PACS

2025

Annual Report

About PACS

PACS was founded in 2013 with two skilled nursing facilities. Since the purchase of those initial facilities, the PACS family consists of 321* independent operating subsidiaries across 17 states, as well as ancillary and support services, and continues to bring its proven model of mission-driven care that balances access to a national network of support and resources with local decision making.

PACS BY THE NUMBERS

321*
Facilities

31k+
Patients

46k+
Employees

WHAT WE DO

PACS is revolutionizing the delivery, leadership, and perception of post-acute care and support services nationally.

HOW WE DO IT

PACS creates value, trust, and confidence for those we support through entrepreneurial expansion across the entire continuum of post-acute care, a respected management team with decades of hands-on experience, and a diverse growth strategy that leverages multiple organic and inorganic vectors.

* as of 12/31/2025

PACS® | Healthcare Elevated

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

FORM 10-K

(Mark One)

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

For the fiscal year ended December 31, 2025

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 001-42011

PACS Group, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**92-3144268**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)

90 S. 400 W. Suite 700
Salt Lake City, Utah 84101
(Address of Principal Executive Offices and Zip Code)

(801) 447-9829
Registrant's telephone number, including area code

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

Title of each class	Trading Symbol(s)	Name of each exchange on which registered
Common Stock, par value $0.001 per share	**PACS**	**The New York Stock Exchange**

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

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

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.

Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days.

Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files).

Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, 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	☐	Accelerated filer	☒
Non-accelerated filer	☐	Smaller reporting company	☐
		Emerging growth company	☐

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

☐

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

☒

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

☐

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

☐

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Act).

Yes ☐ No ☒

As of June 30, 2025, the aggregate market value of the common stock held by non-affiliates of the registrant was approximately $588.5 million based upon the closing price reported for such date on the New York Stock Exchange.

As of February 23, 2026, there were 157,165,029 shares of the registrant's common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive proxy statement relating to its 2026 Annual Meeting of Stockholders to be filed with the SEC within 120 days after the end of the fiscal year ended December 31, 2025, are incorporated herein by reference in Part III of this Annual Report on Form 10-K.

PACS GROUP, INC.
ANNUAL REPORT ON FORM 10-K
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2025
TABLE OF CONTENTS

	Special Note Regarding Forward-Looking Statements	1
	Risk Factors Summary	3
	PART I	
Item 1.	Business	5
Item 1A.	Risk Factors	29
Item 1B.	Unresolved Staff Comments	67
Item 1C.	Cybersecurity	67
Item 2.	Properties	68
Item 3.	Legal Proceedings	69
Item 4.	Mine Safety Disclosures	71
	PART II	
Item 5.	Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities	72
Item 6.	[Reserved]	73
Item 7.	Management's Discussion and Analysis of Financial Condition and Results of Operations	73
Item 7A.	Quantitative and Qualitative Disclosures About Market Risk	88
Item 8.	Financial Statements and Supplementary Data	89
Item 9.	Changes in and Disagreements With Accountants on Accounting and Financial Disclosure	129
Item 9A.	Controls and Procedures	129
Item 9B.	Other Information	132
Item 9C.	Disclosure Regarding Foreign Jurisdictions that Prevent Inspections	132
	PART III	
Item 10.	Directors, Executive Officers and Corporate Governance	133
Item 11.	Executive Compensation	135
Item 12.	Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters	135
Item 13.	Certain Relationships and Related Transactions, and Director Independence	135
Item 14.	Principal Accountant Fees and Services	135
	PART IV	
Item 15	Exhibits and Financial Statement Schedules	136
Item 16	Form 10-K Summary	139
	Signatures	140

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Special Note Regarding Forward-Looking Statements

