

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

**FORM 10-Q**

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

For the quarterly period ended March 31, 2026.  
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: 001-33757



**THE ENSIGN GROUP, INC.**

(Exact Name of Registrant as Specified in Its Charter)

**Delaware**  
(State or Other Jurisdiction of  
Incorporation or Organization)

**33-0861263**  
(I.R.S. Employer  
Identification No.)

**29222 Rancho Viejo Road, Suite 127  
San Juan Capistrano, CA 92675**  
(Address of Principal Executive Offices and Zip Code)

**(949) 487-9500**  
(Registrant's Telephone Number, Including Area Code)

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

<u>Title of each class</u>	<u>Trading Symbol(s)</u>	<u>Name of each exchange on which registered</u>
Common Stock, par value \$0.001 per share	ENSG	NASDAQ Global Select Market

<b>Indicate by check mark:</b>					
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. <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
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). <input checked="" type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act:					
Large accelerated filer <input checked="" type="checkbox"/>	Accelerated filer <input type="checkbox"/>	Non-accelerated filer <input type="checkbox"/>	Smaller reporting company <input type="checkbox"/>	Emerging growth company <input type="checkbox"/>	
If an emerging growth company, indicate 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. <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b>					
whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). <input type="checkbox"/> <b>Yes</b> <input checked="" type="checkbox"/> <b>No</b>					

As of April 27, 2026, 58,445,400 shares of the registrant's common stock, \$0.001 par value, were outstanding.

**THE ENSIGN GROUP, INC.**  
**QUARTERLY REPORT ON FORM 10-Q**  
**FOR THE THREE MONTHS ENDED MARCH 31, 2026**  
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## PART I.

## Item 1. FINANCIAL STATEMENTS

## THE ENSIGN GROUP, INC.

## UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands, except par values)

	March 31, 2026	December 31, 2025
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 539,498	\$ 503,881
Accounts receivable—less allowance for doubtful accounts of \$7,583 and \$7,805 at March 31, 2026 and December 31, 2025, respectively	663,247	636,985
Investments—current	55,677	68,506
Prepaid expenses and other current assets	61,678	62,932
<b>Total current assets</b>	<b>\$ 1,320,100</b>	<b>\$ 1,272,304</b>
Property and equipment, net	1,720,225	1,696,863
Right-of-use assets	2,137,308	2,097,862
Insurance subsidiary deposits and investments	194,309	166,841
Deferred tax assets	83,169	83,138
Restricted and other assets	52,347	41,600
Intangible assets, net	6,322	6,381
Goodwill	97,981	97,981
<b>TOTAL ASSETS</b>	<b>\$ 5,611,761</b>	<b>\$ 5,462,970</b>
<b>LIABILITIES AND EQUITY</b>		
Current liabilities:		
Accounts payable	\$ 116,132	\$ 97,327
Accrued wages and related liabilities	313,517	422,326
Lease liabilities—current	116,500	114,816
Accrued self-insurance liabilities—current	94,868	81,623
Other accrued liabilities	202,766	174,027
Current maturities of long-term debt	4,263	4,227
<b>Total current liabilities</b>	<b>\$ 848,046</b>	<b>\$ 894,346</b>
Long-term lease liabilities—less current portion	1,987,386	1,949,213
Accrued self-insurance liabilities—less current portion	183,860	164,792
Other long-term liabilities	86,281	82,266
Long-term debt—less current maturities	136,491	137,529
<b>TOTAL LIABILITIES</b>	<b>\$ 3,242,064</b>	<b>\$ 3,228,146</b>
Commitments and contingencies (Notes 13 and 18)		
<b>EQUITY</b>		
Ensign Group, Inc. stockholders' equity:		
Common stock: \$0.001 par value; 150,000 shares authorized; 61,990 and 58,423 shares issued and shares outstanding at March 31, 2026, respectively, and 61,652 and 58,085 shares issued and shares outstanding at December 31, 2025, respectively	62	62
Additional paid-in capital	653,401	614,724
Retained earnings	1,852,008	1,756,137
Treasury stock, at cost, 3,567 shares at March 31, 2026 and December 31, 2025	(139,221)	(139,198)
<b>Total Ensign Group, Inc. stockholders' equity</b>	<b>\$ 2,366,250</b>	<b>\$ 2,231,725</b>
Non-controlling interest	3,447	3,099
<b>Total equity</b>	<b>\$ 2,369,697</b>	<b>\$ 2,234,824</b>
<b>TOTAL LIABILITIES AND EQUITY</b>	<b>\$ 5,611,761</b>	<b>\$ 5,462,970</b>

See accompanying notes to the condensed consolidated financial statements.

**THE ENSIGN GROUP, INC.**  
UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF INCOME

	Three Months Ended March 31,	
	2026	2025
	<i>(In thousands, except per share data)</i>	
<b>REVENUE</b>		
Service revenue	\$ 1,382,303	\$ 1,167,040
Rental revenue	6,893	6,001
<b>TOTAL REVENUE</b>	<b>\$ 1,389,196</b>	<b>\$ 1,173,041</b>
Expense:		
Cost of services	1,095,826	927,849
Rent—cost of services	65,506	57,076
General and administrative expense	74,210	62,555
Depreciation and amortization	28,801	24,188
<b>TOTAL EXPENSES</b>	<b>\$ 1,264,343</b>	<b>\$ 1,071,668</b>
Income from operations	124,853	101,373
Other income (expense):		
Interest expense	(1,932)	(2,037)
Interest income	6,536	6,883
Other (expense) income	(885)	361
<b>OTHER INCOME, NET</b>	<b>\$ 3,719</b>	<b>\$ 5,207</b>
Income before provision for income taxes	128,572	106,580
Provision for income taxes	28,816	26,227
<b>NET INCOME</b>	<b>\$ 99,756</b>	<b>\$ 80,353</b>
Less:		
Net income attributable to noncontrolling interests	88	76
<b>NET INCOME ATTRIBUTABLE TO THE ENSIGN GROUP, INC.</b>	<b>\$ 99,668</b>	<b>\$ 80,277</b>
<b>NET INCOME PER SHARE ATTRIBUTABLE TO THE ENSIGN GROUP INC.</b>		
Basic	\$ 1.73	\$ 1.41
Diluted	\$ 1.67	\$ 1.37
<b>WEIGHTED AVERAGE COMMON SHARES OUTSTANDING</b>		
Basic	57,771	57,099
Diluted	59,567	58,500

See accompanying notes to the condensed consolidated financial statements.

## THE ENSIGN GROUP, INC.

### UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

<i>(In thousands)</i>	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Non- Controlling Interest	Total
	Shares	Amount			Shares	Amount		
<b>BALANCE - JANUARY 1, 2026</b>	<b>58,085</b>	<b>\$ 62</b>	<b>\$ 614,724</b>	<b>\$ 1,756,137</b>	<b>3,567</b>	<b>\$ (139,198)</b>	<b>\$ 3,099</b>	<b>\$ 2,234,824</b>
Issuance of common stock to employees and directors resulting from the exercise of stock options	188	—	11,490	—	—	—	—	11,490
Issuance of restricted stock, net of forfeitures	150	—	13,555	—	—	—	—	13,555
Shares of common stock used to satisfy tax withholding obligations	—	—	—	—	—	(23)	—	(23)
Dividends declared (\$0.0650 per share)	—	—	—	(3,797)	—	—	—	(3,797)
Employee stock award compensation	—	—	13,693	—	—	—	—	13,693
Net income attributable to noncontrolling interest	—	—	—	—	—	—	88	88
Noncontrolling interests attributable to subsidiary equity plan	—	—	(61)	—	—	—	260	199
Net income attributable to the Ensign Group, Inc.	—	—	—	99,668	—	—	—	99,668
<b>BALANCE - MARCH 31, 2026</b>	<b>58,423</b>	<b>\$ 62</b>	<b>\$ 653,401</b>	<b>\$ 1,852,008</b>	<b>3,567</b>	<b>\$ (139,221)</b>	<b>\$ 3,447</b>	<b>\$ 2,369,697</b>

<i>(In thousands)</i>	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Non- Controlling Interest	Total
	Shares	Amount			Shares	Amount		
<b>BALANCE - JANUARY 1, 2025</b>	<b>57,438</b>	<b>\$ 61</b>	<b>\$ 528,052</b>	<b>\$ 1,426,762</b>	<b>3,400</b>	<b>\$ (117,764)</b>	<b>\$ 3,317</b>	<b>\$ 1,840,428</b>
Issuance of common stock to employees and directors resulting from the exercise of stock options	106	—	5,050	—	—	—	—	5,050
Issuance of restricted stock, net of forfeitures	87	—	8,003	—	—	—	—	8,003
Shares of common stock used to satisfy tax withholding obligations	—	—	—	—	—	(14)	—	(14)
Dividends declared (\$0.0625 per share)	—	—	—	(3,597)	—	—	—	(3,597)
Employee stock award compensation	—	—	10,691	—	—	—	—	10,691
Repurchase of common stock (Note 19)	(84)	—	—	—	84	(10,775)	—	(10,775)
Acquisition of noncontrolling interest shares	—	—	(11)	—	—	—	—	(11)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	76	76
Noncontrolling interests attributable to subsidiary equity plan	—	—	82	—	—	—	(53)	29
Net income attributable to the Ensign Group, Inc.	—	—	—	80,277	—	—	—	80,277
<b>BALANCE - MARCH 31, 2025</b>	<b>57,547</b>	<b>\$ 61</b>	<b>\$ 551,867</b>	<b>\$ 1,503,442</b>	<b>3,484</b>	<b>\$ (128,553)</b>	<b>\$ 3,340</b>	<b>\$ 1,930,157</b>

See accompanying notes to the condensed consolidated financial statements.

## THE ENSIGN GROUP, INC.

### UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)	Three Months Ended March 31,	
	2026	2025
<b>Cash flows from operating activities:</b>		
<b>Net income</b>	\$ 99,756	\$ 80,353
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	28,801	24,188
Amortization of deferred financing fees	264	266
Stock-based compensation	13,895	10,724
Insurance proceeds and (gain) loss on long-lived assets, net	1,915	420
Other operating activities, net	613	646
Change in operating assets and liabilities		
Accounts receivable	(24,009)	(14,589)
Prepaid income taxes	1,878	13,057
Prepaid expenses and other assets	(986)	(9,360)
Cash surrender value of life insurance policy premiums	(7,490)	(7,489)
Deferred compensation liability	6,926	7,441
Operating lease obligations	(183)	(102)
Accounts payable	18,705	(3,521)
Accrued wages and related liabilities	(97,663)	(60,021)
Other accrued liabilities	27,283	21,497
Accrued self-insurance liabilities	30,449	8,710
<b>NET CASH PROVIDED BY OPERATING ACTIVITIES</b>	<b>\$ 100,154</b>	<b>\$ 72,220</b>
<b>Cash flows from investing activities:</b>		
Purchase of property and equipment	(35,473)	(42,926)
Cash payments for acquisitions	(28,737)	(194,241)
Cash proceeds from insurance recoveries and sale of assets	83	1,494
Purchases of investments	(36,866)	(25,984)
Maturities of investments	29,717	17,862
Other investing activities, net	89	(9)
<b>NET CASH USED IN INVESTING ACTIVITIES</b>	<b>\$ (71,187)</b>	<b>\$ (243,804)</b>
<b>Cash flows from financing activities:</b>		
Payments on debt	(1,042)	(1,009)
Issuance of common stock upon exercise of options	11,490	5,050
Repurchase of shares of common stock to satisfy tax withholding obligations	(23)	(14)
Repurchase of shares of common stock (Note 19)	—	(10,775)
Dividends paid	(3,775)	(3,589)
Other financing activities	—	(11)
<b>NET CASH PROVIDED BY (USED IN) FINANCING ACTIVITIES</b>	<b>\$ 6,650</b>	<b>\$ (10,348)</b>
Net increase (decrease) in cash and cash equivalents	35,617	(181,932)
Cash and cash equivalents beginning of period	503,881	464,598
<b>Cash and cash equivalents end of period</b>	<b>\$ 539,498</b>	<b>\$ 282,666</b>

<i>(In thousands)</i>	Three Months Ended March 31,	
	2026	2025
<b>SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION</b>		
<b>Cash paid during the period for:</b>		
Interest	\$ 1,664	\$ 1,769
Income taxes	425	—
Lease liabilities	66,078	59,165
<b>Non-cash financing and investing activity</b>		
Accrued capital expenditures	\$ 9,970	\$ 7,800
Accrued dividends declared	3,797	3,597
Right-of-use assets obtained in exchange for new and modified operating lease obligations	68,296	57,961

See accompanying notes to the condensed consolidated financial statements.

## THE ENSIGN GROUP, INC.

### NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS

(Dollars, shares and options in thousands, except per share data)

#### 1. DESCRIPTION OF BUSINESS

**The Company** — The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. The Company's independent subsidiaries provide health care services across the post-acute care continuum and engage in the ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare-related properties and ancillary businesses. As of March 31, 2026, the Company's independent subsidiaries operated 378 facilities and other ancillary operations located in 17 states. The Company's independent subsidiaries have a collective capacity of approximately 38,500 operational skilled nursing beds and 3,400 senior living units.

As of March 31, 2026, the Company's independent subsidiaries operated 254 facilities under long-term lease arrangements and had options to purchase eight of those 254 facilities. The Company's real estate portfolio consists of 160 owned real estate properties, which includes 124 facilities operated and managed by the Company's independent subsidiaries, 36 operations leased to and operated by third-party operators and the Service Center (defined below) location. Of those 36 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

During the three months ended March 31, 2026, the Company expanded its presence with the addition of five stand-alone skilled nursing operations in three states. These new operations added a total of 582 operational skilled nursing beds to be operated by the Company's independent subsidiaries. Additionally, the Company entered into definitive agreements to acquire 15 stand-alone skilled nursing operations and two campus operations in Texas subsequent to March 31, 2026, subject to customary closing conditions. These new operations will add 2,080 operational skilled nursing beds and 155 senior living units to be operated by the Company's independent subsidiaries.

The Company's captive real estate investment trust (REIT), Standard Bearer Healthcare REIT, Inc. (Standard Bearer), owns and manages its real estate business. The REIT structure provides the Company with an efficient vehicle for future acquisitions of properties that could be operated by Ensign's independent subsidiaries or other third parties. Standard Bearer has elected to be taxed as a REIT for U.S. federal income tax purposes. Refer to Note 6, *Standard Bearer* for additional information on Standard Bearer.

To support its growth efforts and operational needs, the Company maintains a centralized support structure through its Service Center and captive insurance subsidiary, which provide essential services and risk management to its wholly-owned independent subsidiaries. Certain of the Company's wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide specific accounting, payroll, human resources, compliance, information technology, legal, risk management and other centralized services to the other independent subsidiaries. The Company also has a wholly-owned captive insurance subsidiary that provides some claims-made coverage to the Company's independent subsidiaries for general and professional liabilities, as well as coverage for certain workers' compensation insurance liabilities.

Each of the Company's wholly-owned independent subsidiaries has its own management, employees and assets. References herein to the consolidated "Company" and "its" assets and activities in this Quarterly Report are not meant to imply, nor should it be construed as meaning that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group, Inc.

**Other Information** — The accompanying condensed consolidated financial statements as of March 31, 2026 and for the three months ended March 31, 2026 and 2025 (collectively, the Interim Financial Statements) are unaudited. Certain information and note disclosures normally included in the annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company's audited consolidated financial statements and notes thereto for the year ended December 31, 2025 which are included in the Company's Annual Report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES**

**Basis of Presentation** — The accompanying Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States (GAAP). The Company is the sole member or stockholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing operations, senior living operations and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interests within the equity section of its condensed consolidated balance sheets and the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interests in its condensed consolidated statements of income. The Interim Financial Statements include the accounts of all independent subsidiaries controlled by the Company through its ownership of a majority voting interest.

The preparation of the Interim Financial Statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Interim Financial Statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company's Interim Financial Statements relate to revenue, acquired property and equipment, goodwill, right-of-use assets, impairment of long-lived assets, lease liabilities, general and professional liabilities, workers' compensation and healthcare claims included in accrued self-insurance liabilities and income taxes. Actual results could differ from those estimates. Certain amounts in the prior period statements of cash flows have been reclassified to conform to the presentation of the current period financial statements. These reclassifications had no effect on previously reported net income.

**Recent Accounting Pronouncements** — Except for rules and interpretive releases of the Securities and Exchange Commission (SEC) under authority of federal securities laws and a limited number of grandfathered standards, the FASB ASC is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. For any new pronouncements announced, the Company considers whether the new pronouncements could alter previous generally accepted accounting principles and determines whether any new or modified principles will have a material impact on the Company's reported financial position or operations in the near term. The applicability of any standard is subject to the formal review of the Company's financial management and certain standards are under consideration.

**Recently Issued Accounting Pronouncements Not Yet Adopted** — In November 2024, the FASB issued ASU 2024-03 "Disaggregation of Income Statement Expenses," which requires the Company to disaggregate key expense categories such as employee compensation, depreciation and intangible asset amortization within its financial statements. ASU 2024-03 is effective for annual periods beginning with the Company's fiscal year 2027, and interim periods within the Company's fiscal year 2028, with early adoption permitted. The Company is currently evaluating the impact of this ASU on its Notes to the Consolidated Financial Statements.

In September 2025, the FASB issued ASU 2025-06 "Targeted Improvements to the Accounting for Internal-Use Software," which amends the accounting for and disclosure of software costs under the existing standards. The amendments clarify the requirement for capitalizing software costs. ASU 2025-06 is effective beginning with the Company's fiscal year 2028 for both interim and annual periods, with early adoption permitted. The Company is currently evaluating the impact of this ASU on its Consolidated Financial Statements.

**3. REVENUE AND ACCOUNTS RECEIVABLE**

The Company's service revenue is derived primarily from providing healthcare services to its patients. Revenue is recognized when services are provided to patients at the amount that reflects the consideration that the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care.

**Disaggregation of Revenue**

The Company disaggregates revenue from contracts with its patients by payors. The Company has determined that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**Revenue by Payor**

The Company's revenue is derived primarily from providing healthcare services to patients and is recognized on the date services are provided at amounts billable to individual patients, adjusted for estimates for variable consideration. For patients under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts or rates, adjusted for estimates for variable consideration, on a per patient, daily basis or as services are performed.

Revenue from the Medicare and Medicaid programs accounted for 69.1% and 69.5% of all service revenue for the three months ended March 31, 2026 and 2025, respectively. Settlements with Medicare, Medicaid and managed care payors for retroactive adjustments due to audits and reviews are considered variable consideration and are included in the determination of the estimated transaction price. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company's historical settlement activity. Consistent with healthcare industry practices, any changes to these revenue estimates are recorded in the period the change or adjustment becomes known based on the final settlement. The Company recorded adjustments to revenue which were not material to the Company's revenue for the three months ended March 31, 2026 and 2025.

Service revenue for the three months ended March 31, 2026 and 2025 is summarized in the following tables:

	Three Months Ended March 31,			
	2026		2025	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid <sup>(1)</sup>	\$ 543,450	39.3 %	\$ 453,840	38.9 %
Medicare	335,829	24.3	287,751	24.7
Medicaid-skilled	75,238	5.5	69,551	5.9
<b>Total Medicaid and Medicare</b>	<b>\$ 954,517</b>	<b>69.1 %</b>	<b>\$ 811,142</b>	<b>69.5 %</b>
Managed care	260,851	18.9	227,217	19.5
Private and other <sup>(2)</sup>	166,935	12.0	128,681	11.0
<b>SERVICE REVENUE</b>	<b>\$ 1,382,303</b>	<b>100.0 %</b>	<b>\$ 1,167,040</b>	<b>100.0 %</b>

(1) Medicaid payor includes revenue for senior living operations.

(2) Private and other includes revenue for skilled services (private, Veteran Affairs and hospice payors), senior living and ancillary operations.

In addition to the service revenue above, the Company's rental revenue derived from triple-net lease arrangements with third parties was \$6,893 and \$6,001, respectively, for the three months ended March 31, 2026 and 2025.

**Balance Sheet Impact**

Included in the Company's condensed consolidated balance sheets are contract balances, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no material contract liabilities or contract assets as of March 31, 2026 and December 31, 2025, or activity during the three months ended March 31, 2026 and 2025.

Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration and doubtful accounts. Accounts receivable as of March 31, 2026 and December 31, 2025, is summarized in the following table:

	March 31, 2026	December 31, 2025
Medicaid	\$ 291,960	\$ 296,649
Managed care	180,438	163,463
Medicare	115,292	102,693
Private and other payors	83,140	81,985
	<b>\$ 670,830</b>	<b>\$ 644,790</b>
Less: allowance for doubtful accounts	(7,583)	(7,805)
<b>ACCOUNTS RECEIVABLE, NET</b>	<b>\$ 663,247</b>	<b>\$ 636,985</b>

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

## 4. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing income from operations attributable to stockholders of The Ensign Group, Inc. by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share, except that the denominator is increased to include the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued.

A reconciliation of the numerator and denominator used in the calculation of basic net income per common share follows:

	Three Months Ended March 31,	
	2026	2025
<b>NUMERATOR:</b>		
Net income	\$ 99,756	\$ 80,353
Less: net income attributable to noncontrolling interests	88	76
<b>Net income attributable to The Ensign Group, Inc.</b>	<b>\$ 99,668</b>	<b>\$ 80,277</b>
<b>DENOMINATOR:</b>		
Weighted average shares outstanding	57,771	57,099
<b>Basic net income per common share:</b>	<b>\$ 1.73</b>	<b>\$ 1.41</b>

A reconciliation of the numerator and denominator used in the calculation of diluted net income per common share follows:

	Three Months Ended March 31,	
	2026	2025
<b>NUMERATOR:</b>		
Net income	\$ 99,756	\$ 80,353
Less: net income attributable to noncontrolling interests	88	76
<b>Net income attributable to The Ensign Group, Inc.</b>	<b>\$ 99,668</b>	<b>\$ 80,277</b>
<b>DENOMINATOR:</b>		
Weighted average common shares outstanding	57,771	57,099
Plus: incremental shares from assumed conversion <sup>(1)</sup>	1,796	1,401
<b>Adjusted weighted average common shares outstanding</b>	<b>59,567</b>	<b>58,500</b>
<b>Diluted net income per common share:</b>	<b>\$ 1.67</b>	<b>\$ 1.37</b>

(1) Options and restricted stock awards outstanding that were anti-dilutive and therefore excluded from the calculation of the weighted average common shares outstanding were 733 and 1,171 for the three months ended March 31, 2026 and 2025, respectively.

## 5. FAIR VALUE MEASUREMENTS

The Company's financial assets include held-to-maturity investments carried at amortized cost basis of \$156,945 and \$150,119, of which \$100,578 and \$81,816 are designated to support insurance subsidiary liabilities, as of March 31, 2026 and December 31, 2025, respectively. As of March 31, 2026 and December 31, 2025, the amortized cost basis of these financial assets are considered to approximate fair value and are derived using Level 2 inputs. The Company believes its amortized cost basis investments that were in an unrealized loss position as of March 31, 2026 and December 31, 2025 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The Company's financial assets also include the contracts insuring the lives of certain employees who are eligible to participate in non-qualified deferred compensation plans that are held in a rabbi trust. The cash surrender value of these contracts is based on funds that shadow the investment allocations specified by participants in the deferred compensation plan and are held at fair value. As of March 31, 2026 and December 31, 2025, the fair value of the investment funds was \$81,895 and \$74,405, respectively, which are derived using Level 2 inputs. Refer to Note 16, *Defined Contribution Plans* for more information.

Additionally, the Company has other investments held at historical cost basis, which are not material, for which the fair value is derived using Level 3 inputs.

**6. STANDARD BEARER**

Standard Bearer's real estate portfolio consists of 154 of the Company's 160 owned real estate properties, of which 120 are operated and managed by the Company's independent subsidiaries and 35 are leased to and operated by third-party operators. Of those 35 operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

During the three months ended March 31, 2026, Standard Bearer added \$17,468 of real estate assets associated with two stand-alone skilled nursing operations, both of which are operated by the Company's independent subsidiaries. Additionally, during the three months ended March 31, 2026, the operating responsibility for two stand-alone skilled nursing operations previously acquired by Standard Bearer was transitioned from third-party operators to the Company's independent subsidiaries. Refer to Note 8, *Property and Equipment - Net*, for additional information on real estate acquisitions subsequent to March 31, 2026.

During the three months ended March 31, 2025, Standard Bearer added \$147,796 of real estate assets associated with eight stand-alone skilled nursing operations, one stand-alone senior living operation and two campus operations. Four of these additions were related to the exercise of purchase options under an existing lease arrangement from CareTrust REIT, Inc. (CareTrust). All these additions are operated by the Company's independent subsidiaries.

As part of the formation of Standard Bearer, certain of the Company's independent subsidiaries, Standard Bearer and Standard Bearer's independent real estate subsidiaries entered into several agreements that include leasing, management services and debt arrangements between the operations. All intercompany transactions have been eliminated in consolidation. Refer to Note 7, *Business Segments*, for additional information related to these intercompany eliminations as well as Standard Bearer as a reportable segment.

***Intercompany master lease agreements***

Certain of the Company's independent subsidiaries and 120 Standard Bearer independent real estate subsidiaries have entered into seven triple-net master lease agreements (collectively, the Standard Bearer Master Leases). The lease periods range from 15 to 19 years with three five-year renewal options beyond the initial term, on the same terms and conditions. The rent structure under the Standard Bearer Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the independent subsidiaries are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties; (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Intercompany rental revenue generated from Ensign-affiliated operations for the three months ended March 31, 2026 and 2025 was \$30,832 and \$23,904, respectively, which has been eliminated in consolidation.

***Intercompany management agreement***

Standard Bearer has no employees. The Service Center provides personnel and services to Standard Bearer pursuant to the management agreement between Standard Bearer and the Service Center. The management agreement provides for a base management fee that is equal to 5.0% of total rental revenue and an incentive management fee that is equal to 5.0% of funds from operations (FFO) and is capped at 1.0% of total rental revenue, for a total of 6.0%. Management fee generated between Standard Bearer and the Service Center for the three months ended March 31, 2026 and 2025 was \$2,163 and \$1,692, respectively, which has been eliminated in consolidation.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**Intercompany debt arrangements**

Standard Bearer obtains its funding through various sources including operating cash flows, access to debt arrangements and intercompany loans. The intercompany debt arrangements include mortgage loans and a credit facility to fund acquisitions and working capital needs. The interest rate under the credit facility is a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum.

In addition, as the Department of Housing and Urban Development (HUD) mortgage loans and promissory note are entered into by real estate subsidiaries of Standard Bearer, the interest expense incurred from these debts are included in Standard Bearer's segment income. Refer to Note 13, *Debt*, for additional information related to these debts.

**Equity Instrument Denominated in the Shares of a Subsidiary**

As part of the formation of Standard Bearer in 2022, the Company established the Standard Bearer Healthcare REIT, Inc. 2022 Omnibus Incentive Plan (Standard Bearer Equity Plan). The Company may grant stock options and restricted stock awards under the Standard Bearer Equity Plan to employees and management of Ensign's independent subsidiaries. These awards generally vest over a period of five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of Standard Bearer, which is determined based on an independent valuation of Standard Bearer. The Company can also call the awards, generally upon employee termination. During the three months ended March 31, 2026 and 2025, the Company did not grant any stock options or restricted shares under the Standard Bearer Equity Plan. During the three months ended March 31, 2026 and 2025, there were no restricted stock awards vested for the periods.

The grant-date fair value of the awards is recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interests. The grant value was determined based on an independent valuation of the subsidiary shares. For the three months ended March 31, 2026 and 2025, share-based compensation expense under the Standard Bearer Equity Plan was not material.

**7. BUSINESS SEGMENTS**

The Company has two reportable segments: (1) skilled services, which includes the operation of skilled nursing facilities and rehabilitation therapy services and (2) Standard Bearer, which is comprised of selected real estate properties owned by Standard Bearer and leased to skilled nursing and senior living operators.

As of March 31, 2026, the skilled services segment includes 331 skilled nursing and 31 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. The Company's Standard Bearer segment consists of 154 owned real estate properties.

The Company also reports an "All Other" category that includes results from its senior living operations, which includes 16 stand-alone senior living operations and the senior living operations at 31 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. In addition, the "All Other" category includes mobile diagnostics, medical transportation, other real estate, other ancillary operations and the Service Center. Services included in the "All Other" category are insignificant individually and therefore do not constitute a reportable segment.

The Company's reportable segments are significant operating segments that offer differentiated services. The segment structure reflects the Company's current operational and financial management and provides the best structure to maximize the quality of care and investment strategy provided, while maintaining financial discipline.

Segment income is defined as income before provision for income taxes, excluding gain or loss from sale of real estate, real estate insurance recoveries and impairment of long-lived assets. The Company's chief operating decision maker or CODM, who is the Chief Executive Officer, reviews segment income for each operating segment to evaluate performance and allocate capital resources. The CODM uses segment income to analyze actual results as part of operational planning and to decide whether to reinvest profits into the segments or into other parts of the Company, such as through acquisitions, to pay dividends or to recommend a stock repurchase program. The Company's CODM does not review assets by segment in his resource allocation and therefore assets by segment are not disclosed below.

Intercompany revenue is eliminated in consolidation, along with corresponding intercompany expenses. Included in segment income for Standard Bearer is expense for intercompany services provided by the Service Center as described in Note 6, *Standard Bearer*, as it is part of the CODM financial information.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The following tables set forth financial information for the segments:

	Three Months Ended March 31, 2026		
	Skilled Services	Standard Bearer	Total
Service revenue <sup>(1)</sup>	\$ 1,330,835	\$ —	\$ 1,330,835
Rental revenue	—	36,102	36,102
<b>Segment revenue</b>	<b>\$ 1,330,835</b>	<b>\$ 36,102</b>	<b>\$ 1,366,937</b>
<b>Reconciliation of revenue:</b>			
All other revenue <sup>(2)</sup>			62,256
Elimination of intercompany revenue <sup>(3)</sup>			(39,997)
<b>TOTAL CONSOLIDATED REVENUE</b>			<b>\$ 1,389,196</b>
Less:			
Other segment items <sup>(4)</sup>	1,141,508	3,122	
Depreciation and amortization	15,310	10,783	
Interest expense <sup>(5)</sup>	—	11,388	
<b>Segment income</b>	<b>\$ 174,017</b>	<b>\$ 10,809</b>	<b>\$ 184,826</b>
<b>Reconciliation of profit or loss:</b>			
All other not included in segment income			(56,254)
<b>INCOME BEFORE PROVISION FOR INCOME TAXES</b>			<b>\$ 128,572</b>

(1) Skilled services service revenue does not include intercompany service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in "Elimination of intercompany revenue".

(2) All other revenue includes \$59,061 of service revenue and \$3,195 of rental revenue for the three months ended March 31, 2026, both of which include intercompany revenue that is eliminated in "Elimination of intercompany revenue".

(3) Elimination of intercompany revenue includes the elimination of intercompany rental revenue of \$32,404 and intercompany service revenue of \$7,593 for the three months ended March 31, 2026.

(4) Other segment items include cost of services of \$1,052,724 and rent expense of \$88,784 for the skilled services segment, and cost of services of \$625, rent expense of \$265 and general and administrative expenses of \$2,232 for the Standard Bearer segment. Additionally, there are intercompany expenses of \$39,997 during the three months ended March 31, 2026, which are eliminated in consolidation.

(5) Included in interest expense in Standard Bearer is interest from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. of \$9,767 during the three months ended March 31, 2026, which is eliminated in consolidation.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

	Three Months Ended March 31, 2025		
	Skilled Services	Standard Bearer	Total
Service revenue <sup>(1)</sup>	\$ 1,123,554	\$ —	\$ 1,123,554
Rental revenue	—	28,401	28,401
<b>Segment revenue</b>	<b>\$ 1,123,554</b>	<b>\$ 28,401</b>	<b>\$ 1,151,955</b>
<b>Reconciliation of revenue:</b>			
All other revenue <sup>(2)</sup>			52,426
Elimination of intercompany revenue <sup>(3)</sup>			(31,340)
<b>TOTAL CONSOLIDATED REVENUE</b>			<b>\$ 1,173,041</b>
Less:			
Other segment items <sup>(4)</sup>	966,410	2,606	
Depreciation and amortization	13,213	8,476	
Interest expense <sup>(5)</sup>	—	8,736	
<b>Segment income</b>	<b>\$ 143,931</b>	<b>\$ 8,583</b>	<b>\$ 152,514</b>
<b>Reconciliation of profit or loss:</b>			
All other not included in segment income			(45,934)
<b>INCOME BEFORE PROVISION FOR INCOME TAXES</b>			<b>\$ 106,580</b>

(1) Skilled services service revenue does not include intercompany service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in "Elimination of intercompany revenue".

(2) All Other revenue includes \$49,427 of service revenue and \$2,999 of rental revenue for the three months ended March 31, 2025, both of which include intercompany revenue that is eliminated in "Elimination of intercompany revenue".

(3) Elimination of intercompany revenue includes the elimination of intercompany rental revenue of \$25,399 and intercompany service revenue of \$5,941 for the three months ended March 31, 2025.

(4) Other segment items include cost of services of \$891,855 and rent expense of \$74,555 for the skilled services segment, and cost of services of \$598, rent expense of \$257 and general and administrative expenses of \$1,751 for the Standard Bearer segment. Additionally, there are intercompany expenses of \$31,340 during the three months ended March 31, 2025, which is eliminated in consolidation.

(5) Included in interest expense in Standard Bearer is interest from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. of \$7,040 during the three months ended March 31, 2025, which is eliminated in consolidation.

Service revenue by major payor source were as follows:

	Three Months Ended March 31, 2026			
	Skilled Services	All Other <sup>(3)</sup>	Total Service Revenue	Revenue %
Medicaid <sup>(1)</sup>	\$ 529,333	\$ 14,117	\$ 543,450	39.3 %
Medicare	335,829	—	335,829	24.3
Medicaid-skilled	75,238	—	75,238	5.5
<b>Subtotal</b>	<b>\$ 940,400</b>	<b>\$ 14,117</b>	<b>\$ 954,517</b>	<b>69.1 %</b>
Managed care	260,851	—	260,851	18.9
Private and other <sup>(2)</sup>	129,584	37,351	166,935	12.0
<b>TOTAL SERVICE REVENUE</b>	<b>\$ 1,330,835</b>	<b>\$ 51,468</b>	<b>\$ 1,382,303</b>	<b>100.0 %</b>

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.

(2) Private and other includes revenue for skilled services (private, Veteran Affairs and hospice payors), senior living and ancillary operations.

(3) All Other incorporates intercompany eliminations.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

	Three Months Ended March 31, 2025			
	Skilled Services	All Other <sup>(3)</sup>	Total Service Revenue	Revenue %
Medicaid <sup>(1)</sup>	\$ 443,411	\$ 10,429	\$ 453,840	38.9 %
Medicare	287,751	—	287,751	24.7
Medicaid-skilled	69,551	—	69,551	5.9
<b>Subtotal</b>	<b>\$ 800,713</b>	<b>\$ 10,429</b>	<b>\$ 811,142</b>	<b>69.5 %</b>
Managed care	227,217	—	227,217	19.5
Private and other <sup>(2)</sup>	95,624	33,057	128,681	11.0
<b>TOTAL SERVICE REVENUE</b>	<b>\$ 1,123,554</b>	<b>\$ 43,486</b>	<b>\$ 1,167,040</b>	<b>100.0 %</b>

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.

(2) Private and other includes revenue for skilled services (private, Veteran Affairs and hospice payors), senior living and ancillary operations.

(3) All Other incorporates intercompany eliminations.

## 8. PROPERTY AND EQUIPMENT - NET

Property and equipment, net consists of the following:

	March 31, 2026	December 31, 2025
Land	\$ 221,208	\$ 219,857
Buildings and improvements	1,288,713	1,231,704
Leasehold improvements	268,599	254,309
Equipment	496,938	478,729
Furniture and fixtures	4,647	4,588
Construction in progress	19,341	58,615
	<b>\$ 2,299,446</b>	<b>\$ 2,247,802</b>
Less: accumulated depreciation	(579,221)	(550,939)
<b>PROPERTY AND EQUIPMENT, NET</b>	<b>\$ 1,720,225</b>	<b>\$ 1,696,863</b>

## Real Estate Acquisitions

A majority of the real estate properties were acquired by subsidiaries of Standard Bearer, as detailed in Note 6. *Standard Bearer*. The aggregate purchase price for the real estate purchases during the three months ended March 31, 2026 was \$18,086, which primarily consists of building and improvements of \$16,117 and land of \$1,351, respectively. The aggregate purchase price for the real estate purchases during the three months ended March 31, 2025 was \$159,172, which primarily consists of building and improvements of \$135,654 and land of \$20,453, respectively. The Company finalized the purchase price allocation for certain acquisitions during the three months ended March 31, 2025 resulting in no activities in goodwill during that period.

During the three months ended March 31, 2026, the Company, including Standard Bearer, entered into definitive agreements to acquire real estate assets associated with 19 operations subsequent to March 31, 2026, subject to customary closing conditions, for an aggregate purchase price of approximately \$342,350. The real estate assets are associated with 15 stand-alone skilled nursing operations and two campus operations to be operated by the Company's independent subsidiaries and two stand-alone senior living operations to be leased to a third-party operator beginning on May 1, 2026, in each case, assuming the closing of the acquisitions.

## 9. INTANGIBLE ASSETS - NET

Intangible Assets	Weighted Average Life (Years)	March 31, 2026			December 31, 2025		
		Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Facility trade name	30.0	733	(493)	240	733	(486)	247
Customer relationships	18.4	4,582	(3,166)	1,416	4,582	(3,114)	1,468
<b>TOTAL</b>		<b>\$ 5,315</b>	<b>\$ (3,659)</b>	<b>\$ 1,656</b>	<b>\$ 5,315</b>	<b>\$ (3,600)</b>	<b>\$ 1,715</b>

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

During the three months ended March 31, 2026 and 2025, amortization expense was \$333 and \$811, respectively, of which \$274 and \$142 was related to the amortization of right-of-use assets, respectively.

