respective estimated fair values at October 1, 2022. Subsequent to completing our goodwill impairment tests, no further indicators of impairment were identified. Neither reporting unit includes indefinite-lived intangible assets. The Workforce Solutions reporting unit was subsequently sold effective November 1, 2022.

The determination of whether the carrying value of the reporting unit exceeds its fair value involves a high degree of estimation and can be affected by a number of industry and company-specific risk factors that are subject to change over time. If actual performance does not achieve the projections, or if the assumptions used change in the future, we may be required to recognize additional impairment charges in future periods.

A summary of changes to goodwill is as follows (in thousands):

| | Goodwill | | |
|---|---|---|---|
| | Pharmacy Solutions | Provider Services | Total |
| Goodwill at January 1, 2023* | $ 821,406 | $ 1,754,675 | $ 2,576,081 |
| Goodwill added through acquisitions | 12,583 | 19,111 | 31,694 |
| Measurement period adjustments | — | 540 | 540 |
| Foreign currency adjustments | — | 97 | 97 |
| Goodwill at December 31, 2023* | $ 833,989 | $ 1,774,423 | $ 2,608,412 |
| Goodwill added through acquisitions | 7,063 | 56,144 | 63,207 |
| Measurement period adjustments | — | 237 | 237 |
| Foreign currency adjustments | — | (332) | (332) |
| Goodwill at December 31, 2024* | $ 841,052 | $ 1,830,472 | $ 2,671,524 |

* For the periods presented, the carrying amount of goodwill is presented net of accumulated impairment losses of $40.9 million.

Intangible assets are as follows (in thousands):

| | December 31, 2024 | | | December 31, 2023 | | | |
|---|---|---|---|---|---|---|---|
| | Gross | Accumulated Amortization | Net Carrying Value | Gross | Accumulated Amortization | Net Carrying Value | Life (Years) |
| Customer relationships | $ 700,911 | $ 397,246 | $ 303,665 | $ 697,947 | $ 344,662 | $ 353,285 | 5-20 |
| Trade names | 334,917 | 141,150 | 193,767 | 330,029 | 117,579 | 212,450 | 2-20 |
| Licenses | 235,065 | 66,060 | 169,005 | 238,682 | 56,022 | 182,660 | 10-20 |
| Doctor/payor network | 12,730 | 10,965 | 1,765 | 12,730 | 8,800 | 3,930 | 5-8 |
| Covenants not to compete | 8,832 | 5,925 | 2,907 | 13,126 | 8,535 | 4,591 | 2-7 |
| Other intangible assets | 10,940 | 6,362 | 4,578 | 10,949 | 4,809 | 6,140 | 5-7 |
| Total definite-lived assets | $ 1,303,395 | $ 627,708 | $ 675,687 | $ 1,303,463 | $ 540,407 | $ 763,056 | |
| Licenses | 135,795 | — | 135,795 | 118,420 | — | 118,420 | Indefinite |
| Total intangible assets | $ 1,439,190 | $ 627,708 | $ 811,482 | $ 1,421,883 | $ 540,407 | $ 881,476 | |

Amortization expense for the years ended December 31, 2024, 2023 and 2022 was $114.8 million, $123.1 million, and $126.5 million, respectively.

As of December 31, 2024, total estimated amortization expense for the Company's definite-lived intangible assets for the next five years and thereafter is as follows (in thousands):

| | |
|---|---|
| 2025 | $ 108,907 |
| 2026 | 99,884 |
| 2027 | 66,931 |
| 2028 | 59,883 |
| 2029 | 53,667 |
| Thereafter | 286,415 |
| | $ 675,687 |

**5. Debt and Derivatives**

The table below summarizes the total outstanding debt of the Company (in thousands):

| | December 31, 2024 | | December 31, 2023 | |
|---|---|---|---|---|
| | Rate | Amount | Rate | Amount |
| First Lien - payable to lenders at SOFR plus applicable margin | — | $ — | 8.72% | $ 1,719,360 |
| First Lien Incremental Term Loans Tranches B-2 and B-3 - payable to lenders at SOFR plus applicable margin | — | — | 8.97% | 1,189,975 |
| First Lien Incremental Term Loan Tranche B-5 - payable to lenders at SOFR plus applicable margin | 6.86% | 2,546,787 | — | — |
| Second Lien - payable to lenders at SOFR plus applicable margin | — | — | 13.97% | 450,000 |
| Revolving Credit Loans - payable to lenders at SOFR plus applicable margin | 7.61% | — | 9.59% | 50,000 |
| Swingline Loans and Base Rate Loans - payable to lenders at ABR plus applicable margin | 9.75% | 63,300 | 11.75% | 700 |
| Amortizing Notes [(1)] | | 53,804 | | — |
| Notes payable and other | | 19,428 | | 4,356 |
| Total debt | | 2,683,319 | | 3,414,391 |
| Less: debt issuance costs, net | | 72,736 | | 50,177 |
| Total debt, net of debt issuance costs | | 2,610,583 | | 3,364,214 |
| Less: current portion of long-term debt | | 48,725 | | 32,273 |
| Total long-term debt, net of current portion | | $ 2,561,858 | | $ 3,331,941 |

[(1)] See Note 6 for discussion of Amortizing Notes.

As of December 31, 2024, maturities of long-term debt for the next five years and thereafter are as follows (in thousands):

| | |
|---|---|
| 2025 | $ 48,725 |
| 2026 | 48,462 |
| 2027 | 37,562 |
| 2028 | 103,848 |
| 2029 | 25,548 |
| Thereafter | 2,419,174 |
| | $ 2,683,319 |

See Note 12 for maturities of obligations under financing leases.

The following discussion summarizes the debt agreements and related extinguishments and modifications for the years ended December 31, 2024 and 2023.

Obligations under the First Lien and Second Lien Facility are guaranteed by Phoenix Guarantor, Inc., a subsidiary of the Company, and each of its current and future direct and indirect subsidiaries other than (among others) (i) foreign subsidiaries, (ii) unrestricted subsidiaries, (iii) non-wholly owned subsidiaries, (iv) certain receivables financing subsidiaries, (v) certain immaterial subsidiaries and (vi) certain holding companies of foreign subsidiaries, and are secured by a first lien on substantially all of their assets, including capital stock of subsidiaries.

The current credit facilities described below contain customary negative covenants, including, but not limited to, restrictions on the Company and its restricted subsidiaries' ability to merge and consolidate with other companies, incur indebtedness, grant liens or security interests on assets, make acquisitions, loans, advances or investments, pay dividends, sell or otherwise transfer assets, prepay or modify terms of certain junior indebtedness, enter into transactions with affiliates, or change their lines of business or fiscal year. In addition, the terms of the credit facilities will not permit the consolidated First Lien secured debt to consolidated earnings before interest, taxes, depreciation, and amortization ("EBITDA") to be greater than 6.90 to 1.00, which shall be tested as of the end of the most recent quarter at any time when the aggregate Revolving Credit Facility loans exceed 35% of the total revolving credit commitments.

We were in compliance with all applicable financial debt covenants at December 31, 2024 and 2023.

*First Lien Credit Agreement*

On March 5, 2019, the Company entered into a First Lien Credit Agreement (the "First Lien"), with Morgan Stanley Senior Funding, Inc., as the Administrative Agent and the Collateral Agent. The First Lien originally consisted of a principal amount of $1,650.0 million. In 2019, an additional delayed draw of $150.0 million was made on the First Lien, resulting in a gross borrowing of $1,800.0 million ("Tranche B-1"). Borrowings of Tranche B-1 Term Loans (as defined in the First Lien) under the First Lien bore interest at a rate equal to, at our option, (a) Secured Overnight Financing Rate ("SOFR") (with a floor of 0.00%) plus 3.25% or (b) Alternate Base Rate ("ABR") plus 2.25%. Principal payments were due on the last business day of each quarter, commencing in September 2019 at 0.25% of the aggregate principal of the original loan amount, with a balloon payment due in March 2026.

The First Lien, as amended in 2020, established a Tranche B-2 Term Loan ("Tranche B-2") in an aggregate principal amount equal to $550.0 million. The First Lien, as amended in 2021, established a Tranche B-3 Term Loan ("Tranche B-3") in an aggregate principal amount equal to $675.0 million. Borrowings under Tranche B-2 and Tranche B-3, bore interest at a rate equal to, at our option, (a) SOFR (with a floor of 0.00%) plus 3.50% or (b) ABR plus 2.50%. Principal payments were due on the last business day of each fiscal quarter, commencing in June 2021 at 0.25% of the aggregate principal of the original loan amount, with a balloon payment due in March 2026.

On February 21, 2024, we used a portion of the net proceeds received from the IPO Offerings to repay $343.3 million of the borrowings under the First Lien, and amended the First Lien to establish a new Tranche B-4 Term Loan ("Tranche B-4") in an aggregate principal amount of $2,566.0 million. The proceeds from Tranche B-4 borrowings were used to refinance the equivalent amount of the remaining First Lien Tranches B-1, B-2, and B-3 borrowings at a rate equal to SOFR plus 3.25% with a maturity date of February 21, 2031. The transaction was accounted for as a debt modification. Principal payments were due on the last business day of each quarter, which commenced in the second fiscal quarter of 2024 and equated to 0.25% of the principal at issuance, with a balloon payment due February 21, 2031.

On December 11, 2024, we amended the First Lien to refinance Tranche B-4 by establishing a Tranche B-5 Term Loan ("Tranche B-5") in an aggregate principal amount of $2,553.2 million at a rate equal to SOFR plus 2.50% or ABR plus 1.50% with a maturity date of February 21, 2031. The non-cash transaction was accounted for as a debt modification. Principal payments are due on the last business day of each quarter, which commenced in the first fiscal quarter of 2025 and equate to 0.25% of the principal at issuance, with a balloon payment due February 21, 2031.

*Revolving Credit Facility*

The First Lien also extends credit in the form of Revolving Credit Facility with a borrowing capacity of $475.0 million (the "Revolver"), of which up to $50.0 million is available as swingline loans and up to $82.5 million is available as letters of credit (the "LC Sublimit"). The Revolver will mature on June 30, 2028. In connection with the First Lien modification on February 21, 2024, borrowings of the Revolver bear interest at a rate equal to SOFR (with a floor of 0.00%) plus 3.25% for the Revolving Credit Loans or ABR plus 2.25% for the Swingline Loans. As of December 31, 2024, the Company had $63.3 million of borrowings outstanding under the Revolver and no letters of credit, reducing the available borrowing capacity to approximately $411.7 million. As of December 31, 2023, the Company had $50.7 million of borrowings outstanding under the Revolver and $6.6 million of letters of credit reducing the available borrowing capacity to approximately $417.7 million.