This Annual Report on Form 10-K contains forward-looking statements about PACS Group, Inc. ("we," "us," "our," the "Company" and "PACS") and our industry that involve substantial risks and uncertainties. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements other than statements of historical facts contained in this Annual Report on Form 10-K, including statements regarding our strategy, future financial condition, future operations, projected costs, prospects, plans, objectives of management, and expected market growth, are forward-looking statements. In some cases, you can identify forward-looking statements because they contain words such as "may," "will," "shall," "should," "expects," "plans," "anticipates," "could," "intends," "target," "projects," "contemplates," "believes," "estimates," "predicts," "potential," "goal," "objective," "seeks," or "continue" or the negative of these words or other similar terms or expressions that concern our expectations, strategy, plans, or intentions. Forward-looking statements contained in this Annual Report on Form 10-K include, but are not limited to, statements about:

- our future financial performance, including our expectations regarding our revenue, operating expenses, and our ability to achieve and maintain future profitability;
- the demand for our services in general;
- our ability and the ability of local leaders and others to transform SNFs and other acquired facilities into higher acuity, high value-add short-term transitional care SNFs, including through the implementation of PACS Services;
- our expectations regarding improvement in clinical quality, patient experience, and operating metrics over time as facilities mature over a transition period, and our ability to maintain standards in our Mature facilities;
- our ability to successfully execute upon our strategy to deploy our locally led, PACS Services supported model in acquired SNFs and in existing and new markets;
- our ability to successfully execute upon our acquisition strategy, including with respect to SNFs, and our ability to successfully identify, acquire and integrate facilities, businesses and operations;
- the scalability of PACS Services and our operating model;
- our ability to successfully compete with existing and new competitors generally and in specific existing and new geographical markets;
- the size of our market and market trends, including with respect to SNFs, expected growth rates of the market and our ability to grow within and further penetrate our market;
- our ability to attract, train, and retain motivated, entrepreneurial individuals, including local leaders. administrators, clinicians, and other important employees and personnel;
- our expectations regarding the ongoing civil and criminal government investigative demands;
- our expectations regarding the effects of existing and developing laws and regulations;
- our ability to comply with regulations applicable to our business;
- our ability to develop and protect our brand;
- our expectations regarding, and management of, future growth;
- our ability to maintain, protect and enhance our technology and intellectual property;
- our ability to implement, maintain and improve effective internal controls and remediate the material weaknesses; and

- the sufficiency of our cash to meet our liquidity needs.

We caution you that the foregoing list does not contain all of the forward-looking statements made in this Annual Report on Form 10-K.

You should not rely upon forward-looking statements as predictions of future events. We have based the forward-looking statements contained in this Annual Report on Form 10-K primarily on our current expectations, estimates, forecasts, and projections about future events and trends that we believe may affect our business, results of operations, financial condition, and prospects. Although we believe that we have a reasonable basis for each forward-looking statement contained in this Annual Report on Form 10-K, we cannot guarantee that the future results, levels of activity, performance, or events and circumstances reflected in the forward-looking statements will be achieved or occur at all. The outcome of the events described in these forward-looking statements is subject to risks, uncertainties, and other factors described in the section titled "Risk Factors" and elsewhere in this Annual Report on Form 10-K. Moreover, we operate in a very competitive and rapidly changing environment. New risks and uncertainties emerge from time to time, and it is not possible for us to predict all risks and uncertainties that could have an impact on the forward-looking statements contained in this Annual Report on Form 10-K. The results, events, and circumstances reflected in the forward-looking statements may not be achieved or occur, and actual results, events, or circumstances could differ materially from those described in the forward-looking statements.

The forward-looking statements made in this Annual Report on Form 10-K relate only to events as of the date on which the statements are made. We undertake no obligation to update any forward-looking statements made in this Annual Report on Form 10-K to reflect events or circumstances after the date of this Annual Report on Form 10-K or to reflect new information or the occurrence of unanticipated events, except as required by law. We may not actually achieve the plans, intentions, or expectations disclosed in our forward-looking statements, and you should not place undue reliance on our forward-looking statements. Our forward-looking statements do not reflect the potential impact of any future acquisitions, mergers, dispositions, joint ventures, or investments we may make.

You should read this Annual Report on Form 10-K and the documents that we reference in this Annual Report on Form 10-K and have filed as exhibits to this Annual Report on Form 10-K, completely and with the understanding that our actual future results may be materially different from what we expect. We qualify all of the forward-looking statements in this Annual Report on Form 10-K by these cautionary statements.