Estimated amortization expense for each of the years ending December 31 is as follows:

Year	Amount
2026 (remainder)	\$ 179
2027	238
2028	238
2029	238
2030	238
2031	238
Thereafter	287
	<b>\$ 1,656</b>

Other indefinite-lived intangible assets consist of the following:

	March 31, 2026	December 31, 2025
Trade name	\$ 889	\$ 889
Medicare and Medicaid licenses	3,777	3,777
<b>TOTAL</b>	<b>\$ 4,666</b>	<b>\$ 4,666</b>

## 10. GOODWILL

Goodwill is subject to annual testing for impairment during the fourth quarter of each year. In addition, goodwill is tested for impairment if events occur or circumstances indicate that its carrying value may not be recoverable. There were no indicators of goodwill impairment noted during the three months ended March 31, 2026. The Company anticipates that the majority of goodwill recognized will be fully deductible for tax purposes as of March 31, 2026. There were no activities in goodwill during the three months ended March 31, 2026. The following table represents goodwill value by the skilled services segment and "all other" category for March 31, 2026 and December 31, 2025:

	Skilled Services	All Other	Total
<b>Goodwill</b>	<b>\$ 88,626</b>	<b>\$ 9,355</b>	<b>\$ 97,981</b>

## 11. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	March 31, 2026	December 31, 2025
Quality assurance fee	\$ 15,869	\$ 17,398
Refunds, deferred revenue and advances	104,401	105,642
Cash held in trust for patients	8,208	8,653
Dividends payable	3,797	3,775
Property taxes	11,590	7,150
Income tax payable	27,352	818
Accrued litigation (Note 18)	12,000	12,000
Other	19,549	18,591
<b>OTHER ACCRUED LIABILITIES</b>	<b>\$ 202,766</b>	<b>\$ 174,027</b>

Quality assurance fee represents the aggregate of amounts payable to various states that have a mandated fee based on patient days or licensed beds. Refunds, deferred revenue and advances consist of liabilities related to duplicate payments and credit balances from various payor sources, as well as payments received from residents in advance of services provided. Cash held in trust for patients reflects monies received from or on behalf of patients. Maintaining a trust account for patients is a regulatory requirement and, while the trust assets offset the liabilities, the Company assumes a fiduciary responsibility for these funds. The cash balance related to this liability is included in other current assets in the condensed consolidated balance sheets.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**12. INCOME TAXES**

The Company recorded income tax expense of \$28,816 and \$26,227 during the three months ended March 31, 2026 and 2025, respectively, or 22.4% of earnings before income taxes for the three months ended March 31, 2026, compared to 24.6% for the three months ended March 31, 2025. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, offset by non-deductible expenses including non-deductible compensation.

The Company is not currently under examination by any major income tax jurisdiction. During 2026, the statutes of limitations will lapse on the Company's 2022 federal tax year and certain 2021 and 2022 state tax years. The Company does not believe the federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the three months ended March 31, 2026 and 2025.

**13. DEBT**

Debt consists of the following:

	<b>March 31, 2026</b>	<b>December 31, 2025</b>
Mortgage loans and promissory note	\$ 143,310	\$ 144,352
Less: current maturities	(4,263)	(4,227)
Less: debt issuance costs, net	(2,556)	(2,596)
<b>LONG-TERM DEBT LESS CURRENT MATURITIES</b>	<b>\$ 136,491</b>	<b>\$ 137,529</b>

***Credit Facility with a Lending Consortium Arranged by Truist***

The Company maintains a revolving credit facility between the Company and its independent subsidiaries, including Standard Bearer as co-borrowers, and Truist Securities (Truist) (the Credit Facility) with a revolving line of credit of up to \$600,000 in aggregate principal amount with a maturity date of April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the Credit Facility). In addition, there is a commitment fee on the unused portion of the commitments that ranges from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

Borrowings made under the Credit Facility are guaranteed, jointly and severally, by certain of the Company's wholly-owned subsidiaries, and are secured by a pledge of stock of the Company's material independent subsidiaries as well as a first lien on substantially all of such independent subsidiaries' personal property. The Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the terms of the Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of (i) a maximum consolidated total net debt to consolidated EBITDA ratio (which shall not be greater than 3.75:1.00; provided that if the aggregate consideration for approved acquisitions in a six month period is greater than \$50,000, then the ratio can be increased at the election of the Company with notice to the administrative agent to 4.25:1.00 for the first fiscal quarter and the immediately following three fiscal quarters), and (ii) a minimum interest/rent coverage ratio (which cannot be less than 1.50:1.00). As of March 31, 2026, there was no outstanding debt under the Credit Facility. The Company was in compliance with all loan covenants as of March 31, 2026.

***Mortgage Loans and Promissory Note***

As of March 31, 2026, the Company has 23 subsidiaries that have mortgage loans insured with HUD in the aggregate amount of \$142,571, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates in a range of 3.1% to 4.2%, including fixed interest rates in a range of 2.4% to 3.3% per annum. In addition to the interest rate, the Company incurs other fees for HUD placement, including, but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees based on the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0% and is reduced by 3.0% in the fourth year of the loan and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

In addition to the HUD mortgage loans above, the Company has a promissory note of \$739 that bears a fixed interest rate of 5.3% per annum and has a term of 12 years. The note, which was assumed as part of an acquisition, is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

**Off-Balance Sheet Arrangements**

As of March 31, 2026 and December 31, 2025, the Company had approximately \$8,402 of borrowing capacity under the Credit Facility pledged as collateral to secure outstanding letters of credit. The Company believes that its outstanding letters of credit as of March 31, 2026 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

**14. OPTIONS AND AWARDS**

Stock-based compensation expense consists of stock-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company's condensed consolidated statements of income for the three months ended March 31, 2026 and 2025 was based on awards expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company grants equity awards under the Amended and Restated 2022 Omnibus Incentive Plan (the Amended and Restated Plan), the amendment and restatement of which was approved by the Company's stockholders during the second quarter of 2025. There are 4,231 shares of common stock available for issuance under the Amended and Restated Plan, and the number of shares available for issuance is reduced by one share for each share subject to an option or stock appreciation right award and by two shares for each share subject to an award other than an option or stock appreciation right. At March 31, 2026, 2,804 shares remained available for future issuance under the Amended and Restated Plan.

Non-employee director stock options, to the extent granted, vest and become exercisable in three equal annual installments, or over the term of the award if less than three years, subject to continued service from the grant date through the date of vesting. All other stock options generally vest over five years at a rate of 20% per year on each anniversary of the grant date. Stock options expire ten years from the grant date.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for stock option awards. Determining the appropriate fair-value model and calculating the fair value of stock option awards at the grant date requires judgment, including estimating stock price volatility, expected option life, and forfeiture rates. The fair-value of the restricted stock awards at the grant date is based on the market price on the grant date, adjusted for forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time.

**Stock Options**

The Company used the following assumptions for stock options granted during the three months ended March 31, 2026 and 2025:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2026	312	3.7%	6.2 years	38.4%	0.1%
2025	152	4.3%	6.2 years	39.8%	0.2%

For the three months ended March 31, 2026 and 2025, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2026	312	\$ 212.65	\$ 93.07
2025	152	\$ 126.34	\$ 57.17

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the three months ended March 31, 2026 and 2025 and therefore, the intrinsic value was \$0 at the date of grant.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The following table represents the employee stock option activity during the three months ended March 31, 2026:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
<b>January 1, 2026</b>	<b>4,071</b>	\$ 96.87	1,991	\$ 67.10
Granted	312	212.65		
Forfeited	(22)	123.35		
Exercised	(188)	61.08		
<b>March 31, 2026</b>	<b>4,173</b>	\$ 107.01	1,955	\$ 70.45

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of March 31, 2026 and December 31, 2025 is as follows:

Options	March 31, 2026	December 31, 2025
Outstanding	\$ 397,796	\$ 317,984
Vested	256,158	213,189
Expected to vest	132,838	98,487

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options. The aggregate intrinsic value of options that vested during the three months ended March 31, 2026 and 2025 was \$12,451 and \$6,045, respectively. The total intrinsic value of options exercised during the three months ended March 31, 2026 and 2025 was \$26,483 and \$9,470, respectively.

### Restricted Stock Awards

The Company granted 155 and 92 restricted stock awards during the three months ended March 31, 2026 and 2025, respectively. All awards were granted at an issue price of \$0 and generally vest over five years. The fair value per share of restricted awards granted during the three months ended March 31, 2026 and 2025 ranged from \$183.54 to \$212.65 and \$126.34 to \$134.58, respectively. The fair value per share includes quarterly stock awards to non-employee directors. Included in the restricted stock award grants are \$13,555 and \$8,003 of annual bonuses that were settled in vested restricted stock awards during the three months ended March 31, 2026 and 2025, respectively.

A summary of the status of the Company's non-vested restricted stock awards as of March 31, 2026 and changes during the three months ended March 31, 2026 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
<b>Nonvested at January 1, 2026</b>	<b>436</b>	\$ 129.54
Granted	155	210.77
Vested	(100)	175.06
Forfeited	(5)	116.28
<b>Nonvested at March 31, 2026</b>	<b>486</b>	\$ 146.30

During the three months ended March 31, 2026, the Company granted three automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards was \$183.54 based on the market price on the grant date.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**Stock-based compensation expense**

Stock-based compensation expense recognized for the Company's equity incentive plans and long-term incentive plan for the three months ended March 31, 2026 and 2025 was as follows:

	Three Months Ended March 31,	
	2026	2025
Stock-based compensation expense related to stock options	\$ 8,652	\$ 6,805
Stock-based compensation expense related to restricted stock awards	4,380	3,402
Stock-based compensation expense related to restricted stock awards to non-employee directors	661	484
<b>TOTAL</b>	<b>\$ 13,693</b>	<b>\$ 10,691</b>

In future periods, the Company expects to recognize approximately \$121,924 and \$62,954 in stock-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of March 31, 2026. Future stock-based compensation expense will be recognized over 3.9 and 4.0 weighted average years for unvested options and restricted stock awards, respectively. There were 2,218 unvested and outstanding options as of March 31, 2026, of which 2,049 options are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest as of March 31, 2026 was 6.8 years.

**15. LEASES**

The Company leases real property associated with 104 independent skilled nursing and senior living facilities under eight triple-net master lease agreements with CareTrust REIT, Inc. (collectively, the Master Leases). The Master Leases have initial terms ranging from 13 to 20 years and include two or three five-year renewal options at the Company's election, subject to customary conditions. If the Company elects to renew the term of a Master Lease, the renewal will be effective to all, but not less than all, of the leased property then subject to such Master Lease.

The Master Leases are non-cancelable prior to expiration without the consent of CareTrust. Rent consists of a fixed base amount subject to annual escalation equal to the lesser of 2.5% or the percentage change in the Consumer Price Index (not less than zero). As triple-net leases, the Company is responsible for substantially all property-level operating costs, including taxes, insurance, utilities, and maintenance. Total rent expense under the Master Leases was \$19,631 and \$17,126 for the three months ended March 31, 2026 and 2025, respectively.

The Master Leases require the Company to comply with certain financial covenants, including portfolio coverage and minimum rent coverage ratios, as well as customary reporting and other requirements. The Company was in compliance with all such requirements as of March 31, 2026.

The Company leases facilities where its independent subsidiaries operate under non-cancelable operating leases, most of which have initial lease terms ranging from 15 to 20 years. Most of these leases contain renewal options, certain of which involve rent increases.

The Company's 104 independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases with CareTrust, are operated under 19 separate master lease arrangements. Under the master leases, a default at a single facility could subject one or more of the other facilities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is an event of default under several of the Company's leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in the Company's outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The components of operating lease expense are as follows:

	Three Months Ended March 31,	
	2026	2025
Rent - cost of services <sup>(1)</sup>	\$ 65,506	\$ 57,076
Cost of services <sup>(2)</sup>	6,979	6,429
General and administrative expense	220	199
	<b>\$ 72,705</b>	<b>\$ 63,704</b>

(1) Rent - cost of services includes deferred rent expense adjustments of \$321 and \$208 for the three months ended March 31, 2026 and 2025, respectively. Additionally, rent - cost of services includes other variable lease costs such as consumer price index increases and short-term leases of \$5,131 and \$4,004 for the three months ended March 31, 2026 and 2025, respectively.

(2) Cost of services includes variable lease costs consisting of property taxes and insurance.

Future minimum lease payments for all third-party leases as of March 31, 2026 are as follows:

Year	Amount
2026 (remainder)	\$ 182,707
2027	243,258
2028	242,307
2029	236,831
2030	231,410
2031	221,291
Thereafter	1,780,951
<b>TOTAL LEASE PAYMENTS</b>	<b>\$ 3,138,755</b>
Less: present value adjustment	(1,034,869)
<b>PRESENT VALUE OF TOTAL LEASE LIABILITIES</b>	<b>\$ 2,103,886</b>
Less: current lease liabilities	(116,500)
<b>LONG-TERM OPERATING LEASE LIABILITIES</b>	<b>\$ 1,987,386</b>

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at the lease commencement date. As of March 31, 2026, the weighted average remaining lease term is 13.9 years and the weighted average discount rate used to determine the operating lease liabilities is 6.2%.

### Lessor Activities

The Company leases 36 owned real estate properties to third-party operators, including 32 senior living operations operated by The Pennant Group, Inc. (Pennant). All of the leases are triple-net arrangements, under which the tenants are responsible for substantially all property-level operating costs, including taxes, insurance, utilities, and maintenance. The initial terms range from 14 to 16 years.

During the three months ended March 31, 2026, the Company, through Standard Bearer, entered into a definitive agreement to acquire real estate assets associated with two stand-alone senior living operations on May 1, 2026 subject to customary closing conditions. Assuming the closing of the acquisitions, these operations will be leased to a third-party operator beginning on May 1, 2026.

Total rental income from all third-party sources for the three months ended March 31, 2026 and 2025 is as follows:

	Three Months Ended March 31,	
	2026	2025
Pennant <sup>(1)</sup>	\$ 4,213	\$ 4,122
Other third-party <sup>(2)</sup>	2,680	1,879
<b>TOTAL</b>	<b>\$ 6,893</b>	<b>\$ 6,001</b>

(1) Pennant rental income includes variable rent such as property taxes of \$312 and \$310 during the three months ended March 31, 2026 and 2025, respectively.

(2) Other third-party includes rental revenue associated with the Company's subleases to third parties of \$1,135 and \$1,107 for the three months ended March 31, 2026 and 2025.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

Future contractual minimum annual rental income for all third-party leases as of March 31, 2026 were as follows:

Year	Amount
2026 (remainder)	\$ 20,641
2027	26,922
2028	26,495
2029	26,380
2030	25,316
2031	25,310
Thereafter	98,758
<b>TOTAL</b>	<b>\$ 249,822</b>

## 16. DEFINED CONTRIBUTION PLANS

The Company has a 401(k) defined contribution plan (the 401(k) Plan), whereby eligible employees may contribute up to 90% of their annual basic earnings, subject to applicable annual Internal Revenue Code limits. Additionally, the 401(k) Plan provides for discretionary matching contributions (as defined in the 401(k) Plan) by the Company.

The Company has a non-qualified deferred compensation plan (DCP), whereby highly compensated employees may defer the receipt of a portion of their base compensation and, for certain employees, up to 100% of their eligible bonuses. Additionally, the DCP allows for the employee deferrals to be deposited into a rabbi trust and the funds are generally invested in individual variable life insurance contracts owned by the Company that are specifically designed to fund savings plans of this nature.

As of March 31, 2026 and December 31, 2025, the Company accrued \$86,070 and \$81,553, respectively, as long term deferred compensation in other long term liabilities on the condensed consolidated balance sheets. Cash surrender value of the contracts is based on investment funds that shadow the investment allocations specified by participants in the deferred compensation plan. Refer to Note 5, *Fair Value Measurements* for more information on the funds.

For the three months ended March 31, 2026 and 2025, the Company recorded a loss on its DCP of \$1,694 and \$282, respectively, which is included in other income, net. During the same periods, the Company recorded an offsetting reduction in expenses of \$1,598 and \$234, respectively, which is allocated between cost of services and general and administrative expenses.

## 17. SELF INSURANCE LIABILITIES

The Company is partially self-insured for general and professional liability claims up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. The combined self-insured retention for the Company's independent subsidiaries in California is \$1,000 per claim (\$750 if an enforceable arbitration agreement applies), subject to an additional one-time deductible of \$3,950. For the independent subsidiaries not in California, the self-insured claim is \$750 per claim (\$650 if an enforceable arbitration agreement applies), subject to an additional one-time, deductible of \$5,100. For all independent subsidiaries, except those located in Colorado, the third-party coverage above these limits is \$1,000 per claim, \$3,000 per operation, with a \$10,000 blanket aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits is \$1,000 per claim and \$3,000 per operation, which is independent of the aforementioned blanket aggregate limits that apply outside of Colorado.

The majority of the self-insured retention and deductible limits for general and professional liabilities and workers' compensation liabilities are self-insured through the captive insurance subsidiary, the related assets and liabilities of which are included in the accompanying condensed consolidated balance sheets. The captive insurance subsidiary is subject to certain statutory requirements as an insurance provider.

The Company's policy is to accrue amounts equal to the actuarial estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The Company's independent subsidiaries are self-insured for workers' compensation liabilities in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed \$625 per occurrence. In Texas, the independent subsidiaries have elected non-subscriber status for workers' compensation claims and the Company has purchased individual stop-loss coverage that insures individual claims that exceed \$750 per occurrence. The Company's independent subsidiaries in all other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed \$350 per occurrence. In the State of Washington, the Company is self-insured and has purchased individual specific excess insurance coverage that insures individual claims that exceed \$500 per occurrence. For all of the self-insured plans and retention, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information.

The Company self-funds medical (including prescription drugs) and dental healthcare benefits for the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed \$525 for each covered person for fiscal year 2026.

The following table represents the Company's self-insurance insurance liabilities, on an undiscounted basis, inclusive of anticipated insurance recoveries, as of March 31, 2026 and December 31, 2025:

	March 31, 2026	December 31, 2025
Accrued general liability and professional malpractice liabilities	\$ 214,460	\$ 186,780
Accrued workers' compensation liabilities	43,871	42,121
Accrued health benefits	20,397	17,514
<b>TOTAL SELF-INSURANCE LIABILITIES</b>	<b>\$ 278,728</b>	<b>\$ 246,415</b>
Less: current self-insurance liabilities	94,868	81,623
<b>LONG-TERM SELF-INSURANCE LIABILITIES</b>	<b>\$ 183,860</b>	<b>\$ 164,792</b>

The anticipated insurance recoveries included in the self-insurance liabilities are presented gross rather than net with the corresponding asset of \$19,007 and \$17,143, as of March 31, 2026 and December 31, 2025, respectively, included in Restricted and other assets on the consolidated balance sheets.

The Company believes that adequate provision has been made in the Interim Financial Statements for liabilities that may arise out of patient care, workers' compensation, healthcare benefits and related services provided to date.

## 18. COMMITMENTS AND CONTINGENCIES

**Indemnities** — From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's condensed consolidated balance sheets for any of the periods presented.

**Litigation and Regulatory Matters** — The Company and its independent subsidiaries are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business. Such claims may be related to, but are not limited to, the Health Insurance Portability and Accountability Act of 1996, alleged Medicare or Medicaid false claims, qui tam or "whistleblower" claims related to alleged violations of the False Claims Act and/or the Anti-Kickback Statute, alleged violations of state and federal wage and hour laws, environmental matters, investigations, examinations, audits and surveys or other claims in connection with the delivery of healthcare and non-healthcare services and general business operations. These claims may come from a variety of governmental agencies, including but not limited to, the following federal agencies: U.S. Department of Health and Human Services (HHS), including the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), Office for Civil Rights (OCR) and Office of Inspector General (OIG); U.S. Department of Justice (DOJ); Occupational Safety and Health Administration (OSHA), U.S. Equal Employment Opportunity Commission (EEOC); National Labor Relations Board (NLRB); U.S. Department of Labor (DOL); U.S. Department of Housing and Urban Development (HUD); U.S. Department of Veterans Affairs (VA); Environmental Protection Agency (EPA); and Office of Health Care Affordability (OHCA). In addition to these federal agencies, there are also a variety of state and local authorities with the ability to bring claims against our independent subsidiaries.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

The Company and its independent subsidiaries are also subject to requests for information and investigations by other state and federal governmental entities. For example, representatives of the State Attorney General's Office or the State OIG Office may and do request medical records, operational information, and other such documents and materials from the Company's independent subsidiaries. The Company cannot predict or provide any assurance as to the possible outcome of any such request, inquiry, investigation or subsequent litigation. If any such request, inquiry, investigation or related litigation were to proceed, and the Company and/or its independent subsidiaries are subjected to, alleged to be liable for, or agree to a settlement of related claims or obligations under federal Medicare statutes, the FCA, or similar state and federal statutes and regulations. In addition, if the Company and/or its independent subsidiaries are alleged or found to be liable on theories of general or professional negligence or conduct alleged to be related to its employment practices (including wage and hour violations), the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged violations and may also include the assumption of specific procedural and financial obligations by the Company or its independent subsidiaries under a Corporate Integrity Agreement and/or other such arrangement.

From time to time, various state or Federal agencies may issue requests for information, including but not limited to a subpoena. As an example, California's Office of Health Care Affordability is currently conducting a Cost and Market Impact Review (CMIR) with respect to specific components of a proposed transaction involving three of the Company's independent subsidiaries in California. The Company provided OHCA with requested information regarding specific components of the proposed transaction as part of the CMIR. The Company has been unable to effect resolution including attempts to narrow the scope, and limit the requests to its independent subsidiaries operating in California. The Company has filed a Petition in the Superior Court of the State of California, County of Orange, seeking a declaration that the CMIR regulations violate the United States Constitution and/or the California Constitution, and is void and unenforceable as applied to the Company. It also has requested that OHCA be ordered to withdraw the subpoena and close the inquiry, so the underlying transaction can be completed.

Other claims and suits, including class actions, continue to be filed against the Company and other companies in its industry. The Company and its independent subsidiaries have been subjected to, and are currently involved in, class action litigation alleging violations (alone or in combination) of state and federal wage and hour laws as related to the alleged failure to pay wages, to timely provide and compensate for meal and rest breaks, and related causes of action. In 2025, the Company agreed to settle substantially all alleged wage, hour or labor code-related violations asserted on a class or representative basis against its independent subsidiaries in California for purported violations occurring during the six year period ending December 2025, pending court approval. Accordingly, the Company has recorded an accrual of \$12,000 within *Other accrued liabilities* on the condensed consolidated balance sheet as of December 31, 2025. The Company does not believe that the ultimate resolution of these actions will have an ongoing material adverse effect on the Company's business, cash flows, financial condition or results of operations.

From time to time, the Company has received Civil Investigative Demands (CID) from the U.S. Department of Justice (DOJ). Certain of these matters resulted in settlements that were material to the Company's financial statements in prior periods. In 2024, the Company, on behalf of its independent subsidiaries, received a CID indicating that the DOJ is investigating the Company to determine whether claims have been submitted to Medicare and Texas Medicaid for services which were unnecessary or otherwise not consistent with existing reimbursement requirements. The CID covers the period from January 1, 2016, to the present. As a general matter, the Company's independent subsidiaries maintain policies and procedures to promote compliance with all applicable Medicare and Medicaid requirements, including but not limited to those relating to the presentation of claims for reimbursement for services provided. The Company is fully cooperating with the DOJ in response to the CID. However, the Company cannot predict the outcome of the investigation or its potential impact on the consolidated financial statements.

In 2023, following a four-week medical negligence trial in the State of Arizona, the jury returned a verdict against one of the Company's independent subsidiaries. The Company is in the process of appealing the jury verdict. The Company has in the past appealed similar decisions and has, in some circumstances, received decisions in its favor. Although the Company intends to vigorously defend against these specific claims and in general these types of claims and cases, there can be no assurance that the outcomes of these matters will not have a material adverse effect on operational results and financial condition. The Company has recorded an estimated liability for this matter.

## NOTES TO THE UNAUDITED CONDENSED CONSOLIDATED FINANCIAL STATEMENTS - (Continued)

**Medicare Revenue Recoupments** — The Company's independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare and Medicaid services, billings and potential overpayments as a result of Recovery Audit Contractors (RAC), and various Program Safeguard Contractors and Medicaid Integrity Contractors (collectively referred to as Reviews). Reviews vary in claim selection size and processes, ranging from a single episode/claim month to larger, multi-claim batches; and from single rounds of review to reviews of multiple rounds with pass/fail criteria. If an operation has a significant error rate or fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. The Company anticipates that these Reviews could increase in frequency in the future. As of March 31, 2026, and through the filing date of this report, 22 of the Company's independent subsidiaries had multi-claim Reviews scheduled or in process.

**Concentrations**

**Credit Risk** — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible and continually monitors and adjusts these allowances as necessary.

The Company's receivables from Medicare and Medicaid payor programs accounted for 60.7% and 61.9% of its total accounts receivable as of March 31, 2026 and December 31, 2025, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 69.1% and 69.5% of the Company's revenue for the three months ended March 31, 2026 and 2025, respectively.

**19. COMMON STOCK REPURCHASE PROGRAM**

On May 15, 2025, the Board of Directors approved a stock repurchase program pursuant to which the Company is authorized to repurchase up to \$20,000 of its common stock under the program for a period of approximately 12 months from June 16, 2025. During the three months ended March 31, 2026, the Company did not repurchase any shares pursuant to this stock repurchase program. As of March 31, 2026, the full \$20,000 authorized for repurchase remained available under the stock repurchase program.

On February 21, 2025, the Board of Directors approved a stock repurchase program pursuant to which the Company was authorized to repurchase up to \$20,000 of its common stock under the program for a period of approximately 12 months from March 26, 2025. During the first quarter of 2025, the Company repurchased 84 shares of its common stock for \$10,775. Subsequent to March 31, 2025, the Company repurchased an additional 73 shares of its common stock for \$9,225. This repurchase program expired upon the repurchase of the fully authorized amount under the plan.

Under the repurchase program, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions, tender offers, pursuant to contractual provisions, and block trades, or otherwise in accordance with federal securities laws. The share repurchase program does not obligate the Company to acquire any specific number of shares. Any such repurchases will depend on the Company's business strategy, prevailing market conditions, the Company's liquidity requirements, contractual restrictions or covenants, compliance with securities laws, and other factors. The amounts involved in any such transaction may be material.

**Item 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS**

*The following discussion should be read in conjunction with the condensed consolidated financial statements and accompanying notes, which appear elsewhere in this Quarterly Report on Form 10-Q. We urge you to carefully review and consider the various disclosures made by us in this Quarterly Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Annual Report on Form 10-K for the year ended December 31, 2025 (Annual Report), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Form 10-Q and Form 8-K, for additional information. The section entitled "Risk Factors" contained in Part II, Item 1A of this Quarterly Report on Form 10-Q, and similar discussions in our other SEC filings, also describe some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Quarterly Report on Form 10-Q and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.*

This Quarterly Report on Form 10-Q contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to our expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, and plans and objectives of management. Forward-looking statements can often be identified by words such as "anticipates," "expects," "intends," "plans," "predicts," "believes," "seeks," "estimates," "may," "will," "should," "would," "could," "potential," "continue," "ongoing," similar expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Our actual results could differ materially from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section "Risk Factors" contained in Part II, Item 1A of this Quarterly Report on Form 10-Q. These forward-looking statements speak only as of the date of this Quarterly Report on Form 10-Q, and are based on our current expectations, estimates and projections about our industry and business, management's beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law.

## Overview

We are a provider of health care services across the post-acute care continuum. We engage in the operation, ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare-related properties and ancillary businesses located in 17 states. Our independent subsidiaries, each of which strive to be the operation of choice in the communities they serve, provide a broad spectrum of services. As of March 31, 2026, we offered skilled nursing, long-term acute care, senior living and rehabilitative care services through 378 skilled nursing and senior living facilities. Our real estate portfolio includes 160 owned real estate properties, which includes 124 facilities operated and managed by us, 36 operations leased to and operated by third-party operators and the Service Center location. Of the 36 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that we own and operate.

The following table summarizes our independent subsidiaries and operational skilled nursing beds and senior living units by ownership status as of March 31, 2026:

	Owned and Operated	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total for Facilities Operated
Number of facilities	124	8	246	378
Percentage of total	32.8 %	2.1 %	65.1 %	100.0 %
Operational skilled nursing beds	11,923	687	25,939	38,549
Percentage of total	30.9 %	1.8 %	67.3 %	100.0 %
Senior living units	1,940	142	1,321	3,403
Percentage of total	57.0 %	4.2 %	38.8 %	100.0 %

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. Our subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly-owned subsidiaries including Ensign Services, Inc. and Cornet Limited, Inc., referred to collectively as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other independent subsidiaries. We also have a wholly-owned captive insurance subsidiary that provides some claims-made coverage to our independent subsidiaries for general and professional liability, as well as coverage for certain workers' compensation insurance liabilities. Our captive real estate investment trust, Standard Bearer, owns and manages our real estate business. References herein to the consolidated "Company" and "its" assets and activities, as well as the use of the terms "we," "us," "our" and similar terms in this Quarterly Report, are not meant to imply, nor should they be construed as meaning that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group, Inc.

Our acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within our target markets that offer strong opportunities for return. The operations added by us are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, we believe that prior operating results are not a meaningful representation of our current operating results or indicative of the integration potential of our newly acquired independent subsidiaries.

## Recent Activities

We believe we exist to dignify and transform post-acute care. We set out a strategy to achieve our goal of ensuring our patients are receiving the best possible care through our ability to acquire, integrate and improve our operations. Our results serve as a strong indicator that our strategy is working and our transformation is underway. Our dedication to our cultural and operational fundamentals continues to deliver strong results. Refer to *Results of Operations* for further discussion.

**Operational Expansions** — During the three months ended March 31, 2026, we expanded our operations with the addition of five stand-alone skilled nursing operations in three states. These new operations added a total of 582 operational skilled nursing beds operated by our independent subsidiaries.

In the same period, we entered into definitive agreements to acquire 15 stand-alone skilled nursing operations and two campus operations in Texas on May 1, 2026, subject to customary closing conditions. Assuming the closing of the acquisitions, these new operations will add 2,080 operational skilled nursing beds and 155 senior living units to be operated by our independent subsidiaries. These acquisitions establish Texas as our largest state by skilled nursing and senior living operations, totaling 105 operations, and reaffirm our continued growth in the markets where we began in 1999.

**Standard Bearer Acquisitions** — Standard Bearer Healthcare REIT, Inc. (Standard Bearer), our captive REIT, is a holding company with subsidiaries that own a majority of our real estate portfolio. Management believes that the REIT structure enhances transparency into the value of the Company's owned real estate and provides an efficient platform to support future property acquisitions, which may be operated by the our independent subsidiaries or leased to third-party operators.

During the three months ended March 31, 2026, Standard Bearer added \$17.5 million of real estate assets associated with two stand-alone skilled nursing operations operated by our independent subsidiaries. In addition, during the same period, two stand-alone skilled nursing operations owned by Standard Bearer were transitioned from third-party operators to our independent subsidiaries.

In addition, during the three months ended March 31, 2026, we entered into definitive agreements to acquire real estate assets associated with 19 operations subsequent to March 31, 2026, subject to customary closing conditions, for an aggregate purchase price of approximately \$342.4 million. The real estate assets are associated with 15 stand-alone skilled nursing operations and two campus operations to be operated by our independent subsidiaries and two stand-alone senior living operations to be leased to a third-party operator beginning on May 1, 2026, in each case, assuming the closing of the acquisitions.

### Facility Information

The following table sets forth the location of our facilities and the number of operational beds and units located at our skilled nursing, senior living and campus facilities as of March 31, 2026:

	Facility Counts				Bed / Unit Counts		
	Skilled Operations	Senior Living Communities	Campus Operations <sup>(1)</sup>	Total	Skilled Operational Beds	Senior Living Units	Total Beds / Units
Texas	82	1	5	88	10,501	606	11,107
California	78	4	3	85	8,247	378	8,625
Arizona	35	1	6	42	5,396	891	6,287
Colorado	33	5	1	39	3,567	633	4,200
Utah	26	2	1	29	2,412	163	2,575
Washington	17	1	—	18	1,608	98	1,706
Idaho	14	—	1	15	1,331	21	1,352
Kansas	4	—	8	12	883	251	1,134
Tennessee	11	—	—	11	1,122	—	1,122
South Carolina	9	—	—	9	1,126	—	1,126
Iowa	7	—	2	9	602	31	633
Nebraska	4	1	3	8	496	199	695
Wisconsin	5	—	—	5	350	—	350
Nevada	3	—	—	3	483	—	483
Alaska	1	1	—	2	146	82	228
Alabama	2	—	—	2	181	—	181
Oregon	—	—	1	1	98	50	148
	<b>331</b>	<b>16</b>	<b>31</b>	<b>378</b>	<b>38,549</b>	<b>3,403</b>	<b>41,952</b>

(1) Campuses represent facilities that offer both skilled nursing and senior living services.

The following table provides summary information regarding the location of our owned and operated real estate properties as of March 31, 2026:

	Facility Counts				Bed / Unit Counts		
	Skilled Operations	Senior Living Communities	Campus Operations <sup>(1)</sup>	Total	Skilled Operational Beds	Senior Living Units	Total Beds / Units
Texas	25	1	4	30	3,336	576	3,912
Arizona	12	—	5	17	2,052	494	2,546
Utah	15	—	—	15	1,102	—	1,102
California	11	—	1	12	1,291	42	1,333
Colorado	6	3	—	9	593	369	962
Kansas	2	—	5	7	495	167	662
Washington	6	—	—	6	621	—	621
Idaho	6	—	—	6	590	—	590
South Carolina	5	—	—	5	544	—	544
Wisconsin	5	—	—	5	350	—	350
Nebraska	1	1	1	3	171	160	331
Tennessee	3	—	—	3	300	—	300
Iowa	3	—	—	3	234	—	234
Alaska	1	1	—	2	146	82	228
Oregon	—	—	1	1	98	50	148
	<b>101</b>	<b>6</b>	<b>17</b>	<b>124</b>	<b>11,923</b>	<b>1,940</b>	<b>13,863</b>

(1) Campuses represent facilities that offer both skilled nursing and senior living services.

The following table provides summary information regarding the location of our owned real estate properties as of March 31, 2026:

	Owned and Operated by Ensign <sup>(1)</sup>	Owned and Leased to Third-Party Operators <sup>(1)</sup>	Service Center	Total Properties <sup>(1)</sup>
Texas <sup>(1)</sup>	30	7	—	36
Wisconsin	5	22	—	27
Arizona	17	1	—	18
Utah	15	—	—	15
California	12	2	1	15
Colorado	9	—	—	9
Washington	6	3	—	9
Kansas	7	—	—	7
Idaho	6	—	—	6
South Carolina	5	—	—	5
Iowa	3	—	—	3
Nebraska	3	—	—	3
Tennessee	3	—	—	3
Alaska	2	—	—	2
Oregon	1	—	—	1
Nevada	—	1	—	1
	<b>124</b>	<b>36</b>	<b>1</b>	<b>160</b>

(1) One senior living operation in Texas, which is owned by an independent subsidiary of Ensign and leased to a third-party operator, is located on the same real estate property as a skilled nursing facility that we own and operate. In this situation, the senior living operation is included in the total under "Owned and Leased to Third Party Operators" and the skilled nursing operation is included in the total under "Owned and Operated by Ensign", however, the amount reflected under "Total Properties" only recognizes the operation as a single property.

## Key Performance Indicators

We manage the fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. Revenue associated with these metrics is generated based on contractually agreed-upon amounts or rate, excluding the estimates of variable consideration under the revenue recognition standard, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606. These indicators and their definitions include the following:

### Skilled Services

- **Routine revenue** — Routine revenue is generated by the contracted daily rate charged for all contractually inclusive skilled nursing services. The inclusion of therapy and other ancillary treatments varies by payor source and by contract. Services provided outside of the routine contractual agreement are recorded separately as ancillary revenue, including Medicare Part B therapy services, and are not included in the routine revenue definition.
- **Skilled revenue** — The amount of routine revenue generated from patients in the skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs. The other skilled patients who are included in this population represent very high acuity patients who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care. Skilled revenue excludes any revenue generated from our senior living services.
- **Skilled mix** — The amount of our skilled revenue as a percentage of our total skilled nursing routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving skilled nursing services at the skilled nursing facilities divided by the total number of days patients from all payor sources are receiving skilled nursing services at the skilled nursing facilities for any given period.
- **Average daily rates** — The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period.
- **Occupancy percentage (operational beds)** — The total number of patients occupying a bed in a skilled nursing facility as a percentage of the beds in a facility which are available for occupancy during the measurement period.
- **Number of facilities and operational beds** — The total number of skilled nursing facilities that we own or operate, and the total number of operational beds associated with these facilities.

**Skilled Mix** — Like most skilled nursing providers, we measure both patient days and revenue by payor. Medicare, managed care and other skilled patients, whom we refer to as high acuity patients, typically require a higher level of skilled nursing and rehabilitative care. Accordingly, Medicare and managed care reimbursement rates are typically higher than from other payors. In most states, Medicaid reimbursement rates are generally the lowest of all payor types. Changes in the payor mix can significantly affect our revenue and profitability.