The Company's First Lien also provides for an additional letter of credit commitments (the "LC Facility"), which are not subject to the LC Sublimit and do not reduce the Revolver borrowing capacity. On September 17, 2024, the Company amended the First Lien to increase the LC Facility from $55.0 million to $65.0 million. As of December 31, 2024 and 2023, there were $61.8 million and $54.3 million of letters of credit outstanding under the LC Facility, respectively, resulting in an available borrowing capacity of $3.2 million and $0.7 million, respectively.

*Second Lien Credit Agreement*

The Company's amended and restated Second Lien Credit Agreement (the "Second Lien Facility"), with certain Lenders and Wilmington Trust, National Association, as the Administrative Agent and the Collateral Agent consisted of a principal amount of $450.0 million.

Borrowings under the Second Lien Facility term were subordinated to the First Lien and bore interest at a rate equal to, at our option, (a) SOFR (with a floor of 1.00%) plus 8.50% or (b) ABR plus 7.50%. The aggregate principal was due with a balloon payment in March 2027.

On January 30, 2024, we used a portion of the net proceeds received from the IPO Offerings to repay all outstanding borrowings under the Second Lien Facility. No remaining obligation exists related to the Second Lien Facility. This transaction was accounted for as a debt extinguishment and the Company incurred a loss on extinguishment of debt of $12.7 million related to the write-off of unamortized debt issuance costs during the first fiscal quarter of 2024.

*Derivative Financial Instruments*

To manage fluctuations in cash flows resulting from changes in the variable rates, the Company entered into three receive-variable, pay-fixed interest rate swap agreements, all effective September 30, 2022. Taken together with the related debt, these swaps create the economic equivalent of fixed-rate debt, up to the notional amount of the hedged debt. By using a derivative instrument to hedge exposures to changes in interest rates, we expose ourselves to credit risk. Credit risk is the failure of the counterparty to perform under the terms of the derivative contract. When the fair value of a derivative contract is positive, the counterparty owes the Company, which creates credit risk for the Company. When the fair value of a derivative contract is negative, the Company owes the counterparty and, therefore, the Company is not exposed to the counterparty's credit risk in those circumstances. The Company mitigates counterparty credit risk in derivative instruments by entering into transactions with high-quality counterparties. The derivative instruments entered into by the Company do not contain credit-risk-related contingent features.

As of December 31, 2024, we have the following cash flow hedge agreements with a total notional value of $2.0 billion:

| Financial Institution | Effective Dates | Floating Rate Debt | Fixed Rates |
|---|---|---|---|
| Credit Suisse | September 30, 2022 through September 30, 2025 | $ 500,000,000 | 3.4165% |
| Morgan Stanley | September 30, 2022 through September 30, 2025 | 1,050,000,000 | 3.4200% |
| Credit Agricole Corporate and Investment Bank | September 30, 2022 through September 30, 2025 | 450,000,000 | 3.5241% |

The fair value of the cash flow hedges as of December 31, 2024 and 2023 was $10.6 million and $24.9 million, respectively, and reflected in prepaid expenses and other current assets and other assets, respectively, in the consolidated balance sheets.

Amounts reported in AOCI related to derivatives will be reclassified to interest expense as interest payments are made on the Company's variable-rate debt. Interest received, including payments made or received under the cash flow hedges, was $35.3 million, $31.4 million, and $0.7 million for the years ended December 31, 2024, 2023, and 2022, respectively. The Company expects approximately $10.6 million of pre-tax gains to be reclassified out of AOCI into earnings within the next twelve months.

The debt modifications and extinguishment in 2024 did not impact the effectiveness of the cash flow hedge arrangements outstanding as of December 31, 2024.

**6. Tangible Equity Units**

Concurrently with the IPO, we issued 8,000,000 TEUs, which have a stated amount of $50.00 per unit. Each TEU is comprised of a prepaid stock purchase contract ("Purchase Contract") and a senior amortizing note ("Amortizing Note") due February 1, 2027, each issued by the Company. Each TEU may be separated by a holder into its constituent Purchase Contract and Amortizing Note, each of which is considered a freestanding financial instrument. The proceeds from the issuance were allocated to equity and debt based on the relative fair value of the respective components of each TEU as follows (in thousands, except per unit values):

| | Equity Component | Debt Component | Total |
|---|---|---|---|
| Fair value per unit | $ 41.3382 | $ 8.6618 | $ 50.00 |
| | | | |
| Gross proceeds | $ 330,706 | $ 69,294 | $ 400,000 |
| Less: issuance costs | 9,095 | 1,905 | 11,000 |
| Net proceeds | $ 321,611 | $ 67,389 | $ 389,000 |

The value allocated to the Purchase Contract is reflected net of issuance costs in additional paid-in capital on the consolidated balance sheet. The value allocated to the Amortizing Notes are reflected in long-term debt, with payments expected in the next twelve months reflected in current portion of long-term debt, in the consolidated balance sheet. Issuance costs related to the Amortizing Notes are reflected as a reduction of the carrying amount and will be amortized through the maturity date using the effective interest rate method.

On each February 1, May 1, August 1, and November 1, we pay equal quarterly cash installments of $0.8438 per Amortizing Note commencing on May 1, 2024, except for the May 1, 2024 installment payment, which was $0.8531 per Amortizing Note, with a final installment payment date of February 1, 2027. Each installment payment constitutes a payment of interest and a partial repayment of principal. The Company paid $20.3 million in TEU principal and interest payments during the year ended December 31, 2024.

The Amortizing Notes rank equally in right of payment with all other existing and future unsecured senior indebtedness and rank senior to all of our existing and future indebtedness, if any, that is subordinated to the Amortizing Notes. At any time prior to the second scheduled trading day immediately preceding February 1, 2027, a holder may elect to settle its Purchase Contract early, in whole or in part, at an early settlement rate equal to the minimum settlement rate. The Company has the right to settle the Purchase Contracts on or after November 1, 2024, in whole but not in part, on a date fixed by it at an early mandatory settlement rate equal to

the maximum settlement rate, subject to certain exceptions. During the year ended December 31, 2024, 31,211TEUs were converted at the holder's option.

Unless settled earlier at the holder's option or at the Company's election, each Purchase Contract will, subject to postponement in certain limited circumstances, automatically settle on February 1, 2027 for a number of shares of our common stock, subject to certain anti-dilution adjustments, based upon the 20-day volume-weighted average price ("VWAP") of our common stock as follows:

| VWAP of BTSG Common Stock | Common Stock Issued |
|---|---|
| Greater than $15.28 | 3.2733 shares (minimum settlement rate) |
| Equal to or less than $15.28 but greater than or equal to $13.00 | $50 divided by VWAP |
| Less than $13.00 | 3.8461 shares (maximum settlement rate) |

The Purchase Contracts are mandatorily convertible into a minimum of 26.2 million shares or a maximum of 30.8 million shares of our common stock on the mandatory settlement date (unless redeemed by us or settled earlier at the unit holder's option). The 26.2 million minimum shares are included in the calculation of basic weighted average shares outstanding. The difference between the minimum and maximum shares represents potentially dilutive securities, which are included in the calculation of diluted weighted average shares outstanding on a pro rata basis to the extent that the average applicable market value is equal to or greater than $13.00 but is less than or equal to $15.28 during the period (see Note 9).

## 7. Income Taxes

Loss before income taxes consists of the following (in thousands):

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| U.S. Operations | $ (34,975) | $ (177,610) | $ (45,852) |
| Foreign Operations | 237 | 197 | 98 |
| Loss before income taxes | $ (34,738) | $ (177,413) | $ (45,754) |

Income tax (benefit) expense attributable to loss before income taxes is summarized as follows (in thousands):

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Current provision: | | | |
| Federal | $ 11,463 | $ 25,433 | $ 26,674 |
| State | 5,477 | 6,581 | 9,710 |
| Foreign | 50 | 40 | 43 |
| Total current provision | 16,990 | 32,054 | 36,427 |
| Deferred provision: | | | |
| Federal | (26,406) | (43,853) | (21,878) |
| State | (4,801) | (8,779) | (6,084) |
| Total deferred provision | (31,207) | (52,632) | (27,962) |
| Income tax (benefit) expense | $ (14,217) | $ (20,578) | $ 8,465 |

A reconciliation of the U.S. Federal income tax rate of 21.0% to income tax (benefit) expense expressed as a percent of pretax loss is as follows:

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Federal income tax at the statutory rate | 21.0% | 21.0% | 21.0% |
| (Decrease) increase in income tax (benefit) expense: | | | |
| State and foreign income taxes, net of federal benefits | (6.1) | (0.4) | (5.5) |
| Jobs tax credits, net | 7.4 | 1.7 | 6.7 |
| State deferred rate change | (3.4) | 1.9 | (0.5) |
| Legal claims | (5.8) | (14.4) | — |
| Non-deductible expenses | (1.5) | (0.3) | 0.2 |
| Share-based compensation | (12.6) | 1.1 | 0.3 |
| Executive compensation | (2.9) | — | — |
| Non-deductible goodwill | — | — | (39.7) |
| Uncertain tax positions | 0.0 | (0.6) | 0.1 |
| Adjustments associated with prior year provision | 52.2 | 0.9 | (0.8) |
| Acquisition impacts | (5.2) | — | — |
| Minority interest | (1.5) | — | — |
| Lobbying and political contributions | (1.1) | — | — |
| Other | 0.4 | 0.7 | (0.3) |
| Total | 40.9% | 11.6% | (18.5)% |

The increase in adjustments associated with prior year provision for 2024 is primarily attributable to finalization of the settlement agreement for the Silver matter, including partial deductibility for tax purposes, as well as the reduction in pre-tax loss.

On December 27, 2020, the Consolidated Appropriations Act was signed into law and extended the jobs credit provisions through 2025. Accordingly, jobs credits generated during the year have been recognized in the provision for income taxes for all years presented.