RISK FACTORS SUMMARY

The following is a summary of certain of the principal risks that may materially adversely affect our business, financial condition, results of operations or liquidity. The following should be read in conjunction with the more complete discussion of the risk factors we face, which are described in Part I, Item 1A. "Risk Factors" in this Annual Report on Form 10-K.

- We depend 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 facilities as well as changes in payor mix and payment methodologies and new cost containment initiatives by third-party payors.

- We may not be fully reimbursed for all services for which each facility bills through consolidated billing or bundled payments, which could have an adverse effect on our revenue, financial condition and results of operations.

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

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

- If we fail to attract patients and residents and to compete effectively with other healthcare providers, our revenue and profitability may decline and we may incur losses.

- We review and audit the care delivery, recordkeeping and billing processes of our operating subsidiaries. These reviews from time to time detect instances of noncompliance that we attempt to correct, which in some instances requires reduced or repayment of billed amounts or other costs.

- We are subject to litigation, which is commonplace in our industry, which could result in significant legal costs and large settlement amounts or damage awards, and our self-insurance programs may expose us to significant and unexpected costs and losses.

- We have identified material weaknesses in our internal control over financial reporting. If our remediation of such material weakness is not effective, or if we experience additional material weaknesses or otherwise fail to design and maintain effective internal control over financial reporting, our ability to accurately report our financial condition and results of operations in a timely manner or comply with applicable laws and regulations could be impaired, which may adversely affect investor confidence in us, subject us to litigation or significant financial or other penalties, and, as a result, affect the value of our common stock and our financial condition.

- If we are unable to provide consistently high quality of care, or if our employees or staff members engage in conduct (or fail to take action) that impacts our patients' health, safety, welfare or clinical treatment, our business will be adversely impacted and we may be subject to civil or criminal penalties, fines or other actions.

- We rely significantly on information technology, and any failure, inadequacy or interruption of that technology could harm our ability to effectively operate our business.

- We calculate certain operational metrics using internal systems and tools and do not independently verify such metrics. Certain metrics are subject to inherent challenges in measurement, and real or perceived inaccuracies in such metrics may harm our reputation and negatively affect our business.

- We may be unable to complete future facility 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 operating subsidiaries, which would decrease our revenue.

- We may not be able to successfully integrate acquired facilities and properties into our operations, and we may not achieve the benefits we expect from any of our facility acquisitions.

- In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations, and we may not be able to successfully integrate acquired facilities and properties into our operations, or achieve the benefits we expect from any of our facility acquisitions.

- We may have difficulty completing partnerships that increase our capacity consistent with our growth strategy.

- If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar rating activities, 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.

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

- The actions of national labor unions may adversely affect our revenue and profitability.

- Because we lease the majority of our facilities, 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 have an adverse effect on our business, financial condition and 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 leases could result in defaults under those agreements and cross-defaults under other debt, mortgage or lease arrangements, which could harm our operating subsidiaries and cause us to lose facilities or experience foreclosures.

- We may need additional capital to fund our operating 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.

- 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.

- Our founders, Jason Murray and Mark Hancock, have substantial control over us and hold a substantial portion of our outstanding common stock, and their interests may conflict, or appear to conflict, with our interests and the interests of other stockholders

- We are a “controlled company” within the meaning of the corporate governance standards of The New York Stock Exchange. As a result, we may elect to rely on exemptions from certain corporate governance standards and you may not have the same protections afforded to stockholders of companies that are subject to such requirements.