The following table summarizes our overall skilled mix from our skilled nursing services for the periods indicated as a percentage of our total skilled nursing routine revenue and as a percentage of total skilled nursing patient days:

Skilled Mix:	Three Months Ended March 31,	
	2026	2025
Days	32.0 %	31.4 %
Revenue	50.7 %	50.2 %

**Occupancy** — We define occupancy derived from our skilled services as the ratio of actual patient days (one patient day equals one patient occupying one bed for one day) during any measurement period to the number of beds in facilities which are available for occupancy during the measurement period. The number of beds in a skilled nursing facility that are actually operational and available for occupancy may be less than the total official licensed bed capacity. This sometimes occurs due to the permanent dedication of bed space to alternative purposes, such as enhanced therapy treatment space or other desirable uses calculated to improve service offerings and/or operational efficiencies in a facility. In some cases, three- and four-bed wards have been reduced to two-bed rooms for resident comfort, and larger wards have been reduced to conform to changes in Medicare requirements. These beds are seldom expected to be placed back into service. We believe that reporting occupancy based on operational beds is consistent with industry practices and provides a more useful measure of actual occupancy performance from period to period.

The following table summarizes our overall occupancy statistics for skilled nursing operations for the periods indicated:

Occupancy for skilled services:	Three Months Ended March 31,	
	2026	2025
Operational beds at end of period	38,549	34,946
Available patient days	3,449,159	3,099,677
Actual patient days	2,896,034	2,538,135
Occupancy percentage (based on operational beds)	84.0 %	81.9 %

### Segments

We have two reportable segments: (1) skilled services, which includes the operation of skilled nursing facilities and rehabilitation therapy services and (2) Standard Bearer, which is comprised of select properties owned by us through our captive REIT and leased to skilled nursing and senior living operations, including our own independent subsidiaries and third-party operators.

We also reported an "all other" category that includes operating results from our senior living operations, mobile diagnostics, transportation, other real estate and other ancillary operations. These businesses are neither significant individually, nor in aggregate and therefore do not constitute a reportable segment. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

### Revenue Sources

The following tables set forth our total service revenue by payor source generated by our skilled services segment and our "All Other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Three Months Ended March 31,					
	Skilled Services		All Other <sup>(3)</sup>		Total Service Revenue	
	2026	2025	2026	2025	2026	2025
Medicaid <sup>(1)</sup>	\$ 529,333	\$ 443,411	\$ 14,117	\$ 10,429	\$ 543,450	\$ 453,840
Medicare	335,829	287,751	—	—	335,829	287,751
Medicaid-skilled	75,238	69,551	—	—	75,238	69,551
<b>Subtotal</b>	<b>\$ 940,400</b>	<b>\$ 800,713</b>	<b>\$ 14,117</b>	<b>\$ 10,429</b>	<b>\$ 954,517</b>	<b>\$ 811,142</b>
Managed care	260,851	227,217	—	—	260,851	227,217
Private and other <sup>(2)</sup>	129,584	95,624	37,351	33,057	166,935	128,681
<b>TOTAL SERVICE REVENUE</b>	<b>\$ 1,330,835</b>	<b>\$ 1,123,554</b>	<b>\$ 51,468</b>	<b>\$ 43,486</b>	<b>\$ 1,382,303</b>	<b>\$ 1,167,040</b>

	Three Months Ended March 31,					
	Skilled Services		All Other <sup>(3)</sup>		Total Service Revenue	
	2026	2025	2026	2025	2026	2025
Medicaid <sup>(1)</sup>	39.8 %	39.5 %	27.4 %	24.0 %	39.3 %	38.9 %
Medicare	25.2	25.6	—	—	24.3	24.7
Medicaid-skilled	5.7	6.2	—	—	5.5	5.9
<b>Subtotal</b>	<b>70.7 %</b>	<b>71.3 %</b>	<b>27.4 %</b>	<b>24.0 %</b>	<b>69.1 %</b>	<b>69.5 %</b>
Managed care	19.6	20.2	—	—	18.9	19.5
Private and other <sup>(2)</sup>	9.7	8.5	72.6	76.0	12.0	11.0
<b>TOTAL SERVICE REVENUE</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>

(1) Medicaid payor includes revenue for senior living operations.

(2) Private and other includes revenue for skilled services (private, Veteran Affairs and hospice payors), senior living and ancillary operations.

(3) All Other incorporates intercompany eliminations.

## GOVERNMENT REGULATION

### General

Healthcare is an area of extensive and frequent regulatory change. Changes in the law or new interpretations of existing laws may have a significant impact on our revenue, costs and business operations. Our independent subsidiaries that provide healthcare services are subject to federal, state and local laws relating to, among other things, licensure, quality and adequacy of care, physical plant requirements, life safety, personnel and operating policies. In addition, these same subsidiaries are subject to federal and state laws that govern billing and reimbursement, relationships with vendors, business relationships with physicians and workplace protection for healthcare staff. Such laws include (but are not limited to) the Anti-Kickback Statute (AKS), the federal False Claims Act (FCA), the federal prohibition on physician self-referral known as the Stark Law, state law, and state corporate practice of medicine statutes.

Governmental and other authorities periodically inspect our independent subsidiaries to verify continued compliance with applicable regulations and standards. The operations must pass these inspections to remain licensed under state laws and to comply with Medicare and Medicaid provider agreements and applicable Conditions of Participation. The operations can only participate in these third-party payment programs if unannounced inspections by regulatory authorities reveal that the operations are in substantial compliance with applicable state and federal requirements. In the ordinary course of business, federal or state regulatory authorities may issue notices to the operations alleging deficiencies in certain regulatory practices, which may require corrective action to regain and maintain compliance. In some cases, federal or state regulators may impose other remedies including imposition of directed in-service training, state monitoring, civil monetary penalties, temporary admission and/or payment bans, loss of certification as a provider in the Medicare or Medicaid programs, or revocation of a state operating license.

We believe that the regulatory environment surrounding the healthcare industry subjects providers to intense scrutiny. In the ordinary course of business, providers are subject to inquiries, investigations and audits by federal and state agencies related to compliance with participation and payment rules under government payment programs. These inquiries may originate from the Department of Health and Human Services (HHS), Office of the Inspector General (OIG), state Medicaid agencies, state Attorney Generals, local and state ombudsman offices and the Centers for Medicare and Medicaid Services (CMS) Recovery Audit Contractors, among other agencies. In response to the inquiries, investigations and audits, federal and state agencies may impose citations for regulatory deficiencies and other regulatory penalties, including demands for refund of overpayments, expanded civil monetary penalties that extend over long periods of time and date back to incidents prior to surveyor visits, Medicare and Medicaid payment bans and terminations from those programs, which may be temporary or permanent in nature. We vigorously contest each such regulatory outcome when appropriate; however, there are significant legal and other expenses involved that consume our financial and personnel resources. Expansion of enforcement activity could adversely affect our business, financial condition or the results of operations.

### ***Proposed, Anticipated and Recently Issued Rulemaking and Administrative Actions***

The federal government, through CMS rulemaking, Presidential executive actions or Congressional legislation, and state and local governments have recently released the following proposed or final rulemaking, or administrative actions that may have an impact on our independent Skilled Nursing Facilities (SNFs) or senior living facilities:

***Final Rule Updating Health-Care Related Tax Policies*** — On February 2, 2026, CMS published a final rule, effective April 3, 2026, related to the statistical test used to evaluate state Medicaid health care-related tax waiver requests, implementing requirements codified in the One Big Beautiful Bill (OBBB). In relevant part, this rule limits the circumstances under which states may obtain waivers from CMS to impose taxes that fund state Medicaid programs by assessing taxes that impose a greater burden on Medicaid-participating organizations (whether based on volume or percentage of Medicaid taxable units) than the burden imposed on organizations that do not participate in Medicaid, or have relatively less Medicaid participation. While the rule primarily targets managed care organization taxes, it applies to all permissible provider tax classes, including nursing facilities, for which CMS has identified at least two existing taxes that appear to exploit the loophole. Non-MCO provider taxes, including nursing facility taxes, have a compliance deadline of the end of the applicable state fiscal year ending in calendar year 2028 (no later than September 30, 2028).

***Federal Nurse Staffing Legislation*** — Following the repeal of the federal minimum staffing requirements in December 2025, there has been legislation introduced in Congress, that if enacted, would impose mandatory minimum staffing requirements for skilled nursing facilities participating in the Medicare and Medicaid Programs.

**Controlled Substances Act Telemedicine Flexibilities** — On December 31, 2025, the Drug Enforcement Administration (DEA) in coordination with the HHS, issued a fourth extension of certain telemedicine flexibilities related to the prescribing of controlled substances, extending these provisions through December 31, 2026. Under the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, practitioners are generally required to conduct at least one in-person medical evaluation before prescribing controlled substances to a patient via telemedicine.

**Consolidated Appropriations Act of 2026 (CAA 2026)** — On February 3, 2026, the Consolidated Appropriations Act of 2026 (CAA 2026) was passed, which further extended government funding through September 30, 2026. Of specific importance to our businesses are:

- **Telehealth Waivers:** Since the COVID-19 Pandemic, Congress has temporarily waived restrictions so Medicare beneficiaries can access telehealth services at home and outside of rural areas. Medicare recipients can now continue using telehealth under these relaxed rules, regardless of location. The waivers expired on September 30th but were reinstated effective October 1, 2025 and extended through December 31, 2027. Specifically, key waivers that were restored temporarily include:
  - Lifting geographic limitations for medical telehealth services, allowing them to be provided nationwide, including in a person's home such as an assisted living residence.
  - Allowing physical therapists, occupational therapists and speech-language pathologists to deliver telehealth services.
  - Delay the Medicare requirement for in-person visits for mental health services provided through telehealth or audio-only telecommunications technology.
  - Permits telehealth to be used for face-to-face encounters required for Hospice recertification purposes.
- **Work Geographic Index Floor:** Temporarily and retroactively restores nationwide payment floor multiplier for the work component of Medicare Part B services paid under the physician fee schedule. This is effective October 1, 2025 through at least September 30, 2026.
- **Extension of Funding for Quality Measure Endorsement, Input, and Selection:** This extends such funding through September 30, 2026.
- **Sequestration:** This legislation prevents the triggering of statutory 4.0% Statutory Pay-As-You-Go Act of 2010 (PAYGO) sequestration cuts to Medicare (*See Sequestration of Medicare Rates* below).

CMS has issued guidance instructing Medicare Administrative Contractors (MACs) to perform mass adjustments to any paid claims that are inconsistent with the above and instructing Practitioners to resubmit to CMS any returned claims that were previously determined not payable during the shutdown.

**One Big Beautiful Bill (OBBB)** — The OBBB was signed into law on July 4, 2025, implementing a range of federal reforms targeting Medicaid financing, eligibility, and payment structures. The following provisions of the OBBB are expected to impact Medicaid reimbursement mechanisms and enrollment dynamics relevant to our business.

**Moratorium on New or Increased Provider Taxes** — Provider taxes, which are state taxes assessed on healthcare providers or facilities, are a commonly used by states to generate non-federal share of Medicaid payments, including payments to SNFs. Under the ACA, provider taxes were capped at 6% of a provider's net patient revenue. Existing federal law prohibits states Medicaid programs from guaranteeing providers that they will receive their provider taxes paid back - this is known as the hold harmless provision. The OBBB prohibits states from imposing new provider taxes or increasing existing provider tax rates or tax bases, with specific carve outs for nursing facilities and intermediate care facilities to remain at status quo. The OBBB reduces the hold harmless threshold in expansion states beginning in fiscal year 2028. This threshold will decrease by 0.5% per year in ACA expansion states until the safe harbor limit is 3.5% in fiscal year 2032. While SNFs are exempt from the moratorium, broader limitations on provider taxes could reduce overall state Medicaid financing flexibility, increasing the risk of lower SNF reimbursement rates. In February 2026, CMS issued a final rule implementing these requirements as they pertain to granting state-requested waivers for imposing Medicaid provider taxes to fund those states' Medicaid programs. See Item 1., *Government Regulation, Proposed, Anticipated and Recently Issued Rulemaking and Administrative Actions - Closing a Health Care-Related Tax Loophole Final Rule*.

**Medicaid Recertification Changes and Retroactive Eligibility Cut** — Beginning in the first quarter of 2027, states must conduct Medicaid eligibility redeterminations every six months, rather than annually, for individuals enrolled under Medicaid. Additionally, the OBBB includes a provision to reduce Medicaid retroactive eligibility from 90 days to 30 days for most enrollees but is 60 days for long-term care residents and traditional Medicaid enrollees. We believe that these provisions could create the conditions for coverage interruptions, potential delays or denied payments.

*Revisions to State-Directed Payments (SDPs)* — Prior to the OBBB’s passage, state Medicaid programs could require Medicaid managed care organizations (MCOs) to pay providers certain rates, make uniform rate increases, or to use certain payment methods. These state-mandated payments by MCOs were known as SDPs, the upper limits for which generally were higher than the highest Medicare payment rate for those services, which is used in calculating Medicaid fee-for-service supplemental payments. The OBBB limits total payments under existing CMS-approved SDPs to current levels and caps future SDPs based on whether the state has expanded its Medicaid program under the ACA. SDPs approved prior to the OBBB’s implementation are grandfathered by the OBBB, although those grandfathered payments are reduced by 10% per year starting on January 1, 2028, until those SDPs reach the allowable Medicare-related payment limit. For Medicaid expansion states, new SDPs may not exceed 100% of the Medicare equivalent payment rate; for non-expansion states, the cap is 110%. In the absence of published Medicare payment rates, the OBBB limits SDPs to the Medicaid fee-for-service payment rate. This provision could reduce overall state Medicaid financing flexibility, increasing the risk of lower SNF reimbursement rates. CMS issued implementing guidance on February 2, 2026, clarifying that SDPs covering rating periods for CY 2024 to CY 2026 may be grandfathered and qualify for protection from the OBBB’s reductions in payment, provided that a state seeking this protection provided CMS with completed forms seeking approval for such directed payments before May 1, 2025; however, grandfathered dollar amounts are frozen at current approved levels and cannot be increased through any preprint version, amendment, or renewal. SDPs in rating periods beginning on or after March 30, 2026, will not qualify for grandfathering and must immediately comply with the new payment caps based on Medicare payment rates.

*Cap on Home Equity Excluded for Long-Term Care Eligibility Determination* — The OBBB establishes a limit of \$1.0 million for home equity that can be exempted from calculating an individual’s eligibility for Medicaid in seeking long-term care beginning January 1, 2028. This threshold is not indexed to inflation. States may, however, apply different home equity limits for primary residences that are located on farms.

*Reduced Federal Contributions to State Medicaid Programs* – Beginning in fiscal year 2030, the OBBB requires HHS to reduce federal financial contributions to Medicaid programs in states that identified improper payments to ineligible individuals or overpayments to eligible individuals. The OBBB expanded the scope of these improper payments to include payments where insufficient information is available to confirm the recipient’s eligibility for payment.

*Home and Community Based Services (HCBS)* – The OBBB allows states to obtain waivers from CMS so that Medicaid can be used to pay for HCBS rendered to beneficiaries who do not require an institutional level of care found in a SNF. The OBBB requires these waiver applications to include a demonstration that the state’s waiver will not increase the average amount of time that beneficiaries who need institutional levels of care will have to wait for services, intending to avoid HCBS being used in lieu of adequate SNF access for Medicaid beneficiaries requiring institutional care.

*Overall Impact on State Budgets* – The full effect of the OBBB on state budgets remains uncertain, particularly given the anticipated reduction in federal Medicaid contributions. A key risk to our revenue is that states may generally have fewer financial resources available without federal contributions to Medicaid. In response to how the overall budgets of states will be impacted by the OBBB due to reduced federal Medicaid contributions, some states have already taken legislative and regulatory actions to address the provisions of the OBBB and its potential impact. For instance, on September 17, 2025, California enacted Senate Bill 105, a comprehensive budget bill for the 2025-2026 fiscal year. This legislation allocates funding and makes budgetary adjustments across various state agencies, with notable emphasis on specific areas. Among its provisions, Senate Bill 105 designates targeted funding for the state’s Medicaid program, Medi-Cal, to ensure alignment with the OBBB.

Similarly, Colorado enacted Senate Bill 0001 on August 28, 2025. This law establishes a process for the governor to implement spending reductions if the state is unable to meet its fiscal obligations. It also requires the governor to submit proposed spending reduction plans to a legislative budget committee, which is responsible for advising the governor on these matters.

Overall, we anticipate more states may face challenging choices regarding their state budgets, which will increase the risk of lower SNF reimbursement rates. We will continue to monitor any such developments and advocate accordingly at the federal, state and local levels.

**Medicare Annual Payment Rule** — On April 2, 2026, CMS released the proposed FY 2027 Skilled Nursing Facility Prospective Payment System Final Rule (FY 2027 PPS) which proposes a net 2.4% increase in to the SNF PPS payment rates. The increase is based on a proposed SNF market basket of 3.2% partially offset by a negative 0.8% productivity adjustment. CMS did not propose major changes to the Patient-Driven Payment Model (PDPM), but is seeking public input on whether updates may be needed to address possible case-mix coding concerns and improve payment accuracy. CMS is also considering requiring all-payer Minimum Data Set (MDS) reporting for skilled stays in the future. In addition, CMS proposed several updates to the SNF Quality Reporting Program (QRP) and SNF Value-Based Purchasing Program (VBP), including the planned removal of two COVID-19 vaccination measures beginning in fiscal year 2028, changes to data submission deadlines, and updates to performance standards. CMS is also requesting feedback on alternative wage index approaches designed specifically for skilled nursing facilities.

On July 31, 2025, CMS released the FY 2026 PPS outlining the following key changes:

**FY 2026 Final Updates to the SNF Payment Rates** — For fiscal year 2026, which began on October 1, 2025 and ends on September 30, 2026, CMS has finalized a 3.2% increase to SNF PPS payment rates. This increase is based on the final SNF market basket of 3.3%, plus a 0.6% market basket forecast error adjustment, and a negative 0.7% productivity adjustment. This increase does not incorporate the SNF VBP Program reductions for certain SNFs subject to the net reduction in payments under the SNF VBP.

**Patient-Driven Payment Model (PDPM) ICD-10 code mappings** – CMS finalized several technical revisions to the code mappings used to classify patients under the PDPM. These revisions are intended to enhance the accuracy of patient classification, payment calculations and coding practices under the PDPM.

**SNF QRP** — CMS has announced changes to the QRP that will take effect for residents admitted on or after October 1, 2025, impacting the FY 2027 SNF QRP. Specifically, four standardized patient assessment data elements within the Social Determinants of Health (SDOH) category will be removed. Additionally, CMS has updated the policy and process for submitting reconsideration requests, including amendments and codification of these procedures.

**SNF VBP Program** — For the FY 2028 and FY 2029 program years, CMS has established performance standards to meet the statutory notice requirements. Additionally, starting with the FY 2028 program year, CMS will implement the previously established scoring methodology for the SNF Within-Stay Potentially Preventable Readmission (SNF WS PPR) measure, which will be included in the program’s measure set for the first time. To simplify the scoring process and provide clearer incentives for skilled nursing facilities (SNFs) to enhance the quality of care for all residents, CMS has decided to remove the Health Equity Adjustment. Furthermore, beginning with the FY 2027 program year, CMS will introduce a reconsideration process. This process will allow SNFs to request reconsideration if they are dissatisfied with CMS’s decision regarding a review and correction request.

**Medicare Part B Fee Schedule** — On October 31, 2025, CMS issued the CY 2026 Medicare Physician Fee Schedule (CY 2026 PFS) Final Rule, which outlines significant changes aimed at modernizing Medicare, improving care quality, and reducing unnecessary spending.

**Two Payment Rates Based on Advanced Alternative Payment Model (AAPM) Participation** — For the first time, there are two separate conversion factors for all Medicare-participating providers which impacts reimbursement for therapeutic services (including occupational therapy, speech language therapy, and physical therapy), evaluation and management services, and other services furnished in SNFs covered by Medicare Part B. This is required under the Medicare Access and CHIP Reauthorization Act (MACRA) depending on whether a provider qualifies as a participant in an AAPM. CMS finalized a qualifying AAPM participant conversion factor of \$33.57, representing a 3.77% increase over the CY 2025 conversion factor of \$32.35. The non-AAPM participant conversion factor is \$33.40, a 3.26% increase over such the CY 2025 conversion factor.

**Payment Adjustments** — Under the CY 2026 PFS, CMS decreases payments by 2.5% for certain services that are not time-based, such as certain therapy services. The rationale is that providers are expected to deliver these services more efficiently as they performed them repeatedly over time. This reduction is designed to balance out other areas of Medicare spending increases.

*Telehealth* — Among other things, CMS finalized changes to the Medicare Telehealth Services List (MTSL) by adding additional services and expanding permanent flexibilities for virtual direct supervision. One key change is the permanent lifting of frequency limits on providing subsequent nursing facility visits furnished via telehealth. Previously, when adding some services to the MTSL, CMS has included certain frequency restrictions on how often physicians and other practitioners can furnish the service via telehealth (e.g., one subsequent nursing facility visit furnished through telehealth every 14 days). Removing these restrictions will likely result in increased access to care and allow for additional services to be provided via telehealth. Notably, CMS increased the originating site facility fee to \$31.85 for CY 2026.

These changes could impact how SNFs deliver and bill for physician and ancillary services. The scope of reimbursable therapy and remote care services may expand, but future payment levels could fluctuate, positively or negatively, based on broader assumptions about efficiency and practice cost. SNFs that deliver telehealth-based care or participate in care coordination models may benefit from expanded flexibility and new billing pathways. However, these changes may also introduce added operational complexity and new compliance requirements.

## Medicare

Medicare presently accounts for approximately 25.2% of our skilled nursing services revenue year-to-date, being our second-largest revenue payor. The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins.

**Patient-Driven Payment Model (PDPM)** — The FY 2020 PPS implemented the PDPM, a case mix methodology that bases Medicare reimbursement on the clinical condition and care needs of each patient. Under PDPM, diagnosis codes and various patient characteristics are used to classify residents and determine payment levels. The model incorporates five case-mix adjusted payment components - physical therapy, occupational therapy, speech language pathology, nursing and social services and non-therapy ancillary services - to reflect the complexity of care provided. Additionally, PDPM includes a sixth non-case mix component to account for utilization of SNFs' resources that are unrelated to individual resident characteristics.

PDPM is intended to achieve a more value-based, unified approach to post-acute care payments system. For example, it adjusts Medicare reimbursements to reflect the specific care requirements of each resident, rather than simply the volume or type of services delivered by the facility. As a result, payments to SNFs and nursing homes are primarily determined by the patient's clinical profile, promoting a system that better aligns payment with patient needs.

**Skilled Nursing Facility - Quality Reporting Program (SNF QRP)** — The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) provided data reporting requirements for certain Post-Acute-Care (PAC) providers. If a SNF does not submit required quality data as required by the IMPACT Act, its payment rates are reduced by 2.0% for each such fiscal year, which may result in payment rates for a fiscal year being less than the preceding fiscal year.

The SNF QRP standardized patient assessment data elements. The SNF QRP applies to freestanding SNFs, SNFs affiliated with acute care facilities and all non-critical access hospital swing-bed rural hospitals. These data elements are the subject of frequent change and adjustment. CMS's rulemaking often identifies new data elements to be reported.

CMS continues to revise the calculation of its five-star ratings for the Nursing Home Compare website. Under this methodology, points are assigned to a SNF based on its performance across six measures: (1) case-mix adjusted total nurse staffing levels (including registered nurses, licensed practical nurses, and nursing aides), measured by hours per resident per day; (2) case-mix adjusted registered nurse staffing levels, measured by hours per resident per day; (3) case-mix adjusted total nurse staffing levels (including registered nurses, licensed practical nurses, and nursing aides), measured by hours per resident day on the weekend; (4) total nurse turnover, defined as the percentage of nursing staff that left the nursing home over a 12-month period; (5) registered nurse turnover, defined as the percentage of registered nursing staff that left the nursing home over a 12-month period; and (6) administrator turnover, defined as the percentage of administrators that left the nursing home over a 12-month period. These six measures will be measured on a quarterly basis.

These six measures were included in the five-star rating starting in October 2022. In addition, CMS also implemented a planned increase to the quality measure reporting thresholds, increasing each threshold by one-half of the average improvement of quality measure scores since CMS last set quality measure thresholds. Going forward, CMS plans to implement similar rating threshold increases every six months.

CMS has also continued to refine the QRP, including various measurements such as the adoption of a process measure for influenza vaccination coverage among healthcare personnel within SNFs and a Discharge Function Score (DC Function) measure. The DC Function determines the functional condition of residents by examining the proportion of SNF residents who achieve or surpass a projected discharge functionality score. The assessment includes consideration of mobility and self-care, utilizing data from the Minimum Data Set (MDS). The DC Function replaces the current process and is in effect for the FY 2025 SNF QRP. The FY 2024 PPS also modified the SNF QRP's Healthcare Professional (HCP) Covid Vaccine Measure. The measure will track the proportion of healthcare staff vaccinated for COVID-19 and have kept their vaccination status current per the CDC recommendations. However, this measure may be removed in the future pending final rules published as a result of the FY 2027 PPS. The FY 2024 PPS also removed the Application of Functional Assessment/Care Plan measures from the SNF QRP.

Under the FY 2024 PPS, CMS adopted two measures for the SNF QRP starting in FY 2026. First, CMS raised the Data Completion Thresholds for the MDS. SNFs must report required quality measure data and standardized resident assessment data gathered using the MDS for at least 90% of the assessments they submit to CMS. SNFs who fail to meet this requirement will be subject to a 2.0% reduction on their applicable fiscal year payment starting in FY 2026. Second, CMS adopted the Patient/Resident COVID-19 Vaccine metric. This metric highlights the number of patient stays in which SNF patients received the COVID-19 vaccine. However, this measure may be removed in the future pending final rules published as a result of the FY 2027 PPS.

CMS's FY 2025 PPS adopted several updates to the SNF QRP aimed at enhancing the integration of Social Determinants of Health (SDOH) into patient assessments and ensuring the accuracy of reported data. Starting in FY 2027, CMS will introduce four new SDOH items related to living situation, food security, and utility access, and modify an existing item on transportation availability in the MDS. Additionally, CMS requires that SNFs participating in the SNF QRP undergo a data validation process similar to that already implemented in the SNF VBP Program.

Starting in FY 2026, SNFs participating in the SNF QRP program will be required to take part in a validation program similar to that used for SNFs participating in the SNF VBP Program. Each year, 1,500 SNFs will be randomly chosen to submit MDS records for review. Facilities selected for this audit must provide the requested medical chart documentation within 45 calendar days of notification; failure to do so will result in noncompliance and a 2% reduction in Medicare reimbursement for that fiscal year.

Additionally, as outlined in the FY 2026 PPS, four standardized patient assessment data elements within the SDOH category will be modified for residents admitted on or after October 1, 2025, impacting the FY 2027 SNF QRP. CMS has also finalized changes to the reconsideration request policy and process, formally amending and codifying procedures related to QRP data and evaluations.

**Home Health and Hospice Payment Rules Affecting SNFs** — CMS's final payment rules for other modalities of care delivery also affect the operations of SNFs. Under the CY 2025 Home Health PPS, long-term care facilities, including SNFs, have been required to submit at least weekly reports to CMS on respiratory illnesses beginning January 1, 2025. These reports must include information such as facility census, resident vaccination status for specified respiratory illnesses, confirmed resident cases and residents hospitalized from such illnesses.

**Sequestration of Medicare Rates** — The Budget Control Act of 2011 requires a mandatory, across the board reduction in federal spending, called sequestration. Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013, incur a 2.0% reduction in Medicare payments through at least the end of 2025, unless Congress takes further action. The Consolidated Appropriations Act of 2023 (CAA 2023), waived a further 4.0% cut to Medicare spending that would have been required under the Statutory Pay-As-You-Go Act of 2010 (PAYGO) for fiscal years 2023 and 2024. Instead, the CAA 2023 deferred any further Medicare sequestration under PAYGO until fiscal year 2025. The CAA 2023 also offset planned Medicare sequestrations that would have been as high as 4.0% and instead maintained fee schedule cuts of approximately 2.0%. On October 29, 2024, the Medicare Patient Access and Stabilization Act of 2024 (MPASA) was introduced in the House of Representatives, seeking to increase the amount paid to physicians under Medicare by 4.73%. MPASA was referred to the House Ways and Means Committee and House Committee on Energy and Commerce on October 29, 2024, and referred to the Subcommittee on Health on December 17, 2024, with no further action taken on the bill, which did not pass into law before the end of the 118th Congress in December of 2024. As part of the Continuing Resolution that ended the federal government shutdown in late 2025 (CR), Congress reset the balances on PAYGO scorecard, which are used to determine whether a law creates a sufficient amount of budget deficit that it would require mandatory spending cuts like those to Medicare, to zero. Because the OBBB's requirements were likely to result in a deficit, the 4.0% deduction required by sequestration was expected to start in January of 2026 before the CR's passage. However, as the CR reset the PAYGO scorecards to zero, the expected 4.0% reduction of Medicare rates under sequestration will not materialize, further delaying the 4.0% reduction. On February 3, 2026, the CAA 2026 was passed and keeps the protections from the CR in place.

**Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program** — The SNF-VBP Program incentivizes SNFs by awarding payments based on the quality of care provided to Medicare beneficiaries, primarily measured through hospital readmission rates. Each year, CMS adjusts its payment rules for SNFs using this program, which now includes additional quality measures such as sharing of health information and standardized patient assessment data elements that evaluate cognitive function and mental status, special services and social determinants of health. CMS regulations outline both the performance metrics and the required data reporting for SNFs. Reporting deadlines for baseline period and performance periods began with fiscal year 2023. The FY 2023 PPS expanded the SNF VBP program beyond the single hospital readmission measure, adding new metrics for fiscal year 2026, such as healthcare associated infections requiring hospitalization (SNF HAI) and total nursing hours per resident day, and in fiscal year 2027, the discharge to community post-acute care measure for SNFs, which tracks of successful transitions from SNFs to community settings.

In the FY 2024 PPS, CMS elected to replace the SNFRM measure with the SNF WS PPR measure starting in FY 2028. The PPR measure assesses the risk-standardized rate of unplanned, avoidable readmissions during SNF stays for Medicare fee-for-service beneficiaries. This new measure refines the previous 30-Day readmission metric by extending the observation period to the entire SNF stay and increasing the allowable gap between hospital discharge and the SNF admission to 30 days. These changes better align with the IMPACT Act and enhance the reliability of preventable readmissions tracking. The measure uses two years of Medicare claims data to calculate provider-specific risk-standardized readmission rate.

The FY 2025 PPS adopted several operational and administrative updates to the SNF VBP Program, including policies for selecting, updating and removing measurements to ensure ongoing relevance and effectiveness for assessing care quality. CMS also updated technical measures and procedures for reviewing and correcting data used to calculate its measures.

The FY 2026 PPS finalized several updates, including setting performance standards for the FY 2028 and FY 2029 program years to meet statutory notice requirements. CMS will apply the previously established scoring methodology to the SNF WS PPR measure starting in FY 2028. Additionally, CMS removed the Health Equity Adjustment to simplify scoring and clarify incentives for quality improvement. A new reconsideration process was also adopted, enabling SNFs to request a review if they are dissatisfied with CMS’s decision on a correction request, beginning with the FY 2027 program year.

**Part B Rehabilitation Requirements** — A portion of our revenue is paid by the Medicare Part B program under a fee schedule. Part B services are limited with a payment cap by combined speech-language pathology services (SLP), physical therapy (PT) services and a separate annual cap for occupational therapy (OT) services. Part B services are limited by a payment cap as there is one amount for physical therapy (PT) services and speech-language pathology (SLP) services combined and a separate amount for occupational therapy (OT) services.

The Bipartisan Budget Act of 2018 (BBA) establishes coding modifier requirements to obtain payments beyond certain payment thresholds, discussed below and reaffirms the specific \$3,000 claim audit threshold requirements for Medicare Administrative Contractors. For PT and SLP combined the threshold for coding modifier requirements was \$2,410 for CY 2025 with the same threshold for OT services. The KX modifier is added to medical claims to indicate the providing clinician attests that the services corresponding to that claim were medically necessary and that the justification for those services is contained within the patient’s medical records. This modifier is intended for use where the services will exceed the threshold for those services set by the BBA and updated by annual fee schedule rules, yet are still appropriate and medically necessary, and thus should be compensated by Medicare.

Consistent with CMS’s “Patients over Paperwork” initiative, the agency has also been moving toward eliminating burdensome claims-based functional reporting requirements. Beginning in 2021, CMS rescinded 21 problematic National Correct Coding Initiative edits impacting outpatient therapy services, including services furnished under Medicare Part B primarily related to PT and OT services, removing a coding burden caused by requirements for additional documentation and claim modifier coding.

Additionally, the Multiple Procedure Payment Reduction (MPPR) continues at a 50.0% reduction, which is applied to therapy procedures by reducing payments for practice expense of the second and subsequent procedures when services provided beyond one unit of one procedure are provided on the same day. The implementation of MPPR includes (1) facilities that provide Medicare Part B speech-language pathology, occupational therapy and physical therapy services and bill under the same provider number; and (2) providers in private practice, including speech-language pathologists, who perform and bill for multiple services in a single day.

Certain of our Part B services provided through telehealth would qualify for Medicare reimbursement based on flexibility first provided under the emergency waivers first issued during PHE, which added physical therapy (PT), occupational therapy (OT) and speech-language pathology (SLP) to the list of approved telehealth Providers for the Medicare Part B programs provided by a SNF. During the PHE, CMS added certain PT and OT services to the list of Medicare-covered telehealth services on a temporary basis, some of which were made permanent for use and new codes were added for PT, OT, or SLP telehealth services—including some “sometimes therapy” codes that were not subject to MPPR. These flexibilities were most recently extended by the CAA 2026 through December 31, 2027.

The CY 2025 PFS adopted a regulatory change that allowed physical therapy assistants and occupational therapy assistants to be generally supervised by physical therapists and occupational therapists, respectively, in private practice, non-institutional settings, thus allowing greater flexibility in billing for those assistants’ services. Additionally, the CY 2025 PFS exempted a therapist-established initial plan of care (POC) for PT, OT, or SLT services from the requirement for a physician or non-physician provider’s (NPP’s) signature, provided that (1) the patient’s physician or NPP referred the patient to the therapist and (2) the therapist has evidence that the POC was transmitted to the patient’s physician or NPP within 30 days of the patient’s initial evaluation. This flexibility applies only to the initial certification of the POC. While the OBBB did not affect the CY 2025 PFS, the OBBB provided a one-year increase of 2.5% to the CF for services provided between January 1, 2026 and January 1, 2027.

Under the CY 2026 PFS, the 2.93% increase to the 2024 PFS Conversion Factor (CF) expired and CMS sought to impose an estimated 0.05% adjustment thereto based on changes in work relative value units (RVUs) for certain services. As a result, the CY 2025 PFS implemented a reimbursement reduction of 2.83%, with a CF of \$32.35, which is a reduction from the 2024 CF of \$33.29. The CY 2025 PFS adopts a 3.6% increase to the threshold for coding modifier requirements for PT and SLP combined, totaling \$2,410 for 2025 with the same threshold for OT services. The threshold for targeted medical review for PT and OT (combined) and SLP is expected to remain at \$3,000 through 2027.

In addition, the CY 2026 PFS contains numerous significant changes regarding payment and models, encourages care coordination, reduces collection and reporting of data measurements, and continues certain telehealth flexibilities that began during the PHE (*see Medicare Part B Fee Schedule above*).

### **Programs of All-Inclusive Care for the Elderly**

The requirements under the Programs of All-Inclusive Care for the Elderly (PACE) provide greater operational flexibility and update information under the Medicare and Medicaid programs, including leniency in compliance with program requirements during and after a 3-year trial period and relieving restrictions placed on the team that assesses and provides for the needs of each PACE participant. Further, non-physician primary care providers can provide certain services in place of primary care physicians. The final rule, which went into effect on April 3, 2023, requires the collection of data by Medicare Advantage organizations and their service providers and the submission of data to CMS for risk adjustment data validation (RADV) audits. The purpose of these RADV audits is to maintain the accuracy of risk-adjusted payments made to Medicare Advantage organizations.

In 2024, CMS issued a new prescription drug event (PDE) reporting requirements for PACE organizations to receive manufacturer discounts for drugs provided through Medicare Part D as provided for in the Inflation Reduction Act of 2022 (IRA). The additional PDE information must be submitted beginning January 1, 2025. In June of 2024, CMS also updated its statement of rights for PACE participants.

### **Decisions Regarding Skilled Nursing Facility Payment**

Reimbursement rates and rules are subject to frequent change that historically, have had a significant effect on our revenue. The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. We are not able to predict the outcome of the legislative process. We also cannot predict the extent to which proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and existing new legislation will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue and could adversely affect our business, financial condition and results of operations.

These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions influenced by budgetary or political pressures, which may materially adversely affect the rates at which Medicare reimburses us for our services. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins. For a discussion of historic adjustments and recent changes to the Medicare program and other reimbursement rates, see Part I, Item 1A *Risk Factors* under the headings *Risks Related to Our Business and Industry*.

### ***Patient Protection and Affordable Care Act (ACA)***

Various healthcare reform provisions became law upon enactment of the ACA. The reforms contained in the ACA have affected our independent subsidiaries in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment.

The IRA, which continued and expanded certain provisions of the ACA, extended the premium subsidies paid by the federal government, until the end of 2025, resulting in subsidies being available to offset or reduce the costs of private health insurance policies for qualifying individuals. This may aid older patients in obtaining or keeping their health insurance in order to pay for long-term care services.

On July 4, 2025, the OBBB was enacted into law and intends to be a budget reconciliation law that by 2028 may significantly change the automatic reenrollment process for ACA marketplace health plans and impose work requirements as a condition of Medicaid eligibility, among other things. The OBBB reflects broader legislative efforts to roll back provisions of the ACA, and its enactment along with ongoing executive actions that run counter to the ACA, could reduce the availability of insurance coverage and may affect the population and payer mix of our independent subsidiaries.