The tax effects of temporary differences that give rise to significant portions of the deferred tax assets and liabilities are presented below (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Deferred tax assets: | | |
| Accrued expenses | $ 45,221 | $ 48,404 |
| Allowance for credit losses and contractual allowances | 22,546 | 23,986 |
| Net operating losses | 18,796 | 18,846 |
| Share-based compensation | 15,799 | 4,628 |
| IRC §163(j) interest | 96,961 | 84,696 |
| Operating lease liability | 65,958 | 68,939 |
| Other | 21,353 | 18,258 |
| Deferred tax assets | 286,634 | 267,757 |
| Valuation allowances | (8,968) | (9,866) |
| Deferred tax assets, net | 277,666 | 257,891 |
| | | |
| Deferred tax liabilities: | | |
| Operating lease right-of-use asset | (64,014) | (67,633) |
| Property and equipment | (6,338) | (13,896) |
| Goodwill and other intangible assets | (190,458) | (178,881) |
| Insurance recovery | (8,677) | (15,048) |
| Interest rate swaps | (2,604) | (6,101) |
| Deferred tax liabilities | (272,091) | (281,559) |
| Deferred income taxes, net | $ 5,575 | $ (23,668) |

As of December 31, 2024, the Company has federal net operating loss ("NOL") carryforwards of $11.0 million ($2.3 million deferred tax asset) that resulted from stock acquisitions the Company completed from 2013 through 2019. These NOLs are subject to limitations under Internal Revenue Code ("IRC") §382. However, the Company expects that it will more-likely-than-not be able to use the recorded amount which takes into account the limitations of the carryforwards. The deferred tax asset for state NOL carryforwards is $7.2 million, net of the federal tax impact and valuation allowances of $9.0 million. The state NOLs have carryforward periods ranging from 1 to 20 years depending on the taxing jurisdiction.

With the enactment of the Tax Cuts and Jobs Act of 2019 on December 22, 2017, as of January 1, 2018 and as adjusted by the enactment of the CARES Act on March 25, 2020, the Company is subject to a limitation on interest expense in excess of 30% (50% for 2019 and 2020 pursuant to the CARES Act) of adjusted taxable income calculated for purposes of IRC §163(j). The limitation in any given year may be carried forward indefinitely and deducted as interest expense in future periods. The Company has federal interest expense carryforwards of $386.2 million ($81.1 million deferred tax asset) available for utilization in future years. The deferred tax asset for state interest expense carryforwards is $15.9 million.

A valuation allowance for deferred tax assets was provided as of December 31, 2024 and 2023 related to state income tax NOL carryforwards. The realization of deferred tax assets is dependent upon generating future taxable income when temporary differences become deductible. Based upon the historical and projected levels of taxable income, we believe it is more-likely-than-not that we will realize the benefits of the deductible differences after consideration of the valuation allowance.

A reconciliation of the beginning and ending amount of total unrecognized tax benefits is as follows (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Balance at beginning of year | $ 1,502 | $ 505 |
| (Decrease) increase related to prior year tax positions | (9) | 1,502 |
| Decrease related to current year tax positions | — | (42) |
| Lapse of statue of limitations | — | (463) |
| Balance at end of year | $ 1,493 | $ 1,502 |

Included in the balance of total unrecognized tax benefits at December 31, 2024 are potential benefits of $0.0 million, which if recognized, would affect the effective tax rate for the year ending December 31, 2025. Unrecognized tax benefits that reduce a NOL, similar tax loss or tax credit carryforward are presented as a reduction to deferred income taxes.

We file numerous consolidated and separate income tax returns in the U.S. federal and various state and foreign jurisdictions. With few exceptions, we are no longer subject to income tax examinations by the taxing authorities for years prior to 2019. We believe that we have appropriate support for the income tax positions taken and to be taken on our income tax returns and that our accruals for income tax liabilities are adequate for all open years based on an assessment of many factors including past experience and interpretations of the tax laws as applied to the facts of each matter. We expect that the amounts of unrecognized tax benefits will be reduced by $1.5 million within the next twelve months. Total accrued interest and penalties was $0.0 million and $0.1 million as of December 31, 2024 and 2023, respectively, and are included in accrued expenses on the consolidated balance sheets.

**8. Detail of Certain Balance Sheet Accounts**

Prepaid expenses and other current assets consist of the following (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Rebate receivable | $ 49,538 | $ 41,791 |
| Non-trade receivables | 46,176 | 67,126 |
| Prepaid insurance | 13,892 | 13,206 |
| Income tax receivable | 13,468 | 4,935 |
| Inventory returns receivable | 11,245 | 15,300 |
| Interest rate swaps | 10,633 | — |
| Prepaid maintenance | 3,673 | 3,619 |
| Other prepaid expenses and current assets | 13,954 | 13,190 |
| Total prepaid expenses and other current assets | $ 162,579 | $ 159,167 |

Other assets consist of the following (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Deposits | $ 8,788 | $ 7,137 |
| Notes receivable | 8,577 | 7,840 |
| Insurance recoveries | 7,564 | 8,509 |
| Cloud computing | 7,362 | 9,453 |
| Deferred debt issuance costs | 2,470 | 3,349 |
| Equity method investments | 670 | 720 |
| Interest rate swaps | — | 24,947 |
| Deferred offering costs | — | 3,850 |
| Other assets | 9,040 | 7,033 |
| Total other assets | $ 44,471 | $ 72,838 |

Accrued expenses consist of the following (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Wages and payroll taxes | $ 139,417 | $ 127,707 |
| Compensated absences | 34,263 | 32,085 |
| Checks in excess of cash balance | 27,643 | 9,018 |
| Automobile insurance reserves | 21,353 | 27,381 |
| Workers compensation insurance reserves | 19,966 | 22,480 |
| Health insurance reserves | 14,934 | 13,452 |
| Legal settlements and professional fees | 13,982 | 114,677 |
| Deferred revenue | 11,001 | 30,848 |
| Taxes other than income taxes | 10,325 | 9,305 |
| Interest | 8,779 | 3,125 |
| General and professional liability insurance reserves | 8,328 | 22,738 |
| Contingent consideration | 3,136 | 2,650 |
| Recoupment fees | 536 | 36,071 |
| Other | 42,875 | 40,826 |
| Total accrued expenses | $ 356,538 | $ 492,363 |

Long-term liabilities consist of the following (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Workers compensation insurance reserves | $ 25,360 | $ 30,514 |
| General and professional liability insurance reserves | 21,182 | 28,350 |
| Automobile insurance reserves | 9,034 | 8,526 |
| Contingent consideration | 5,250 | 2,681 |
| Employee incentives | 3,993 | 5,189 |
| Deferred gain | 764 | 1,346 |
| Legal settlements and professional fees | — | 10,000 |
| Other | 6,176 | 5,337 |
| Total long-term liabilities | $ 71,759 | $ 91,943 |

**9. Earnings Per Share ("EPS")**

Basic net loss per share of common stock is calculated by dividing net loss attributable to common shareholders by the weighted average number of shares outstanding for the reporting period. Diluted net loss per share of common stock is computed by giving effect to all potential weighted average dilutive common stock. In periods of net loss, no potentially dilutive common shares are included in the diluted shares outstanding as the effect is anti-dilutive.

The number of additional shares of common stock related to stock option awards subject to only a time-based condition is calculated using the treasury stock method, if dilutive. Stock option awards subject to a performance condition are not included in the denominator of the diluted EPS calculation using the treasury stock method for the years ended December 31, 2023 and 2022, as the

performance condition had not been satisfied. Upon completion of the IPO in January 2024, the performance condition was met and a portion of the Tier I options vested (Note 10). Thus, the number of additional shares of common stock related to stock option awards subject to a performance condition are included in the denominator of the diluted EPS calculation using the treasury stock method for the year ended December 31, 2024, if dilutive.

The number of additional shares of common stock related to restricted stock units ("RSUs") is reflected in the denominator of the diluted EPS calculation using the treasury stock method, if dilutive.

For the year ended December 31, 2024, the TEUs were assumed to be outstanding at the minimum settlement amount for weighted-average shares for basic EPS. For diluted EPS, the shares were assumed to be settled at a conversion factor based on the 20-day VWAP per share of the Company's common stock not to exceed 3.8461 shares per Purchase Contract, if dilutive. See Note 6 for further discussion of TEUs.

The following table sets forth the computation of basic and diluted net loss per share attributable to common shareholders (in thousands, except per share amounts):

| | For The Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Numerator: | | | |
| Net loss | $ (20,521) | $ (156,835) | $ (54,219) |
| Net loss attributable to noncontrolling interests | (2,459) | (2,232) | (312) |
| Net loss attributable to common shareholders | $ (18,062) | $ (154,603) | $ (53,907) |
| Denominator: | | | |
| Weighted-average shares outstanding - basic | 192,997 | 117,868 | 117,840 |
| | | | |
| Effect of dilutive securities: | | | |
| Stock options | — | — | — |
| RSUs | — | — | — |
| TEUs | — | — | — |
| Weighted-average shares outstanding - diluted | 192,997 | 117,868 | 117,840 |
| | | | |
| Basic net loss per share | $ (0.09) | $ (1.31) | $ (0.46) |
| Diluted net loss per share | $ (0.09) | $ (1.31) | $ (0.46) |

The following potentially common share equivalents were excluded from the computation of diluted net loss per share because their effect would have been anti-dilutive for the periods presented, as well as options that are contingent upon the satisfaction of certain conditions which were not satisfied by the end of the period (in thousands):

| | For The Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Stock options [(1)] | 14,936 | 14,140 | 14,324 |
| RSUs | 10,587 | — | — |
| TEUs | — | — | — |
| Total | 25,523 | 14,140 | 14,324 |

[(1)] For all periods presented, the dilutive effect of stock options were excluded from the computation of loss per share because the assumed proceeds from the awards' exercise were greater than the average market price of the common shares.

All share and per share amounts have been retroactively adjusted to reflect the effects of the stock split that occurred in January 2024 (see Note 10).

**10. Common Stock, Preferred Stock, and Share-Based Compensation**

*Common Stock*

The Company's Board of Directors approved a 15.7027-for-one stock split of the Company's common stock on January 24, 2024, with an effective date of January 25, 2024. The par value per share of the Company's common stock remained unchanged at $0.01 per share, and the authorized shares of the Company's common stock increased from 8,750,000 to 137,398,625. Upon completion of the

IPO Offerings in January 2024, the Company's Board of Directors approved an amendment to our articles of incorporation to authorize 1,500,000,000 shares of common stock with a par value of $0.01 per share. The holders of the Company's common stock are entitled to one vote for each share held of record on all matters on which stockholders may vote. There are no preemptive, subscription, conversion, redemption, or sinking fund provisions applicable to the Company's common stock. In addition, the Company's Credit Agreement imposes restrictions on its ability to pay cash dividends.