PART I

Item 1. BUSINESS

Business Overview

We are a leading post-acute healthcare company primarily focused on delivering high-quality skilled nursing care through a portfolio of independently operated facilities. Founded in 2013, we are one of the largest skilled nursing providers in the United States based on number of facilities. We also provide senior care, assisted living, and independent living options in some of our communities. In total, we operate 321 post-acute care facilities across 17 states serving over 31,700 patients daily. Our significant historical growth has been primarily driven by our expertise in acquiring underperforming long-term custodial care skilled nursing facilities and transforming them into higher acuity, high value-add short-term transitional care skilled nursing facilities. We believe our success is driven in significant part by our locally led, centrally supported operating model, through which we empower local leaders at each facility to operate their facility autonomously and deliver excellence in clinical quality and a superior experience for our patients. We provide our independently operated facilities with a comprehensive suite of technology, support, and back-office services that enable local leadership teams to focus more of their time and effort on providing quality care to patients. We believe our operating model delivers value to all of our healthcare stakeholders, including patients and families, referring providers, payors, and administrators and clinicians.

The post-acute care ecosystem serves individuals who need additional help recuperating from acute conditions, illnesses, or serious medical procedures after they have been discharged from the hospital. This ecosystem ranges from higher acuity, higher-cost settings, such as long-term acute care hospitals and inpatient rehabilitation facilities, to lower acuity, lower-cost settings, such as assisted living facilities, and home health. Skilled nursing facilities (SNFs) are positioned at the center of this ecosystem and play an essential role in providing cost efficient facility-based care to patients that have been discharged from hospitals but still require 24-hour in-patient services. SNFs can provide both long-term custodial care and higher value short-term transitional care. The SNF industry is large and growing, with the Centers for Medicare & Medicaid Services (CMS) expecting total industry expenditures to increase from $193.6 billion in 2022 to $283.3 billion in 2031, representing a compound annual growth rate (CAGR) of 4.3%. Based on the number of facilities as reported by CMS, we are one of the largest SNF operators in the United States. We are primarily focused on providing higher value short-term transitional care and believe we are uniquely positioned to capitalize on the current underlying trends within the SNF industry and to capture a growing portion of the expected demand.

We believe that healthcare is local and we operate through a locally led, centrally supported model, recognizing that each patient, facility, and community is unique. To that end, we believe that our local leaders and their teams understand the distinct needs and priorities of their patients, staff, and facilities and are best positioned to make clinical and operational decisions in order to optimize patient outcomes and experience. To facilitate this, each of our facilities operates independently, led by a facility administrator and his or her interdisciplinary team of medical directors, nurses, therapists, specialty consultants, and operators. To assist these local teams in achieving their best clinical and operating potential, we provide each facility with access to PACS Services, and they are subject to the PACS Code of Business Conduct and Ethics (which is described elsewhere in this report) and a variety of other policies and procedures designed to help ensure our operations are conducted consistent with applicable law and prudent business practices. PACS Services is a comprehensive suite of offerings, including accounting, finance, human resources, payroll, accounts receivable and payable, legal, compliance, and risk management services, as well as a robust suite of technology tools. We operate in a highly regulated industry with stringent regulatory compliance obligations, which require robust regulatory compliance operations. Failure to operate in compliance with applicable laws and regulations could require significant expenditures and result in regulatory deficiencies and other regulatory penalties. PACS Services functions to support our regulatory compliance obligations across our organization, including through controlled billing and cost reporting practices and legal, risk management, and compliance support. PACS Services also provides teams of regional professionals available as resources to each facility, including a regional vice president (RVP) for each operational region, and regional clinical and non-clinical directors and consultants. We developed PACS Services to be a resource to help reduce administrative burden so that local leadership teams can focus on making decisions that improve the care, well-being, and quality of life of their patients.

We believe that talented local leadership is critical to the success of our model of independently operated, centrally supported facilities. At the facility level, administrators are effectively the chief executive officers, and together with other local licensed professionals, are ultimately responsible for the day-to-day operations of their respective facilities. We seek to recruit, train, and reward dynamic administrators for our facilities, and rely on them to work with their interdisciplinary