The changes in the Presidential Administration may significantly alter the current health care regulatory framework, payment activity, and impact our business and the health care industry, including any repeals, curtailments, extensions or expansions of certain ACA provisions, included, but not limited to recent rulemaking activity regarding ACA Section 1557's anti-discrimination provisions. We continually monitor these developments so we can respond to the changing regulatory environment impacting our business.

### ***Requirements of Participation***

CMS has requirements that providers, including SNFs, must meet in order to participate in the Medicare and Medicaid Programs. Some of these requirements can be burdensome and costly. One such requirement of participation in the Medicare and Medicaid programs involves limitations around the use of pre-dispute, binding arbitration agreements by SNFs. CMS has historically issued guidance and direction around arbitration that must be satisfied for any admission agreement to be enforceable.

Phase 2 and 3 of the Requirements of Participation focuses on: (1) resident abuse and neglect; (2) admission, transfer and discharge; (3) mental health and substance abuse disorders; (4) staffing sufficiency; (5) residents' rights; (6) potential inaccurate diagnoses or assessments; (7) prescription and use of pharmaceuticals; (8) infection prevention and control; (9) arbitration of disputes between facilities and residents; (10) psychosocial outcomes and related severity; and (11) the timeliness and completion of state investigations.

In 2022, CMS updated the Medicare Requirements of Participation for SNFs, to modify the requirements associated with a facility's physical environment to minimize unnecessary renovation expenses and avoid closure of SNFs due to the related expense. CMS "grandfathered" certain facilities and will allow SNFs that were participating in Medicare before July 5, 2016, and that previously used the Fire Safety Evaluation System (FSES) to continue using the 2001 FSES mandatory values when determining compliance with applicable standards. CMS also updated the Requirements of Participation to revise existing qualification requirements for directors of food and nutrition services in SNFs, while "grandfathering" in directors with two or more years of experience and certain minimum training in food safety so they may continue in that role without satisfying further educational requirements.

In 2023, CMS revised the survey resources that CMS and state surveyors use in evaluating SNFs' compliance with federal Requirements for Participation. This revision incorporated changes to CMS's focused infection control survey item, which CMS had removed in favor of standard infection control survey measures. These updates provided more information for state surveyors to utilize when evaluating SNFs' compliance with the Medicare Requirements of Participation, as well as included guidance for facilities on operationalizing compliance with these requirements based on how surveyors would measure and evaluate facility performance.

CMS issued comprehensive updates to the Medicare State Operations Manual (Appendix PP) that took effect on April 28, 2025. These updates revised surveyor guidance across multiple areas, including infection control, staffing, PBJ reporting, psychotropic medication use, and medical director oversight responsibilities. These revisions are intended to enhance survey consistency and align with CMS's broader focus on care quality and resident outcomes.

Additionally, CMS issued guidance on March 24, 2025, clarifying that SNFs may not include pre-dispute, binding arbitration provisions or third-party financial guarantee requirements in admission agreements. If these provisions are not removed, they may result in survey citations and potential penalties for non-compliant SNFs.

### ***Civil and Criminal Fraud and Abuse Laws and Enforcement***

Various complex federal and state laws exist that govern a wide array of referrals, relationships and arrangements, and prohibit fraud by healthcare providers. Governmental agencies are devoting increasing attention and resources to such anti-fraud efforts. The Balanced Budget Act of 1997 expanded the penalties for healthcare fraud. Additionally, the government or those acting on its behalf may bring an action under the FCA, alleging that a healthcare provider has defrauded the government by submitting a claim for items or services not rendered as claimed, which may include coding errors, billing for services not provided and submitting false or erroneous cost reports. The FCA clarifies that if an item or service is provided in violation of the AKS, the claim submitted for those items or services is a false claim that may be prosecuted under the FCA as a false claim. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Many states also have a false claim prohibition that mirrors or closely tracks the federal FCA.

Federal law also provides that the OIG has the authority to exclude individuals and entities from federally funded health care programs on a number of grounds, including, but not limited to, certain types of criminal offenses, licensure revocations or suspensions and exclusion from state or other federal healthcare programs. CMS can recover overpayments from health care providers up to six years following the year in which payment was made.

Over the years, the OIG has released the results of audit findings of Medicare overpayments, potentially affecting SNFs. These investigatory actions by OIG demonstrate its increased scrutiny into post-hospital SNF care provided to beneficiaries and may encourage additional oversight or stricter compliance standards. The DOJ has indicated that its healthcare enforcement trends would emphasize opioid prescribing, Medicare Advantage and managed care plan fraud, and COVID-19 related fraud, including under various relief programs available during and in conjunction with the pandemic. In November of 2023, OIG added to its work plan an audit of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, for which OIG expected to issue a report in FY 2025. However, the report has not yet been issued. In addition, the OIG identified the following areas as its "key goals" for oversight: (1) protecting residents from fraud, abuse, neglect, and promoting quality of care; (2) promoting emergency preparedness and emergency response efforts; (3) strengthening frontline oversight; and (4) supporting federal monitoring of nursing homes to mitigate risks to residents.

In 2024, the OIG added to its work plan a series of studies that include: (a) the use of the National Background Check Program (NBCP) in conducting background checks of prospective long-term care provider employees to prepare a report regarding the cost of background checks, number of applicants who received background checks and disqualification of employees during and after NBCP participation; (b) the use of Medicaid supplemental payments for use in satisfying the state's obligations to pay nursing facilities any amounts due under the state's nursing facility upper payment limit; and (3) the assessment of the implementation of the Special Focus Facility Program for nursing facilities based on facilities that participated in the program from 2013 through 2022.

The OIG continues to increase its oversight of skilled nursing facility operations through its active Work Plan, with several new audits and studies that may impact SNFs. In June 2025, OIG announced a new evaluation of whether SNFs are properly engaging medical directors and accurately reporting medical directors' hours of service in CMS's PBJ reporting system. This review will examine whether medical directors are meeting regulatory expectations and whether reported hours reflect actual services provided, with potential implications for regulatory compliance and reimbursement oversight.

Separately, OIG announced an audit assessing whether SNFs are inappropriately billing Medicare Part D for prescription drugs provided during a Medicare Part A stay, as the OIG previously found potential overpayments of more than \$465 million in Part D payments for drugs that were already covered under Part A. OIG is also reviewing state-level enforcement of minimum spending requirements for direct resident care in nursing facilities, which could affect state Medicaid reimbursement mechanisms and facility-level allocation of resources. In addition, a May 2025 OIG report identified deficiencies in how CMS shares PBJ staffing data with state survey agencies, limiting surveyors' ability to assess RN staffing compliance and potentially delaying corrective action.

In November of 2025, OIG announced that along with the State survey agencies it would begin assessing the effect of ownership changes on quality of care provided in nursing homes via onsite surveys, state monitoring visits, and requesting additional documentation. The OIG's Fall 2025 semiannual report to Congress described the OIG's ongoing focus on the standard of care provided within SNFs and enforcement actions based on those concerns, as well as identifying certain nursing facilities' noncompliance with the return of provider relief funds paid to facilities during the COVID-19 PHE and which were due to be repaid to HHS. OIG announced in February of 2026 that it would be studying the efficacy and performance of nursing home pharmacy services' internal controls to prevent the diversion, misuse, and over-use of opioids in the nursing home setting.

Our business model is based in part on serving higher acuity patients. Over time our overall patient mix has consistently shifted to higher acuity in most facilities we operate. Further scrutiny of high-acuity residents and the treatment they receive may affect our business and subject us to increased governmental oversight. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording services in order to, among other things, increase reimbursement to levels appropriate for the care actually delivered. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

### **Other Federal Legislation and Healthcare Reform**

**Five-Star Quality Reporting Metrics** — The Quality Payment Program (QPP) was created under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015. This program was based on the Merit-based Incentive Payment System (MIPS) or the use of Alternative Payment Models (APM), which relied on quality data CMS gathered and evaluated using the Five-Star Quality Rating system, which includes a rating of one to five in various categories. These categories include (but are not limited to) the results of surveys conducted by state inspectors, other health inspection outcomes, staffing, spending, readmissions and stay durations; the data collected and its weighting in determining a rating on a scale of one to five stars is subject to periodic and ongoing revision, re-balancing and adjustment by CMS to reflect market conditions and CMS's priorities in patient care. Since 2020, CMS's measurement of the data reported by providers, including SNFs, has become more competitive and resulted in a reduction of four- and five-star rankings available under CMS's Five-Star Quality Rating system.

The Five-Star Quality reporting system for nursing homes is displayed on CMS's consumer-based Nursing Home Compare website, along with a consumer alert icon next to nursing homes that have been cited for incidents of abuse, neglect, or exploitation on the Nursing Home Compare website. The Nursing Home Compare website is updated monthly with CMS's refresh of survey inspection results on that website. Additionally, the Nursing Home Compare website publishes ownership information for Medicare-enrolled nursing facilities based on disclosures made to CMS from 2016 through 2022 due to mergers, acquisitions, or other changes in ownership, to allow for the identification of common ownership of nursing facilities. The Five Star Quality Ratings incorporated staffing data such as staff tenure and SNF weekend staffing beginning with the October 2022 refresh of the Nursing Home Compare website.

In June 2025, CMS announced upcoming modifications to Nursing Home Care Compare platform and the Five Star Quality Rating system, set to take effect on July 30, 2025. Under these changes, CMS discontinued the use of the third most recent standard health survey in calculating the health inspection rating, relying instead on only the two latest surveys. The most recent survey will be weighted at 75% of the total score, while the second most recent survey result will contribute to the remaining 25% of the score. Additionally, CMS will begin publishing aggregated five-star performance metrics for nursing home chains and will remove COVID-19 vaccination measures from facility profile pages.

CMS is updating the long-stay antipsychotic quality measure to incorporate additional data sources, including Medicare and Medicaid claims and Medicare Advantage encounter records. The updated measure, effective January 28, 2026, will assign providers to ten equal deciles for scoring purposes. CMS expects this methodology change to increase the reported national long-stay antipsychotic rate from approximately 14.6% to 17.0%. While the overall national rate is expected to increase, the impact on individual facility ratings will vary.

Additionally, starting July 30, 2025 until October 2025, updates to Nursing Home Care Compare were temporarily paused as CMS transitions to a cloud-based Internet Quality Improvement and Evaluation System (iQIES) for survey data management. This pause is intended to give CMS time to validate the accuracy and integrity of the data and ensure that publicly reported information meets quality standards before resuming updates to the five-star ratings. The move to iQIES, along with the other changes, may also result in further adjustments to the rating system and could prompt additional audits by CMS or state surveyors.

In April 2024, CMS froze four quality measures and three staffing measures to prevent changes until a subsequent date. It also updated the staffing rating methodology to assign the lowest score to facilities that fail to submit (or submit incorrect) staffing data. However, in January of 2025, CMS unfroze four of its quality measures that it previously froze with its April 2024 refresh. CMS updated these measures to reflect recent changes in the minimum data set collected from SNFs. First, the measure of percentage of SNF residents who are at or above an expected ability to care for themselves and move around at discharge replaced the measure of percentage of residents who made improvements in function during a short stay. Second, the following measures have been respecified: (1) percentage of residents whose need for help with activities of daily living has increased during a long stay, and (2) percentage of residents whose ability to walk independently worsened during a long stay. Finally, the measure of percentage of all residents with pressure ulcers (regardless of stay duration) will replace the measure of percentage of high-risk residents with pressure ulcers during a long stay. Additionally, CMS recalculated the scoring cut points for these four measures to obtain an even distribution of scores. Additionally, the quality measure rating cut points were also adjusted to maintain their same overall distribution of ratings across measured facilities.

In July 2024, CMS updated the Nursing Home Five-Star Quality Rating System to reflect several key changes. The staffing case-mix methodology now uses the PDPM model, replacing measures that were previously frozen in April. CMS also extended the definition of staffing turnover. Employees are now considered “turned over” if they haven’t worked for 90 consecutive days, up from 60. Additionally, CMS revised risk-adjustment models for claims-based measures to focus on residents’ functional abilities and goals, rather than just their status. To maintain consistency in star ratings, CMS adjusted thresholds so the distribution of 4- and 5-star ratings remains stable.

**Ownership Transparency Final Rule** — In November 2023, CMS finalized a rule requiring SNFs to publicly disclose information regarding their ownership and management structure. SNF must identify any person or legal entity that: (1) exercises financial, operational, or managerial control over any facility or part of a facility, or provides services to facility that includes its policies and procedures or cash management services; (2) leases or subleases real property to the facility, or owns at least 5% of the real property’s total value; and (3) provides any management or administrative services (or consult regarding the same), or provides accounting or financial services to SNFs. The rule also requires disclosures of governing body members, officers, directors or managing employees, plus a comprehensive breakdown of the organizational structure of any additional disclosable party that is not a natural person along with a description of their relationships with the facility. Starting in November of 2024, all SNFs must comply with these requirements by submitting a new "SNF Attachment" with CMS form 855A during revalidation. Although CMS initially required all SNFs to complete revalidation using this new attachment by January 1, 2026, this deadline was indefinitely suspended in December 2025 by CMS until further notice. On February 24, 2026, CMS provided further guidance regarding SNF revalidation, which further confirmed the January 1, 2026 deadline for revalidation with new information required by the Ownership Transparency Final Rule remained indefinitely suspended.

Certain states have adopted laws reflecting their concerns regarding ownership transparency. For example, Iowa adopted laws requiring disclosure of ownership information not previously required for licensure to promote transparency in 2023. In California, the California Department of Health Care Access and Information of the California Health and Human Services Agency issued its notice of approval of regulatory action in March 2024, establishing policies and procedures that implement financial and ownership transparency requirements for California-licensed SNFs that are required by California law passed in 2021. Additionally, the State of Washington enacted H.B. 1686 in July 2025, directing state agencies to develop a plan and recommendations for creating a registry of health care entities, including SNFs.

### **State-level Legislation and Healthcare Reform**

The states where we operate have varied legislative priorities and accordingly legislation. These different legislative priorities vary for many reasons but ultimately result in the operations of our independent subsidiaries having different profiles for risk, regulatory burden, taxation and benefits based on the state in which the facility operates. By way of example, in 2022, California’s Governor signed into law the Skilled Nursing Facility Ownership and Management Reform Act of 2022. This law increased the authority of the California Department of Public Health and changed several provisions regarding SNF licensing in the State of California. These changes include eliminating previous regulatory provisions that permitted SNFs to operate in advance of receiving their formal license from the State. This law also requires SNF license applicants to disclose additional information in connection with a license application and evaluates more data regarding the applicant’s prior operations, including prior citations, CMS sanctions and legal proceedings against the applicant or other facilities owned or managed by the applicant before issuing a license. In contrast, on June 20, 2025, Texas passed SB 457 which will allow a new operator to receive uninterrupted Medicaid payments during the change of ownership process beginning on September 1, 2025. These examples highlight the varied approaches that occur from state to state, with different approaches making it either easier or harder for our independent subsidiaries to operate. In addition, the impacts of the OBBB, as discussed above, will create varying approaches by state legislatures to address the provisions of such bill. We continue to monitor and advocate for positions that protect the interests of our employees, residents and those of our independent subsidiaries at all levels of government, particularly at the state and local levels.

## **The Impact of United States Supreme Court Decisions**

On June 28, 2024, the United States Supreme Court issued its opinion in *Loper Bright Enterprises v. Raimondo*, deciding to vacate and remand decisions by the United States Courts of Appeals that relied on the Supreme Court's own 1984 precedent in *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, which sometimes required courts to defer to "permissible" agency interpretations of the statutes those agencies administered and enforced—a legal doctrine known as the "Chevron doctrine." In *Loper*, the Supreme Court had to decide whether it should overrule or clarify the Chevron doctrine based on its application more than 40 years after its creation, and the Supreme Court chose to overrule it.

The Chevron doctrine required courts to use a two-step process to interpret statutes administered by federal agencies. After determining that the Chevron doctrine may apply to a dispute before it, a federal court must assess whether Congress has directly spoken to the precise question at issue. If (and only if) the congressional intent of the statute is clear, that is the end of the inquiry as to the statute's meaning. If the court determines that the statute is silent or ambiguous regarding the issue at hand, then the Chevron doctrine requires the court to defer to the agency's interpretation if it "is based on a permissible construction of the statute."

The Supreme Court's *Loper* decision found that the Chevron doctrine is incompatible with the federal Administrative Procedure Act's requirement for courts to exercise their independent judgment in deciding whether a federal agency has acted within its statutory authority. It further held that courts may not defer to an agency's interpretation of a statute merely because the statute is ambiguous, as it is the responsibility of the court, rather than an agency that administers or acts under a statute, to discern the statute's meaning. The Supreme Court reasoned that allowing agencies to interpret the laws they enforce or act under, rather than reserving that activity for the courts, was an impermissible delegation of an activity reserved to the courts.

While the decisions at issue in *Loper* pertained to fishing regulations promulgated by the Department of Commerce, the Chevron doctrine's significance to the highly regulated field of healthcare is profound. The Chevron doctrine is frequently implicated in litigation over healthcare regulation, ranging from rules concerning staffing requirements and the validity of arbitration provisions, to requirements for healthcare workers to be vaccinated. Subsequent analysis has focused on the limits of the *Loper* decision, including any deference that courts may still afford to administrative agencies when based on agency fact-finding and policymaking, particularly where such power is expressly delegated to the agency by statute. The *Loper* decision likely will have significant and lasting consequences for the promulgation and enforcement of federal regulations by HHS and CMS, and may bear on the depth and detail of future legislation that is passed and enacted as statutes by Congress so that such laws can be enforced without administrative rulemaking or agency enforcement mechanisms.

## **Monitoring Compliance in Our Independent Subsidiaries**

Governmental agencies and other authorities periodically inspect our independent subsidiaries to assess compliance with various standards, rules and regulations, with potential fines, sanctions and other penalties for noncompliance. Unannounced surveys or inspections generally occur at least annually and may also follow a government agency's receipt of a complaint about a facility. Facilities must pass these inspections to maintain licensure under state law, to obtain or maintain certification under the Medicare and Medicaid programs, to continue participation in the Veterans Administration program at some facilities, and to comply with provider contracts with managed care clients at many facilities. From time to time, our independent subsidiaries, like others in the healthcare industry, may receive notices from federal and state regulatory agencies of an alleged failure to substantially comply with applicable standards, rules or regulations. These notices may require corrective action, may impose civil monetary penalties for noncompliance, and may threaten or impose other operating restrictions on SNFs such as admission holds, provisional skilled nursing license, or increased staffing requirements. If our independent subsidiaries fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, the facility could lose its certification as a Medicare or Medicaid provider or lose its license permitting operation in the State.

Facilities with otherwise acceptable regulatory histories generally are given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within six months of inspection; however, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, may not be given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility's existing agreement. However, new owners nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before acquisition by our independent subsidiaries and that develop new deficiencies after acquisition are more likely to have sanctions imposed upon them by CMS or state regulators.

In addition, CMS has increased its focus on facilities with a history of serious or sustained quality of care problems through the Special Focus Facility (SFF) program. SFFs receive heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility "graduates" from the SFF program once it demonstrates significant improvements in quality of care that are continued over a defined period of time.

In October 2022, CMS increased penalties for SFFs that fail to improve their performance upon further inspection by CMS, increasing the standards SFFs must meet to graduate from the SFF program, maintaining heightened oversight of any SFF for a period of three years after it graduates and increasing the technical assistance CMS provides to SFFs.

On October 24, 2025, OIG issued a report titled "CMS's Special Focus Facility Program for Nursing Homes Has Not Yielded Lasting Improvements." Within this report, OIG set out its observation that, from 2013 to 2022, SNFs that graduated from the SFF program failed to maintain the improvements achieved while in the SFF program. The report also addresses OIG's findings on the impact of staffing on sustaining the gains seen in the SFF program and additional factors to consider such as facility ownership, and its recommendations for improving the program. OIG recommended that CMS (1) impose more non-financial enforcement remedies to promote compliance; (2) examine the extent to which it took enhanced enforcement actions for facilities that graduated the SFF program. In January of 2026, CMS issued new guidance updating the SFF program to place a greater emphasis on resident falls, increase the frequency of inspections, and decrease notice to facilities in advance of inspections to enhance the oversight powers of CMS and state survey agencies in monitoring facilities that are recommended to or participating in the SFF program.

Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their re-evaluation, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice, leaving operators with the task of deciding whether to continue accepting patients after the potential denial of payment date--risking the retroactive denial of revenue. Some of our independent subsidiaries have been or will be in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of revenue associated with patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, could include various remedies up to and including decertification.

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state surveyors. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards and to identify multi-facility providers with patterns of noncompliance. CMS is also increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey facilities more consistently.

### ***Regulations Regarding Financial Arrangements***

We are also subject to federal and state laws that regulate financial arrangement by and between healthcare providers, such as the federal and state anti-kickback laws, the Stark laws, and various state anti-referral laws.

The Social Security Act prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of an individual, in return for recommending, or to arrange for, the referral of an individual for any item or service payable under any federal healthcare program, including Medicare or Medicaid. The OIG has issued regulations that create “safe harbors” for certain conduct and business relationships that are deemed protected under the Social Security Act. In order to receive safe harbor protection, all of the requirements of a safe harbor must be met. The fact that a given business arrangement does not fall within one of these safe harbors does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria, if investigated, will be evaluated on a case-by-case basis based upon all facts and circumstances and risk increased scrutiny and possible sanctions by enforcement authorities.

Violations of the Social Security Act can result in inflation-adjusted criminal penalties of more than \$0.1 million and ten years' imprisonment. It can also result in inflation-adjusted civil monetary penalties of more than \$0.1 million per violation and an assessment of up to three times the total amount of remuneration offered, paid, solicited, or received. It may also result in an individual's or organization's exclusion from future participation in federal healthcare programs. State Medicaid programs are required to enact an anti-kickback statute. Many states in which our independent subsidiaries operate have adopted or are considering similar legislative proposals, some of which extend beyond that state's Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients regardless of the source of payment for the care.

Additionally, the "Stark Law" of the Social Security Act provides that a physician may not refer a Medicare or Medicaid patient for a “designated health service” to an entity with which the physician or an immediate family member has a financial relationship unless the financial arrangement meets an exception under the Stark Law or its regulations. Designated health services include, in relevant part, inpatient and outpatient hospital services, PT, OT, SLP, durable medical equipment, prosthetics, orthotics and supplies, diagnostic imaging, and home health services. Under the Stark Law, a “financial relationship” is defined as an ownership or investment interest or a compensation arrangement. If such a financial relationship exists and does not meet a Stark Law exception, the entity is disallowed from seeking payment under the Medicare or Medicaid programs or from collecting from the patient or other payor. Statutory and regulatory exceptions and exemptions to this exist and have specific rules that must be followed to qualify for such exception or exemption. Any funds collected for an item or service resulting from a referral that violates the Stark Law are not eligible for payment by federal healthcare programs and must be repaid. Violations of the Stark Law may result in the imposition of civil monetary penalties, including treble damages. Individuals and organizations may also be excluded from participation in federal healthcare programs for Stark Law violations. Many states have enacted healthcare provider referral laws that go beyond physician self-referrals or apply to a greater range of services than just the designated health services under the Stark Law.

### ***Regulations Regarding Patient Record Confidentiality***

Health care providers are also subject to laws and regulations enacted to protect the confidentiality of patient health information and patients' right to access such information. For example, HHS has issued rules pursuant to HIPAA, including the Health Information Technology for Economic and Clinical Health (HITECH) Act which governs our use and disclosure of protected health information of patients. We and our independent subsidiaries have established policies and procedures to comply with HIPAA privacy and security requirements and our independent subsidiaries have adopted and implemented HIPAA compliance plans, which we believe comply with the HIPAA privacy and security regulations, which impose significant costs for ongoing compliance activities.

On February 8, 2024, HHS through the Substance Abuse and Mental Health Services Administration (SAMHSA) finalized rules that align the confidentiality of substance use disorder records (i.e., 42 CFR Part 2, also known as "Part 2") with HIPAA; the compliance deadline for such rules was February 16, 2026. Such rules align many Part 2 requirements with HIPAA, extend HIPAA's breach notification and enforcement regime to records subject to Part 2, and permit broader care coordination of such records while preserving heightened protections under Part 2. In addition, such rules require us and our independent subsidiaries to include information regarding Part 2 uses and disclosures in applicable "Notice of Privacy Practices" that inform individuals of the uses and disclosures of certain health information.

There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our independent subsidiaries are also subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA.

On January 17, 2024, CMS published the CMS Interoperability and Prior Authorization Final Rule (Interoperability Final Rule), which affects the data standards and application programming interfaces (APIs) used by entities that are payors for our services, including but not limited to Medicare Advantage organizations, Medicaid fee-for-service providers, and MCOs. This new rule requires these payor entities to adopt new patient access APIs beginning January 1, 2026, and to complete implementation of both patient and provider access APIs by January 1, 2027, to facilitate the sharing of payor information with payors and providers. While the purpose of this final rule is predominantly oriented to sharing information in the clinical setting and expediting the exchange of prior authorization data, this new rule may have implications for our business and how information is shared among our independent subsidiaries that participate in these programs, the payors, residents, and residents' families involved in their care.

### **Antitrust Laws**

We are also subject to federal and state antitrust laws. Enforcement of the antitrust laws against healthcare providers is common, and antitrust liability may arise in a wide variety of circumstances, including third party contracting, physician relations, joint venture, merger, affiliation and acquisition activities. On February 3, 2023, the DOJ's Antitrust Division withdrew its support for three policies that had been jointly created by the DOJ and the Federal Trade Commission (FTC) in 1993, 1996, and 2011, announcing instead, without providing further alternative guidance, that the DOJ would take a case-by-case enforcement approach to evaluate conduct in the healthcare industry, citing that the previous policies were outdated and overly permissive. Similarly, on July 14, 2023, the FTC withdrew two antitrust policy statements related to enforcement in healthcare markets. Moving forward, the FTC will evaluate mergers and conduct in healthcare markets on a case-by-case basis using principles of antitrust enforcement and competition policy.

On July 19, 2023, the DOJ and FTC released a draft joint statement of antitrust policy that outlines 13 guidelines to be used when determining if a merger is unlawfully anticompetitive under antitrust laws. These guidelines cover various aspects of antitrust enforcement relevant to SNF and senior living facilities, such as market concentration, competition between firms, risk of coordination, elimination of potential entrants, control of products or services, vertical mergers, dominant positions, trends toward concentration, series of multiple acquisitions, multi-sided platforms, competing buyers, partial ownership or minority interests and overall impact on competition. The draft joint statement also includes detailed sections on the application of the guidelines, defining relevant markets and approaches to rebuttal evidence. These proposed statements are not exhaustive, and the DOJ and FTC may focus on one or multiple guidelines depending on the specific circumstances of each merger. These proposed general statements of antitrust policy, once finalized, may be a prelude to a new joint statement of healthcare antitrust policy of the DOJ and FTC, with the agencies' finalized general statements providing insight into whether healthcare-specific statements will be issued. This development and potential new guidance regarding DOJ and FTC antitrust policy increases risk and uncertainty regarding transactions that may be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

Further change is expected with respect to the DOJ and FTC's antitrust policies due to the outcome of the 2024 presidential election, including as to how they relate to healthcare. As a result, these changes to the DOJ and FTC's antitrust policies may be changed materially, not implemented, or reverted to prior statements that were withdrawn in February of 2023.

Several states in which we operate have enacted laws that mirror the Federal Hart-Scott-Rodino (HSR) Act. The HSR Act mandates that parties involved in certain transactions must provide advance notice to the Department of Justice (DOJ) and the Federal Trade Commission (FTC) to obtain clearance, ensuring the transaction complies with federal antitrust regulations. Similarly, the state-level HSR analogues require parties to notify state authorities and secure approval before finalizing mergers or acquisitions.

This regulatory trend has accelerated in 2025, with more states actively considering or enacting such legislation. In some cases, state requirements align closely with the federal HSR Act, simply requiring that a copy of the federal HSR filing be submitted to a designated state agency. However, other states have established distinct or more rigorous standards, sometimes necessitating state approval for transactions that would not trigger federal reporting obligations under the HSR Act.

Among the states where we operate, California implemented its relevant laws in 2024, and Washington expanded the scope of its HSR-like requirements with new legislation effective July 27, 2025. Nevada, while it did not pass a comprehensive HSR when proposed in 2025, does require notification or approval for certain healthcare transactions prior to closing. These evolving state regulations add new layers of compliance for mergers and acquisitions, particularly in the healthcare sector.

### **California Office of Health Care Affordability**

The California Office of Health Care Affordability (OHCA) requires healthcare entities to provide OHCA with written notice of proposed qualifying agreements or transactions (referred to as a “Material Change Notice”) at least 90 days prior to entering into the agreement or transaction. Reportable transactions are determined based on a variety of factors outlined in the applicable regulations.

If OHCA determines, on its own or in conjunction with other state agencies, that a proposed agreement or transaction may have a risk of significant impact on certain aspects of the healthcare market, OHCA will conduct a Cost and Market Impact Review (CMIR) to analyze the transaction in more detail. This CMIR process involves a deeper analysis than OHCA’s initial review of the information contained in a reporting party’s Material Change Notice. OHCA’s CMIR process has the potential to result in findings of anti-competitive effects. If such an impact is identified, OHCA may refer the matter to the California Attorney General for further action.

Between March and September 2025, we provided OHCA with requested information regarding specific components of a proposed transaction. Despite our ongoing cooperation, on October 10, 2025, OHCA issued an investigatory subpoena to us to produce (among other things) certain confidential and proprietary documents. We timely responded to the investigatory subpoena and asserted objections. We have been unable to effect resolution including attempts to narrow the scope, and limit the requests to our independent subsidiaries operating in California. We have filed a Petition in the Superior Court of the State of California, County of Orange, seeking a declaration that the CMIR regulations violate the United States Constitution and/or the California Constitution, and is void and unenforceable as applied to us. We have also requested that OHCA be ordered to withdraw the subpoena and close the inquiry, so the underlying transaction can be completed.

### **Americans with Disabilities Act (ADA)**

Our independent subsidiaries must also comply with the ADA, and similar state and local laws to the extent that the facilities are "public accommodations" as defined in those laws. The obligation to comply with the ADA and other similar laws is an ongoing obligation, and the independent subsidiaries continue to assess their facilities relative to ADA compliance and make appropriate modifications as needed.

### **Civil Rights**

The Office for Civil Rights (OCR) for HHS issued guidance to hospitals and long-term care facilities, emphasizing their obligation under CMS regulations to ensure non-discriminatory visitation policies, especially during public health emergencies. This guidance, part of the U.S. National Strategy to Counter Antisemitism, clarifies that these facilities cannot discriminate based on religion or other classes or characteristics protected against discrimination under federal civil rights laws. The guidance includes examples where non-compliance occurred, such as unequal treatment based on religious affiliation or dietary restrictions, and stricter screening processes for certain religious groups. OCR offers assistance to facilities to obtain compliance with these standards and encourages residents and other affected individuals to file complaints with OCR for potential administrative or civil action in cases of civil rights violations. OCR has been increasingly involved in the monitoring and enforcement of patient and resident rights, particularly under rulemaking completed under Section 1557 of the ACA. However, recent litigation and political efforts have seen a reduction in enforcement of Section 1557. Specifically, HHS announced that it would not enforce certain regulations promulgated under Section 1557 related to discrimination based on sex, gender identity, and pregnancy status.

### **Real Estate Investment Trust (REIT) Qualification**

We elected for Standard Bearer to be taxed as a REIT for U.S. federal income tax purposes. Standard Bearer's qualification as a REIT will depend upon its ability to meet, on a continuing basis, various complex requirements under the Internal Revenue Code, relating to, among other things, the sources of its gross income, the composition and value of its assets, distribution levels to its stockholders and the concentration of ownership of its capital stock. We believe that Standard Bearer is organized in conformity with the requirements for qualification and taxation as a REIT under the Code and that its manner of operation has and will enable it to continue to meet the requirements for qualification and taxation as a REIT.

### **REGULATIONS SPECIFIC TO SENIOR LIVING COMMUNITIES AND ANCILLARY SERVICES**

As previously mentioned, senior living services revenue, which accounted for 2.2% of total revenue, is primarily derived from private pay residents and senior living revenue derived from Medicaid funds. Thus, some of the regulations discussed above applicable to Medicaid providers, also apply to senior living.

A majority of states provide, or are approved to provide, Medicaid payments for personal care and medical services to some residents in licensed senior living communities. As rates paid to senior living community operators are generally lower than rates paid to SNF operators, some states use Medicaid funding of senior living services as a means of lowering the cost of services for residents who may not need the higher level of health services provided in SNFs. States that administer Medicaid programs for services in senior living communities are responsible for monitoring the participating communities and, as a result of the growth of senior living in recent years, these states have adopted licensing standards applicable to senior living communities. Similarly, states that elect to provide Medicaid coverage for an expanded range of HCBS services for individuals who do not require institutional care may also offer lower rates of reimbursement for those HCBS services than services provided in SNFs. This cost differential may make those HCBS services more attractive to Medicaid programs than SNF-based care.

CMS has continued to commence a series of actions to increase its oversight of state quality assurance programs for senior living communities and has provided guidance and technical assistance to states to improve their ability to monitor and improve the quality of services paid through Medicaid waiver programs. CMS is encouraging state Medicaid programs to expand their use of home and community-based services as alternatives to facility-based services, pursuant to provisions of the ACA, and other authorities, through the use of several programs.

The types of laws and statutes affecting the regulatory landscape of the post-acute industry continue to expand and the pressure to enforce those laws by federal and state authorities continues to grow as well. In order to operate our businesses, we and our independent subsidiaries must comply with federal, state and local laws from healthcare including provisions regarding patient safety, staffing, and prescription drugs to environmental issues. Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

## RESULTS OF OPERATIONS

Our total revenue for the three months ended March 31, 2026 increased \$216.2 million, or 18.4%, compared to the three months ended March 31, 2025, while our diluted GAAP earnings per share grew by 21.9%, from \$1.37 to \$1.67, compared to the three months ended March 31, 2025. Our Same Facilities occupancy increased by 2.3% to 84.3% during the three months ended March 31, 2026 compared to the same period in 2025, demonstrating our ability to gain additional market share even at our more mature operations. Further, our Transitioning Facilities occupancy increased by 3.8% to 85.1% compared to the same period in 2025, highlighting our ability to organically grow and transform underperforming operations that we have acquired.

Throughout most of our history, our operating results have been affected by seasonal fluctuations in occupancy and patient acuity, which are most notable when comparing the summer and winter months. For skilled nursing occupancy and skilled mix, we typically experience stronger occupancy and acuity during the first and fourth quarters and softer demand in the second and third quarters. Additionally, our recently acquired facilities typical include operations that historical have had lower occupancy and skilled mix at the time of acquisition. As these operations become "operations of choice" within their respective healthcare markets, we generally experience increases in both occupancy and skilled mix.

We have continued to make progress on targeted initiatives related to increasing occupancy and the level of acuity and complexity of the patients we serve in our facilities, attracting and developing our people and acquiring underperforming skilled nursing operations and integrating them with our proven cultural and operational principles. During the three months ended March 31, 2026, we added 5 new operations. We continue to generate healthy growth in both revenue and overall results as we continue to work diligently with existing and recently acquired operations, so that each operation can reach its full clinical and financial potential.

Our strength remains in our operating model, which empowers each operator to form their own market-specific strategy and adjust to the needs of their local medical communities, including methods for attracting new healthcare professionals into our workforce and retaining and developing existing staff. As we continue to execute on core fundamentals, we continue to see positive trends on both turnover and agency usage across our operations.

The following table sets forth details of operating results for our revenue, expenses and earnings and their respective components, as a percentage of total revenue for the periods indicated:

	Three Months Ended March 31,	
	2026	2025
<b>REVENUE:</b>		
Service revenue	99.5 %	99.5 %
Rental revenue	0.5	0.5
<b>TOTAL REVENUE</b>	<b>100.0 %</b>	<b>100.0 %</b>
Expenses:		
Cost of services	78.9	79.1
Rent—cost of services	4.7	4.9
General and administrative expense	5.3	5.3
Depreciation and amortization	2.1	2.1
<b>TOTAL EXPENSES</b>	<b>91.0 %</b>	<b>91.4 %</b>
Income from operations	9.0	8.6
Other income (expense):		
Interest expense	(0.1)	(0.2)
Interest income	0.5	0.6
Other expense	(0.1)	—
<b>OTHER INCOME, NET</b>	<b>0.3 %</b>	<b>0.4 %</b>
Income before provision for income taxes	9.3	9.0
Provision for income taxes	2.1	2.2
<b>NET INCOME</b>	<b>7.2 %</b>	<b>6.8 %</b>
Less: net income attributable to noncontrolling interests	—	—
<b>Net income attributable to The Ensign Group, Inc.</b>	<b>7.2 %</b>	<b>6.8 %</b>

	Three Months Ended March 31,	
	2026	2025
<i>(In thousands)</i>		
<b>SEGMENT INCOME<sup>(1)</sup></b>		
Skilled services	\$ 174,017	\$ 143,931
Standard Bearer <sup>(2)</sup>	10,809	8,583
<b>NON-GAAP FINANCIAL MEASURES:</b>		
<b>PERFORMANCE METRICS</b>		
Adjusted EBT	\$ 147,051	\$ 118,730
Adjusted Net Income	110,200	88,972
Adjusted Earnings Per Share	1.85	1.52
EBITDA	152,681	125,846
Adjusted EBITDA	171,160	137,385
FFO for Standard Bearer	21,592	17,059
<b>VALUATION METRICS</b>		
Adjusted EBITDAR	\$ 236,666	

(1) Segment income represents operating results of the reportable segments excluding gain and loss on sale of assets, real estate insurance recoveries and losses, impairment charges and provision for income taxes. Included in segment income for Standard Bearer are expenses for intercompany management fees between Standard Bearer and the Service Center and intercompany interest expense. Segment income is reconciled to the Condensed Consolidated Statement of Income in Note 7, *Business Segments* in Notes to Interim Financial Statements of this Quarterly Report on Form 10-Q.