*Preferred Stock*

Upon completion of the IPO Offerings in January 2024, the Company's Board of Directors approved an amendment to our articles of incorporation to authorize 250,000,000 shares of preferred stock with a par value of $0.01 per share. Each series of preferred stock will have the number of shares, designations, preferences, voting powers, qualifications and special or relative rights or privileges as shall be determined by the Board of Directors, which may include, but are not limited to, dividend rights, voting rights, redemption, and sinking fund provisions, liquidation preferences, conversion rights, and preemptive rights. There were no shares of preferred stock issued or outstanding at December 31, 2024 and December 31, 2023.

*Share-Based Compensation Plans*

On January 24, 2024, the Board of Directors adopted the 2024 Incentive Plan. Concurrent with the adoption of the 2024 Incentive Plan, the previously existing share-based compensation plan, the 2017 Stock Plan, was terminated and no further issuances are permitted under the 2017 Stock Plan; however, awards granted under the 2017 Stock Plan will continue to be governed by their existing terms.

The Company recorded share-based compensation expense on the consolidated statements of operations for the periods indicated as follows (in thousands):

| | For The Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Cost of goods | $ 2,115 | $ — | $ — |
| Cost of services | $ 3,296 | $ — | $ — |
| Selling, general, and administrative expense | $ 63,763 | $ 3,917 | $ 3,547 |

*2017 Stock Plan*

In January 2018, the Compensation Committee of the Company’s Board of Directors approved a grant of 4,874,558 options in the Company under a stock option plan established in 2017 to key members of the Company’s management. The options are divided into tranches: (i) 50% vest based on the passage of time over five (5) years (the “Time-Based Options”), (ii) 25% vest based on the achievement of annual adjusted EBITDA targets over five (5) years (the “Tier I Performance Options”) and (iii) 25% vest based on KKR recovering a specified return on its investment or internal rate of return (the “Tier II Performance Options”).

Following the BrightSpring Corp. Acquisition in 2019, the Compensation Committee of the Company’s Board of Directors approved the modification of the previously granted Tier I and Tier II Performance Options. Tier 1 Performance options now vest upon the attainment of Sponsor Month over Month (“MoM”) (quotient obtained by dividing sponsor cash available by sponsor cash invested) of at least 2.0 or greater and Tier II Performance Options vest upon the attainment of a Sponsor MoM of at least 2.5 or greater. The MoM levels are considered a market condition which also create an implied performance condition because the MoM levels cannot be achieved without the occurrence of a liquidity event. In January 2024, the Compensation Committee of the Company’s Board of Directors approved the vesting of Tier I performance-vesting options in connection with the IPO Offerings. The options all have a 10-year life and we record forfeitures as they occur.

Concurrent with the adoption of the 2024 Incentive Plan on January 24, 2024, no further awards are authorized to be granted under the 2017 Stock Plan.

*2024 Incentive Plan*

The 2024 Incentive Plan initially reserved 17,119,039 shares for issuance and provides for the granting of various forms of equity awards including non-qualified options and incentive stock options, restricted shares of our common stock, restricted stock units, other equity-based awards tied to the value of shares, and cash-based awards.

Under the 2024 Incentive Plan, the Company granted stock options, representing options to purchase shares of the Company’s common stock at a stated price, and RSUs, which represent the conditional right to receive one share of common stock, both upon satisfaction of a vesting requirement. Stock options and RSUs granted under the 2024 Incentive Plan vest upon the satisfaction of time-based requirements. We recognize expense for stock options and RSUs over the vesting term based on the grant date fair value of the award. In each case, vesting of the Company’s outstanding and unvested stock options and RSUs is contingent upon the holder’s

continued service through the date of each applicable vesting event. The options all have a 10-year life and we record forfeitures as they occur.

Concurrent with the IPO, the Compensation Committee of the Company's Board of Directors granted approximately $63.3 million of share-based compensation (4.1 million RSUs and 1.5 million stock options), in each case, with a per-share price or a per-share exercise price of $13.00, respectively to our management and certain other full-time employees upon completion of the IPO. In the second fiscal quarter of 2024, the Compensation Committee of the Company's Board of Directors granted an additional 7.7 million RSUs to a broad group of eligible employees.

*Summary details for RSUs*

The following table summarizes the RSU activity under the 2024 Incentive Plan for the period presented:

| | Units | Weighted Average Grant Date Fair Value | Weighted Average Remaining Contractual Term (years) | Aggregate Intrinsic Value (in millions) |
|---|---|---|---|---|
| Outstanding RSUs at January 1, 2024 | — | $ — | | $ — |
| Granted | 11,992,687 | 11.85 | | |
| Forfeited | (1,163,490) | 11.53 | | |
| Vested | (241,971) | 13.00 | | |
| Outstanding RSUs at December 31, 2024 | 10,587,226 | $ 11.85 | 2.51 | $ 180.3 |

As of December 31, 2024, there was $85.1 million of unrecognized compensation cost that is expected to be recognized over a weighted-average period of 2.5 years related to unvested RSUs. The vesting terms of all RSUs range from 0.25 to 5 years. The total intrinsic value of RSUs vested during the year ended December 31, 2024 was $3.1 million. The excess tax benefit associated with vested RSUs for the year ended December 31, 2024 was not material.

*Summary details for Stock Options*

The following table summarizes the Time-Based Options stock incentive plan activity under the 2017 Stock Plan and the 2024 Incentive Plan for the period presented:

| | Number of Shares | Weighted Average Exercise Price | Weighted Average Grant Date Fair Value (in millions) | Aggregate Intrinsic Value (in millions) | Weighted Average Remaining Contractual Term (years) |
|---|---|---|---|---|---|
| Outstanding options at January 1, 2024 | 7,053,665 | $ 9.57 | $ 26.7 | $ 89.7 | 6.3 |
| Granted | 1,662,309 | 12.85 | 11.4 | | |
| Forfeited, repurchased or expired | (290,997) | 16.56 | (2.3) | | |
| Exercised | (146,159) | 6.52 | (0.3) | | |
| Outstanding options at December 31, 2024 | 8,278,818 | $ 9.98 | $ 35.5 | $ 64.2 | 6.1 |
| | | | | | |
| Exercisable options at December 31, 2024 | 6,082,815 | $ 8.28 | $ 19.60 | $ 56.4 | 5.1 |

The following table summarizes the Tier I and II Performance Option stock incentive plan activity under the 2017 Stock Plan for the period presented:

| | Number of Shares | Weighted Average Exercise Price | Weighted Average Grant Date Fair Value (in millions) | Aggregate Intrinsic Value (in millions) | Weighted Average Remaining Contractual Term (years) |
|---|---|---|---|---|---|
| Outstanding options at January 1, 2024 | 7,086,458 | $ 8.14 | $ 15.1 | $ 100.3 | 5.9 |
| Granted | — | — | — | | |
| Forfeited, repurchased or expired | (341,010) | 14.58 | (1.1) | | |
| Exercised | (88,449) | 6.58 | (0.2) | | |
| Outstanding options at December 31, 2024 | 6,656,999 | $ 7.82 | $ 13.8 | $ 63.9 | 5.0 |
| | | | | | |
| Exercisable options at December 31, 2024 | 3,355,049 | $ 7.84 | $ 7.00 | $ 32.2 | 5.0 |

Cash received from stock option exercises for the years ended December 31, 2024, 2023 and 2022 was $1.5 million, $0.6 million, and $0.2 million, respectively. There were no material tax benefits realized in our tax returns from tax deductions associated with share based compensation for 2024, 2023 and 2022.

As of December 31, 2024, there was $6.8 million of unrecognized compensation cost that is expected to be recognized over a weighted-average period of 2.3 years related to unvested stock options. The total intrinsic value of stock options exercised in the years ended December 31, 2024, 2023, and 2022 was $1.5 million, $1.1 million, and $0.6 million, respectively. The total fair value at grant date of awards that vested was $14.6 million, $3.6 million, and $6.2 million during the years ended December 31, 2024, 2023, and 2022, respectively.

*Fair Value Assumptions*

The Company estimates the fair value of options granted using the Black-Scholes-Merton model for Time-Based Options under the 2017 Stock Plan and 2024 Incentive Plan, and a Monte Carlo simulation for Performance Options granted under the 2017 Stock Plan. The assumptions used to calculate the fair value of options granted are evaluated and modified, as necessary, to reflect current market conditions and experience. The Company estimates the volatility of its common stock utilizing the historical re-levered volatility, re-levered to account for differences in leverage, of the Company and its peer-group. The peer-group utilized consisted of eight companies, in the same or similar industries as the Company. The risk-free rate is based on the U.S. Treasury yield curve in effect at the time of grant for the expected term of the option. The dividend yield was based on the expectation that no dividends will be paid. The Company has never paid cash dividends on its common stock and does not anticipate paying cash dividends in the foreseeable future. In 2024, 2023 and 2022, the Company used a Simplified Method to estimate the expected term for the Time-Based Options, which assumes that options will be exercised early at a uniform rate over the period between vesting and the end of the contractual term, as adequate historical experience is not available to provide a reasonable estimate. For the Tier I and II Performance Options, the Company used management estimates of the performance events that trigger vesting and subsequent exercising of the options.

The following table summarizes the weighted average assumptions used to estimate the fair value of options granted during the periods presented:

| | 2024 | 2023 | 2022 |
|---|---|---|---|
| Expected volatility (range) | 43.8 - 52.5% | 35.0 - 50.0% | 40.0 - 50.0% |
| Risk free interest rate (range) | 3.9 - 4.1% | 4.24 - 5.52% | 2.35 - 4.78% |
| Expected dividends | — | — | — |
| Average expected term (years) | 6.0 | 0.5 - 7.5 | 1.0 - 7.5 |
| Average fair value per share of time-based stock options based on the Black-Scholes-Merton model (dollars) | $ 6.86 | $ 9.69 | $ 10.08 |
| Average fair value per share of performance stock options based on the Monte Carlo simulation (dollars) | $ — | $ 3.10 | $ 5.77 |
| Weighted average fair value of options granted (in millions) | $ 11.40 | $ 9.20 | $ 7.76 |

**11. Property and Equipment, Net**

Property and equipment, net is summarized as follows (in thousands):

| | December 31, 2024 | December 31, 2023 |
|---|---|---|
| Land and land improvements | $ 8,355 | $ 8,404 |
| Furniture and equipment | 237,025 | 202,287 |
| Software | 213,374 | 190,351 |
| Buildings | 37,600 | 36,209 |
| Leasehold improvements | 105,761 | 91,872 |
| Property and equipment under finance lease (Note 12) | 97,590 | 83,329 |
| Construction in progress | 890 | 1,545 |
| Property and equipment | 700,595 | 613,997 |
| Less: accumulated depreciation | 450,309 | 368,089 |
| Property and equipment, net | $ 250,286 | $ 245,908 |

Depreciation expense is recorded within cost of goods, cost of services, and selling, general, and administrative expenses within our consolidated statements of operations, depending on the nature of the underlying fixed assets. Depreciation expense was $89.7 million, $79.2 million and $77.5 million for the years ended December 31, 2024, 2023 and 2022, respectively.