teams to implement policies and procedures that are appropriate and effective and result in positive outcomes. We support the delivery of excellent care by building excellent teams. We believe our model attracts high caliber, entrepreneurial professionals who value having considerable autonomy, accountability, and aligned incentives. We provide these professionals with leadership and industry training, guidance, and operational support. Our model is intended to align local leaders' incentives with facility and organizational success, encouraging them to dedicate themselves to the long-term future of their facilities. To create such alignment, we have developed an administrator compensation structure that prioritizes operational and financial performance, as well as quality of care. Our administrators understand that a well-performing facility is the result of providing quality care in an environment of healing and caring, and one that is appropriately staffed, supplied, and equipped to meet the needs of its patients. This dedicated focus by our administrators and their local teams on patient outcomes drives demand for our services and can ultimately result in higher patient census and profitability. We also seek to provide opportunities for upward career mobility, with many of our administrators being promoted from within our company to roles of increasing levels of responsibility. Our culture of meritocracy and pride of ownership has helped us retain experienced facility administrators as well as RVPs who had an average industry experience of 12.9 years as of December 31, 2025.

Excellence in clinical quality and experience for our patients is at the forefront of our mission. We believe our focus on quality is reflected in our CMS Quality Measures (QM) Star rating, occupancy rate, and skilled mix by nursing patient days (which refers to the number of days our Medicare and managed care patients receive skilled nursing services at SNFs as a percentage of the total number of days that patients from all payor sources receive skilled nursing services at SNFs for any given period). The QM Star rating is a number between 1 and 5 that is assigned to SNFs that participate in Medicare or Medicaid, and is based on an aggregate score across a range of quality reporting program requirements. As of December 31, 2025, 2024, and 2023, our average QM Star rating across our Mature facilities, which we define as facilities purchased more than 36 months prior to the measurement date, was 4.4, 4.3 and 4.2 Stars, respectively, compared to the industry average of 3.5, 3.4 and 3.6 Stars, respectively. For the years ended December 31, 2025, 2024, and 2023, our average occupancy rate across our Mature facilities was 95%, 94%, and 93%, respectively, compared to the industry average of 79%, 77% and 76%, respectively. For the year ended December 31, 2025, our skilled mix by nursing patient days was 29%, as defined in Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

We have historically grown primarily through our disciplined and balanced acquisition strategy. We generally aim to create value by identifying and acquiring underperforming custodial care focused facilities and converting them into higher-value short-term transitional care focused facilities by investing in clinical teams and processes and upgrading technology, equipment, training, staffing, aesthetics, and other aspects of the business. The resources and guidance offered by PACS Services are key to rapid integration of new facilities and provides our local leadership teams with an effective technology infrastructure, support tools, and regional support teams that enable local leadership to focus on operational improvements. Our facilities generally undergo an up to three-year post-acquisition transition period. During this period, we seek to implement best practices designed to realize and sustain the facility's full potential. These practices often result in significant improvements to clinical quality and other operational metrics, including skilled mix, occupancy rates and payor contracting. We believe the results of our acquisition strategy are demonstrated by our high average QM Star rating and occupancy rate for Mature facilities of 4.4 and 95%, respectively, as of December 31, 2025. As of December 31, 2025, the average QM Star rating and occupancy rate for New facilities, which we define as facilities purchased less than 18 months prior to the measurement date, was 3.5 and 81%, respectively.

Our portfolio of owned and leased properties is strategically located in 17 states: Alaska, Arizona, California, Colorado, Idaho, Kansas, Kentucky, Missouri, Montana, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington. We anticipate that available acquisition opportunities will enable us to further penetrate our reach into these 17 states and to enter new states in the future. We believe our current markets are attractive and that the states in which we operate each has unique benefits, such as favorable reimbursement dynamics, high barriers to entry, or population growth of adults aged 65 and older, which is our primary patient demographic. We generally look for similar attributes in new markets that we enter. As of December 31, 2025 we leased 219 facilities, directly owned the real estate at 53 facilities, and owned partial interests in an additional 49 facilities through partnerships managed by third parties. As we continue to grow, we intend to explore additional purchases of real-estate assets, through purchase options or rights-of-first refusal in existing leases, as well as acquisitions and de novo construction of purpose-built facilities.