(2) Standard Bearer segment income includes rental revenue and expenses from our independent subsidiaries.

The following discussion includes references to Adjusted EBT, Adjusted net income, Adjusted earnings per share, EBITDA, Adjusted EBITDA, Adjusted EBITDAR and Funds from Operations (FFO) which are non-GAAP financial measures (collectively, the Non-GAAP Financial Measures). Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Securities Exchange Act of 1934, as amended (the Exchange Act), define and prescribe the conditions for use of certain non-GAAP financial information. These Non-GAAP Financial Measures are used in addition to and in conjunction with results presented in accordance with GAAP. These Non-GAAP Financial Measures should not be relied upon to the exclusion of GAAP financial measures. These Non-GAAP Financial Measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

We believe the presentation of certain Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as interest income, interest expense and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets, capital structure and the method by which assets were acquired; and
- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our capital structure and asset base from our operating results.

We use the Non-GAAP Financial Measures:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;
- to allocate resources to enhance the financial performance of our business;
- to assess the value of a potential acquisition;
- to assess the value of a transformed operation's performance;
- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We use certain Non-GAAP Financial Measures to compare the operating performance of each operation. These measures are useful in this regard because they do not include such costs as other expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the amount of debt that we have incurred, whether an operation is owned or leased, the date of acquisition of a facility or business, and the tax law of the state in which a business unit operates.

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of certain Non-GAAP Financial Measures.

Despite the importance of these measures in analyzing our underlying business, designing incentive compensation and for our goal setting, the Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, certain of our Non-GAAP Financial Measures have limitations as analytical tools, and they should not be considered in isolation, or as a substitute for analysis of our results as reported in accordance with GAAP. Some of these limitations are:

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- they do not reflect rent expenses, which are necessary to operate our leased operations, in the case of Adjusted EBITDAR;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using them only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business. Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' Non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table below, along with our Interim Financial Statements and related notes included elsewhere in this document.

We use the following Non-GAAP financial measures that we believe are useful to investors as key valuation and operating performance measures:

## **PERFORMANCE MEASURES**

### ***Adjusted EBT***

We adjust income before provision for income taxes (Adjusted EBT) when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance. We believe that the presentation of Adjusted EBT, when combined with income before provision for income taxes and GAAP net income attributable to The Ensign Group, Inc., is beneficial to an investor's complete understanding of our operating performance. We use this performance measure as an indicator of business performance, as well as for operational planning, decision-making purposes and to determine compensation in our executive compensation plan.

Adjusted EBT is income before provision for income taxes adjusted for non-core business items, which for the reported periods includes, to the extent applicable. These items are generally infrequent or variable in nature, or do not represent current operating activities.

- stock-based compensation expense;
- acquisition related costs;
- costs incurred related to system implementations;
- loss on long-lived assets; and
- amortization of patient base intangible assets.

### ***Adjusted Net Income and Adjusted Earnings Per Share***

We adjust net income attributable to The Ensign Group, Inc. (adjusted net income) and diluted earnings per share (adjusted earnings per share) when evaluating our performance because we believe these measures provide useful supplemental information to management and investors regarding our ongoing operating performance. We believe that the presentation of adjusted net income and adjusted earnings per share, when considered together with GAAP net income attributable to The Ensign Group, Inc. and GAAP diluted earnings per share, enhances an investor's understanding of our results of operations. Management uses these measures for performance evaluation, operational planning and decision-making purposes.

Adjusted net income is net income adjusted for non-core business items as listed in adjusted EBT, as well as the related income tax effects of these adjustments.

Adjusted earnings per share is calculated by dividing adjusted net income by the weighted-average diluted shares outstanding for the applicable period.

### ***EBITDA***

We believe EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate EBITDA as net income, adjusted for net losses attributable to noncontrolling interest, before (a) interest income, (b) provision for income taxes, (c) depreciation and amortization, and (d) interest expense.

### Adjusted EBITDA

We adjust EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance, in the case of Adjusted EBITDA. We believe that the presentation of Adjusted EBITDA, when combined with EBITDA and GAAP net income attributable to The Ensign Group, Inc., is beneficial to an investor’s complete understanding of our operating performance.

Adjusted EBITDA is EBITDA adjusted for the same non-core business items as listed in Adjusted EBT, except for amortization of patient base intangible assets.

### Funds from Operations (FFO)

We consider FFO to be a useful supplemental measure of the operating performance of Standard Bearer. Historical cost accounting for real estate assets in accordance with U.S. GAAP implicitly assumes that the value of real estate assets diminishes predictably over time as evidenced by the provision for depreciation. However, since real estate values have historically risen or fallen with market conditions, many real estate investors and analysts have considered presentations of operating results for real estate companies that use historical cost accounting to be insufficient. In response, the National Association of Real Estate Investment Trusts (NAREIT) created FFO as a supplemental measure of operating performance for REITs, which excludes historical cost depreciation from net income. We define (in accordance with the definition used by NAREIT) FFO to consist of Standard Bearer segment income, excluding depreciation and amortization related to real estate, gains or losses from the sale of real estate, insurance recoveries related to real estate and impairment of long-lived assets.

### VALUATION MEASURE

#### Adjusted EBITDAR

We use Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a commonly used measure by our management, research analysts and investors, to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures and leasing arrangements. Adjusted EBITDAR is a financial valuation measure that is not specified in GAAP. This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense, and is therefore presented only for the current period.

The adjustments made and previously described in the computation of Adjusted EBITDA are also made when computing Adjusted EBITDAR. We calculate Adjusted EBITDAR by excluding rent-cost of services from Adjusted EBITDA.

We believe the use of Adjusted EBITDAR allows the investor to compare operational results of companies who have operating and capital leases. A significant portion of capital lease expenditures are recorded in interest, whereas operating lease expenditures are recorded in rent expense.

The table below reconciles income before provision for income taxes to Adjusted EBT for the periods presented:

	Three Months Ended March 31,	
	2026	2025
<i>(In thousands)</i>		
<b>Consolidated statements of income data:</b>		
Income before provision for income taxes	\$ 128,572	\$ 106,580
Stock-based compensation expense	13,895	10,724
Costs incurred related to system implementations	3,019	334
Loss on long-lived assets	1,284	—
Acquisition related costs <sup>(1)</sup>	281	481
Depreciation and amortization - patient base <sup>(2)</sup>	—	611
<b>ADJUSTED EBT</b>	<b>\$ 147,051</b>	<b>\$ 118,730</b>

(1) Represents costs incurred to acquire operations that are not capitalizable.

(2) Represents amortization expenses related to patient base intangible assets at newly acquired skilled nursing and senior living facilities.

The table below reconciles net income to adjusted net income and diluted earnings per share to adjusted earnings per share for the periods presented:

	<b>Three Months Ended March 31,</b>	
	<b>2026</b>	<b>2025</b>
Net income attributable to The Ensign Group, Inc.	\$ 99,668	\$ 80,277
Adjustments:		
Stock-based compensation expense	13,895	10,724
Costs incurred related to system implementations	3,019	334
Loss on long-lived assets	1,284	—
Acquisition related costs <sup>(1)</sup>	281	481
Depreciation and amortization - patient base <sup>(2)</sup>	—	611
Provision for income taxes on Non-GAAP adjustments <sup>(3)</sup>	(7,947)	(3,455)
<b>Adjusted Net Income</b>	<b>\$ 110,200</b>	<b>\$ 88,972</b>
Average number of diluted shares outstanding	59,567	58,500
<b>Diluted Earnings Per Share</b>	<b>\$ 1.67</b>	<b>\$ 1.37</b>
<b>Adjusted Earnings Per Share</b>	<b>\$ 1.85</b>	<b>\$ 1.52</b>

(1) Represents costs incurred to acquire operations that are not capitalizable.

(2) Represents amortization expenses related to patient base intangible assets at newly acquired skilled nursing and senior living facilities.

(3) Represents an adjustment to the provision for income tax to our historical effective tax rate of 25.0%.

The table below reconciles net income to EBITDA, Adjusted EBITDA and Adjusted EBITDAR for the periods presented:

	<b>Three Months Ended March 31,</b>	
	<b>2026</b>	<b>2025</b>
<b>Consolidated statements of income data:</b>	<i>(In thousands)</i>	
Net income	\$ 99,756	\$ 80,353
Less: Net income attributable to noncontrolling interests	88	76
Interest income	6,536	6,883
Add: Provision for income taxes	28,816	26,227
Depreciation and amortization	28,801	24,188
Interest expense	1,932	2,037
<b>EBITDA</b>	<b>\$ 152,681</b>	<b>\$ 125,846</b>
Adjustments to EBITDA:		
Stock-based compensation expense	13,895	10,724
Costs incurred related to system implementations	3,019	334
Loss on long-lived assets	1,284	—
Acquisition related costs <sup>(1)</sup>	281	481
<b>ADJUSTED EBITDA</b>	<b>\$ 171,160</b>	<b>\$ 137,385</b>
Rent—cost of services	65,506	57,076
<b>ADJUSTED EBITDAR</b>	<b>\$ 236,666</b>	

(1) Represents costs incurred to acquire operations that are not capitalizable.

### Three Months Ended March 31, 2026 Compared to the Three Months Ended March 31, 2025

The following tables set forth details of operating results for our revenue and earnings, and their respective components, by our reportable segments for the periods indicated:

	Three Months Ended March 31, 2026				
	Skilled services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	\$ 1,330,835	\$ 36,102	\$ 62,256	\$ (39,997)	\$ 1,389,196
Total expenses, including other income, net	1,156,818	25,293	118,510	(39,997)	1,260,624
Segment income (loss)	174,017	10,809	(56,254)	—	128,572
<b>Income before provision for income taxes</b>					<b>\$ 128,572</b>

	Three Months Ended March 31, 2025				
	Skilled services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	\$ 1,123,554	\$ 28,401	\$ 52,426	\$ (31,340)	\$ 1,173,041
Total expenses, including other income, net	979,623	19,818	98,360	(31,340)	1,066,461
Segment income (loss)	143,931	8,583	(45,934)	—	106,580
<b>Income before provision for income taxes</b>					<b>\$ 106,580</b>

Our total revenue increased by \$216.2 million, or 18.4%, compared to the three months ended March 31, 2025. The increase in revenue was primarily driven by increases in occupancy of 2.3% and 3.8% from our skilled services in Same Facilities and Transitioning Facilities, respectively, coupled with increasing daily revenue rates and the impact of acquisitions. In addition, our Recently Acquired Facilities revenue increased by \$128.0 million, when compared to the same period in 2025.

#### Skilled Services

##### REVENUE

The following tables present the skilled services revenue and key performance metrics by category during the three months ended March 31, 2026 and 2025:

	Three Months Ended March 31,			
	2026	2025	Change	% Change
<b>TOTAL FACILITY RESULTS:</b>	<i>(Dollars in thousands)</i>			
Skilled services revenue	\$ 1,330,835	\$ 1,123,554	\$ 207,281	18.4 %
Number of facilities at period end	331	297	34	11.4 %
Number of campuses at period end <sup>(1)</sup>	31	31	—	— %
Actual patient days	2,896,034	2,538,135	357,899	14.1 %
Occupancy percentage — Operational beds	84.0 %	81.9 %	2.1 %	2.6 %
Skilled mix by nursing days	32.0 %	31.4 %	0.6 %	1.9 %
Skilled mix by nursing revenue	50.7 %	50.2 %	0.5 %	1.0 %

	Three Months Ended March 31,			
	2026	2025	Change	% Change
<b>SAME FACILITY RESULTS:<sup>(2)</sup></b>				
<i>(Dollars in thousands)</i>				
Skilled services revenue	\$ 979,208	\$ 916,488	\$ 62,720	6.8 %
Number of facilities at period end	233	233	—	— %
Number of campuses at period end <sup>(1)</sup>	26	26	—	— %
Actual patient days	2,145,381	2,078,851	66,530	3.2 %
Occupancy percentage — Operational beds	84.3 %	82.4 %	1.9 %	2.3 %
Skilled mix by nursing days	32.6 %	32.2 %	0.4 %	1.2 %
Skilled mix by nursing revenue	51.2 %	51.2 %	— %	— %

	Three Months Ended March 31,			
	2026	2025	Change	% Change
<b>TRANSITIONING FACILITY RESULTS:<sup>(3)</sup></b>				
<i>(Dollars in thousands)</i>				
Skilled services revenue	\$ 195,486	\$ 178,922	\$ 16,564	9.3 %
Number of facilities at period end	50	50	—	— %
Number of campuses at period end <sup>(1)</sup>	4	4	—	— %
Actual patient days	402,264	385,106	17,158	4.5 %
Occupancy percentage — Operational beds	85.1 %	82.0 %	3.1 %	3.8 %
Skilled mix by nursing days	30.1 %	28.8 %	1.3 %	4.5 %
Skilled mix by nursing revenue	49.7 %	48.3 %	1.4 %	2.9 %

	Three Months Ended March 31,			
	2026	2025	Change	% Change
<b>RECENTLY ACQUIRED FACILITY RESULTS:<sup>(4)</sup></b>				
<i>(Dollars in thousands)</i>				
Skilled services revenue	\$ 156,141	\$ 28,144	\$ 127,997	NM
Number of facilities at period end	48	14	34	NM
Number of campuses at period end <sup>(1)</sup>	1	1	—	NM
Actual patient days	348,389	74,178	274,211	NM
Occupancy percentage — Operational beds	80.5 %	70.1 %	NM	NM
Skilled mix by nursing days	30.5 %	22.9 %	NM	NM
Skilled mix by nursing revenue	48.9 %	33.3 %	NM	NM

(1) Campus represents a facility that offers both skilled nursing and senior living services. Revenue and expenses related to skilled nursing and senior living services have been allocated and recorded in the respective operating segment.

(2) Same Facility results represent all facilities purchased prior to January 1, 2023.

(3) Transitioning Facility results represent all facilities purchased from January 1, 2023 to December 31, 2024.

(4) Recently Acquired Facility results represent all facilities purchased on or subsequent to January 1, 2025.

Skilled services revenue increased by \$207.3 million, or 18.4%, compared to the three months ended March 31, 2025. The increases in skilled services revenue were across all payer types, primarily driven by strong occupancy across our skilled services operations. Our consolidated occupancy increased by 2.6% to 84.0%, during the three months ended March 31, 2026 compared to the same period in 2025, with an increase in skilled days from our operations within Same Facilities and Transitioning Facilities.

Revenue in our Same Facilities increased by \$62.7 million, or 6.8%, compared to the three months ended March 31, 2025, due to increased occupancy from skilled days and revenue per patient day. Our continuous efforts to strengthen our partnerships with various managed care organizations, hospitals and local communities, increased our managed care revenue by 4.5%, resulting from an increase in managed care days and revenue per patient day. In addition to our growing Medicare Advantage market, we experienced meaningful growth in our Medicare patient base.

Revenue in our Transitioning Facilities increased by \$16.6 million, or 9.3%, compared to the three months ended March 31, 2025, due to improved occupancy growth, increases in skilled mix days and revenue per patient day, across all payors. The increases reflect our operational fundamentals as we continue to transition and integrate these facilities.

Revenue in our Recently Acquired Facilities increased by approximately \$128.0 million compared to three months ended March 31, 2025. The 34 operational expansions between April 1, 2025 and March 31, 2026 across 11 states contributed \$109.8 million of the total increase.

Historically, we have generally experienced lower occupancy rates and lower skilled mix at Recently Acquired Facilities and therefore, we anticipate lower overall occupancy during years of growth. In the future, if we acquire additional turnaround or start-up operations, we expect to see lower occupancy rates and skilled mix and these metrics are expected to vary from period to period based upon the type of facilities and operations that we acquire.

The following table reflects the change in skilled nursing average daily revenue rates by payor source, excluding services that are not covered by the daily rate<sup>(1)</sup>:

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2026	2025	2026	2025	2026	2025	2026	2025
<b>SKILLED NURSING AVERAGE DAILY REVENUE RATES:</b>								
Medicare	\$ 809.73	\$ 775.66	\$ 881.32	\$ 841.61	\$ 810.36	\$ 594.17	\$ 821.83	\$ 783.71
Managed care	590.96	565.01	646.11	601.62	625.12	458.40	600.27	566.74
Other skilled	644.34	643.99	683.09	651.50	633.76	725.44	647.28	645.88
Total skilled revenue	679.26	653.22	769.54	733.85	715.40	548.85	695.15	662.14
Medicaid	312.34	296.93	330.24	312.02	320.14	328.01	315.81	300.27
Private and other payors	312.14	289.78	369.09	352.08	377.49	319.08	329.27	300.96
Total skilled nursing revenue	\$ 431.80	\$ 410.86	\$ 466.55	\$ 437.78	\$ 446.96	\$ 377.44	\$ 438.42	\$ 413.94

(1) The rates are based on contractually agreed-upon amounts or rates, excluding the estimates of variable consideration under the revenue recognition standard, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 4.4% and 4.7%, respectively, compared to the three months ended March 31, 2025. The increase is attributable to the 3.2% net market basket increase that became effective in October 2025 as well as a shift toward higher acuity patients. As hospitals continue to discharge individuals with more complex medical conditions to skilled nursing facilities, we are experiencing a greater proportion of higher acuity patients, which necessitates more advanced and specialized care.

Our average Medicaid rates increased 5.2%, compared to the three months ended March 31, 2025, due to state reimbursement increases and our participation in Medicaid supplemental payment and quality improvement programs in various states.

**Payor Sources as a Percentage of Skilled Nursing Services.** We use our skilled mix as a measure of the quality of reimbursements we receive at our affiliated skilled nursing facilities over various periods.

The following tables set forth our percentage of skilled nursing patient revenue and days by payor source:

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2026	2025	2026	2025	2026	2025	2026	2025
<b>PERCENTAGE OF SKILLED NURSING REVENUE</b>								
Medicare	21.7 %	21.4 %	28.5 %	29.1 %	26.6 %	16.2 %	23.3 %	22.5 %
Managed care	19.9	20.8	14.7	14.0	15.6	12.2	18.6	19.5
Other skilled	9.6	9.0	6.5	5.2	6.7	4.9	8.8	8.2
<b>Skilled Mix</b>	<b>51.2 %</b>	<b>51.2 %</b>	<b>49.7 %</b>	<b>48.3 %</b>	<b>48.9 %</b>	<b>33.3 %</b>	<b>50.7 %</b>	<b>50.2 %</b>
Private and other payors	6.8	6.9	8.2	8.6	9.0	10.8	7.3	7.3
Medicaid	42.0	41.9	42.1	43.1	42.1	55.9	42.0	42.5
<b>TOTAL SKILLED NURSING</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2026	2025	2026	2025	2026	2025	2026	2025
<b>PERCENTAGE OF SKILLED NURSING DAYS</b>								
Medicare	11.6 %	11.3 %	15.1 %	15.1 %	14.7 %	10.3 %	12.4 %	11.9 %
Managed care	14.5	15.1	10.6	10.2	11.1	10.1	13.6	14.2
Other skilled	6.5	5.8	4.4	3.5	4.7	2.5	6.0	5.3
<b>Skilled Mix</b>	<b>32.6 %</b>	<b>32.2 %</b>	<b>30.1 %</b>	<b>28.8 %</b>	<b>30.5 %</b>	<b>22.9 %</b>	<b>32.0 %</b>	<b>31.4 %</b>
Private and other payors	9.4	9.8	10.4	10.8	10.7	12.8	9.7	10.0
Medicaid	58.0	58.0	59.5	60.4	58.8	64.3	58.3	58.6
<b>TOTAL SKILLED NURSING</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>	<b>100.0 %</b>

### Cost of Services

The following table sets forth total cost of services for our skilled services segment for the periods indicated (dollars in thousands):

	Three Months Ended March 31,					
	2026		2025		Change	
	\$	%	\$	%	\$	%
Cost of service	\$ 1,052,724		\$ 891,855		\$ 160,869	18.0 %
Revenue percentage		79.1 %		79.4 %		(0.3)%

Cost of services related to our skilled services segment increased by \$160.9 million, or 18.0%, from the same period in 2025. Cost of services as a percentage of revenue decreased by 0.3% to 79.1% reflecting continued cost management, a shift towards higher acuity as we serve more clinically complex patients, and improving operational performance at our newer acquisitions. In addition, our cost of services as a percentage of revenue varies depending on the volume of acquisitions during the period, which typically have higher costs during the transition period.

### Standard Bearer

	Three Months Ended March 31,					
	2026		2025		Change	
	\$	%	\$	%	\$	%
<i>(Dollars in thousands)</i>						
Rental revenue generated from third-party tenants	\$ 5,270		\$ 4,497		\$ 773	17.2 %
Rental revenue generated from Ensign's independent subsidiaries	30,832		23,904		6,928	29.0
<b>TOTAL RENTAL REVENUE</b>	<b>\$ 36,102</b>		<b>\$ 28,401</b>		<b>\$ 7,701</b>	<b>27.1 %</b>
Segment income	10,809		8,583		2,226	25.9
Depreciation and amortization	10,783		8,476		2,307	27.2
<b>FFO</b>	<b>\$ 21,592</b>		<b>\$ 17,059</b>		<b>\$ 4,533</b>	<b>26.6 %</b>

**Rental revenue** — Our rental revenue, including revenue generated from our independent subsidiaries, increased by \$7.7 million, or 27.1%, to \$36.1 million, compared to the three months ended March 31, 2025. The increase in revenue is primarily attributable to 19 real estate purchases, as well as annual rent increases since the three months ended March 31, 2025.

**FFO** — Our FFO increased by \$4.5 million, or 26.6%, to \$21.6 million, compared to the three months ended March 31, 2025. The increase in rental revenue of \$7.7 million was offset by increases in interest expense of \$2.7 million associated with the debt agreements between Standard Bearer and us as Standard Bearer continues to grow its real estate portfolio.

## All Other Revenue

Our other revenue increased by \$9.8 million, or 18.8%, to \$62.3 million, compared to the three months ended March 31, 2025. Other revenue includes senior living revenue of \$30.6 million, revenue from other ancillary services of \$28.5 million and rental income of \$3.2 million. The increase in other revenue is primarily attributable to the growth in our other ancillary services.

## Consolidated Financial Expenses

**Rent-cost of services** — Our rent-cost of services as a percentage of revenue decreased by 0.2% to 4.7%, as the expansions in our footprint have resulted from more real estate purchases than leased properties.

**General and administrative expense** — General and administrative expense increased \$11.7 million or 18.6%, to \$74.2 million. This increase was primarily driven by additional headcount due to acquisition activities, increases in wages and benefits due to enhanced performance and growth and costs incurred related to our system implementation. General and administrative expense as a percentage of revenue remained consistent at 5.3%.

**Depreciation and amortization** — Depreciation and amortization expense increased \$4.6 million, or 19.1%, to \$28.8 million. This increase was primarily related to the additional depreciation incurred as a result of our newly acquired operations, which have a greater mix of real estate purchases than leases, and capital investments. Depreciation and amortization expense remained consistent at 2.1%, as a percentage of revenue.

**Other income, net** — Other income, net primarily includes interest income from our investments, interest expense related to our debt and deferred compensation gains and losses. Other income, net decreased by \$1.5 million due primarily due to a \$1.7 million loss on our deferred compensation plan and a decrease in interest income of \$0.3 million as we utilized our cash on hand to fund more real estate purchases during the period coupled with a lower interest rate environment. Changes in our deferred compensation plan are a result of gains or losses depending on market performance. Other income, net as a percentage of revenue decreased by 0.1%.

**Provision for income taxes** — Our effective tax rate was 22.4% for the three months ended March 31, 2026, compared to 24.6% for the same period in 2025. The effective tax rate for both periods was driven by the impact of excess tax benefits from stock-based compensation, partially offset by non-deductible expenses including non-deductible compensation. See Note 12, *Income Taxes*, in the Notes to the Interim Financial Statements for further discussion.

## Liquidity and Capital Resources

Our principal sources of liquidity have historically been derived from our cash flows from operations, long-term debt secured by our real property and borrowings under our Credit Facility (defined below). Our liquidity as of March 31, 2026 is impacted by cash generated from strong operational performance offset by our real estate acquisitions, as well as capital expenditures to improve the quality of care at our existing operations.

Historically, we have primarily financed the majority of our acquisitions through cash generated from operations, mortgages on our properties and our Credit Facility. Cash paid to fund acquisitions was \$28.7 million for the three months ended March 31, 2026 compared to \$194.2 million for the three months ended March 31, 2025. Total capital expenditures for property and equipment were \$35.5 million and \$42.9 million for the three months ended March 31, 2026 and 2025, respectively. We currently have approximately \$175.0 million budgeted for renovation projects in 2026.

As further discussed in *Recent Activities*, during the three months ended March 31, 2026, we entered into definitive agreements to acquire real estate assets associated with 19 operations subsequent to March 31, 2026, subject to customary closing conditions, for an aggregate purchase price of approximately \$342.4 million.

Our cash and cash equivalents of approximately \$539.5 million as of March 31, 2026 consisted of bank deposits and money market funds. In addition, as of March 31, 2026, we held investments of approximately \$250.0 million. We believe our investments that were in an unrealized loss position as of March 31, 2026 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so. We may, in the future, seek to raise additional capital to fund growth, capital renovations, operations and other business activities, but such additional capital may not be available on acceptable terms, on a timely basis, or at all.

Our primary source of cash is from our ongoing operations. Our positive cash flows have supported our business and have allowed us to pay regular dividends to our stockholders. We currently anticipate that existing cash and total investments as of March 31, 2026, along with projected operating cash flows and available financing, will support our normal business operations for the foreseeable future.

### Share Repurchases

On May 15, 2025, the Board of Directors approved a stock repurchase program pursuant to which we are authorized to repurchase up to \$20.0 million of our common stock under the program for a period of approximately 12 months from June 16, 2025. During the three months ended March 31, 2026, we did not repurchase any shares pursuant to this stock repurchase program. As of March 31, 2026, the full \$20.0 million authorized for repurchase remained available under the stock repurchase program.

Under our repurchase program, we are authorized to repurchase our issued and outstanding common shares from time to time in open-market and privately negotiated transactions, tender offers, pursuant to contractual provisions, and block trades, or otherwise in accordance with federal securities laws. The stock repurchase program does not obligate us to acquire any specific number of shares. Any such repurchases will depend on our business strategy, prevailing market conditions, our liquidity requirements, contractual restrictions or covenants, compliance with securities laws, and other factors. The amounts involved in any such transaction may be material.

The following table presents selected data from our condensed consolidated statement of cash flows for the periods presented:

	<b>Three Months Ended March 31,</b>	
	<b>2026</b>	<b>2025</b>
<b>NET CASH PROVIDED BY (USED IN):</b>	<i>(In thousands)</i>	
Operating activities	\$ 100,154	\$ 72,220
Investing activities	(71,187)	(243,804)
Financing activities	6,650	(10,348)
<b>Net increase (decrease) in cash and cash equivalents</b>	<b>\$ 35,617</b>	<b>\$ (181,932)</b>
Cash and cash equivalents beginning of period	503,881	464,598
<b>Cash and cash equivalents at end of period</b>	<b>\$ 539,498</b>	<b>\$ 282,666</b>

### Operating Activities

Cash provided by operating activities is net income adjusted for certain non-cash items and changes in operating assets and liabilities.

The \$27.9 million increase in cash provided by operating activities for the three months ended March 31, 2026 compared to the same period in 2025 was due to an increase in operational performance offset by timing of payments.

### Investing Activities

Investing cash flows consist primarily of capital expenditures, investment activities, insurance proceeds and cash used for acquisitions.

The \$172.6 million decrease in cash used in investing activities for the three months ended March 31, 2026 compared to the same period in 2025 was primarily attributable to fewer acquisitions and reduced capital expenditures, partially offset by maturities of our investments.

### Financing Activities

Financing cash flows consist primarily of cash provided by the issuance of common stock upon exercise of stock options, payment of dividends to stockholders, issuance and repayment of short-term and long-term debt and payment for share repurchases.

The \$17.0 million increase in cash provided by financing activities for the three months ended March 31, 2026 compared to the same period in 2025, was primarily attributable to increased cash proceeds from the exercise of stock options in 2026 and share repurchase activity in 2025 under our stock repurchase program that did not recur in 2026.

### ***Credit Facility with a Lending Consortium Arranged by Truist***

We maintain a revolving credit facility with Truist Securities (Truist) (the Credit Facility) with availability of up to \$600.0 million in aggregate principal. The maturity date of the Credit Facility is April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin ranging from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the Credit Facility). In addition, there is a commitment fee on the unused portion of the commitments that ranges from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

### ***Mortgage Loans and Promissory Note***

As of March 31, 2026, 23 of our subsidiaries had mortgage loans insured with HUD for an aggregate amount of \$142.6 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates at a range of 3.1% to 4.2%, including fixed interest rates at a range of 2.4% to 3.3% per annum. In addition to the interest rate, we incur other fees for HUD placement, including but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0%, and is reduced by 3.0% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

In addition to the HUD mortgage loans, one of our subsidiaries has a promissory note that bears a fixed interest rate of 5.3% per annum and has a term of 12 years. The note, which was used for an acquisition, is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

While the mortgage loans and promissory note requires ongoing principal and interest payments over their respective terms, we currently expect these obligations to be satisfied through cash from ongoing operations.

### ***Operating Leases***

As of March 31, 2026, 254 of our facilities have long-term lease arrangements, of which 104 of the operations are under eight triple-net Master Leases with CareTrust. The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%. At our option, we can extend the Master Leases for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If we elect to renew the term of a Master Lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the Master Lease.

We also lease certain facilities under non-cancelable operating leases, most of which have initial lease terms ranging from 15 to 20 years and are subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, we lease certain of our equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases.

Our 104 independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases from CareTrust, are operated under 19 separate Master Leases. Under these master leases, a default at a single facility could subject one or more of the other independent subsidiaries covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of our leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in our outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

## Inflation

We have historically derived a substantial portion of our revenue from the Medicare program. We also derive revenue from state Medicaid and similar reimbursement programs. Payments under these programs generally provide for reimbursement levels that are adjusted for inflation annually based upon the state's fiscal year for the Medicaid programs and in each October for the Medicare program. These adjustments may not continue in the future, and even if received, such adjustments may not reflect the actual increase in our costs for providing healthcare services.

Labor, supply expenses and capital expenditures make up a substantial portion of our cost of services. Those expenses can be subject to increase in periods of rising inflation, tariffs enforcement and when labor shortages occur in the marketplace. To date, we have generally been able to implement cost control measures or obtain increases in reimbursement sufficient to offset increases in these expenses. There can be no assurance that we will be able to anticipate fully or otherwise respond to any future inflationary pressures.

### Item 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

**Interest Rate Risk** — We are exposed to risks associated with market changes in interest rates through our borrowing arrangements and investments. In particular, our Credit Facility exposes us to variability in interest payments due to changes in SOFR interest rates. We manage our exposure to this market risk by monitoring available financing alternatives. Our mortgages and promissory note require principal and interest payments through maturity pursuant to amortization schedules.

Our mortgages generally contain provisions that allow us to make repayments earlier than the stated maturity date. In some cases, we are not allowed to make early repayment prior to a cutoff date. Where prepayment is permitted, we are generally allowed to make prepayments only at a premium which is often designed to preserve a stated yield to the note holder. These prepayment rights may afford us opportunities to mitigate the risk of refinancing our debts at maturity at higher rates by refinancing prior to maturity.

We have a Credit Facility with Truist of up to \$600.0 million in aggregate principal. We have no outstanding borrowings under our Credit Facility as of March 31, 2026 and through the filing date of this report. In addition, we have outstanding indebtedness under mortgage loans insured with HUD and a promissory note payable to a third party of \$143.3 million, all of which are at fixed interest rates.

Our cash and cash equivalents as of March 31, 2026 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of March 31, 2026, we held investments of approximately \$250.0 million. We believe our investments that were in an unrealized loss position as of March 31, 2026 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so. Our market risk exposure is interest rate sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal, while at the same time maximizing the income we receive from our investments without significantly increasing risk. We invest in marketable securities with the positive intent and ability to hold to maturity. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of March 31, 2026 and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

### Item 4. CONTROLS AND PROCEDURES

#### *Disclosure Controls and Procedures*

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act as of the end of the period covered by this Quarterly Report on Form 10-Q. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures are effective.

## Changes in Internal Control over Financial Reporting

In the first quarter of fiscal year 2026, we substantially completed the implementation of our enterprise resource planning (ERP) system, which was designed to accurately maintain the Company's financial records, process transactions and provide timely information to our management team. We have made changes to our internal control over financial reporting to address the related processes and systems.

There were no other changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended March 31, 2026, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

## PART II.

### Item 1. LEGAL PROCEEDINGS

**Indemnities** — From time to time, we enter into contracts that contingently require us to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which we may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from our use of the applicable premises, (ii) operations transfer agreements, in which we agree to indemnify past operators of facilities we acquire against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer to our independent subsidiary, (iii) certain lending agreements, under which we may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with our officers, directors and others, under which we may be required to indemnify such persons for liabilities based on the nature of their relationship to us. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for any such potential obligation on our balance sheets for any of the periods presented.

**Litigation and Regulatory Matters** — Laws and regulations governing Medicare and Medicaid programs are complex and subject to review and interpretation. Compliance with such laws and regulations is evaluated regularly, the results of which can be subject to future governmental review and interpretation and can include significant regulatory action with the possibility of fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations is the Health Insurance Portability and Accountability Act of 1996 (monitored and enforced by the Office of Civil Rights), the terms of which require healthcare providers (among other things) to safeguard the privacy and security of certain patient protected health information.

We and our independent subsidiaries are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that services provided to patients by our independent subsidiaries have resulted in injury or death, and claims related to employment and commercial matters. For example, in a four-week medical negligence trial in the State of Arizona, the jury returned a verdict against one of our independent subsidiaries in late November 2023. We are in the process of appealing the jury verdict. We have in the past appealed similar decisions and have, in some circumstances, received decisions in our favor. Although we intend to vigorously defend against these claims and in general these types of claims and cases, there can be no assurance that the outcomes of these matters will not have a material adverse effect on operational results and financial condition. Additionally, in certain states in which we have or have had independent subsidiaries, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law and/or public policy prohibitions. There can be no assurance that we and or our independent subsidiaries will not be liable for punitive damages awarded in litigation arising in states for which punitive damage insurance coverage is not available.

The skilled nursing and post-acute care industry is heavily regulated. As such, we and our independent subsidiaries are continuously subject to state and federal regulatory scrutiny, supervision and intervention in the ordinary course of business. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine. In addition to being subject to regulatory oversight from state and federal agencies, the skilled nursing and post-acute care industry is also subject to regulatory requirements which, if noncompliance is identified, could result in civil, administrative or criminal fines, penalties or restitutionary relief, and/or reimbursement; authorities could also seek the suspension or exclusion of a provider or individual from participation in State and Federal healthcare programs. We believe that there has been, and will continue to be, an increase in governmental investigations of post-acute providers, particularly in alleged Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse determinations in civil legal proceedings or governmental investigations, whether currently asserted or arising in the future, could have a material adverse effect on our financial position, results of operations, and cash flows. Additionally, such proceedings and/or investigations can be a distraction to the business of our independent subsidiaries.

We, on behalf of our independent subsidiaries, received a Civil Investigative Demand (CID) from the U.S. Department of Justice (DOJ) in January of 2024 indicating that the DOJ is investigating the Company to determine whether claims have been submitted to Medicare and Texas Medicaid for services which were unnecessary or otherwise not consistent with existing reimbursement requirements. The CID covers the period from January 1, 2016 to the present. As a general matter, our independent subsidiaries maintain policies and procedures to promote compliance with all applicable Medicare and Medicaid requirements, including but not limited to those relating to the presentation of claims for reimbursement for services provided. We are fully cooperating with the DOJ in response to the CID. However, we cannot predict the outcome of the investigation or its potential impact on the consolidated financial statements.

In addition to the potential lawsuits and claims described above, we and our independent subsidiaries are also subject to potential lawsuits under the FCA and comparable state laws alleging the submission of fraudulent claims for services to any Federal and State healthcare program (such as Medicare or Medicaid). A violation may provide the basis for exclusion from federally funded healthcare programs. Such exclusions could also have a correlative negative impact on our financial performance. In addition, and pursuant to the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the Federal government, and receive a percentage of any recovery obtained. Due to these whistleblower incentives, qui tam lawsuits have become more frequent.

For example, on May 31, 2018, we, on behalf of our independent subsidiaries, received a CID from the DOJ stating that it was investigating to determine whether there had been a violation of the FCA and/or the Anti-Kickback Statute (AKS) with respect to the relationships between certain of our independent subsidiaries and persons who serve or have served as medical directors. We fully cooperated with the DOJ and promptly responded to its requests for information. In April 2020, we were advised that the DOJ declined to intervene in any subsequent action filed in connection with the subject matter of this investigation. Despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its previously issued CID, the involved qui tam relator moved forward with the complaint in December 2020. From that time until December 2023, and notwithstanding our success in early pre-trial motions, we continued to incur legal defense costs and fees. In 2024, we entered into mediation with the involved parties and agreed to settle the civil case for \$48.0 million. Following the finalization of the settlement documents and payment of the settlement funds, the qui tam complaint was dismissed and the matter was fully resolved. The settlement does not include admissions on the part of the Company or our independent subsidiaries, and we maintain that we have consistently complied with and continue to comply with all applicable State and Federal statutes (including but not limited to the FCA and the AKS).

In addition to the FCA, some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. Further, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the FCA. As such, we and our independent subsidiaries could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets where our independent subsidiaries do business.