## 12. Lease Arrangements

The Company has a significant population of leases that primarily includes residential and pharmacy locations, as well as office space and office equipment. The Company has real estate and equipment leases that have expiration dates through 2036. Real estate and office space leases generally contain renewal options for periods ranging from 3 to 10 years. Because the Company is not reasonably certain to exercise the renewal options on most office space and leases utilized within our Provider Services segment, the options are not considered in determining the lease term and associated potential option payments are excluded from the lease payments. Generally, for leases utilized within our Pharmacy Solutions segment, the initial lease term is equivalent to the first term plus one renewal option.

Lease expense consists of operating and finance lease costs, short-term lease costs, and variable lease costs, which primarily include common area maintenance, real estate taxes, and insurance for the Company's real estate leases.

Lease expense is summarized as follows (in thousands):

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Finance leases: | | | |
| Amortization of right-of-use assets | $ 13,514 | $ 12,164 | $ 11,030 |
| Interest on lease liabilities | 2,702 | 2,526 | 2,036 |
| Operating leases: | | | |
| Operating lease cost | 98,870 | 95,031 | 92,752 |
| Short-term lease cost | 11,577 | 11,649 | 28,426 |
| Variable lease cost | 9,721 | 9,544 | 8,325 |
| Total lease costs | $ 136,384 | $ 130,914 | $ 142,569 |

Future minimum lease payments of our leases as of December 31, 2024 are as follows (in thousands):

| Fiscal Year | Finance Lease Costs | Operating Lease Costs |
|---|---|---|
| 2025 | $ 14,295 | $ 85,996 |
| 2026 | 11,395 | 71,955 |
| 2027 | 8,470 | 53,604 |
| 2028 | 4,960 | 38,181 |
| 2029 | 2,101 | 23,823 |
| Thereafter | 787 | 29,450 |
| Total future minimum lease payments | $ 42,008 | $ 303,009 |
| Less: imputed interest | 4,904 | 45,730 |
| Total present value of lease liabilities | $ 37,104 | $ 257,279 |

*Supplemental Cash Flow & Other Information*

Supplemental cash flow information related to leases are summarized as follows (dollars in thousands):

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| Cash paid for amounts included in the measurement of lease liabilities: | | | |
| Operating cash flows from finance leases | $ (2,702) | $ (2,526) | $ (2,036) |
| Financing cash flows from finance leases | (11,629) | (11,596) | (10,909) |
| Operating cash flows from operating leases | (99,165) | (94,731) | (91,611) |
| Right-of-use assets obtained in exchange for new finance lease liabilities | 13,095 | 11,562 | 10,652 |
| Right-of-use assets obtained in exchange for new operating lease liabilities | 79,450 | 82,336 | 65,684 |
| Weighted-average remaining lease term (in years): | | | |
| Finance leases | 3.81 | 3.89 | 4.36 |
| Operating leases | 4.32 | 4.68 | 4.78 |
| Weighted-average discount rate: | | | |
| Finance leases | 6.86% | 7.32% | 6.39% |
| Operating leases | 6.94% | 7.15% | 6.58% |

## 13. Fair Value

Assets and liabilities measured at fair value are based on one or more of the following three valuation techniques:

A. *Market approach:* Prices and other relevant information generated by market transactions involving identical or comparable assets or liabilities.

B. *Cost approach:* Amount that would be required to replace the service capacity of an asset (replacement cost).

C. *Income approach:* Techniques to convert future amounts to a single present amount based upon market expectations (including present value techniques, option-pricing, and excess earnings models).

*Assets and Liabilities Measured at Fair Value on a Recurring Basis*

The financial assets or liabilities recorded at fair value on a recurring basis are set forth in the table below (in thousands):

| | December 31, 2024 | December 31, 2023 | Valuation Technique |
|---|---|---|---|
| Assets: | | | |
| Interest rate swaps (Level 2) | $ 10,633 | $ 24,947 | A |
| Total assets | $ 10,633 | $ 24,947 | |
| | | | |
| Liabilities: | | | |
| Contingent consideration (Level 3) | $ 8,386 | $ 5,331 | C |
| Total liabilities | $ 8,386 | $ 5,331 | |

The fair values of our interest rate swaps are based upon Level 2 inputs, which include valuation models. The key inputs for the valuation models are quoted market prices, interest rates, forward yield curves, and credit risk adjustments that are necessary to reflect the probability of default by the counterparty or us. For disclosures about the fair value measurements of our derivative instruments, refer to Note 5.

The contingent consideration represents future earn-outs and a post-closing equity adjustment feature, both associated with acquisitions, which are recognized as part of the purchase price at the estimated fair value on the acquisition date. These liabilities are classified as accrued expenses and long-term liabilities in our accompanying consolidated balance sheets.

The fair values of the liabilities associated with future earn outs were derived using the income approach with unobservable inputs, which included future earnings forecasts and present value assumptions, and there was little or no market data (Level 3). The Company will re-assess the fair values on each reporting period thereafter until settlement.

The preliminary fair value of the liability associated with post-closing equity adjustment feature related to the Haven Hospice acquisition was derived with unobservable inputs using a Monte Carlo simulation, where the common stock price of the Company was

evolved using a Geometric Brownian Motion of a period from the valuation date to the end of the fourth anniversary of closing. Estimated equity volatility was based on historical volatility, implied volatility, and peer group volatility over various periods. The Company will re-assess the fair value at each reporting period with changes in value being recorded through the consolidated statements of operations. The ultimate settlement of the liability will be through either issuance of additional equity shares and/or additional cash paid in the case of net realized losses on sales; or reduction of the outstanding balance of the seller note, in the case of net aggregate realized gain on sales up to the amounts previously paid.

The following table summarizes the changes in fair value of the Company's contingent consideration for the years ended December 31, 2024 and 2023, as follows (in thousands):

| | | |
|---|---|---|
| Balance at January 1, 2023 | $ | 5,818 |
| Additions from acquisitions | | 3,319 |
| Contingent consideration payments | | (3,362) |
| Change in fair value | | (444) |
| Balance at December 31, 2023 | $ | 5,331 |
| Addition of acquisition earn-out | | 200 |
| Addition of post-closing equity adjustment feature | | 4,750 |
| Contingent consideration payments | | (4,156) |
| Change in fair value | | 2,261 |
| Balance at December 31, 2024 | $ | 8,386 |

*Assets Measured at Fair Value on a Non-Recurring Basis*

The Company's non-financial assets, such as goodwill and long-lived assets are adjusted to fair value when an impairment charge is recognized.

During the years ended December 31, 2024 and 2023, we recorded no goodwill impairment.

Long-lived assets include operating lease assets and definite-lived intangible assets. During the year ended December 31, 2024 and 2023, we concluded that sufficient indicators existed to require us to perform recoverability tests by comparing the sum of the estimated undiscounted future cash flows attributable to the assets to their carrying values. Approximately $10.2 million and $10.6 million of impairment charges related to definite-lived intangible assets and operating lease right-of-use assets were recorded for the years ended December 31, 2024 and 2023, respectively. The fair value of these assets at the time of impairment was determined to be zero. To determine fair value, we used the income approach, which assumes that the future cash flows reflect current market expectations. These fair value measurements require significant judgment using Level 3 inputs, such as discounted cash flows from operations, which are not observable from the market, directly or indirectly. There is uncertainty in the projected future cash flows used in the Company's impairment analysis, which requires the use of estimates and assumptions.

If actual performance does not achieve the projections, or if the assumptions used change in the future, we may be required to recognize impairment charges in future periods.

**14. Commitments and Contingencies**

*Legal Proceedings*

On March 4, 2011, Relator Marc Silver, on behalf of the U.S. Government and various state governments, filed a complaint in the United States District Court for the District of New Jersey ("the District Court") against PharMerica, seeking relief, with respect to alleged violations of the federal False Claims Act and state false claims acts, including three times the amount of damages to the federal government plus civil penalties and no less than a certain amount for each alleged false claim, as well as any other recoveries or relief provided for by the federal False Claims Act; damages, fines, penalties, and other recoveries or relief permitted under state false claims acts; and other forms of relief, including attorneys' fees. The complaint alleged that, in violation of the Anti-Kickback Statute and the False Claims Act, PharMerica offered below-cost or below-fair-market-value prices on drugs in exchange for so-called preferred or exclusive provider status that would allow PharMerica to dispense drugs to patients for which PharMerica could bill federal health care program payers. The U.S. Government and state governments declined to intervene in the case.

The District Court issued an order dismissing the case in full in 2016. In 2018, however, the Third Circuit Court of Appeals issued an order reinstating the case. In April 2023, the District Court issued an order denying Relator's motion seeking to strike portions of the opinions of PharMerica's experts and granted in part PharMerica's motions to exclude Relator's experts. On June 28, 2023, the District Court issued an order setting a trial date of December 4, 2023. On November 6, 2023, the District Court denied our motion for summary judgment. On November 18, 2023, the Company agreed to settle the matter without admitting liability. On May 29, 2024,

the parties entered into a final settlement agreement, which was approved by both the United States Department of Justice and the District Court. The total financial impact of the settlement is $120.0 million; $110.0 million of which was paid during the year ended December 31, 2024, with the remaining $10.0 million in accrued expenses in the consolidated balance sheet as of December 31, 2024. As of December 31, 2023, the estimated financial impact of the settlement was $115.0 million, $105.0 million of which was included in accrued expenses and $10.0 million in long-term liabilities in the consolidated balance sheet. The District Court entered an order dismissing the Silver action in its entirety, with prejudice, on July 3, 2024.