Under the Fraud Enforcement and Recovery Act of 2009 (FERA), health care providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government can argue, therefore, that an FCA violation can occur without any affirmative fraudulent action or statement, if the action or statement is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories. We and our independent subsidiaries have been subjected to, and/or are currently involved in, class action litigation alleging violations (alone or in combination) of state and federal wage and hour law related to the alleged failure to pay wages, to timely provide and compensate meal and rest breaks, and other such similar causes of action. For example, in 2025, we agreed to settle substantially all alleged wage, hour or labor code-related violations asserted on a class or representative basis against our independent subsidiaries in California for purported violations occurring during the six year period ending December 2025, for \$12.0 million, pending court approval. While we have been able to settle or otherwise resolve many of these types of claims without an ongoing material adverse effect on our business, a significant increase in the number of these claims, or an increase in the amounts owed should plaintiffs be successful in their prosecution of remaining or future claims, could materially adversely affect our business, financial condition, results of operations and cash flows.

We and our independent subsidiaries have been, and continue to be, subject to claims, findings and legal actions that arise in the ordinary course of the various businesses, including in connection with the delivery of healthcare and non-healthcare services. These claims include but are not limited to potential claims related to patient care and treatment (professional negligence claims). These claims could impact our ability to procure insurance to cover our exposure related to the various services provided by our independent subsidiaries to their residents, customers and patients.

From time to time, various state or Federal agencies may issue requests for information, including but not limited to a subpoena. As an example, OHCA is currently conducting a CMIR with respect to specific components of a proposed transaction involving three of our independent subsidiaries in California. We provided OHCA with requested information regarding specific components of the proposed transaction as part of the CMIR. We have been unable to effect resolution including attempts to narrow the scope, and limit the requests to our independent subsidiaries operating in California. We have filed a Petition in the Superior Court of the State of California, County of Orange, seeking a declaration that the CMIR regulations violate the United States Constitution and/or the California Constitution, and is void and unenforceable as applied to us. We also have requested that OHCA be ordered to withdraw the subpoena and close the inquiry, so the underlying transaction can be completed.

Both government and private pay sources have instituted cost-containment measures designed to limit payments made to providers of healthcare services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect us.

**Medicare Revenue Recoupments** — We and our independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments resulting from reviews conducted via RAC, and various Program Safeguard Contractors and Medicaid Integrity Contractors (collectively referred to as Reviews). Reviews vary in claim selection size and processes, ranging from a single episode/claim to larger, multi-claim batches; and from single rounds of review to reviews of multiple rounds with pass/fail criteria. If an operation has a significant error or fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. We anticipate that these Reviews could increase in frequency in the future. As of March 31, 2026, and through the filing date of this report, 22 of our independent subsidiaries had multi-claim Reviews scheduled or in process.

## Item 1A. RISK FACTORS

We are providing the following summary of the risk factors contained in our Form 10-Q to enhance the readability and accessibility of our risk factor disclosures. We encourage our stockholders to carefully review the risk factors contained in this Form 10-Q in their entirety for additional information regarding the risks and uncertainties that could cause our actual results to vary materially from recent results or from our anticipated future results.

### *Risks Related to our Business and Industry*

- The rules of Medicare and Medicaid, including reductions of reimbursement rates, changes to spending requirements, data reporting, measurement and evaluation standards could have a material, adverse effect on our revenues, financial condition and results of operations.
- State-level direct spending requirements could negatively impact our results of operations.
- Changes to the U.S. healthcare system, both at a state and federal level, including recent regulations, new transparency and disclosure requirements, and potential spending levels, continue to impose new requirements upon us that could materially impact our business.
- Anticipated changes in the U.S. political environment, including those as a result of the current Presidential administration and Congress, potential changes in control of one or both houses of Congress due to mid-term elections to occur in November 2026, and to regulatory agencies, particularly HHS, may result in significant changes to regulatory framework, enforcements, reimbursements and our business.
- We are subject to various government reviews, audits and investigations that could adversely affect our business, including an obligation to refund amounts previously paid to us, potential criminal charges, loss of licensure, the imposition of fines and sanctions.
- We are subject to extensive and complex laws and government regulations. If we are not operating in compliance with these laws and regulations or if these laws and regulations change, we could be required to make significant expenditures or change our operations in order to bring our facilities and operations into compliance.
- Public and government calls for increased enforcement efforts toward SNFs, past and potential rulemaking that results in enhanced enforcement and penalties, and new guidance for surveyors regarding the review of SNFs and enforcement of their Requirements of Participation, could result in increased scrutiny by state and federal survey agencies, including sanctions that could negatively affect our financial condition and results of operations.
- CMS's changes to the SFF program and its look-back period may create greater risk of our facilities being subject to this program and subject to potential fines and sanctions, even after graduating from the SFF program.
- Future cost containment initiatives undertaken by payors may limit our revenue and profitability.
- Reductions in reimbursements for physician and non-physician services could impact reimbursement for medical professionals.
- We may be subject to increased investigation and enforcement activities related to HIPAA violations.
- Security breaches and other cyber-security incidents could violate security laws and subject us to significant liability.
- If our independent subsidiaries are not fully reimbursed for all services for which each facility bills through consolidated billing, our revenue, financial condition and results of operations could be adversely affected.
- Increased competition for, or a shortage of, nurses and other skilled personnel, could increase our staffing and labor costs and subject us to monetary fines resulting from a failure to maintain minimum staffing requirements under state law, or may affect reimbursement.
- Annual caps, uncertainty regarding reimbursement and other cost-reductions for outpatient therapy services may reduce our future revenue and profitability or cause us to incur losses.
- Increased scrutiny of our activities and billing practices by the OIG or other regulatory authorities may result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.
- State efforts to regulate or deregulate the healthcare services industry or the construction or expansion of healthcare facilities could impair our ability to expand our operations, or could result in increased competition.
- Newly enacted legislation in the States where our independent subsidiaries are located may impact the volume and exposure in claims filed and the overall cost of those cases from a defense and indemnity standpoint.
- Changes to federal and state employment-related laws and regulations could increase our cost of doing business.
- Required regulatory approvals could delay or prohibit transfers of our healthcare operations, which could result in periods in which we are unable to receive reimbursement for such properties.
- Compliance with federal and state fair housing, fire, safety, staffing, and other regulations may require us to incur unexpected expenses, which could be costly to us.
- Our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our independent subsidiaries as well as payor mix and payment methodologies.
- We are subject to litigation that could result in significant legal costs and large settlement amounts or damage awards. Similarly, a change in the enforceability of arbitration provisions between SNFs and senior living facilities and residents and patients may affect the risks we face from claims and potential litigation.

- If our regular internal investigations into the care delivery, recordkeeping and billing processes of our independent subsidiaries detect instances of noncompliance, efforts to correct such non-compliance could materially decrease our revenue.
- The OHCA CMIR has the potential to delay, and ultimately prevent, proposed transactions and require disclosure of confidential information.
- We may be unable to complete future facility or business acquisitions at attractive prices or at all, or may elect to dispose of underperforming or non-strategic independent subsidiaries, either of which could decrease our revenue.
- We may not be able to successfully integrate acquired facilities and businesses into our operations, or we may be exposed to costs, liabilities and regulatory issues that may adversely affect our operations.
- In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations.
- If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar monitoring activities, which frequently change, our business may be negatively affected.
- If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected, and our self-insurance programs may expose us to significant and unexpected costs and losses.
- The geographic concentration of our independent subsidiaries could leave us vulnerable to economic downturn, regulatory changes or acts of nature in those areas.
- The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.
- The risks associated with leased property where our independent subsidiaries operate could adversely affect our business, financial position or results of operations.
- Failure to generate sufficient cash flow to cover required payments or meet operating covenants under our long-term debt, mortgages and long-term operating leases could result in defaults under such agreements and cross-defaults under other debt, mortgage or operating lease arrangements, which could harm our independent subsidiaries and cause us to lose facilities or experience foreclosures.
- A continued housing slowdown or housing downturn could decrease demand for senior living services.
- As we continue to acquire and lease real estate assets, we may not be successful in identifying and consummating these transactions.
- As we expand our presence in other relevant healthcare industries, we would become subject to risks in a market in which we have limited experience.
- If our referral sources fail to view us as an attractive skilled nursing provider, or if our referral sources otherwise refer fewer patients, our patient base may decrease.
- We may need additional capital to fund our independent subsidiaries and finance our growth, and we may not be able to obtain it on terms acceptable to us, or at all, which may limit our ability to grow.
- Delays in reimbursement may cause liquidity problems.
- The utilization and expansion of managed care organizations may contribute to delays or reductions in our reimbursement, including Managed Medicaid.
- Compliance with the regulations of the Department of Housing and Urban Development may require us to make unanticipated expenditures which could increase our costs.
- Failure to safeguard our patient trust funds may subject us to citations, fines and penalties.
- We are a holding company with no operations and rely upon our multiple independent subsidiaries to generate revenue.
- Our implementation of a new enterprise resource planning (ERP) system may adversely affect our business and results of operations or the effectiveness of our internal controls over financial reporting.
- Certain directors who serve on our Board of Directors also serve as directors of Pennant, and ownership of shares of Pennant common stock by our directors and executive officers may create, or appear to create, conflicts of interest.
- Standard Bearer's failure to remain qualified as a REIT may cause it to be subject to U.S. federal income tax. Additionally, legislative or other actions affecting REITs could have a negative effect on Standard Bearer.
- Failure to comply with existing environmental laws could result in increased expenditures, litigation and potential loss to our business and in our asset value.

#### ***Risks Related to Ownership of our Common Stock***

- We may not be able to pay or maintain dividends and the failure to do so would adversely affect our stock price.
- Our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law contain provisions that could discourage transactions resulting in a change in control, which may negatively affect the market price of our common stock.

## Risks Related to Our Business and Industry

***The rules of Medicare and Medicaid, including reductions of reimbursement rates, changes to spending requirements, data reporting, measurement and evaluation standards could have a material, adverse effect on our revenues, financial condition and results of operations.***

We derived 24.3% and 24.7% of our service revenue from the Medicare programs for the three months ended March 31, 2026 and 2025, respectively. In addition, many other payors may use published Medicare rates as a basis for reimbursements. Accordingly, if Medicare reimbursement rates are reduced or fail to increase as quickly as our costs, if there are changes in the rules governing the Medicare program that are disadvantageous to our business or industry, or if there are delays in Medicare payments, our business and results of operations will be adversely affected.

The Medicare program and its reimbursement rates and rules are subject to frequent change, including statutory and regulatory changes, rate adjustments (including retroactive adjustments), annual caps that limit the amount that can be paid (including deductible and coinsurance amounts), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. See Item 2., under *Government Regulation, Sequestration of Medicare Rates*, for further information. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenue and operating margins.

Additionally, payments can be delayed or declined due to determinations that certain costs are not reimbursable or reasonable because either adequate or additional documentation was not provided or because certain services were not covered or considered medically necessary. Additionally, revenue from these payors can be retroactively adjusted after a new examination during the claims settlement process or as a result of post-payment audits. New legislation and regulatory proposals could impose further limitations on government payments to healthcare providers.

CMS often changes the rules governing the Medicare program, including those governing reimbursement. Changes to the Medicare program that could adversely affect our business could include, but are not limited to the following:

- administrative or legislative changes to base rates or the bases for payment, including changes to the rates at which Medicare will reimburse services, including the imposition of, and periodic delay in imposing, reductions in reimbursement based on the sequestration of Medicare reimbursement;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- changes in methodology for patient assessment and/or determination of payment levels;
- the reduction or elimination of annual rate increases, implementation of reimbursement decreases, or the end of the reduced payments deferment (See also, Item 2., under *Government Regulation*); and
- an increase in co-payments or deductibles payable by beneficiaries.

Among the changes being implemented by CMS are provisions of the IMPACT Act, which imposes a stringent timeline for implementing benchmark quality measures and data metrics across facilities that include SNFs. The enactment mandates specific actions to design a unified payment methodology for post-acute providers, which CMS implements through ongoing regulations. The costs of final implementation may be significant, with potential fines and payment reductions resulting from a failure to meet CMS's implementation requirements. The current Presidential Administration, whether through executive orders or through the actions of HHS, may take additional actions through rulemaking, priority-setting and other exercises of discretion that may materially affect our business in ways that cannot presently be foreseen.

Reductions in reimbursement rates or the scope of services being reimbursed could have a material, adverse effect on our revenue, financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating costs. Although the FY 2027 PPS proposes an overall increase in SNF reimbursement rates, the proposed rule also sets forth provisions that, if finalized and implemented in future fiscal years, would expand the data that must be reported as part of the QRP, shortens the time for reporting, and require the reduction of reimbursements to SNFs participating in the VBP during FY 2027. In addition, CMS may make future adjustments to reimbursement levels and underlying reimbursement formulae as it continues to monitor the impact of current payments system on patient outcomes and budget neutrality. Previous Presidential Administrations focused on studying the nursing home industry and directed HHS to issue proposed rules based on those studies, including changes to SNF facility reimbursement and specifically, the SNF VBP Program, which may also adversely affect our reimbursement. The current Presidential Administration's policy directives and priorities regarding the nursing home industry and SNFs in particular are not yet fully known. As of July 4, 2025, Congress passed and the current Presidential Administration signed into law the OBBB, which reversed and limited the efficacy of certain parts of the ACA, including expansion of the Medicaid program in participating states. Congress's passage of CAA 2026 and its signing into law also preserved certain telehealth flexibilities beneficial to our business and financial performance, and deferred sequestration of Medicare reimbursement rates.

The metrics potentially affecting our revenues and expenses in future government fiscal years include the SNF healthcare-associated infections (HAI) measurement, total nursing hours per resident day measures, and discharge to community - post acute care measure. The Interoperability Final Rule's implementation beginning in 2026, and to be completed by January 1, 2027, may also adversely affect our reimbursement paid through Medicare, specifically including Medicare Advantage.

Loss of Medicare reimbursement, or a delay or default by the government in making Medicare payments, would also have a material adverse effect on our revenue. Non-compliance with Medicare regulations exist, and any penalty, suspension, termination, or other sanction under any state's Medicaid program could lead to reciprocal and commensurate penalties being imposed under the Medicare program, up to termination or rescission of our Medicare participation and payor agreements as noted above.

A significant portion of reimbursement for skilled nursing services comes from Medicaid. In fact, Medicaid is our largest source of revenue, accounting for 44.8% of our revenue for both the three months ended March 31, 2026 and 2025, respectively., respectively. Medicaid is a state-administered program financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets, which has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending. Since a significant portion of our revenue is generated from our skilled nursing independent subsidiaries in California, Texas and Arizona, any budget reductions or delays in these states could adversely affect our net patient service revenue and profitability. Due to recent fluctuations in state budgets many of the states in which we operate (including those with current budget surpluses), are seeking to contain costs on Medicaid outlays for SNFs, and any such decline could adversely affect our financial condition and results of operations.

The Medicaid program and its reimbursement rates and rules are subject to frequent change at both the federal and state level, including through changes in laws, regulations, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which our services are reimbursed by state Medicaid plans or the amount of expense we incur.

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements commonly referred to as provider taxes. The OBBB's passage prohibits the imposition of new provider taxes or increase of existing provider taxes, except for intermediate care facilities and nursing homes. Under provider tax arrangements, states collect taxes from healthcare providers and then use the revenue to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the providers' total revenue. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. CMS's recent rulemaking to carry provisions of the OBBB into effect have made it more difficult for states to obtain waivers in enacting taxes on Medicaid-participating providers in order to fund that state's share of its Medicaid obligations. To the extent the Company operates in states that restructure or reduce provider tax programs to achieve compliance, supplemental Medicaid payments to the Company's skilled nursing facilities could be reduced, which could have a material adverse effect on the Company's revenues, results of operations, and financial condition.

The changes to the Medicaid program enacted in the OBBB limits avenues for states to generate Medicaid funding, and may limit who may qualify for Medicaid long-term care benefits. Additionally, states must conduct Medicaid eligibility redeterminations every six months, rather than annually, for individuals enrolled under Medicaid. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures or delays in eligibility or coverage could have a significant and adverse effect on states' Medicaid expenditures (e.g., California, Colorado, and Nevada), and as a result could have a material and adverse effect on our business, financial condition or results of operations.

Additionally, although the CAA 2026 extends telehealth waivers and flexibilities for SNFs and providers, uncertainty about their permanent status continues to create significant payment and reimbursement challenges.

As the initial telehealth waivers and flexibilities have remained in place over time, Congress has suggested making such waivers and flexibilities permanent through permanent legislation changing the Medicare Act. No amendment to existing law has occurred to make the telehealth waivers that were first granted during the PHE permanent, and the payment for telehealth continues to be addressed through periodic spending legislation passed by Congress (see *Proposed, Anticipated and Recently Issued Rulemaking and Administrative Actions*). The lack of formality making these telehealth flexibilities permanent through a change in law creates continued uncertainty around their future availability. During the government shutdown, certain telehealth services became non-reimbursable because they did not conform to pre-pandemic telehealth rules, requiring providers and suppliers to revert back to pre-pandemic operation models.

Based on this treatment of telehealth flexibilities through periodic spending bills and temporary rulemaking, rather than a permanent amendment of the Medicare Act, providers, SNFs, and our independent subsidiaries face difficult decisions about how to conduct their operations so that they may be reimbursed for their services provided to Medicare beneficiaries.

***State-level direct spending requirements could negatively impact our results of operations.***

Certain states where the Company operates have implemented direct spending requirements requiring SNFs to spend a portion of their revenue, particularly including Medicaid-derived revenue, on expenses directly relating to care. These spending requirements could affect our operational results and place the Company at higher risk of suffering non-compliance consequences, such as penalties, pay-backs, restrict admissions and/or operational/financial penalties.

For example, Washington state incorporates the costs of direct care, indirect care, and capital expenditures for SNF services in computing the State's Medicaid payments to nursing facilities. Using periodically updated calculations that account for factors including case acuity, fair market value of capital expenditures, inflation, and facility performance, Washington sets facility compensation so that the majority of Medicaid reimbursement paid to a skilled nursing facility is used for care-related activities, with limitations on how much a facility's reimbursement may increase from year to year. Washington state first adopted this care-based payment model in 2015 and has periodically updated it since, including in 2020, 2022, and 2023; it is expected that Washington will continue to amend this law in the future. For state fiscal year 2024, Texas requires all nursing facilities must show that a portion of funds paid to SNFs by Texas's Medicaid program, including both fee-for-service and managed care reimbursement, were expended for direct care activities, including direct care staff wages and benefits. For state fiscal year 2025, Texas replaced the previous spending requirement with the patient care expense ratio (PCER) which measures the proportion of a facility's Medicaid revenue that is spent on patient care expenses. The PCER is a financial accountability metric and will be reported annually. If our independent subsidiaries in Texas fail to meet the specified PCER thresholds, Texas may recoup Medicaid payments and persistent non-compliance may affect Medicaid participation.

In addition, California in the past has proposed bills that, if passed, would require nursing facilities to spend a stated percentage of revenue on direct patient-related services. While the most recent attempt by the California Assembly (Bill 1537) to impose direct spending requirements on SNFs has been placed in suspense with no action being taken, similar legislation in the future may seek to impose identical or analogous funding requirements for SNFs operating in California or other states.

***Reforms to the U.S. healthcare system, including new regulations under the ACA, continue to impose new requirements upon us that could materially impact our business.***

As discussed in greater detail in Item 2., under *Government Regulation*, the ACA has resulted in significant changes to our operations and reimbursement models for services we provide. CMS continues to issue rules to implement the ACA, including rules regarding the implementation of the anti-discrimination provisions and disclosure of SNF ownership, organization, management and the identity of the real property owners from which the SNF leases or subleases its operating space.

With the passage of the IRA in 2022, Congress expanded and supplemented the ACA, including through the continuation of federally funded insurance premium subsidies. This modification of the ACA by the IRA indicates that Congress may continue to change and expand the ACA in the future. Since the commencement of the current Presidential Administration in January of 2025, there have been executive actions and proposed legislation, including the enactment of the OBBB, which undoes or limits the effect of portions of the ACA, including its Medicaid expansion provisions. The OBBB's provisions may also affect the availability of Medicaid for potential beneficiaries due to work requirements, limit eligibility for our independent subsidiaries' services due to caps on home equity that may be disregarded for eligibility purposes and limit the reimbursement available for our services under Medicaid. These legislative changes, and the effects of the current Presidential Administration's executive orders, are not yet fully realized in terms of their effects on our business.

The efficacy of the ACA is the subject of much debate among members of Congress and the public and it has been the subject of extensive litigation before numerous courts, including the United States Supreme Court, with varying outcomes — some expanding and others limiting the ACA. If the ACA is repealed or any elements of the ACA that are beneficial to our business are materially amended or changed, as is the case under the OBBB as enacted, such as provisions regarding the health insurance industry, reimbursement and insurance coverage by payers, our business, operating results and financial condition could be harmed. Thus, the future impact of the ACA on our business is difficult to predict and its continued uncertain future may negatively impact our business.

While it is not possible to predict whether and when any such changes will occur, proposals discussed by the current Presidential Administration, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. The ACA continues to be a salient political topic and proposed changes to it may become the subject of campaign promises, litigation, administrative action, or legislation under the current Presidential Administration, and the Senate, where the Republican party now holds a majority of seats. In addition, even if the ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS, have a significant impact on the implementation of the provisions of the ACA. It is expected that the current Presidential Administration will make changes affecting the implementation and enforcement of the ACA, which could harm our business, operating results and financial condition. We have seen such changes with the current Presidential Administration's impacts to the Biden-Harris Administration's regulatory activity promulgating rules regarding anti-discrimination under Section 1557 of the ACA and rulemaking requiring SNFs to disclose their ownership and the ownership of service providers under Section 6101 of the ACA. It is not possible to know whether, when, or how any or all these regulations or their implementation will be changed, the manner in which any change may be effected, and the ultimate effects of such changes on our business. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

In 2023, CMS issued a final rule requiring SNFs to disclose certain information regarding their ownership and managerial relationships which was fully implemented in November of 2024. In furtherance of this rule, CMS requires all SNFs to revalidate certain information using CMS's newly promulgated SNF Attachment by January 1, 2026. However, CMS issued sub-regulatory guidance suspending the deadline for submitting this information indefinitely and did not set a new deadline for the submission; through the filing date of this report, this deadline remains suspended with no indication when it may be reimposed in the future. CMS may set a new deadline for the submission of this information in the future, with an unknown period of notice ahead of compliance. Nevertheless, these disclosure requirements, if put into effect in the future, are more invasive and comprehensive than the ownership information already disclosed through Medicare's Nursing Home Compare website. Refer to Item 2., under Government Regulation, for additional information. The breadth of disclosure required by this new rule may be adverse to our business interests and detrimental to our operations, revenue, and profitability and may have a chilling effect on investment due to the depth of the new reporting and transparency requirements. Similarly, California passed a comparable law requiring the disclosure of certain ownership and financial information for SNFs in 2021. On March 6, 2024, California's regulations implementing this law took effect, which may invite further scrutiny and potential legal action, whether by the state agencies or private parties, within California based on the information disclosed as required by this law and its enabling regulations.

We cannot predict what effect future reforms to the U.S. healthcare system will have on our business, including the demand for our services or the amount of reimbursement available for those services. However, it is possible these new laws may lower reimbursement or increase the cost of doing business and adversely affect our business.

***Anticipated changes in the U.S. political environment, including those as a result of the current Presidential administration and control of Congress, and to regulatory agencies, particularly HHS, may result in significant changes to regulatory framework, enforcements, reimbursements and our business.***

The current Presidential administration and control of Congress by the President's political party have resulted in changes that have caused, and will continue to cause, uncertainty with respect to legislation, regulation, implementation or repeal of laws and rules related to government health programs, including Medicare and Medicaid. This includes changes in health care payment through the CAA 2026, and more extensive changes to the Medicaid program contained in the OBBB and CMS's subsequent rulemaking discussed in Item 2., under *Government Regulation*, which could reduce Medicaid funds available for reimbursement, potentially limit the amount of reimbursement paid by Medicaid for our services, potentially limit our potential resident population, adversely affect potential residents' eligibility and ability to pay for services performed by our independent subsidiaries. Further, proposals regarding HHS and certain programs and regulations concerning health care, including Medicare, Medicaid, and the ACA, have indicated that the current Presidential administration seeks to make changes to these programs and laws.

On April 2, 2025, President Trump signed an executive order to impose a variety of tariffs on the global trading partners of the United States. In the months since then, the tariffs with various countries have been increased, decreased, paused, and been reinstated as part of a broader trade negotiation strategy that has caused uncertainty in various product markets. These tariffs have the potential to increase costs on goods that are imported into the United States. As it pertains to our independent subsidiaries, tariffs on medical supplies may lead to higher costs to providers and the federal government through the Medicare and Medicaid programs and may impact the formulas used to calculate federal reimbursements.

Changes to existing policies and rules regarding nursing facilities, including those recently instituted, in addition to anticipated new rule proposals, may result in significant regulatory changes, increased survey frequency and scope, and increased penalties for non-compliance. As a result of the current Presidential administration, we anticipate that there may be changes in legislative control and legislative priorities. As a result, future legislation may be proposed or passed that may adversely affect our business, operating results and financial condition. In addition, the U.S. political environment, as illustrated by the recent government shutdown, may also result in significant uncertainty regarding our business, operating results, and financial condition.

We continually monitor these developments in order to respond to the changing regulatory environment impacting our business. While it is not possible to predict whether and when any such changes will occur, specific proposals made by the current Administration or others in anticipation of mid-term elections in the U.S., including a repeal or material amendment of the ACA, potential cuts to the Medicare or Medicaid programs by Congress through the budget reconciliation process, or other laws affecting the provision of healthcare services, could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

***We are subject to various government reviews, audits and investigations that could adversely affect our business, including an obligation to refund amounts previously paid to us, potential criminal charges, the imposition of fines, and/or the loss of our right to participate in Medicare and Medicaid programs.***

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with the rules associated with these programs and related applicable laws and regulations, including our claims for payments submitted to those programs, which are subject to reviews by Recovery Audit Contractors, Zone Program Integrity Contractors, Program Safeguard Contractors, Unified Program Integrity Contractors, Supplemental Medical Review Contractors and Medicaid Integrity Contractors programs (collectively referred to as Reviews). In these Reviews, third-party firms engaged by CMS conduct extensive analysis of claims data and medical and other records to identify potential improper payments under the federal and state programs. The FY 2025 PPS introduced higher penalties that surveyors can impose on SNFs if they are found to be non-compliant with CMS's requirements for SNF participation in Medicare program. In addition, in 2023, CMS updated the survey resources and guidelines used both by CMS and state surveyors in evaluating our SNFs' compliance with federal participation requirements. These updates included new approaches for evaluating infection control procedures, reflecting recent changes in CMS's survey methodologies.

In 2022, CMS updated guidance for Phase 2 and 3 of the requirements of participation, discussed in greater detail in Item 2., under *Government Regulation*. The application of CMS's new guidance could result in more aggressive and stringent surveys, and potential fines, penalties, sanctions, or administrative actions taken against our independent subsidiaries. Also described in Item 2., under *Government Regulation*, the Interoperability Final Rule and its changes intended to facilitate data exchange between and among patients, providers, and payors, will be implemented beginning in 2026 and must be fully implemented by January 1, 2027. This rule and the greater access to and use of data between and among payors transmitting funds for state and federal healthcare programs, may also trigger additional scrutiny or review of facilities such as ours, and may adversely affect our reimbursement paid through state and federal programs including Medicaid.

CMS announced a new nationwide audit the "SNF 5-Claim Probe & Educate Review," in which the Medicare Administrative Contractors will review five claims from each of the facilities to check for compliance with PDPM billings, which could result in individual claim payment denials if errors are identified. All facilities that are not undergoing Targeted Probe and Educate (TPE) reviews, or have not recently passed a TPE review, will be subject to the nationwide audit.

Private payors also reserve the right to conduct audits. We believe that billing and reimbursement errors and disagreements are common in our industry, and thus we are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the process related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce. An adverse review, audit or investigation could result in:

- an obligation to refund amounts previously paid to us pursuant to the Medicare or Medicaid programs or from private payors, in amounts that could be material to our business;
- state or federal agencies imposing fines, penalties or other sanctions on us;
- temporary or permanent loss of our right to participate in the Medicare or Medicaid programs or one or more private payor networks;
- an increase in private litigation against us; and
- damage to our reputation in the geographies served by our independent subsidiaries.

Although we have always been subject to post-payment audits and reviews, more intensive “probe reviews” performed by Medicare administrative contractors in recent years appear to be a regular procedure with our fiscal intermediaries. All findings of overpayment from CMS contractors are eligible for appeal. With the exception of rare findings of overpayment related to objective errors in Medicare payment methodology or claims processing, we utilize all defenses reasonably available to us to demonstrate that the services provided meet all clinical and regulatory requirements for reimbursement.

In cases where claim and documentation review by a CMS contractor yields repeated unsatisfactory results, an operation can be subjected to protracted regulatory oversight. This CMS oversight may include education and sampling of claims, extended pre-payment review, referral of the operating business to recovery audit or integrity contractors, or extrapolation of an error rate to other reimbursement made outside of specifically reviewed claims. Ongoing failure to demonstrate improvement towards meeting all claim filing and documentation requirements could ultimately lead to Medicare decertification. As of March 31, 2026 and through the filing date of this report, 22 of our independent subsidiaries had multi-claim reviews scheduled or in process, either pre- or post-payment. We anticipate that these reviews could increase in frequency in the future.

Additionally, both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, SNFs. The focus of these investigations includes, among other things, billing and cost reporting practices; quality of care provided; financial relationships with referral sources; and the medical necessity of rendered services. For example, refer to the matter discussed in Part II., Item 1., *Legal Proceedings*.

If we should agree to a settlement of claims or obligations under Medicare statutes, the FCA, or similar federal or state statutes and related regulations, our business, financial condition and results of operations and cash flows could be materially and adversely affected, and our stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations and may also include our assumption of specific procedural and financial obligations going forward under a corporate integrity agreement or other arrangement with the government.

If the government or a court were to conclude that errors and deficiencies constitute criminal violations and/or that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable levels, we and certain of our officers might face potential criminal charges and civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we or some of the key personnel of our independent subsidiaries could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare.

If any of our independent subsidiaries is decertified or loses its licenses, our revenue, financial condition or results of operations would be adversely affected. In addition, the report of such issues at any of our independent subsidiaries could harm our reputation for quality care and lead to a reduction in the patient referrals to and ultimately a reduction in occupancy at these facilities. Also, responding to auditing and enforcement efforts diverts material time, resources and attention away from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings, regardless of whether we prevail on the underlying claim.

***We are subject to extensive and complex laws and government regulations. If we are not operating in compliance with these laws and regulations or if these laws and regulations change, we could be required to make significant expenditures or change our operations in order to bring our facilities and operations into compliance.***

We, along with other companies in the healthcare industry, are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

- licensure and certification;
- disclosure of ownership and affiliated parties;
- adequacy and quality of healthcare services;
- qualifications of healthcare and support personnel;
- state-specified mandates for specific nurse staffing levels;
- quality and maintenance of medical services equipment and facilities;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources and recipients;
- constraints on protective contractual provisions with patients and third-party payors;

- operating policies and procedures;
- addition of facilities and services; and
- billing for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we conduct our business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to frequent change. CMS's ownership transparency rule, which was fully implemented by November of 2024, and similar state disclosure requirements such as California's, discussed in Item 2., under *Government Regulation*, may provide an additional basis for further investigation, administrative action and ultimately fines, penalties, or sanctions if finalized, and may dissuade parties from working with us or our independent subsidiaries due to the reporting and disclosure obligations of being an Additional Disclosable Party under that final rule.

We believe that such regulations may adversely affect our business, operation and profitability. The quantity and scope of these regulations may increase in the future, and we cannot predict the ultimate content, timing or impact on us of any healthcare reform legislation. If we fail to comply with these applicable laws and regulations, or their interpretations as determined by courts or enforced by regulators, we could suffer civil or criminal penalties and other detrimental consequences, including denial of reimbursement, imposition of fines, temporary suspension of admission of new patients, suspension or decertification from the Medicaid and Medicare programs, restrictions on our ability to acquire new facilities or expand or operate existing facilities, the loss of our licenses to operate and the loss of our ability to participate in federal and state reimbursement programs. Additionally, in the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses.

As discussed in greater detail in Item 2., under *Government Regulation*, we are subject to federal and state laws intended to prevent healthcare fraud and abuse. Possible sanctions for violation of any of these laws and regulations include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations, refund payments to the government, enter into a corporate integrity agreement, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

These anti-fraud and abuse laws and regulations are complex, and we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. While we do not believe we are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing these prohibitions will not assert that we are violating the provisions of such laws and regulations.

We are unable to predict the future course of federal, state and local regulation or legislation, including as it pertains to Medicare, Medicaid, or fraud and abuse laws, and how they are enforced. Changes in the regulatory framework, our failure to obtain or renew required regulatory approvals, credentials, qualifications, or licenses or to comply with applicable regulatory requirements, or the imposition of other enforcement sanctions, fines or penalties could have a material adverse effect upon our business, financial condition or results of operations. Furthermore, should we lose licenses or certifications for a number of our facilities or other businesses as a result of regulatory action or legal proceedings, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness.

***Public and government calls for increased survey and enforcement efforts toward SNFs, past and potential rulemaking that results in enhanced enforcement and penalties, could result in increased scrutiny by state and federal survey agencies. In addition, potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.***

CMS's efforts to enhance its enforcement powers and increase enforcement activities towards SNFs, as discussed in Item 2., under *Government Regulation*, result in state survey agencies having more accountability for their survey and enforcement efforts. Within the FY 2025 PPS, CMS obtained greater ability to impose monetary penalties upon SNFs for incident-based and day-based violations of CMS's conditions of participation. Further, the enhanced penalties against SFFs under the Biden-Harris Administration represented further federal calls for transparency, oversight and penalties for low-ranked and underperforming SNFs. These policies may prove to be popular, effective, or otherwise desirable and might not change with a new Presidential Administration, including under new leadership of HHS and CMS. These enhanced penalties and enforcement activities precedes greater focus by CMS in obtaining oversight over SFFs, and continuing that oversight even after those SFFs improve as recommended by the OIG in its October 24, 2025 report and recommendations regarding the SFF program, and subjecting them to more exacting and routine oversight. The likely result may be more frequent surveys of our independent subsidiaries, with more substantial penalties, fines and other consequences if they do not perform well.

For low-performing facilities in the SFF program, the standards for successfully emerging from that program and not being subject to ongoing and enhanced government oversight will be higher and measured over a longer period of time, prolonging the risks of monetary penalties, fines and potential suspension or exclusion from the Medicare and Medicaid programs.

From time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. CMS's updated guidance to these surveyors incorporate recent changes to CMS's methods for surveying infection control procedures. Additionally, CMS's rule requiring disclosure of ownership and financial relationships between nursing facilities and property owners or management entities, which now carries new requirements for re-certification that have been delayed in implementation and may take effect at a future, yet-unknown date, as well as other state rules over ownership transparency, may provide an additional basis for further investigation, administrative action, and ultimately fines, penalties, or sanctions and could dissuade individuals and businesses from doing business with us or our independent subsidiaries.

Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility. These remedial actions could result in the imposition of fines, imposition of a license to a conditional or provisional status, suspension or revocation of a license, suspension or denial of payment for new admissions, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including criminal penalties. In the past, we have experienced inspection deficiencies that have resulted in the imposition of a provisional license and could experience these results in the future.

Furthermore, in some states, citation of one independent subsidiary could negatively impact other independent subsidiaries in the same state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew, or maintain, existing licenses at other facilities, which may also trigger defaults or cross-defaults under our leases and our credit arrangements, or adversely affect our ability to operate or obtain financing in the future. CMS's rules requiring disclosure of ownership, management and the owners of real property lessors or sublessors, which are greater and more intrusive than existing disclosure requirements heighten this risk. Our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations.

From time to time, we have opted to voluntarily stop accepting new patients pending completion of a revisit survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements. If we elect to voluntarily close any operations in the future or to opt to stop accepting new patients pending completion of a state or federal survey, it could negatively impact our financial condition and results of operation.

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our independent subsidiaries. We have had independent subsidiaries placed on SFF status in the past and other independent subsidiaries may be identified for such status in the future. We currently have one facility placed on SFF status.

***CMS's changes to the SFF program and its look-back period may create greater risk of our facilities being subject to this program and subject to potential fines and sanctions, even after graduating from the SFF program.***

As discussed in greater detail in Item 2., under *Government Regulation*, in 2022 CMS updated the SFF program with the intent to reduce the amount of time a SNF spends as an SFF and increase the number of nursing homes that progress through the SFF program. The OIG has been studying the SFF program, including its 2022 updates, to understand the program's outcomes, identify factors that aided SFFs that successfully graduated the SFF program with sustained quality improvements, and make further changes based on the data obtained in this study. In June of 2024, the OIG added the SFF program to its Work Plan for continued attention. CMS clarified certain details of the SFF program updates in 2023 and how they are to be implemented by each state survey agency (SA). As part of the revisions to the SFF program, a priority in revising the SFF program was to address "yo-yo" noncompliance of SNFs that would graduate from the SFF program only to later see their compliance and quality measures regress after graduation, potentially requiring readmission to the SFF program. Among the measures implemented to avoid this issue of "yo-yo" noncompliance was a three-year look-back period for facilities that graduate from the SFF program to ensure that the quality and compliance improvements achieved through the SFF program were sustained.

On January 28, 2026, CMS updated its guidance for the SFF program to place greater emphasis on the prevalence of resident falls when selecting facilities for inclusion in the program. As a result, CMS will prioritize falls-related data, rather than staffing metrics, when evaluating comparable facilities recommended by state survey agencies for participation in the SFF program. The January 2026 guidance also enhances program oversight by making inspections less predictable, including requiring life safety code and emergency preparedness surveys to be conducted at least annually, with other surveys occurring more frequently as determined by CMS or the applicable state surveying agency.

The SFF program's lookback period and focus on maintaining a high level of improvement over time are consistent with the OIG's findings regarding the need for greater oversight to sustain improved outcomes at facilities that graduate from the SFF program. Facilities that graduate from the SFF program but continue to demonstrate poor compliance as evidenced by any SA's survey, such as for actual harm, substandard quality of care, or immediate jeopardy deficiencies, may be subject to enhanced enforcement by CMS, up to and including termination from the Medicare and/or Medicaid programs.

This three-year look-back for sustained improvements by facilities that graduate the SFF program poses risk for our independent subsidiaries, specifically those that may be subject to the SFF program or that have been subject to the SFF program in the past. As of March 31, 2026 and through the filing date of this report, we have one facility that graduated from the SFF program within the past three years. First, for SNFs that are selected by CMS for participation in the SFF program, or which currently are in the SFF program, even graduation from the program is no longer an assurance that the SNF will be able to continue its operations. Even one survey with a significant compliance deficiency, such as actual harm or an immediate jeopardy deficiency, may result in CMS—acting solely within its discretion—terminating the SNF's Medicare or Medicaid participation, likely triggering the termination of other payor contracts and rendering the facility economically unviable. Second, for SNFs that have graduated from the SFF program, they are subject to a three-year period of enhanced scrutiny where adverse findings by a SA and a single survey's finding of poor compliance may result in CMS discretionally terminating that facility's Medicare and/or Medicaid participation, which would likely cause other payors to terminate their agreements with the facility as well. As a result, the financial and manpower resources needed for graduation from the SFF program may be for nothing if, in the three years following graduation from the SFF program, a SNF receives a poor survey result and CMS imposes fines and penalties up to the termination of the facility's Medicare and Medicaid participation.

As discussed above, Medicare and Medicaid represent significant sources of payment for our independent subsidiaries. Any of our facilities' loss of a Medicare or Medicaid contract would significantly harm the financial performance of that facility. Additionally, if CMS perceived there to be common upstream ownership of multiple facilities that were participants in or graduates of the SFF program, CMS may seek to take enforcement actions against those other facilities due to their common ownership based on another facility's deficiencies after graduating the SFF program, with CMS imposing penalties up to and potentially including termination of those SNFs' participation in the Medicare and/or Medicaid programs.

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

Our non-Medicare and non-Medicaid revenue and profitability are affected by continuing efforts of third-party payors to maintain or reduce costs of healthcare, such as by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. In addition, sustained unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates.

Third-party payors may not make timely payments for our services, and we may be unable to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare and non-Medicaid sources of revenue and any changes in payment levels from current or future third-party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

***Reductions in Medicare reimbursements for physician and non-physician services could impact reimbursement for medical professionals.***

As discussed in greater detail in Item 2., under *Government Regulation*, MACRA revised the payment system for physician and non-physician services. The changes to the therapy caps imposed on Medicare Part B outpatient therapy from this law have been changed by the BBA and are subject to future budgetary changes through rulemaking and legislation, resulting in ongoing uncertainty regarding payment for these Medicare Part B services. Under both the CY 2024 and CY 2025 PFS, reductions in conversion factor, payments to providers and conditions imposed in exchange for higher payments may impose operational requirements and working conditions that further detract from and reduce our financial performance. However, the CY 2026 PFS finalized an increase in conversion factors, which may continue in the CY 2027 PFS based on spending levels contained in the CAA 2026. Although there may be relief from the recent reductions in reimbursement in the future, such regulatory relief does not guarantee increases will occur again in the future rulemakings, or that Congress will defer or limit the impact of cuts due to Medicare sequestration. Similarly, new final rules concerning the PACE program and the information it will collect from our independent subsidiaries may adversely affect the risk-adjusted reimbursement.

***We may be subject to increased investigation and enforcement activities related to HIPAA violations.***

HIPAA, as amended by the HITECH Act, requires us to adopt and maintain business procedures and systems designed to protect the privacy, security and integrity of patients' individual health information, in addition to state laws governing the privacy of patient information. We must comply with these state privacy laws to the extent that they are more protective of healthcare information or provide additional protections not afforded by HIPAA. The regulations enacting HIPAA periodically change and the last proposed change was issued in late 2022. In 2024, CMS published the Interoperability Final Rule, which affects the data standards and APIs that entities may use. Additionally, the 42 CFR Part 2 final rule issued in 2024 updating the separate confidentiality requirements for substance use disorder (SUD) records requires compliance by February 16, 2026. Changes to these regulations may require our independent subsidiaries to modify certain policies, procedures and practices regarding the disclosure of residents' information to the extent such records would be considered SUD records. If we fail to comply with these state and federal laws, we could be subject to criminal penalties, civil sanctions, litigation, and be forced to modify our policies and procedures, in addition to undertaking costly breach notification and remediation efforts, as well as sustaining reputational harm.

In addition to breaches of protected patient information, under HIPAA and the 21st Century Cures Act (Cures Act) and other federal regulations, healthcare entities are also required to afford patients with certain rights of access to their health information and to promote sharing of patient data between and among healthcare providers involved in the same patient's course of care. Recently, the Office for Civil Rights, the agency responsible for HIPAA enforcement, has targeted investigative and enforcement efforts on violations of patients' rights of access, imposing significant fines for violations largely initiated from patient complaints. If we fail to comply with our obligations under HIPAA, we could face significant fines. Likewise, if we fail to comply with our obligations under the Cures Act, we could face fines from the Assistant Secretary for Technology Policy (formerly known as the Office of the National Coordinator for Health Information Technology), the agency responsible for Cures Act enforcement.

***Security breaches and other cyber-security incidents could violate security laws and subject us to significant liability.***

Healthcare businesses are increasingly the target of cyberattacks whereby hackers disrupt business operations or obtain protected health information, often demanding large ransoms. For years, healthcare has been among the most-breached sector of the economy based on publicly disclosed information. This trend of healthcare as a vulnerable cybersecurity target continues in 2026 and is expected to remain a significant risk in the future. The frequency of this activity has increased precipitously over the last five years. Our business is dependent on the proper functioning and availability of our computer systems and networks. We cannot assure you that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations. Additionally, we cannot control the safety and security of our information held by third-party vendors with whom we contract. The techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect, and as such we (or third-party vendors) may be unable to anticipate these techniques or implement adequate preventive measures. In addition, hardware, software or applications we (or third-party vendors) develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise the security of information systems. Unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud or other forms of deception. Additionally, the rapid ongoing evolution and increased adoption of emerging technologies such as artificial intelligence and machine learning may make it more difficult to anticipate and implement protective measures to recognize, detect and prevent the occurrence of data breaches, including but not limited to cybersecurity breaches.

On occasion, we have acquired additional information systems through our business acquisitions, and these acquired systems may expose us to risk. We also license certain third-party software to support our operations and information systems. Our inability, or the inability of third-party vendors, to continue to maintain and upgrade information systems and software could disrupt or reduce the efficiency of our operations. In addition, costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our operations.

A cyber-attack or other incident that bypasses the security measures of our information systems could cause a security breach, which may lead to a material disruption to our information systems infrastructure or business, significant costs to remediate (e.g., data recovery) and may involve a significant loss of business or patient health information. If a cyber-attack or other unauthorized attempt to access our systems or facilities were successful, it could also result in the theft, destruction, loss, misappropriation or release of confidential information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cyber-attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties and could subject us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to, disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, FTC, OCR, the OIG or state attorneys general), fines, private litigation with those affected by the data breach (including class action litigation), loss of customers, disputes with payors and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations, liquidity, and stock price.

***We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations.***

SNFs are required to perform consolidated billing for certain items and services furnished to patients and residents. The consolidated billing requirement requires the SNF to effectively bill for the entire package of care that its patients receive in these situations. If more payments are required to be bundled in the future, this trend may continue, with our SNFs not receiving full reimbursement for all the services they provide, and have a further adverse effect on SNF utilization and revenue.

***Increased competition for, or a shortage of, nurses and other skilled personnel could increase our staffing and labor costs and subject us to monetary fines.***

Our success depends upon our ability to retain and attract nurses of all levels and other skilled personnel, such as Certified Nurse Assistants, social workers and speech, physical and occupational therapists, as well as skilled management personnel responsible for day-to-day facility operation. Each facility has a facility leader responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Depending upon the size of the facility, each facility leader is supported by facility staff who are directly responsible for day-to-day care of the patients, marketing and community outreach programs. Other key positions supporting each facility may include individuals responsible for physical, occupational and speech therapy, food service and maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

Our independent SNFs are located in the states of Alabama, Alaska, Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oregon, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. All states follow the current federal regulation relative to staffing, which establishes that SNFs are required to staff to meet the needs of the residents present in the facility. In addition, several states have established minimum staffing requirements for facilities operating in those states.

Failure to comply with these requirements can, among other things, jeopardize a facility's compliance with the conditions of participation under relevant state and federal healthcare programs. If a facility is determined to be out of compliance with these requirements, it may be subject to a notice of deficiency, a citation, or a significant fine or litigation risk, with penalties including the suspension of patient admissions and the termination of Medicaid participation, or the suspension, revocation or non-renewal of the SNF's license.

Nonetheless, for the federal government or any state government to materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly. The broader labor market where we compete is in a state of disequilibrium where the needs of businesses such as ours outstrip the supply of available and willing workers. There is additional upward pressure on wages from different industries and more generally due to the current rate of inflation. Some of these industries compete with us for labor and others that do not, which makes it difficult to make significant hourly wage and salary increases due to the fixed nature of our reimbursement under insurance contracts as well as Medicare and Medicaid (which may face challenges as a result of the enactment of the OBBB), in addition to our increasing variable costs. Due to the limited supply of qualified applicants who seek or are willing to accept employment, these broader concerns, may increase our labor costs or lead to potential staffing shortages, reduced operations to comply with applicable laws and regulations, or difficulty complying with those laws and regulations at current operational levels.

Laws and regulations may increase our costs of maintaining qualified nursing and skilled personnel, or make it more difficult for us to attract or retain qualified nurses and skilled staff members. Proposed legislation, such as the Nurses Belong in Nursing Homes Act and Safe Staffing Saves Lives Act, may make it more expensive to compete for, hire, and retain nursing staff, if passed into law in substantially the same form as previously introduced to Congress. Although the likelihood of the enactment of such legislation is unclear and the current administration's abandonment of implementation of any minimum staffing requirements, future presidential administrations may revive this concept and seek to restore that rule or impose new staffing rules that are equally or more stringent.

State-level staffing requirements in the states where our independent SNFs operate, whether such requirements are passed by statute, regulation, or executive order, may result in a shortage or inability to obtain nurses and skilled staff.

Increased competition for, or a shortage of, nurses or other trained personnel, or general ongoing inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. Recent changes in federal immigration policy have exacerbated these issues at all levels of the wage and skill spectrum. For example, the cost of a H-1B visa can be up to \$0.1 million which has changed the economic viability of a visa commonly used for skilled care providers to work in the United States and increasing the cost of engaging skilled labor from outside of the United States. This indirectly increases the wage pressure for skilled workers such as physicians and NPs eligible to work in the United States. Increased scrutiny of other visa types, such as H-4 visas and reviews of applicants' presence and activities on their social media accounts, has also affected the availability and ability to participate in the workforce by other workers who have provided care in other less-skilled positions. This, too, increases the cost of delivering care, reduces the pool of skilled and eligible workers, and like the issues posed by H-1B visa costs and competitiveness, may affect our operations, financial performance, and profitability. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from operation to operation and may adversely affect those operations' quality ratings based on data reported to CMS. In addition, state laws regarding minimum wage increases, such as California's minimum wage increases for both healthcare and fast-food workers, may intensify competition for unskilled labor in both skilled and unskilled settings. For skilled workers within the skilled care market where we operate, the costs of skilled labor, which are already greater than unskilled labor, could increase further. Similarly, the increased minimum wage of unskilled labor will not only increase the cost of unskilled labor but may also have effects that dissuade workers from training to join the skilled workforce to earn higher wage growth, resulting in a smaller pool of available skilled workers and further increased competition—and higher wages—for them. If we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations could be harmed.

***Annual caps and other cost-reductions for outpatient therapy services may reduce our future revenue and profitability or cause us to incur losses.***

As discussed in detail in Item 2., under *Government Regulation*, sub-heading *Part B Rehabilitation Requirements*, several government actions have been taken in recent years to try and contain the costs of rehabilitation therapy services provided under Medicare Part B, including the MPPR, institution of annual caps, mandatory medical reviews for annual claims beyond a certain monetary threshold, and a reduction in reimbursement rates. Of specific concern has been CMS efforts to lower Medicare Part B reimbursement rates for outpatient therapy services, which are reduced by 2.83% in the CY 2025 PFS. The CY 2026 PFS represents an effort to reverse this trend and increase payments for provider services, carrying into effect the provisions of the OBBB. Any future cost-containment measures and ongoing payment changes will likely have an effect on our revenue, whether positively or negatively depending on the trend of rulemakings going forward.

***The Office of the Inspector General or other regulatory authorities may choose to more closely scrutinize billing practices in areas where we operate or propose to expand, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.***

As discussed in greater detail in Item 2., under *Government Regulation*, Civil and Criminal Fraud and Abuse Laws and Enforcement, the OIG regularly conducts investigations regarding certain payment or compliance issues within the healthcare industry. The OIG continued to identify SNF compliance as an issue of concern in its 2025 semi-annual reports to Congress. The OIG's November 2025 report to Congress indicated that quality of resident care in nursing facilities was an enforcement concern for that office, and also identified SNFs that had failed to properly repay to HHS provider relief funds they had received during the COVID-19 PHE. In March of 2025, OIG found that, over a 3-year period, Medicare Part D improperly paid approximately \$465 million for drugs that should have been reimbursed under Medicare Part A through its SNF benefits. This issue was also added to the OIG's work plan, with a focus on SNFs' compliance with Medicare Part A billing requirements for drugs that the OIG found were improperly paid by Medicare Part D. In June 2024, the OIG continued to focus on SNFs, adding the SFF Program to its Work Plan. Among other things, the OIG recommended attention to the rate of reimbursement for professional services rendered within facilities. The OIG's reports to Congress have also recommended a reduction in the use of psychotropic drugs in nursing homes and urged CMS to evaluate the appropriateness of psychotropic drug use among residents, including the use of data to identify nursing homes with higher rates of use for potential further scrutiny and action. Based on this information, SNFs in particular are potential targets for more robust scrutiny and examination by regulators.

To respond to the local community needs and the shifting of higher acuity patients from the acute care setting to the SNF setting, over time our overall patient mix has consistently shifted to higher acuity and higher-resource utilization patients in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording activities of daily living services, among other things. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

***State efforts to regulate or deregulate the healthcare services industry or the construction or expansion of healthcare facilities could impair our ability to expand our operations, or could result in increased competition.***

Some states require healthcare providers, including SNFs, to obtain prior approval, known as a certificate of need, for: (1) the purchase, construction or expansion of healthcare facilities; (2) capital expenditures exceeding a prescribed amount; or (3) changes in services or bed capacity.

Other states that do not require certificates of need have effectively barred the expansion of existing facilities and the establishment of new ones by placing partial or complete moratoria on the number of new Medicaid beds those states will certify in certain areas or throughout the entire state. Still other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. In addition, some states require the approval of the state Attorney General for acquisition of a facility being operated by a non-profit organization. For example, in California a non-profit seller must provide written notice to the Attorney General detailing the proposed transaction. The Attorney General must then review the transaction and provide written consent (or conditional consent) before it can proceed to closing. The Attorney General's review often includes at least one public meeting to gather community input on the transaction's effects. An independent healthcare impact statement may be prepared to assess potential effects on the availability, accessibility, and affordability of healthcare services, including charity care levels, emergency services, and community benefits. The Attorney General has discretion to approve, conditionally approve, or deny the transaction.

Our ability to acquire or construct new facilities or expand or provide new services at existing facilities would be adversely affected if we are unable to obtain the necessary approvals, if there are changes in the standards applicable to those approvals, or if we experience delays and increased expenses associated with obtaining those approvals. We may not be able to obtain licensure, certificate of need approval, Medicaid certification, state Attorney General approval or other necessary approvals for future expansion projects. Conversely, the elimination or reduction of state regulations that limit the construction, expansion or renovation of new or existing facilities could result in increased competition to us or result in overbuilding of facilities in some of our markets. If overbuilding in the skilled nursing industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

***Newly enacted and proposed legislation in the States where our independent subsidiaries are located may affect our operations in terms of individual litigation and the broader regulatory environment.***

A bill in the State of California was signed into law which increases the cap of non-economic damages awarded to plaintiffs who are successful in medical malpractice litigation. The cap increases from \$0.25 million to \$0.35 million beginning on January 1, 2023, then increases over the following 10 years until the cap reaches a maximum of \$0.75 million, with further adjustments for inflation. In wrongful death cases, the cap increases from \$0.25 million to \$0.5 million on January 1, 2023, with incremental increases over the following 10 years until the cap reaches a maximum of \$1.0 million, with adjustments for inflation. Due to California's influence on other states, other jurisdictions where we operate have enacted similar laws (namely Iowa and Nevada) and may enact similar laws in the future. Similar to the potential incentive of increased damages caps, recent Supreme Court decisions may increase public interest in potential claims against SNFs and senior living facilities, particularly pertaining to specific civil rights claims against governmental actors rather than general liability claims against privately owned SNFs such as those operated by our independent subsidiaries. While there may be additional claims and litigation that arise from the Supreme Court's decision that have an adverse impact on our cash flow, it is not expected that the decision will have a significant impact on our business.

Another example, California's adoption of the Skilled Nursing Facility Ownership and Management Reform Act of 2022, discussed in Item 2., under *Government Regulation*, imposes new requirements for obtaining licenses to operate SNFs. These new requirements may delay or limit the ability to obtain new SNF licenses within that state, whether through acquisition of existing facilities or opening a new facility. This new law's obligations may increase the costs of obtaining licensure, make applications more time-consuming and complex, and may result in civil penalties and other sanctions against our independent subsidiaries in the event they are not compliant with these new licensure application requirements. As a result, this new law may delay or impede growth within California. As with the bill that increases the cap of non-economic damages for medical malpractice litigation, California's influence on other states may result in this legislation becoming a model for other states and having similar, potentially adverse effects within those jurisdictions as well.

Other new and proposed legislation may impose the same regulatory requirements and limitations inherent in both the proposed legislation in other states and the federally proposed rule requiring disclosure of such information in applications and change-of-ownership disclosures, which may adversely affect our business, operations, and profitability.

***Changes to federal and state employment-related laws and regulations could increase our cost of doing business.***

Our independent subsidiaries are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act that governs such matters as minimum wages, overtime and other working conditions and similar state laws such as the California Private Attorneys General Act (PAGA), the ADA and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the EEOC, regulations of the Office of Civil Rights, regulations of state attorney generals, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Changes to federal and state regulations and laws are discussed in more detail in Item 2., under *Government Regulation*.

The Biden-Harris Administration requested that HHS and CMS study and issue proposed rules regarding care-based careers, including improving access to training, increasing the attractiveness of compensation in care-based positions, and improving the retention and career progression of care workers. The current Presidential Administration, as well as new leadership of HHS or CMS, may discontinue these studies, discontinue ongoing rulemaking activity, and may pursue significantly different policy-setting and rulemaking priorities that do not include any of the Biden-Harris Administration's priorities. Simultaneously, certain actions taken under the Biden-Harris Administration, such as increased enforcement authority by HHS and CMS, may be retained and utilized by the current Presidential Administration and its new leaders of HHS and CMS. The current Presidential Administration has not clearly supported these priorities, but has not renounced support of them or communicated an affirmative reversal of course from these positions.

Other previously introduced legislation, such as the HCBS Access Act, reflects a legislative priority of providing funding for care-based careers that may affect our pool of desired workers. The OBBB's allowance for states to seek waivers allowing Medicaid to cover HCBS may also affect our business, and may signal a legislative and administrative preference for care outside of nursing facilities and other institutions, which may be obtained at a lower rate of reimbursement. Due to a change of political party control of both houses of Congress, though, other HCBS-related legislation may have a lower likelihood of passing, even if reintroduced in a subsequent congress. Rising operating costs due to labor shortages, greater compensation and incentives required to attract and retain qualified personnel and higher-than-usual inflation on items including energy, utilities, food and other goods used in our facilities and the costs for transporting these items could increase our operating cost and decrease our profits.

The compliance costs associated with these laws and evolving regulations could be substantial. By way of example, all of our independent subsidiaries are required to comply with the ADA, which has separate compliance requirements for “public accommodations” and “commercial properties,” but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law.

***Required regulatory approvals could delay or prohibit transfers of our healthcare operations, which could result in periods in which we are unable to receive reimbursement for such properties.***

The operations of our independent subsidiaries must be licensed under applicable state law and, depending upon the type of operation, certified or approved as providers under the Medicare and/or Medicaid programs. In the process of acquiring or transferring operating assets, our operations must receive change of ownership approvals from state licensing agencies, Medicare and Medicaid as well as third-party payors. Rules regarding the disclosure of SNF facility ownership when such disclosure is required in the future may increase the scrutiny placed on companies that operate, directly or indirectly, multiple SNFs, and may subject our licensing and approval process to additional scrutiny or delays. If there are any delays in receiving regulatory approvals from the applicable federal, state or local government agencies, or the inability to receive such approvals, such delays or denials could result in delayed or lost reimbursement related to periods of service prior to the receipt of such approvals, which could negatively impact our cash position.

***Compliance with federal and state fair housing, fire, safety and other regulations may require us to make unanticipated expenditures, which could be costly to us.***

We must comply with the federal Fair Housing Act and similar state laws, which prohibit us from discriminating against individuals if it would cause such individuals to face barriers in gaining residency in any of our independent subsidiaries. Additionally, the Fair Housing Act and other similar state laws require that we do not advertise our services in a way that may be discriminatory. We may be required, among other things, to change our marketing techniques to comply with these requirements.

In addition, our independent subsidiaries are required to operate in compliance with applicable fire and safety regulations, building codes and other land use regulations and food licensing or certification requirements as they may be adopted by governmental agencies and bodies from time to time. Like other healthcare facilities, our independent SNFs are subject to periodic surveys or inspections by governmental authorities to assess and assure compliance with regulatory requirements. Surveys occur on a regular (often annual or biannual) schedule, and special surveys may result from a specific complaint filed by a patient, a family member or one of our competitors. We may be required to make substantial capital expenditures to comply with these requirements. In some cases, we may be unable to comply with new regulations prior to their effective date exposing us to potential fines or regulatory action.

***We depend largely upon reimbursement from third-party payors, and our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our independent subsidiaries as well as payor mix and payment methodologies.***

Our revenue is affected by the percentage of the patients of our independent subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability. Changes to federal law affecting Medicaid funding and availability, including the enactment of the OBBB, may materially affect our business and the operations of our independent subsidiaries. We generally receive higher reimbursement rates for high acuity patients, and payors reimburse us at different rates. For the three months ended March 31, 2026 and 2025, 69.1% and 69.5% of our revenue was provided by government payors that reimburse us at predetermined rates, respectively. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of the patients of our independent subsidiaries for whom we receive Medicaid reimbursement, our results of operations may be adversely affected.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs may adversely affect our business. These tactics include contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services and we did not wish to accept such reductions, we may lose patients if we choose not to renew our contracts with these insurers at lower rates. Additionally, trade publications within the healthcare industry have reported on the trend of payors using the No Surprises Act as a means to force re-negotiation of reimbursement rates for providers and facilities, leading to litigation between these providers and/or facilities against payors and it may adversely affect us as well.

As discussed under Item 2., under *Government Regulation*, the Biden-Harris Administration requested HHS and CMS conduct studies to evaluate potential staffing, data reporting, employee compensation and retention, and resident experience regulations that may result in a reduction of our revenue from Medicare and Medicaid. CMS first requested information regarding these priorities in 2022 and subsequently published further requests for information from the public in the Federal Register to aid in studies and anticipated rulemaking. Following the change in Presidential Administration and control of the Senate, both the OBBB and changes in HHS legal priorities, including the abandonment of appeals defending the Staffing Rule and interim rulemaking to stop the Staffing Rule's staffing ratios from taking effect, have resulted in the Staffing Rule being unenforceable at this time and not likely to be pursued in the future. Other rules from the Biden-Harris Administration, such as increased ownership disclosure requirements, however, remain in effect despite CMS indefinitely suspending that rule's compliance deadline. The identification and pursuit of HHS priorities under the current Presidential Administration may continue to be unpredictable in the future. Certain results of the Biden-Harris Administration's rulemaking, including enhanced enforcement ability, may be retained under the current Presidential Administration, as signaled by its recent decision to prohibit pre-dispute agreements to arbitrate disputes in SNF admission agreements. We continue to monitor this area and look for public disclosures from the current Presidential Administration and expected heads of HHS and CMS to better anticipate what policy priorities and changes we can expect regarding Medicare and Medicaid reimbursement, including payment models and factors affecting our independent subsidiaries' reimbursement for the services they provide.

***We are subject to litigation that could result in significant legal costs and large settlement amounts or damage awards.***

The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents of our independent subsidiaries and the services we provide. The industry has experienced an increased trend in the number and severity of litigation claims, due in part to the number of large verdicts, including large punitive damage awards. These claims are filed based upon a wide variety of claims and theories, including deficiencies under conditions of participation under certain state and federal healthcare programs. Plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers, employing a wide variety of advertising and solicitation activities to generate more claims. The increased caps on damages awarded in such actions, as discussed above, may trigger a larger number of these lawsuits against our independent subsidiaries in California and other states that adopt similar legislation. The defense of lawsuits has in the past, and may in the future, result in significant legal costs, regardless of the outcome. Additionally, increases to the frequency and/or severity of losses from such claims and suits may result in increased liability insurance premiums or a decline in available insurance coverage levels, which could materially and adversely affect our business, financial condition and results of operations. In addition to carrying third-party liability insurance, our captive insurance subsidiary provides professional liability and general liability insurance to various independent subsidiaries. See the risk factor titled "*Our self-insurance programs may expose us to significant and unexpected costs and losses.*"

We have in the past been subject to class action litigation involving claims of violations of various regulatory requirements and been able to settle these claims without an ongoing material adverse effect on our business. Future claims could be brought that may materially affect our business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. For example, there has been a general increase in the number of wage and hour class action claims filed in several of the jurisdictions where we operate, typically based on alleged failures to permit or properly compensate for meal and rest periods, or failure to pay for time worked. If there were a significant increase in the number of these claims against us or an increase in amounts owing should plaintiffs be successful in their claims, this could have a material adverse effect on our business, financial condition, results of operations and cash flows.

We are subject to potential lawsuits under the FCA and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare or Medicaid) or other payor. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Due to these whistleblower incentives, qui tam lawsuits have become more frequent.

Beyond our skilled nursing business, we engage in numerous ancillary businesses through one or more of our subsidiaries. These ancillary businesses generally support and provide services complementary to our operations, including but not limited to non-emergent ground transportation for patients and residents. Our ancillary businesses may also be the subject of claims, lawsuits, and regulatory oversight that are specific to the particular services they offer. Noncompliance with the laws and regulations that may apply to our ancillary businesses may result in fines, penalties, and civil claims paid by our affected independent subsidiaries. Specific to our non-emergent ground transportation business, the drivers employed by this business may be subject to additional state-specific regulations regarding working time allowed to be spent driving, waiting time, and break or rest periods, and violations of these rules may lead to regulatory fines, penalties, or claims to be paid to individual drivers, in addition to the general employment risks described above.

Our ancillary businesses also are susceptible to general liability claims based on facts and circumstances that are specific to their activities and operations, such as claims for automobile-involved accidents against our non-emergent ground transportation business. The defense of claims and lawsuits relating to our ancillary businesses in the past, and may in the future, result in significant legal costs, regardless of the outcome. As our ancillary businesses grow, the independent subsidiaries may be subject to increased frequency and/or severity of losses from such claims and suits which may result in increased liability insurance premiums and decline in available coverage as described above, which could materially and adversely affect our business, financial condition and results of operations.

In addition, we contract with a variety of landlords, lenders, vendors, suppliers, consultants and other individuals and businesses. These contracts typically contain covenants and default provisions. If the other party to one or more of our contracts were to allege that we have violated the contract terms, we could be subject to civil liabilities which could have a material adverse effect on our financial condition and results of operations.

If litigation is instituted against one or more of our subsidiaries, a plaintiff might attempt to hold us or another subsidiary liable for the alleged wrongdoing of the subsidiary principally targeted by the litigation. If a court in such litigation decided to disregard the corporate form, the resulting judgment could increase our liability and adversely affect our financial condition and results of operations.

Prior to CMS's most recent action prohibiting binding pre-dispute arbitration provisions contained in admission agreements, Congress repeatedly considered, without passage, a bill that would require, among other things, that agreements to arbitrate nursing home disputes be made after the dispute has arisen rather than before prospective patients move in, to prevent nursing home operators and prospective patients from mutually entering into a pre-admission, pre-dispute arbitration agreement. This bill, known as the Fairness in Nursing Home Arbitration Act, was introduced in the House of Representatives in 2021; the bill and its analog introduced in the Senate have never made it out of the committees to which they were referred for discussion. The Fairness in Nursing Home Arbitration Act was re-introduced in the House of Representatives on January 29, 2024, and was referred to the Committee on Ways and Means and the Committee on Energy and Commerce. No action was taken in the prior Congress following referral of the bill to those committees.

Our independent subsidiaries have used arbitration agreements where permissible by law, which have generally been favored by the courts, to streamline the dispute resolution process and reduce our exposure to legal fees and excessive jury awards. CMS previously identified these arbitration agreements as an area of focus and issued guidance to state surveyors regarding federal requirements for the use of arbitration agreements in nursing home care, with non-compliance potentially resulting in fines and other sanctions. Absent some judicial or legislative intervention, or other ability to potentially resolve claims without the cost and unpredictability of a jury trial (for example, obtaining a jury trial waiver if and where permitted by state law), our litigation exposure and costs of defense in patient liability actions could increase, our liability insurance premiums could increase, and our business may be adversely affected.

The outcomes of any of these litigation matters are difficult to predict and litigation and other legal claims are subject to inherent uncertainties. Those uncertainties include, but are not limited to, litigation costs and attorneys' fees, unpredictable judicial or jury decisions and the differing laws and judicial proclivities regarding damage awards among the states in which we operate. A further complication is that even where the possibility of an adverse outcome is remote under traditional legal analysis, juries sometimes substitute their subjective views in place of facts and established legal principles. Unexpected outcomes in such legal proceedings, or changes in management's evaluation or predictions of the likely outcomes of such proceedings (possibly resulting in changes in established reserves) could have a material adverse effect on our business, financial condition, and results of operations.

***We conduct regular internal investigations into the care delivery, recordkeeping and billing processes of our independent subsidiaries. These reviews sometimes detect instances of noncompliance which we attempt to correct, which can decrease our revenue.***

As an operator of healthcare facilities through our independent subsidiaries, we have a program to aid them in complying with various requirements of federal and private healthcare programs. Our compliance program includes, among other things, (1) policies and procedures modeled after applicable laws, regulations, sub-regulatory guidance and industry practices and customs that govern the clinical, reimbursement and operational aspects of our subsidiaries; (2) training about our compliance process for all of the employees of our independent subsidiaries, our directors and officers, and training about Medicare and Medicaid laws, fraud and abuse prevention, clinical standards and practices, and claim submission and reimbursement policies and procedures for appropriate employees; and (3) internal controls that monitor, among other things, the accuracy of claims, reimbursement submissions, cost reports and source documents, provision of patient care, services, and supplies as required by applicable standards and laws, accuracy of clinical assessment and treatment documentation, and implementation of judicial and regulatory requirements (i.e., background checks, licensing and training).

From time to time our systems and controls highlight potential compliance issues, which we investigate as they arise. Historically, we have initiated, and will continue to do so in the future, internal inquiries into possible recordkeeping and related irregularities at our independent subsidiaries, which were detected by our internal compliance team in the course of its ongoing reviews.

Through these internal inquiries, we have identified potential deficiencies in the assessment of and recordkeeping for small subsets of patients. We have assisted in implementing targeted improvements in the assessment and recordkeeping practices to make them consistent with the existing standards and policies applicable to our independent subsidiaries. We continue to monitor the measures implemented for effectiveness and perform follow-up reviews to ensure compliance. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

If additional reviews result in identification and quantification of additional amounts to be refunded, we will accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course and within the time permitted by law. Failure to refund overpayments within required time frames (as described in greater detail above) could result in FCA liability and our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

***The OHCA CMIR has the potential to delay or prevent proposed transactions and require disclosure of confidential information.***

The California OHCA CMIR process may delay, and potentially ultimately prevent, the closing of certain proposed transactions. If a CMIR results in a negative finding and generates a referral to the California Attorney General, that could result in the parties not being able to conclude the proposed transaction and possibly require the subject facilities to appoint new managers. Any delay or prevention of completing transactions could have adverse effect on the operations of our independent subsidiaries. The risk of an adverse regulatory outcome, competitive harm, or potential legal action will persist until the CMIR is successfully concluded.

The CMIR process also seeks the disclosure of confidential information regarding our independent subsidiaries' reimbursement rates and financial performance. This information is subject to contractual confidentiality obligations and otherwise proprietary to our business and is likewise a source of competitive advantage in the marketplace. If this information is disclosed to, or otherwise obtained by OHCA, we anticipate that it will be publicly available and could provide competitors with otherwise unavailable data on the financial operations and reimbursement relationships of our independent subsidiaries.

We have filed a Petition in the Superior Court of the State of California, County of Orange, seeking a declaration that the CMIR regulations violate the United States Constitution and/or the California Constitution, and is void and unenforceable as applied to us. We have requested that OHCA be ordered to withdraw the subpoena and close the inquiry, so the underlying transaction can be completed.

***We may be unable to complete future asset or business acquisitions at attractive prices or at all, which may adversely affect our revenue; we may also elect to dispose of underperforming or non-strategic independent subsidiaries, which would also decrease our revenue.***

To date, our revenue growth has been significantly impacted by our acquisition of new facilities and businesses. Subject to general market conditions and the availability of essential resources and leadership within our company, we continue to seek both single-and multi-facility acquisition and business acquisition opportunities that are consistent with our geographic, financial and operating objectives.

We face competition for the acquisition of facilities and businesses and expect this competition to increase. Based upon factors such as our ability to identify suitable acquisition candidates, future regulations affecting our ability to purchase facilities, the purchase price of the facilities, increasing interest rates for debt-financed purchases, prevailing market conditions, the availability of leadership to manage new facilities and our own willingness to take on new operations, the rate at which we have historically acquired facilities has fluctuated significantly. In the future, we anticipate the rate at which we may acquire facilities will continue to fluctuate, which may affect our revenue.

We have also previously acquired a few operations, which were or have proven to be non-strategic or less desirable, and we may consider disposing of such operations or exchanging them for operations that are more desirable, either because they were included in larger, indivisible groups of operations or under other circumstances. To the extent we dispose of such an operation without simultaneously acquiring an operation in exchange, our revenue may decrease.

***We may not be able to successfully integrate acquired assets and businesses into our operations, and we may not achieve the benefits we expect from any of our acquisitions.***

We may not be able to successfully or efficiently integrate new acquisitions of assets and businesses with our existing independent subsidiaries, culture and systems. The process of integrating acquisitions into our existing operations may result in unforeseen operating difficulties, divert management's attention from existing operations, or require an unexpected commitment of staff and financial resources, and may ultimately be unsuccessful. Existing operations available for acquisition frequently serve or target different markets than those that we currently serve. We also may determine that renovations of acquired facilities and changes in staff and operating management personnel are necessary to successfully integrate those acquisitions into our existing operations. We may not be able to recover the costs incurred to reposition or renovate newly independent subsidiaries. The financial benefits we expect to realize from many of our acquisitions are largely dependent upon our ability to improve clinical performance, overcome regulatory deficiencies, rehabilitate or improve the reputation of the operations in the community, increase and maintain occupancy, control costs, and in some cases change the patient acuity mix. If we are unable to accomplish any of these objectives at the independent subsidiaries we acquire, we will not realize the anticipated benefits and we may experience lower than anticipated profits, or even losses.

During the three months ended March 31, 2026, we expanded our operations through a combination of a long-term lease and real estate purchases, with the addition of five stand-alone skilled nursing operations. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage operations we may acquire in the future. Also, the newly acquired operations may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such operations quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our acquisitions, and our business may suffer.

***In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations.***

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those businesses, against whom we may have little or no recourse. Many operations we have historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved independent subsidiaries and patient care, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status.

Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant operations into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, operations that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable.

In addition, we might encounter unanticipated difficulties and expenditures relating to any of the acquired operations, including contingent liabilities. For example, when we acquire operations, we generally assume the operation's existing Medicare provider number for purposes of billing Medicare for services. If CMS later determines that the prior owner of the operation had received overpayments from Medicare for the period of time during which it ran the operation, or had incurred fines, CMS could hold us liable for repayment of the overpayments or fines. We may be unable to improve every operation that we acquire. In addition, operation of these newly acquired operations may divert management time and attention from other operations and priorities, negatively impact cash flows, result in adverse or unanticipated accounting charges, or otherwise damage other areas of our company if they are not timely and adequately improved.

We also incur regulatory risk in acquiring certain facilities due to the licensing, certification and other regulatory requirements affecting our right to operate the acquired facilities. For example, in order to acquire facilities on a predictable schedule, or to acquire declining operations quickly to prevent further pre-acquisition declines, we frequently acquire such facilities prior to receiving license approval or provider certification. We operate such facilities as the interim manager for the outgoing licensee, assuming financial responsibility, among other obligations for the facility. To the extent that we may be unable or delayed in obtaining a license, we may need to operate the facility under a management agreement from the prior operator. Any inability in obtaining consent from the prior operator of a target acquisition to utilizing its license in this manner could impact our ability to acquire additional facilities. Further, anticipated future regulations may cause delays in acquiring the required licenses and certifications, if it is possible to do so at all. If we were subsequently denied licensure or certification for any reason, we might not realize the expected benefits of the acquisition and would likely incur unanticipated costs and other challenges which could cause our business to suffer.