The Company is also party to various legal and/or administrative proceedings arising out of the operation of our programs and arising in the ordinary course of business. We record accruals for such contingencies to the extent that we conclude it is probable that a liability has been incurred and the amount of the loss can be reasonably estimated. We do not believe the ultimate liability, if any, for outstanding proceedings or claims, individually or in the aggregate, in excess of amounts already provided, will have a material adverse effect on our consolidated financial condition, results of operations, or cash flows. It is reasonably possible that an adverse determination might have an impact on a particular period. While we believe our provision for legal contingencies is adequate, the outcome of legal proceedings is difficult to predict, and we may settle legal claims or be subject to judgments for amounts that exceed our estimates.

**15. Redeemable Noncontrolling Interests**

The Company has a 60% ownership interest in SHC Medical Partners LLC (“Abode Care Partners”) which meets the definition of a VIE. The Company is deemed to be the primary beneficiary of the VIE because it possesses the power to direct activities of the VIE that most significantly impact its economic performance and has the obligation to absorb losses or the right to receive benefits from the VIE that is significant to it. Through a management agreement with the entity, we manage and handle all day-to-day operating decisions for Abode Care Partners. The terms of the agreement prohibits the Company from using the assets of the entity to satisfy the obligations of other entities. The combined assets of the entity, excluding goodwill and intangible assets, are insignificant to the Company’s consolidated balance sheets.

The respective joint venture agreement contains both a put option for the minority partners and a call option for the Company, requiring or allowing the Company, in certain circumstances, to purchase the partners’ remaining interest in the joint venture at a price based on predetermined earnings multiples. Each of these options is to be triggered upon the occurrence of specified events and/or upon the passage of time. The Company calculates the redemption amount related to the Abode Care Partners options using a Monte Carlo simulation and records the amount, if any, by which the redemption amount exceeds the carrying value as a charge to accumulated deficit.

The total redeemable noncontrolling interest associated with Abode Care Partners was $3.7 million and $5.5 million as of December 31, 2024 and December 31, 2023, respectively. There was no change in the recorded redemption amount for Abode Care Partners for the years ended December 31, 2024 or 2023.

On March 1, 2024, the Company purchased the remaining 30% noncontrolling interest related to Gateway Pediatric Therapy, LLC (“Gateway”) for $5.4 million. Subsequently, the Company owns 100% of common stock in Gateway. Of the $5.4 million purchase price, $0.3 million was paid during the first fiscal quarter of 2024 and the remaining $5.1 million is recorded in trade accounts payable in the consolidated balance sheet as of December 31, 2024. As of December 31, 2023, Gateway met the definition of a VIE and the Company was deemed to be the primary beneficiary of the VIE. The total redeemable noncontrolling interest associated with the Company's 70% ownership in Gateway was $20.6 million as of December 31, 2023. The transaction was accounted for as an equity transaction with the difference between the redeemable noncontrolling interest carrying amount at the time of closing and cash consideration being recognized as an increase in additional paid-in capital of $15.0 million in the consolidated balance sheets as of the purchase date.

On August 1, 2024, the Company purchased the remaining 45% noncontrolling interest related to Harvest Grove LTC, LLC (“Harvest Grove”) for $3.8 million. Subsequently, the Company owns 100% of common stock in Harvest Grove. Of the $3.8 million purchase price, $2.0 million was paid in cash by the Company during the third fiscal quarter of 2024, and the remaining $1.8 million was paid in settled trade receivables owed to the joint venture by the minority owner. As of December 31, 2023, Harvest Grove met the definition of a VIE and the Company was deemed to be the primary beneficiary of the VIE. The total redeemable noncontrolling interest associated with the Company's 55% ownership in Harvest Grove was $1.0 million as of December 31, 2023. The transaction was accounted for as an equity transaction with the difference between the redeemable noncontrolling interest carrying amount at the

time of closing and the purchase price being recognized as a decrease in additional paid-in capital of $2.5 million in the consolidated balance sheets as of the purchase date.

Income tax impacts related to the purchase of Gateway and Harvest Grove of $3.8 million were recorded to additional paid-in capital in the consolidated balance sheet for the year ended December 31, 2024.

The following table summarizes the changes in the carrying value of the Company's redeemable noncontrolling interest (in thousands):

| | | |
|---|---|---|
| Balance at December 31, 2023 | $ | 27,139 |
| Adjustment of Gateway redeemable noncontrolling interest to redemption amount | | (14,981) |
| Adjustment of Harvest Grove redeemable noncontrolling interest to redemption amount | | 2,542 |
| Purchase of Gateway redeemable noncontrolling interest | | (5,400) |
| Purchase of Harvest Grove redeemable noncontrolling interest | | (3,781) |
| Net loss attributable to redeemable noncontrolling interests | | (1,789) |
| Balance at December 31, 2024 | $ | 3,730 |

**16. Related Party Transactions**

The Company was party to a Monitoring Agreement with KKR and WBA, which required payment of an aggregate advisory fee equivalent to 1% of consolidated EBITDA, payable in quarterly installments in arrears at the end of each quarter. The Monitoring Agreement terminated upon the completion of the IPO Offerings in January 2024.

Prior to the termination of the Monitoring Agreement, the Company recognized $0.7 million in monitoring and advisory fees during the first fiscal quarter of 2024 as a component of selling, general, and administrative expenses in our accompanying consolidated statements of operations compared to $5.6 million and $4.9 million for the years ended December 31, 2023 and 2022, respectively.

As a result of the termination of the Monitoring Agreement and in accordance with the agreement, the Company paid $22.7 million in termination fees to KKR and WBA. The termination fees were recognized in the first fiscal quarter of 2024 as selling, general. and administrative expense in our consolidated statement of operations.

KKR Capital Markets LLC ("KCM"), a wholly owned subsidiary of KKR, acted as an underwriter in the IPO Offerings during the first fiscal quarter of 2024 and received $7.4 million in underwriting discounts and commission  In connection with debt refinancing in 2024 and the Revolver upsize in 2023, the Company paid underwriter, arranger, and transaction fees to KCM of $3.7 million and $2.4 million, respectively. These fees are included within selling, general, and administrative expenses in our consolidated statement of operations for the years ended December 31, 2024 and 2023. There were no similar fees paid to KCM in 2022.

KKR has ownership interests in a broad range of portfolio companies, and we may enter into commercial transactions for goods or services in the ordinary course of business with these companies. We do not believe such transactions are material to our business.

The Company has agreements with WBA and/or certain of its affiliates under which the Company purchases significant volume of inventory, including a Joinder Agreement to the Pharmaceutical Purchase and Distribution Agreement (the "WBAD Membership Agreement") between WBA and ABDC. The Company, as a third-party beneficiary to the Pharmaceutical Purchase and Distribution Agreement, has the right to participate in certain pricing and payment related terms as well as appoint WBA to negotiate certain commercial and other mutually agreed upon terms for generic pharmaceutical products in accordance with guiding principles that address topics such as improvements in pricing and notification regarding switches in suppliers. The WBAD Membership Agreement was terminated in the first fiscal quarter of 2025, and we entered into a separate agreement with ABDC.

**17. Segment Information**

The Company's CODM is its Chief Executive Officer, who evaluates the performance of our segments and allocates resources based on segment EBITDA. Segment EBITDA is used as the key profitability measure when we set our annual operating plan for each segment, is the metric with which our CODM assesses segment results, and is a key component of our annual variable compensation

plans. Segment EBITDA is commonly used as an analytical indicator within the health care industry and is utilized in the evaluation of segment operating performance as it is a profit measure that is generally within the control of the operating segments.

For all segments, the CODM uses segment EBITDA in the annual budgeting and monthly forecasting process. The CODM considers actual-to budget and actual-to current forecast variances for segment EBITDA on a monthly basis for evaluating performance of each segment and making decisions about allocating capital and other resources to each segment.

Segment amounts exclude certain expenses not specifically identifiable to the segments for functions performed in a centralized manner, which include accounting, finance, human resources, legal, information technology, corporate office support and overall corporate management. Segment assets and capital expenditures are not provided to the Company's CODM and, therefore, are not disclosed.

The following tables set forth information about the Company's reportable segments, along with the items necessary to reconcile the segment information to the totals reported in the Company's consolidated statements of operations as follows (in thousands):

| | For the Year Ended December 31, 2024 | | |
|---|---|---|---|
| | Pharmacy Solutions | Provider Services | Total Segments |
| Product revenue | $ 8,754,282 | $ — | $ 8,754,282 |
| Service revenue | — | 2,512,190 | 2,512,190 |
| Cost of drugs | 7,368,426 | — | 7,368,426 |
| Cost of services | — | 1,669,536 | 1,669,536 |
| Other direct costs [1] | 640,075 | — | 640,075 |
| Segment selling, general, and administrative expenses [2] | 462,219 | 549,025 | 1,011,244 |
| Segment depreciation and amortization expense [3] | 111,103 | 67,013 | 178,116 |
| **Segment EBITDA** | **$ 394,665** | **$ 360,642** | **$ 755,307** |

| | For the Year Ended December 31, 2023 | | |
|---|---|---|---|
| | Pharmacy Solutions | Provider Services | Total Segments |
| Product revenue | $ 6,522,450 | $ — | $ 6,522,450 |
| Service revenue | — | 2,303,725 | 2,303,725 |
| Cost of drugs | 5,291,630 | — | 5,291,630 |
| Cost of services | — | 1,551,665 | 1,551,665 |
| Other direct costs [1] | 549,086 | — | 549,086 |
| Segment selling, general, and administrative expenses [2] | 426,521 | 518,297 | 944,818 |
| Segment depreciation and amortization expense [3] | 115,749 | 64,676 | 180,425 |
| **Segment EBITDA** | **$ 370,962** | **$ 306,776** | **$ 677,738** |

| | For the Year Ended December 31, 2022 | | | |
|---|---|---|---|---|
| | Pharmacy Solutions | Provider Services | Other | Total Segments |
| Product revenue | $ 5,264,423 | $ — | $ — | $ 5,264,423 |
| Service revenue | — | 2,181,487 | 274,650 | 2,456,137 |
| Cost of drugs | 4,142,064 | — | — | 4,142,064 |
| Cost of services | — | 1,491,953 | 238,959 | 1,730,912 |
| Other direct costs [1] | 493,340 | — | — | 493,340 |
| Segment selling, general, and administrative expenses [2] | 398,080 | 475,159 | 16,841 | 890,080 |
| Segment depreciation and amortization expense [3] | 113,532 | 66,115 | 2,144 | 181,791 |
| **Segment EBITDA** | **$ 344,472** | **$ 288,825** | **$ 19,745** | **$ 653,042** |

(1) Other direct costs primarily includes direct labor costs, delivery costs, insurance, and depreciation and amortization expense that relates to revenue-generating assets.

(2) Segment selling, general, and administrative expense includes indirect labor costs, depreciation and amortization, insurance, rent, lease, supplies, professional services, maintenance, repairs, utilities, and communications expense.

(3) Total segment depreciation and amortization expense is presented in other direct costs, costs of services, and segment general and administrative expenses, based on the associated asset.

| | For the Years Ended December 31, | | |
|---|---|---|---|
| | 2024 | 2023 | 2022 |
| *Reconciliation of income or loss:* | | | |
| Total Segment EBITDA | $ 755,307 | $ 677,738 | $ 653,042 |
| Segment depreciation and amortization | 178,116 | 180,425 | 181,791 |
| Expenses not allocated at segment level: | | | |
| Selling, general, and administrative expenses | 344,451 | 328,222 | 220,386 |
| Depreciation and amortization | 26,366 | 21,911 | 22,179 |
| Goodwill impairment loss | — | — | 40,856 |
| Loss on extinguishment of debt | 12,726 | — | — |
| Interest expense, net | 228,386 | 324,593 | 233,584 |
| Income tax (benefit) expense | (14,217) | (20,578) | 8,465 |
| Net loss | $ (20,521) | $ (156,835) | $ (54,219) |

**18. Subsequent Events**

On January 17, 2025, the Company entered into a purchase agreement to divest the Company's community living services, home and community based waiver programs, and intermediate care facilities (the “Community Living business”) for $835 million, subject to typical adjustments for working capital and other customary items. The transaction is subject to customary closing conditions and certain other antitrust laws and is expected to close in 2025. The Community Living business is a part of Provider Services reportable segment.

**Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.**

None.

**Item 9A. Controls and Procedures.**

***Evaluation of Disclosure Controls and Procedures***

We maintain disclosure controls and procedures (as that term is defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act")) that are designed to ensure that information required to be disclosed in our reports under the Exchange Act, is recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms, and that such information is accumulated and communicated to our management, including our Chief Executive Officer ("CEO") and our Chief Financial Officer ("CFO"), as appropriate, to allow timely decisions regarding required disclosures. Any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives.

Our management, with the participation of our CEO and our CFO, evaluated the effectiveness of the design and operation of our disclosure controls and procedures as of the end of the period covered by this Annual Report. Based on such evaluation, our CEO and CFO have concluded that, as of the end of the period covered by this Annual Report, the design and operation of the Company's disclosure controls and procedures were effective to accomplish their objectives at the reasonable assurance level.

***Management's Annual Report on Internal Control over Financial Reporting***

Under Section 404 of the Sarbanes-Oxley Act of 2002, our management is required to assess the effectiveness of the Company's internal control over financial reporting as of the end of each fiscal year and report, based on that assessment, whether the Company's internal control over financial reporting is effective.

Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting. As defined in Exchange Act Rule 13a-15(f), internal control over financial reporting is a process designed by, or under the supervision of, our principal executive and principal financial officers and effected by our Board of Directors, management and other personnel, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Therefore, internal control over financial reporting determined to be effective can provide only reasonable assurance with respect to financial statement preparation and may not prevent or detect all misstatements.

Under the supervision and with the participation of our management, including our CEO and CFO, we assessed the effectiveness of the Company's internal control over financial reporting as of the end of the period covered by this report. In this assessment, the Company applied criteria based on the "Internal Control-Integrated Framework (2013)" issued by the Committee of Sponsoring Organizations of the Treadway Commission. These criteria are in the areas of control environment, risk assessment, control activities, information and communication, and monitoring. The Company's assessment included documenting, evaluating and testing the design and operating effectiveness of its internal control over financial reporting. Based upon this evaluation, our management concluded that our internal control over financial reporting was effective as of the end of the period covered by this Annual Report.

***Changes in Internal Control over Financial Reporting***

No changes in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the Company's most recently completed fiscal quarter that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

**Item 9B. Other Information.**

None.

**Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.**

Not applicable.

## PART III

### Item 10. Directors, Executive Officers and Corporate Governance.

The information required by this Item is set forth in our Proxy Statement for the 2025 Annual Meeting of Stockholders to be filed with the SEC within 120 days of December 31, 2024 and is incorporated into this Annual Report on Form 10-K by reference.

### Item 11. Executive Compensation.

The information required by this Item is set forth in our Proxy Statement for the 2025 Annual Meeting of Stockholders to be filed with the SEC within 120 days of December 31, 2024 and is incorporated into this Annual Report on Form 10-K by reference.

### Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholders

The information required by this Item is set forth in our Proxy Statement for the 2025 Annual Meeting of Stockholders to be filed with the SEC within 120 days of December 31, 2024 and is incorporated into this Annual Report on Form 10-K by reference.

### Item 13. Certain Relationships and Related Party Transactions and Director Independence

The information required by this Item is set forth in our Proxy Statement for the 2025 Annual Meeting of Stockholders to be filed with the SEC within 120 days of December 31, 2024 and is incorporated into this Annual Report on Form 10-K by reference.

### Item 14. Principal Accountant Fees and Services.

The information required by this Item is set forth in our Proxy Statement for the 2025 Annual Meeting of Stockholders to be filed with the SEC within 120 days of December 31, 2024 and is incorporated into this Annual Report on Form 10-K by reference.

## PART IV

**Item 15. Exhibits and Financial Statement Schedules.**

**(a)(1) Financial Statements:**

The following Consolidated Financial Statements, notes related thereto and reports of independent auditors are included in Item 8 of this Report:

- Report of Independent Registered Public Accounting Firm (PCAOB ID: 185)
- Consolidated Balance Sheets as of December 31, 2024 and 2023
- Consolidated Statements of Operations for the years ended December 31, 2024, 2023, and 2022
- Consolidated Statements of Comprehensive Loss for the years ended December 31, 2024, 2023, and 2022
- Consolidated Statements of Shareholders' Equity for the years ended December 31, 2024, 2023, and 2022
- Consolidated Statements of Cash Flows for the years ended December 31, 2024, 2023, and 2022
- Notes to Consolidated Financial Statements

**(a)(2) Financial Statement Schedules:**

All financial statements schedules have been omitted because they are not applicable, not required or the information required is shown in the financial statements or the notes thereto.

**(a)(3) Exhibits:**

| Exhibit Number | Description | Form | File No. | Exhibit | Filing Date |
|---|---|---|---|---|---|
| 2.1* | Purchase Agreement, dated January 17, 2025, by and among Res-Care, Inc., certain other affiliated entities, National Mentor Holdings, Inc., and BrightSpring Health Services, Inc. (solely for purposes of Section 5.24). | 8-K | 001-41938 | 2.1 | 1/21/2024 |
| 3.1 | Second Amended and Restated Certificate of Incorporation of BrightSpring Health Services, Inc. | 8-K | 001-41938 | 3.1 | 1/30/2024 |
| 3.2 | Amended and Restated Bylaws of BrightSpring Health Services, Inc. | 8-K | 001-41938 | 3.2 | 1/30/2024 |
| 4.1 | Purchase Contract Agreement, dated as of January 30, 2024, between BrightSpring Health Services, Inc. and U.S. Bank Trust Company, National Association, as purchase contract agent, as attorney-in-fact for the Holders from time to time as provided therein and as trustee under the indenture referred to therein. | 8-K | 001-41938 | 4.1 | 1/30/2024 |
| 4.2 | Form of Unit (included in Exhibit 4.1). | 8-K | 001-41938 | 4.2 | 1/30/2024 |
| 4.3 | Form of Purchase Contract (included in Exhibit 4.1). | 8-K | 001-41938 | 4.3 | 1/30/2024 |
| 4.4 | Indenture, dated as of January 30, 2024, between BrightSpring Health Services, Inc. and U.S. Bank Trust Company, National Association, as trustee. | 8-K | 001-41938 | 4.4 | 1/30/2024 |
| 4.5 | First Supplemental Indenture, dated as of January 30, 2024, between BrightSpring Health Services, Inc. and U.S. Bank Trust Company, National Association, as trustee, paying agent and security registrar. | 8-K | 001-41938 | 4.5 | 1/30/2024 |
| 4.6 | Form of Amortizing Note (included in Exhibit 4.5). | 8-K | 001-41938 | 4.6 | 1/30/2024 |
| 4.7 | Registration Rights Agreement, dated as of December 7, 2017, by and among Phoenix Parent Holdings Inc., KKR Phoenix Aggregator L.P., and Walgreens Co. | S-1/A | 333-276348 | 4.1 | 1/10/2024 |
| 4.8 | Description of Securities. | 10-K | 001-41938 | 4.8 | 3/6/2024 |
| 10.1† | BrightSpring Health Services, Inc. 2024 Equity Incentive Plan. | 8-K | 001-41938 | 10.1 | 1/30/2024 |

| Exhibit Number | Description | Form | File No. | Exhibit | Filing Date |
|---|---|---|---|---|---|
| 10.2† | Amended and Restated Phoenix Parent Holdings Inc. 2017 Stock Incentive Plan. | S-1/A | 333-260334 | 10.14 | 1/14/2024 |
| 10.3 | Amended and Restated Stockholders' Agreement, dated as of March 5, 2019, among Registrant, KKR Phoenix Aggregator L.P., Walgreen Co., KKR Americas Fund XII L.P., Walgreens Boots Alliance, Inc., and PharMerica Corporation. | S-1/A | 333-276348 | 10.1 | 1/10/2024 |
| 10.4 | First Lien Credit Agreement, dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., as Holdings, Phoenix Guarantor Inc., as the Borrower, the several lenders from time to time parties thereto, and Morgan Stanley Senior Funding, Inc. as Administrative Agent and Collateral Agent. | S-1/A | 333-276348 | 10.2 | 1/10/2024 |
| 10.5 | Technical Amendment, dated as of May 17, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.3 | 1/10/2024 |
| 10.6 | Joinder Agreement, dated as of September 30, 2019, among Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.4 | 1/10/2024 |
| 10.7 | Amendment No. 1, dated as of January 30, 2020, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.5 | 1/10/2024 |
| 10.8 | Joinder Agreement and Amendment No. 2, dated as of June 30, 2020, among Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.6 | 1/10/2024 |
| 10.9 | Joinder Agreement and Amendment No. 3, dated as of October 7, 2020, among Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.7 | 1/10/2024 |
| 10.10 | Amendment No. 4, dated as of April 8, 2021, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among | S-1/A | 333-276348 | 10.8 | 1/10/2024 |