***If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar monitoring activities, our business may be negatively affected.***

As discussed in Item 2., under *Government Regulation*, CMS provides comparative public data, rating every SNF operating in each state based upon quality-of-care indicators. Certain private organizations engage in similar monitoring and ranking activities. CMS's system is the Five-Star Quality Rating System which gives each nursing home a rating of between one and five stars in various categories, with five-star ratings harder to obtain over time. The ratings are available on a consumer-facing website, Nursing Home Compare. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating and the rating may not reflect the improvements we were able to make until it is recalculated. Based on CMS's guidance and regulations, we expect more data to be collected by CMS and reported on the Nursing Home Compare website in the future. Additionally, CMS's ownership transparency final rule, which requires the disclosure of SNF ownership and affiliated parties, will ultimately provide for the public disclosure of information reported to CMS under that rule when revalidation of enrollment is required at a future time to be announced by CMS. Other states, including Iowa and California, have adopted similar statutes and regulations requiring the disclosure of this information. The publicly available information disclosed as a result of these laws and rules may result in potential residents perceiving our highly rated facilities to be less desirable if they share ownership with lower rated facilities, even if the lower rated facility is a new acquisition or has a lower score for reasons beyond our control.

CMS continues to increase quality measure thresholds, which are regularly increased every six months, making it more difficult to achieve upward and five-star ratings. CMS increased its quality measure thresholds in 2022, making it more difficult for facilities to obtain or maintain four- and five-star ratings. Some facilities may see a decline in their overall five-star rating absent any new inspection information, and as a result the five-star ratings of our independent subsidiaries may decline even as their quality measures remain unchanged or improve. Additionally, on the Nursing Home Compare website, CMS began displaying a consumer alert icon next to nursing homes that have been cited on inspection reports for incidents of abuse, neglect, or exploitation. In 2022, CMS updated the scoring measures used for SNFs to include six dimensions of staffing and turnover.

In July 2023, CMS revised the nursing-home level exclusion criteria used on the administrator turnover measure, adding information regarding its calculation of the staff turnover measure and publishing an updated ratings table, which identifies the points needed for each nursing facility to obtain certain star ratings within its state. This change made it more competitive to obtain a five-star rating, and more difficult to maintain such a rating once achieved. Only 10% of nursing facilities can receive a five-star rating in the state where they operate. These changes also increase the pressure on our independent subsidiaries to obtain a smaller number of available five-star ratings, as lower ratings may make it more difficult to attract prospective residents to receive our services.

CMS announced that it is changing its staffing rating methodology to give the lowest possible score to and penalize providers that fail to provide staffing data or provide erroneous staffing data. These changes risk our independent subsidiaries' facilities being incorrectly awarded a lower star rating, or prevented from attaining a deserved higher ranking due to favorable data not being reflected in CMS's five-star ratings due to the freeze or replacement of certain measures. These lower ratings may cause potential residents to evaluate these independent subsidiaries' facilities as less desirable, and result in fewer admissions and thus reduced revenue.

In July 2024, CMS changed the staffing case-mix adjustment methodology to a model based on PDPM. The Nursing Home Compare website has begun posting staffing level measures that use this methodology. CMS will revise the staffing rating thresholds to maintain the same distribution of points for staffing measures that will be affected by this freeze and replacement. Further, CMS will penalize SNFs that submit erroneous data, or fail to submit data, by awarding them the lowest possible rating on that measure. We may be significantly affected if any of our independent subsidiaries fail to submit information for the MDS in 2024, or if CMS deems their MDS submissions to be erroneous. In addition to the uncertainty created by future changes to CMS's five-star ratings that currently are unknown, the potential negative consequences of freezing unfavorable data may adversely affect our star rating and negatively impact our ability to attract residents.

In June 2025, CMS announced that from July 2025 onward, it will only incorporate the two most recent surveys for Nursing Home Care Compare and the Five Star Quality Rating system. In addition, CMS changed certain weight factors to scores under such survey programs. These changes have the potential to affect the sample of data evaluated under such surveys which could negatively impact SNFs with more recent compliance issues.

As of July 30, 2025, the Nursing Home Compare updates have been temporarily paused until October 2025 due to CMS's transition to a cloud-based system for survey data. During this pause, CMS indicated it will validate data integrity and engage in verification of reporting information for meeting quality standards. This impacts existing viewpoint of SNFs because there is no opportunity to provide new data to update scores. Further it increases the chance of audit by CMS if there are potential findings of data integrity or verification issues. Beginning in January 2026, CMS's change to the reporting of its long-stay antipsychotic medication quality measure reflecting both Medicare and Medicaid claims data, as well as Medicare Advantage data. The consequences of this measurement is expected by industry observers to cause an upward shift in reported rates of antipsychotic medication usage, with CMS applying more scrutiny to data within the MDS excluded from this specific measure.

The FY 2027 PPS proposes further changes that may affect our independent subsidiaries' abilities to be more competitive in these rankings in the future. First, the FY 2027 PPS proposes removing two rankings in the FY 2028 SNF QRP; if finalized, such a removal may adversely affect our SNFs that ranked highly and performed well in those categories. Second, the FY 2027 PPS proposes accelerating the timeframe for data submission from 4.5 months to approximately 45 days following the end of a reportable calendar quarter. If this proposal is finalized and implemented, it may increase the costs and administrative requirements to collect, authenticate, and submit such data to CMS, and may make it more difficult, or impose more expense, for our SNFs to maintain high star ratings while complying with these deadlines. Finally, the FY 2027 PPS proposes that SNFs submit MDS data for all SNF residents and patients, and not just those receiving skilled services within the SNF, regardless of payor. This requirement too, if finalized, would create a new obligation for our SNFs that would impose financial and administrative cost, and the collection of more data used in making star ratings under the QRP program may result in the SNFs operated by our independent subsidiaries experiencing reduced ratings, or finding it more difficult or expensive to maintain high ratings under the program's five-star rating measure.

Providing quality patient care is the cornerstone of our business. We believe that hospitals, physicians and other referral sources refer patients to us in large part because of our reputation for delivering quality care. If we should fail to achieve our internal rating goals or fail to exceed the national average rating on the Five-Star Quality Rating System, including due to nursing and administrative staffing and turnover, or have facilities displaying a consumer alert icon for incidents of abuse, neglect, or exploitation, it may affect our ability to generate referrals, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

***If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected.***

It may become more difficult and costly for us to obtain coverage for resident care liabilities and other risks, including property, automobile and casualty insurance. For example, the following circumstances may adversely affect our ability to obtain insurance at favorable rates:

- we experience higher-than-expected professional liability, property and casualty, or other types of claims or losses;
- a limitation or inability to require arbitration of disputes increases legal costs, exposure, and the unpredictability of jury decisions;
- we receive survey deficiencies or citations of higher-than-normal scope or severity;
- we acquire especially troubled operations or facilities that present unattractive risks to current or prospective insurers;
- insurers choose to stop operating or offering policies in certain states due to changes in economic conditions or laws;
- insurers tighten underwriting standards applicable to us or our industry; or
- insurers or reinsurers are unable or unwilling to insure us or the industry at historical premiums and coverage levels.

If any of these potential circumstances were to occur, our insurance carriers may cancel or not renew our policies, or require us to significantly increase our self-insured retention levels or pay substantially higher premiums for the same or reduced coverage for insurance, including workers compensation, property and casualty, automobile, employment practices liability, directors and officers liability, employee healthcare and general and professional liability coverages.

In some states, the law prohibits or limits insurance coverage for the risk of punitive damages arising from professional liability and general liability claims or litigation. Other states where we operate have experienced a withdrawal of insurers from the marketplace due to prior losses, or are at risk of insurers leaving the market due to changes in the law that make it difficult for those insurers to operate within the state, such as increased caps on non-economic damages in malpractice or professional liability claims. Coverage for punitive damages is also excluded under some insurance policies. As a result, we may be liable for punitive damage awards in these states that either are not covered or are in excess of our insurance policy limits. Claims against us, regardless of their merit or eventual outcome, could also inhibit our ability to attract patients or expand our business and could require our management to devote time to matters unrelated to the day-to-day operation of our business.

With few exceptions, general, professional, workers compensation, and employee health insurance costs have also increased markedly in recent years and are expected to increase in the future. To partially offset these increases, we have increased the amounts of our self-insured retention and deductibles in connection with general and professional liability claims. We also have implemented a self-insurance program for workers compensation in all states, and elected non-subscriber status for workers compensation in Texas. Due to the nature of our business and the residents we serve, including the risk of claims from residents as well as potential governmental action, it may be difficult to complete the underwriting process and obtain insurance at commercially reasonable rates. If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, or if the coverage levels we can economically obtain decline, our business may be adversely affected.

***Our self-insurance programs may expose us to significant and unexpected costs and losses.***

We maintain general and professional liability insurance and workers compensation insurance through a wholly owned captive insurance subsidiary to insure our self-insurance reimbursements and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. These significant and unpredictable claims may increase in number, frequency, and amount of loss due to not being able to predictably and reliably arbitrate these disputes with our independent subsidiaries. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted.

Further, because our self-insurance reimbursements under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.

We also self-insure our employee health benefits. With respect to our health benefits self-insurance, our reserves and premiums are computed based on a mix of company specific and general industry data that is not specific to our own company. Even with a combination of limited company-specific loss data and general industry data, our loss reserves are based on actuarial estimates that may not correlate to actual loss experience in the future. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.

***The geographic concentration of our independent subsidiaries could leave us vulnerable to an economic downturn, regulatory changes or acts of nature in those areas.***

Our independent subsidiaries located in Arizona, California, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies and real estate markets, changes in governmental rules, presence and participation of insurers, regulations and reimbursement rates or criteria, changes in demographics, state funding, natural disasters and acts of nature (such as fires, flooding, hurricanes and tornadoes), and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since over 22% of our independent subsidiaries are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as electrical power shortages, fires, earthquakes or mudslides, or increased liabilities that may arise from regulations as discussed within Item 2., under *Government Regulation*.

In addition, our independent subsidiaries in certain states are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, fires, tornadoes and flooding. These acts of nature may cause disruption to us, the employees of our independent subsidiaries, which could have an adverse impact on the patients of our independent subsidiaries and our business. In order to provide care for the patients of our independent subsidiaries, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our independent subsidiaries, and the availability of employees to provide services. If the delivery of goods or the ability of employees to reach our independent subsidiaries were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our independent subsidiaries and our business. Furthermore, the impact, or impending threat, of a natural disaster may require that we evacuate one or more facilities, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters and similar events is inherently uncertain. Such events could harm the patients and employees of our independent subsidiaries, severely damage or destroy one or more of our independent subsidiaries, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

***The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.***

We continue to maintain our right to inform the employees of our independent subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. Historically, the staff at our independent subsidiaries that have been approached to unionize have uniformly rejected union organizing efforts. Previous rulemaking under the Biden-Harris Administration and previously proposed legislation such as the HCBS Access Act, which increase resources for care-based jobs, may make such positions more lucrative and desirable in the future, and therefore more desirable for unions to organize these workers into their membership. The current Presidential Administration may reverse some of these orders, cause significant changes in HHS and CMS policy and rulemaking, and reduce the likelihood of successful legislation that seeks to provide more resources to creating pathways to care-based careers. The policies of the current Presidential Administration may also affect the favorability of unionization efforts before the Department of Labor. If employees successfully decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

***Because we lease the majority of the facilities operated by our independent subsidiaries, we are subject to risks associated with leased real property, including risks relating to lease termination, lease extensions and special charges, any of which could adversely affect our business, financial position or results of operations.***

As of March 31, 2026, our independent subsidiaries operated 254 of our 378 facilities under long term lease arrangements. Most of our leases are triple-net leases, which means that, in addition to rent, we are required to pay for the costs related to the property (including property taxes, insurance, and maintenance and repair costs). We are responsible for paying these costs notwithstanding the fact that some of the benefits associated with paying these costs accrue to the landlords as owners of the associated facilities.

Each lease provides that the landlord may terminate the lease for a variety of reasons, including the default in any payment of rent, taxes or other payment obligations or the breach of any other covenant or agreement in the lease. Termination of a lease could result in a default under our debt agreements and could adversely affect our business, financial position or results of operations. There can be no assurance that we will be able to comply with all of our obligations under the leases in the future.

***Failure to generate sufficient cash flow to cover required payments or meet operating covenants under our long-term debt, mortgages and long-term operating leases could result in defaults under such agreements and cross-defaults under other debt, mortgage or operating lease arrangements, which could harm our independent subsidiaries and cause us to lose facilities or experience foreclosures.***

Our Credit Facility has a borrowing capacity of up to \$600.0 million in aggregate principal amount. As of March 31, 2026 and through the filing date of this report, we had no outstanding borrowings under our Credit Facility. Twenty-three of our subsidiaries have mortgage loans insured with the Department of Housing and Urban Development (HUD) for an aggregate amount of \$142.6 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The terms of the mortgage loans range from 25- to 35-years. We also have one outstanding promissory note with an aggregate principal amount of approximately \$0.7 million as of March 31, 2026. The term of the note is 12 years.

In addition, we had \$3.1 billion of future operating lease obligations as of March 31, 2026. We intend to continue financing our independent subsidiaries through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

Our Credit Facility will mature on April 8, 2027, and we may not be able to renew, refinance, or replace it on acceptable terms, or at all. Our ability to obtain new financing will depend on market conditions and our financial performance, among other factors. If we are unable to secure replacement financing at maturity, we may be required to use available cash or reduce spending, which could adversely affect our liquidity, financial condition, and results of operations.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, our outstanding Credit Facility and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage, project yield, net leverage ratios, minimum interest coverage ratios and minimum asset coverage ratios. These restrictions may interfere with our ability to obtain additional advances under our Credit Facility or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue.

From time to time, the financial performance of one or more of our mortgaged facilities may not comply with the required operating covenants under the terms of the mortgage. Any non-payment, noncompliance or other default under our financing arrangements could, subject to cure provisions, cause the lender to foreclose upon the facility or facilities securing such indebtedness or, in the case of a lease, cause the lessor to terminate the lease, each with a consequent loss of revenue and asset value to us or a loss of property. Furthermore, in many cases, indebtedness is secured by both a mortgage on one or more facilities, and a guaranty by us. In the event of a default under one of these scenarios, the lender could avoid judicial procedures required to foreclose on real property by declaring all amounts outstanding under the guaranty immediately due and payable, and requiring us to fulfill our obligations to make such payments. If any of these scenarios were to occur, our financial condition would be adversely affected. For tax purposes, a foreclosure on any of our properties would be treated as a sale of the property for a price equal to the outstanding balance of the debt secured by the mortgage. If the outstanding balance of the debt secured by the mortgage exceeds our tax basis in the property, we would recognize taxable income on foreclosure, but would not receive any cash proceeds, which would negatively impact our earnings and cash position. Further, because our mortgages and operating leases generally contain cross-default and cross-collateralization provisions, a default by us related to one facility could affect a significant number of other facilities and their corresponding financing arrangements and operating leases.

Because our term loans, promissory note, bonds, mortgages and lease obligations are fixed expenses and secured by specific assets, and because our revolving loan obligations are secured by virtually all of our assets, if reimbursement rates, patient acuity mix or occupancy levels decline, or if for any reason we are unable to meet our loan or lease obligations, we may not be able to cover our costs and some or all of our assets may become at risk. Our ability to make payments of principal and interest on our indebtedness and to make lease payments on our operating leases depends upon our future performance, which will be subject to general economic conditions, industry cycles and financial, business and other factors affecting our independent subsidiaries, many of which are beyond our control. If we are unable to generate sufficient cash flow from operations in the future to service our debt or to make lease payments on our operating leases, we may be required, among other things, to seek additional financing in the debt or equity markets, refinance or restructure all or a portion of our indebtedness, sell selected assets, reduce or delay planned capital expenditures or delay or abandon desirable acquisitions. Such measures might not be sufficient to enable us to service our debt or to make lease payments on our operating leases. The failure to make required payments on our debt or operating leases or the delay or abandonment of our planned growth strategy could result in an adverse effect on our future ability to generate revenue and sustain profitability. In addition, any such financing, refinancing or sale of assets might not be available on terms that are economically favorable to us, or at all.

***A housing downturn could decrease demand for senior living services.***

Seniors often use the proceeds of home sales to fund their admission to senior living facilities. A downturn in the housing markets, including reductions in sales prices caused by increasing mortgage interest rates, economic uncertainty, recession, or a reduction in activity in the market for residential real estate, could adversely affect seniors' ability to afford our resident fees and entrance fees. Relatedly, a limitation of the amount of home equity that may be exempt from evaluating potential residents' eligibility for Medicaid long-term care benefits may adversely affect the availability of our services for residents and the payer mix for our independent subsidiaries. If national or local housing markets, particularly in Arizona, California, and Texas, which are the markets that account for the majority of our total revenue, enter a persistent decline, our occupancy rates, revenues, results of operations and cash flow could be negatively impacted.

***As we continue to acquire and lease real estate assets, we may not be successful in identifying and consummating these transactions.***

As of March 31, 2026, we lease 36 of our properties to third-party operators. In the future, we might expand our leasing property portfolio to additional tenants. We have very limited control over the success or failure of our tenants' and operators' businesses and, at any time, a tenant or operator may experience a downturn in its business that weakens its financial condition. If that happens, the tenant or operator may fail to make its payments to us when due. Although our lease agreements give us the right to exercise certain remedies in the event of default on the obligations owing to us, we may determine not to do so if we believe that enforcement of our rights would be more detrimental to our business than seeking alternative approaches.

An important part of our business strategy is to continue to expand and diversify our real estate portfolio through accretive acquisition and investment opportunities in healthcare properties. Our execution of this strategy by successfully identifying, securing and consummating beneficial transactions is made more challenging by increased competition and can be affected by many factors, including our relationships with current and prospective tenants, our ability to obtain debt and equity capital at costs comparable to or better than our competitors and our ability to negotiate favorable terms with property owners seeking to sell and other contractual counterparties. Our competitors for these opportunities include healthcare REITs, real estate partnerships, healthcare providers, healthcare lenders and other investors, including developers, banks, insurance companies, pension funds, government-sponsored entities and private equity firms, some of whom may have greater financial resources and lower costs of capital than we do. Potential regulations may affect the ability of these entities, as well as ourselves, to compete for these opportunities or enter into transactions for real estate related to our business. If we are unsuccessful at identifying and capitalizing on investment or acquisition opportunities, our growth and profitability in our real estate investment portfolio may be adversely affected.

Investments in and acquisitions of healthcare properties entail risks associated with real estate investments generally, including risks that the investment will not achieve expected returns, that the cost estimates for necessary property improvements will prove inaccurate or that the tenant or operator will fail to meet performance expectations. Income from properties and yields from investments in our properties may be affected by many factors, including changes in governmental regulation (such as licensing and government payment), general or local economic conditions (such as fluctuations in interest rates, senior savings, and employment conditions), the available local supply of and demand for improved real estate, a reduction in rental income as the result of an inability to maintain occupancy levels, natural disasters (such as hurricanes, earthquakes and floods) or similar factors. Furthermore, healthcare properties are often highly customized, and the development or redevelopment of such properties may require costly tenant-specific improvements. As a result, we cannot assure you that we will achieve the economic benefit we expect from acquisition or investment opportunities.

***As we expand our presence in other relevant healthcare industries, we would become subject to risks in a market in which we have limited experience.***

The majority of our independent subsidiaries have historically been SNFs. As we expand our presence in other relevant healthcare industries, our existing overall business model will continue to change and expose our company to risks in markets in which we have limited experience, such as the Eliminating Kickbacks in Recovery Act and other state laws that are not as well-developed in regulation and decisional authority as their federal equivalents. We expect that we will have to adjust certain elements of our existing business model, which could have an adverse effect on our business.

***If our referral sources fail to view us as an attractive skilled nursing provider, or if our referral sources otherwise refer fewer patients, our patient base may decrease.***

We rely significantly on appropriate referrals from hospitals, physicians, and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our independent subsidiaries. Our referral sources are not obligated to refer business to us and may refer business to other healthcare providers. We believe many of our referral sources refer business to us as a result of the quality of our patient care and our efforts to establish and build a relationship with our referral sources. If we lose, or fail to maintain, existing relationships with our referral resources, fail to develop new relationships, or if we are perceived by our referral sources as not providing high quality patient care, our occupancy rate and the quality of our patient mix could suffer. In addition, if any of our referral sources have a reduction in patients whom they can refer due to a decrease in their business, our occupancy rate and the quality of our patient mix could suffer.

***We may need additional capital to fund our independent subsidiaries and finance our growth, and we may not be able to obtain it on terms acceptable to us, or at all, which may limit our ability to grow.***

Our ability to maintain and enhance our independent subsidiaries and equipment in a suitable condition to meet regulatory standards, operate efficiently and remain competitive in our markets requires us to commit substantial resources to continued investment in our independent subsidiaries and equipment. We are sometimes more aggressive than our competitors in capital spending to address issues that arise in connection with aging and obsolete facilities and equipment. In addition, continued expansion of our business through the acquisition of existing facilities, expansion of our existing facilities and construction of new facilities may require additional capital, particularly if we were to accelerate our acquisition and expansion plans. Financing may not be available to us or may be available to us only on terms that are not favorable, including being subject to interest rates that are higher than those incurred in the recent past. In addition, some of our outstanding indebtedness and long-term leases restrict, among other things, our ability to incur additional debt. If we are unable to raise additional funds or obtain additional funds on terms acceptable to us, we may have to delay or abandon some or all of our growth strategies. Further, if additional funds are raised through the issuance of additional equity securities, the percentage ownership of our stockholders would be diluted. Any newly issued equity securities may have rights, preferences or privileges senior to those of our common stock.

***Delays in reimbursement may cause liquidity problems.***

If we experience problems with our billing information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. The changes enacted in the OBBB and taking effect through 2028 may impose further strain and limitation of funds available through the Medicaid programs in the states where our independent subsidiaries operate. Additionally, our independent subsidiaries may experience delay in receiving reimbursement as a result of the U.S. political environment, for example, as a result of a government shutdown. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews.

Some states in which we operate are operating with budget deficits or could have budget deficits in the future, which may delay reimbursement in a manner that would adversely affect our liquidity. In addition, from time to time, procedural issues require us to resubmit or appeal claims before payment is remitted, which contributes to our aged receivables. Unanticipated delays in receiving reimbursement from state programs or commercial payors due to changes in their policies or billing or audit procedures may adversely impact our liquidity and working capital.

***The continued use and growth of managed care organizations (MCOs) may contribute to delays or reductions in our reimbursement, including Managed Medicaid.***

In 42 states, including some of the largest where we operate, state Medicaid benefits are administered through MCOs. Some states seek to direct more of their Medicaid participation to these MCOs in the future as a measure to combat fraud and abuse in the Medicaid system. Typically, these MCOs manage commercial health and federal Medicare Advantage benefits under a managed care contract. Nationally, more than two-thirds of all Medicaid beneficiaries receive most or all of their care from MCOs. MCOs may be more aggressive than state Medicaid and federal Medicare agencies in denying claims or seeking recoupment of payments so that their services under these managed contracts are profitable. Additionally, restrictions on the availability and utilization of Medicaid funds under the OBBB, may result in MCOs becoming more aggressive in the denial of claims or declination of prior authorization to preserve limited Medicaid funds. The additional steps created by the use of MCOs in disbursement of funds creates more risk of delayed, reduced, or recouped payments for our independent subsidiaries, and additional avenues for risks that include fines and other sanctions, including suspension or exclusion from participation in various governmental programs.

***Compliance with the regulations of the Department of Housing and Urban Development may require us to make unanticipated expenditures which could increase our costs.***

Twenty-three of our independent subsidiaries are currently subject to regulatory agreements with HUD that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. Compliance with HUD's requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

***If we fail to safeguard the monies held in our patient trust funds, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties.***

Each of our independent subsidiaries is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the amount of money that was misappropriated. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties pursuant to federal and state laws.

***We are a holding company with no operations and rely upon our multiple independent subsidiaries to generate revenue and provide us with the funds necessary to meet our financial obligations. Liabilities of any one or more of our subsidiaries could be imposed upon us or our other subsidiaries.***

We are a holding company with no direct operating assets, employees or revenue. Each of our independent subsidiaries is operated through a separate, wholly owned, independent subsidiary, which has its own management, employees and assets. Our principal assets are the equity interests we directly or indirectly hold in our multiple operating and real estate holding subsidiaries. As a result, we are dependent upon distributions from our subsidiaries to generate the funds necessary to meet our financial obligations and pay dividends. Our subsidiaries are legally distinct from us and have no obligation to make funds available to us. The ability of our subsidiaries to make distributions to us will depend substantially on their respective operating results and will be subject to restrictions under, among other things, the laws of their jurisdiction of organization, which may limit the amount of funds available for distribution to investors or stockholders, agreements of those subsidiaries, the terms of our financing arrangements and the terms of any future financing arrangements of our subsidiaries.

***Our implementation of a new enterprise resource planning (ERP) system may adversely affect our business and results of operations or the effectiveness of our internal controls over financial reporting.***

In January 2026, we implemented a new ERP system designed to unify our existing processes, enhance access to real-time operational data, and ensure we are equipped to support future growth. This implementation process involves significant complexity, including data migration, system integration, process redesign, and requires significant resources and changes to our existing business and financial processes. Further, implementation carries risks such as operational disruptions and delays that could adversely affect our ability to operate our business. Any material weakness in the design and implementation of the new ERP system could also result in materially higher costs than we had incurred previously and otherwise negatively impact our financial reporting and internal controls. Any of these consequences could have a material adverse effect on our results of operations and financial condition.

***Certain directors who serve on our Board of Directors also serve as directors of Pennant, and ownership of shares of Pennant common stock by our directors and executive officers may create, or appear to create, conflicts of interest.***

Certain of our directors who serve on our Board of Directors also serve on the board of directors of Pennant. This may create, or appear to create, conflicts of interest when our, or Pennant's management and directors face decisions that could have different implications for us and Pennant, including the resolution of any dispute regarding the terms of the agreements governing the spin-off transaction and the relationship between us and Pennant after the spin-off transaction or any other commercial agreements entered into in the future between us and Pennant and the allocation of such directors' time between us and Pennant.

All of our executive officers and some of our non-employee directors own shares of the common stock of Pennant. The continued ownership of such common stock by our directors and executive officers following the spin-off creates, or may create, the appearance of a conflict of interest when these directors and executive officers are faced with decisions that could have different implications for us and Pennant.

***If Standard Bearer fails to remain qualified as a REIT, it will be subject to U.S. federal income tax as a regular corporation and could face substantial tax liability.***

Standard Bearer currently operates, and intends to continue to operate, in a manner that allows it to qualify to be taxed as a REIT for U.S. federal income tax purposes. If Standard Bearer fails to remain qualified to be taxed as a REIT in any year, it would be subject to U.S. federal income tax, including any applicable alternative minimum tax, on our taxable income at regular corporate rates, and dividends paid to its stockholders would not be deductible by it in computing its taxable income. Any resulting corporate liability could be substantial and would reduce the amount of cash available for distribution to its stockholders. Unless it was entitled to relief under certain Code provisions, it also would be disqualified from re-electing to be taxed as a REIT for the four taxable years following the year in which it failed to qualify to be taxed as a REIT.

***Legislative or other actions affecting REITs could have a negative effect on Standard Bearer.***

The rules dealing with U.S. federal income taxation are constantly under review by persons involved in the legislative process and by the IRS and the U.S. Department of the Treasury (Treasury). Changes to the tax laws or interpretations thereof, with or without retroactive application, could materially and adversely affect Standard Bearer's investors or Standard Bearer. We cannot predict how changes in the tax laws, including any tax reform called for by the current presidential administration, might affect Standard Bearer or its investors. New legislation, Treasury regulations, administrative interpretations or court decisions could significantly and negatively affect its ability to qualify to be taxed as a REIT or the U.S. federal income tax consequences to Standard Bearer or its investors of such qualification. Changes to the U.S. federal tax laws and interpretations thereof, could adversely affect an investment in our stock. Additionally, REITs that are related to our operation or those operations of our independent subsidiaries will likely be subject to the disclosure requirements of CMS's ownership transparency final rule (and analogous state rules), and may subject these REITs to additional public scrutiny.

No prediction can be made regarding whether new legislation or regulation (including new tax measures) will be enacted by legislative bodies or governmental agencies, nor can we predict what consequences would result from this legislation or regulation. Accordingly, no assurance can be given that the currently anticipated tax treatment of an investment will not be modified by legislative, judicial or administrative changes, possibly with retroactive effect.

***Even if Standard Bearer remains qualified as a REIT, it may face other tax liabilities that reduce its cash flow.***

Even if Standard Bearer remain qualified for taxation as a REIT, it may be subject to certain U.S. federal, state, and local taxes on its income and assets, including taxes on any undistributed income and state or local income, property and transfer taxes. For example, Standard Bearer may hold some of its assets or conduct certain of its activities through one or more taxable REIT subsidiaries or other subsidiary corporations that will be subject to U.S. federal, state, and local corporate-level income taxes as regular C corporations. In addition, it may incur a 100% excise tax on transactions with a TRS if they are not conducted on an arm's-length basis. Any of these taxes would decrease cash available for distribution to its stockholders.

***Failure to comply with existing environmental laws could result in increased expenditures, litigation and potential loss to our business and in our asset value.***

Our independent subsidiaries are subject to regulations under various federal, state and local environmental laws, primarily those relating to the handling, storage, transportation, treatment and disposal of medical waste; the identification and warning of the presence of asbestos-containing materials in buildings, as well as the encapsulation or removal of such materials; and the presence of other substances in the indoor environment.

Our independent subsidiaries generate infectious or other hazardous medical waste due to the illness or physical condition of the patients. Each of our independent subsidiaries has an agreement with a waste management company for the proper disposal of all infectious medical waste, but the use of a waste management company does not immunize us from alleged violations of such laws even if carried out by a third party, nor does it immunize us from third-party claims for the cost to cleanup disposal sites at which such wastes have been disposed.

Some of the independently operated facilities we lease, own or may acquire may have asbestos-containing materials. Federal regulations require building owners and those exercising control over a building's management to identify and warn their employees and other employers operating in the building of potential hazards posed by workplace exposure to installed asbestos-containing materials and known or suspected asbestos-containing materials in their buildings. Significant fines can be assessed for violation of these regulations. Building owners and those exercising control over a building's management may be subject to an increased risk of personal injury lawsuits. Federal, state and local laws and regulations also govern the removal, encapsulation, disturbance, handling and disposal of asbestos-containing materials and potential asbestos-containing materials when such materials are in poor condition or in the event of construction, remodeling, renovation or demolition of a building. Such laws may impose liability for improper handling or a release into the environment of asbestos containing materials and potential asbestos-containing materials and may provide for fines to, and for third parties to seek recovery from, owners or operators of real properties for personal injury or improper work exposure associated with asbestos-containing materials and potential asbestos-containing materials.

The presence of mold, lead-based paint, underground storage tanks, contaminants in drinking water, radon and/or other substances at our independent subsidiaries may lead to the incurrence of costs for remediation, mitigation or the implementation of an operations and maintenance plan and may result in third party litigation for personal injury or property damage. If we fail to comply with applicable environmental laws, we will face increased expenditures in terms of fines and remediation of the underlying problems, potential litigation relating to exposure to such materials, and a potential decrease in value to our business and in the value of our underlying assets.

***Risks Related to Ownership of our Common Stock***

***We may not be able to pay or maintain dividends and the failure to do so would adversely affect our stock price.***

Our ability to pay and maintain cash dividends is based on many factors, including our ability to make and finance acquisitions, our ability to negotiate favorable lease and other contractual terms, anticipated operating cost levels, the level of demand for occupancy at our facilities, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. The Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under the agreement. The failure to pay or maintain dividends could adversely affect our stock price.

***Our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law contain provisions that could discourage transactions resulting in a change in control, which may negatively affect the market price of our common stock.***

Our amended and restated certificate of incorporation and our amended and restated bylaws contain provisions that may enable our Board of Directors to resist a change in control. These provisions may discourage, delay or prevent a change in the ownership of our company or a change in our management, even if doing so might be beneficial to our stockholders. In addition, these provisions could limit the price that investors would be willing to pay in the future for shares of our common stock. Such provisions set forth in our amended and restated certificate of incorporation or our amended and restated bylaws include:

- our Board of Directors is authorized, without prior stockholder approval, to create and issue preferred stock, commonly referred to as “blank check” preferred stock, with rights senior to those of common stock;
- advance notice requirements for stockholders to nominate individuals to serve on our Board of Directors or to submit proposals that can be acted upon at stockholder meetings;

- our Board of Directors is classified so not all members of our board are elected at one time, which may make it more difficult for a person who acquires control of a majority of our outstanding voting stock to replace our directors;
- stockholder action by written consent is limited;
- special meetings of the stockholders are permitted to be called only by the chairman of our Board of Directors, our chief executive officer or by a majority of our Board of Directors;
- stockholders are not permitted to cumulate their votes for the election of directors;
- newly created directorships resulting from an increase in the authorized number of directors or vacancies on our Board of Directors are filled only by majority vote of the remaining directors;
- our Board of Directors is expressly authorized to make, alter or repeal our bylaws; and
- stockholders are permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

We are also subject to the anti-takeover provisions of Section 203 of the General Corporation Law of the State of Delaware. Under these provisions, if anyone becomes an “interested stockholder,” we may not enter into a “business combination” with that person for three years without special approval, which could discourage a third-party from making a takeover offer and could delay or prevent a change of control. For purposes of Section 203, “interested stockholder” means, generally, someone owning more than 15% or more of our outstanding voting stock or an affiliate of ours that owned 15% or more of our outstanding voting stock during the past three years, subject to certain exceptions as described in Section 203.

These and other provisions in our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law could discourage acquisition proposals and make it more difficult or expensive for stockholders or potential acquirers to obtain control of our Board of Directors or initiate actions that are opposed by our then-current Board of Directors, including delaying or impeding a merger, tender offer or proxy contest involving us. Any delay or prevention of a change of control transaction or changes in our Board of Directors could cause the market price of our common stock to decline.

## Item 5. OTHER INFORMATION

### *Rule 10b5-1 Plan Elections*

Dr. Ann S. Blouin, a member of our Board of Directors, entered into a Rule 10b5-1 trading arrangement on March 12, 2026. Dr. Blouin's 10b5-1 Plan provides for the potential sale of up to 375 shares of the Company's common stock between June 12, 2026 and February 26, 2027.

Swati B. Abbott, a member of our Board of Directors, entered into a Rule 10b5-1 trading arrangement on March 2, 2026. Ms. Abbott's 10b5-1 Plan provides for the potential sale of up to 1,100 shares of the Company's common stock between June 1, 2026 and March 1, 2027.

Spencer Burton, President and Chief Operations Officer, entered into a Rule 10b5-1 trading arrangement on February 9, 2026. Mr. Burton's 10b5-1 Plan provides for the potential exercise of vested stock options and the associated sale of up to 4,719 shares of the Company's common stock between May 11, 2026 and October 30, 2026. Pursuant to the 10b5-1 Plan, Mr. Burton may also make a gift of up to 2,500 shares of the Company's common stock between May 11, 2026 and October 30, 2026.

These Rule 10b5-1 trading arrangements were entered into during open trading windows and are intended to satisfy the affirmative defense conditions of Rule 10b5-1 (c) under the Securities Exchange Act of 1934, as amended, and the Company's policies regarding transactions in Company securities.

## Item 6. EXHIBITS

### EXHIBIT INDEX

Exhibit	Description
<b>3.1</b>	Fifth Amended and Restated Certificate of Incorporation of The Ensign Group, Inc., filed with the Delaware Secretary of State on November 15, 2007, and all Certificates of Amendment thereto filed with the Delaware Secretary of State through May 23, 2024 (attached as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on July 27, 2024)
<b>3.2</b>	Amended and Restated Bylaws of The Ensign Group, Inc. (attached as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on December 21, 2007)
<b>3.3</b>	Amendment to the Amended and Restated Bylaws of The Ensign Group, Inc., dated August 5, 2014 (attached as Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 001-33757) filed with the SEC on August 8, 2014)
<b>3.4</b>	Amendment to the Amended and Restated Bylaws of The Ensign Group, Inc., dated March 15, 2024 (attached as Exhibit 3.4 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on April 29, 2025)
<b>31.1</b>	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
<b>31.2</b>	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
<b>32.1</b>	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
<b>32.2</b>	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
<b>101.INS</b>	XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document.
<b>101.SCH</b>	Inline XBRL Taxonomy Extension Schema Document
<b>101.CAL</b>	Inline XBRL Taxonomy Extension Calculation Linkbase Document
<b>101.DEF</b>	Inline XBRL Taxonomy Extension Definition Linkbase Document
<b>101.LAB</b>	Inline XBRL Taxonomy Extension Label Linkbase Document
<b>101.PRE</b>	Inline XBRL Taxonomy Extension Presentation Linkbase Document
<b>104</b>	Cover Page Interactive Data File - the cover page XBRL tags are embedded within the Inline XBRL document.

\* Documents not filed herewith are incorporated by reference to the prior filings identified in the table above.

## SIGNATURES

Pursuant to the requirements 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.

April 30, 2026

THE ENSIGN GROUP, INC.

BY: /s/ SUZANNE D. SNAPPER

Suzanne D. Snapper

Chief Financial Officer, Executive Vice President and  
Director (Principal Financial Officer and Principal  
Accounting Officer)