| Exhibit Number | Description | Form | File No. | Exhibit | Filing Date |
|---|---|---|---|---|---|
| | Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | | | | |
| 10.11 | Joinder Agreement and Amendment No. 5, dated as of April 16, 2021, among Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.9 | 1/10/2024 |
| 10.12 | Joinder Agreement and Amendment No. 6, dated as of June 30, 2023, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the Lenders party thereto, and Morgan Stanley Senior Funding, Inc., as the Administrative Agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | S-1/A | 333-276348 | 10.10 | 1/10/2024 |
| 10.13 | Joinder Agreement and Amendment No. 7, dated as of February 21, 2024, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the several lenders from time to time parties thereto and Morgan Stanley Senior Funding, Inc. as administrative agent and collateral agent to the First Lien Credit Agreement dated as of March 5, 2019, among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. | 10-Q | 001-41938 | 10.1 | 5/2/2024 |
| 10.14 | Joinder Agreement and Amendment No. 8, dated as of September 17, 2024, by and among Credit Agricole Corporate and Investment Bank, Phoenix Guarantor Inc., Phoenix Intermediate Holdings Inc., each 2020 Additional Revolving Credit Lender, each 2020 Letter of Credit Issuer, and Morgan Stanley Senior Funding, Inc., as Administrative Agent. | 10-Q | 001-41938 | 10.1 | 11/1/2024 |
| 10.15 | Amendment No. 9, dated as of December 11, 2024, by and among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the several lenders from time to time parties thereto and Morgan Stanley Senior Funding Inc. as administrative agent and collateral agent to the First Lien Credit Agreement, dated as of March 5, 2019, by and among Phoenix Intermediate Holdings Inc., Phoenix Guarantor Inc., the lenders party thereto, and Morgan Stanley Senior Funding, Inc. (with amended First Lien Credit Agreement attached as Exhibit A). | 8-K | 001-41938 | 10.1 | 12/11/2024 |
| 10.16 | Management Stockholders' Agreement, dated as of December 7, 2017, by and among the Registrant, KKR Phoenix Aggregator, L.P., and the other parties thereto. | S-1/A | 333-276348 | 10.16 | 1/10/2024 |
| 10.17 | Joinder Agreement and Eighth Amendment to the Pharmaceutical Purchase and Distribution Agreement, dated as of December 7, 2017, between Walgreens Boots Alliance, Inc. and certain of its affiliate, and AmerisourceBergen Drug Corporation and its affiliate acknowledged by PharMerica Corporation, to the Pharmaceutical Purchase and Distribution Agreement, between Walgreens Boots Alliance, Inc., and certain of its | S-1/A | 333-276348 | 10.17 | 1/10/2024 |

| Exhibit Number | Description | Form | File No. | Exhibit | Filing Date |
|---|---|---|---|---|---|
| | affiliates, and AmerisourceBergen Drug Corporation and its affiliate, dated as of March 18, 2013. | | | | |
| 10.18 | WBAD – Membership Agreement, by and among Walgreens Boots Alliance Development GmbH and PharMerica Corporation, dated as of May 30, 2018. | S-1/A | 333-276348 | 10.18 | 1/10/2024 |
| 10.19 | Amendment to WBAD – Membership Agreement, by and among Walgreens Boots Alliance Development GmbH and PharMerica Corporation, dated as of April 20, 2022. | S-1/A | 333-276348 | 10.19 | 1/10/2024 |
| 10.20† | Employment Agreement between Phoenix Parent Holdings Inc. and Jon B. Rousseau, effective as of March 5, 2019. | S-1/A | 333-276348 | 10.22 | 1/10/2024 |
| 10.21† | Amended and Restated Employment Agreement between Res-Care, Inc. and James Mattingly, dated December 14, 2017. | S-1/A | 333-276348 | 10.23 | 1/10/2024 |
| 10.22† | Employment Agreement between Res-Care, Inc. and Robert A. Barnes, effective as of July 9, 2018. | S-1/A | 333-276348 | 10.24 | 1/10/2024 |
| 10.23† | Amended and Restated Employment Agreement, dated as of October 11, 2024, by and between Res-Care, Inc. and Steven S. Reed. | 8-K | 001-41938 | 10.1 | 10/11/2024 |
| 10.24† | Special Retention Agreement, dated as of October 11, 2024, by and between Res-Care, Inc. and Steven S. Reed. | 8-K | 001-41938 | 10.2 | 10/11/2024 |
| 10.25† | Employment Agreement between PharMerica Corporation and Jennifer Yowler, effective as of May 4, 2019. | S-1/A | 333-276348 | 10.26 | 1/10/2024 |
| 10.26† | Amended and Restated Employment Agreement between Res-Care, Inc. and Jennifer Phipps, effective as of January 1, 2023. | | | | |
| 10.27† | Option Grant Notice and Agreement (Phoenix Parent Holdings Inc. 2017 Stock Incentive Plan) – Jon B. Rousseau, dated October 16, 2019. | S-1/A | 333-276348 | 10.27 | 1/10/2024 |
| 10.28† | Option Cancellation Agreement between BrightSpring Health Services, Inc., Jon B. Rousseau, and The Margaret Rousseau Children Trust, dated November 22, 2023. | S-1/A | 333-276348 | 10.28 | 1/10/2024 |
| 10.29† | Option Grant Notice and Agreement (Phoenix Parent Holdings Inc. 2017 Stock Incentive Plan) – Jon B. Rousseau, dated November 22, 2023. | S-1/A | 333-276348 | 10.29 | 1/10/2024 |
| 10.30† | Form of Option Grant Notice and Agreement (Phoenix Parent Holdings Inc. 2017 Stock Incentive Plan) – Jim Mattingly, Robert Barnes, Steven Reed, and Jennifer Yowler. | S-1/A | 333-276348 | 10.30 | 1/10/2024 |
| 10.31† | Form of Director Restricted Unit Agreement under the 2024 Equity Incentive Plan. | S-1/A | 333-276348 | 10.22 | 1/17/2024 |
| 10.32† | Form of Employee Restricted Stock Unit Agreement under the 2024 Equity Incentive Plan (IPO Grants). | S-1/A | 333-276348 | 10.23 | 1/17/2024 |
| 10.33† | Form of Employee Restricted Stock Unit Agreement under the 2024 Equity Incentive Plan (Post-IPO Grants). | S-1/A | 333-276348 | 10.24 | 1/17/2027 |
| 10.34† | Form of Option Agreement under the 2024 Equity Incentive Plan (IPO Grants). | S-1/A | 333-276348 | 10.25 | 1/17/2027 |
| 10.35† | Form of Option Agreement under the 2024 Equity Incentive Plan (Post-IPO Grants). | S-1/A | 333-276348 | 10.26 | 1/17/2027 |
| 10.36 | Form of Director and Executive Officer Indemnification Agreement. | S-1/A | 333-276348 | 10.31 | 1/10/2024 |
| 10.37† | BrightSpring Health Services, Inc. Senior Executive Cash Incentive Bonus Plan, adopted May 29, 2024. | 8-K | 001-41938 | 10.1 | 5/31/2024 |
| 19.1 | Securities Trading Policy | | | | |
| 21.1 | Subsidiaries of BrightSpring Health Services, Inc. | S-1/A | 333-276348 | 21.1 | 1/10/2024 |
| 23.1 | Consent of KPMG LLP. | | | | |
| 31.1 | Certification of Principal Executive Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities | | | | |

| Exhibit Number | Description | Form | File No. | Exhibit | Filing Date |
|---|---|---|---|---|---|
| | Exchange Act of 1934, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. | | | | |
| 31.2 | Certification of Principal Financial Officer Pursuant to Rules 13a-14(a) and 15d-14(a) under the Securities Exchange Act of 1934, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002. | | | | |
| 32.1 | Certification of Principal Executive Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. | | | | |
| 32.2 | Certification of Principal Financial Officer Pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002. | | | | |
| 97.1 | BrightSpring Health Services, Inc. Incentive Compensation Clawback Policy. | 10-K | 001-41938 | 97.1 | 3/6/2024 |

* Schedules and similar attachments have been omitted pursuant to Item 601(a)(5) of Regulation S-K. The registrant hereby undertakes to furnish supplementally copies of any of the omitted schedules or similar attachments upon request by the SEC or its staff.

† Management contract or compensatory plan in which directors and/or executive officers are eligible to participate.

The agreements and other documents filed as exhibits to this report are not intended to provide factual information or other disclosure other than with respect to the terms of the agreements or other documents themselves, and you should not rely on them for that purpose. In particular, any representations and warranties made by us in these agreements or other documents were made solely within the specific context of the relevant agreement or document and may not describe the actual state of affairs as of the date they were made or at any other time.

**Item 16. Form 10-K Summary**

None.

**SIGNATURES**

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

BrightSpring Health Services, Inc.

Date: March 6, 2025 By: /s/ Jon Rousseau

**Jon Rousseau**

Chairman, President, and Chief Executive Officer

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

| Name | Title | Date |
|---|---|---|
| /s/ Jon Rousseau<br>**Jon Rousseau** | Chairman, President, and Chief Executive Officer<br>(Principal Executive Officer) | March 6, 2025 |
| /s/ Jennifer Phipps<br>**Jennifer Phipps** | Executive Vice President and Chief Financial Officer<br>(Principal Financial Officer and Principal Accounting Officer) | March 6, 2025 |
| /s/ Hunter Craig<br>**Hunter Craig** | Director | March 6, 2025 |
| /s/ Johnny Kim<br>**Johnny Kim** | Director | March 6, 2025 |
| /s/ Max Lin<br>**Max Lin** | Director | March 6, 2025 |
| /s/ Olivia Kirtley<br>**Olivia Kirtley** | Director | March 6, 2025 |
| /s/ Timothy Wicks<br>**Timothy Wicks** | Director | March 6, 2025 |
| /s/ Steve Miller<br>**Steve Miller** | Director | March 6, 2025 |