For the year ended December 31, 2025, we generated total revenue of $5.3 billion, representing a CAGR of 30.4% over the last three years. A substantial portion of our revenue is generated from payments from third-party payors, including Medicare and Medicaid, which represent our largest sources of revenue and accounted for 33.7% and 40.5% of our routine revenue for the year ended December 31, 2025, respectively. For the year ended December 31, 2024, we

generated total revenue of $4.1 billion, and Medicare and Medicaid accounted for 33.8% and 40.4% of our routine revenue, respectively.

For the year ended December 31, 2025, our total operating expenses were $5.0 billion. For the same period, we generated net income of $191.5 million and Adjusted EBITDA of $505.0 million. For the year ended December 31, 2024, our total operating expenses were $4.0 billion and we generated net income of $55.3 million and Adjusted EBITDA of $279.5 million. Adjusted EBITDA is a non-GAAP financial measure. See the section titled "Item 7. Management's Discussion and Analysis of Financial Conditions and Results of Operations—Key Skilled Services Metrics and Non-GAAP Financial Measures—Non-GAAP Financial Measures" for a reconciliation of Adjusted EBITDA to the most directly comparable GAAP financial measure.

As of December 31, 2025, we had total long-term liabilities of $3.6 billion.

Our Operating Model

Locally Led, Centrally Supported Operations

Our locally led, centrally supported model is informed by our beliefs that "healthcare is local" and that each patient, facility and community is unique. Our administrators have significant autonomy in the decision-making process, subject to adherence to company policies and procedures, because we believe they know what is best for their community and their markets. Our 321 post-acute facilities are independently operated by interdisciplinary teams with robust administrative and consulting support from PACS Services.

We strive to have each of our facilities led by experienced and highly qualified administrators, who serves in effect as a "local CEO," alongside an interdisciplinary team of medical directors, clinicians, specialty consultants, and operators. In addition to a full clinical team of certified nursing assistants (CNAs), licensed practical nurses (LPNs), registered nurses (RNs), directors of nursing (DONs), and clinical directors, each facility has a local team of non-clinical staff including supervisors, admissions professionals, marketing professionals, and other business support personnel who have the common goal of providing excellent care and superior experiences for patients.

We provide PACS Services to each of our facilities, which includes support through a regional team of seasoned, highly qualified, cross-functional professionals, and led by an RVP. The team also includes regional clinical support personnel (such as directors of therapy, quality assurance, medical records, and clinical services personnel) as well as non-clinical personnel such as regional directors of recruitment and accounts receivable and accounts payable, reimbursement, and risk and compliance personnel. As of December 31, 2025, we had 21 RVPs overseeing each regional team, covering an average of 14 facilities within a region and having an intimate understanding of the intricacies and challenges of the post-acute industry. We place the utmost importance on clinical quality, and as a result, many employees that provide PACS Services are clinicians by trade. We also have PACS policies and procedures applicable to all employees, including a Code of Business Conduct and Ethics, which are designed to help ensure our operations are conducted in accordance with the law and prudent business practices.

Technology and Services

Our technology focus delivers real-time data access to caregivers and administrators, enabling delivery of the best care at the right time. We have invested into internally developed and third-party technologies that comprise part of PACS Services. This robust suite of technologies helps support facility administrators, clinicians, and local teams by providing them with valuable tools to enable them to reduce the time and effort they spend on administrative tasks so that they can better focus on providing quality care and driving efficient business operations. PACS Services includes access to an industry-leading, third-party Electronic Health Record system, and a singular Enterprise Resource Program. In addition, we have internally developed an operational dashboard that is custom-built to provide valuable tools and real-time data insights to our local teams in order to enhance resource management and improve the delivery of care. This app-based, mobile technology integrates facility-level detail on admissions, occupancy, revenue, staffing, collections, and other key operational data points. Our technology platform enables local leaders and regional teams to continually review and monitor this data, which enables them to be agile in assessing the ongoing needs of their facility and to more easily identify and address the unique needs and priorities.

With this readily-available, real-time data, our local leaders are able to more easily assess what works well in their facilities and can appropriately manage their operations and share best practices with their colleagues within the company.

This data also facilitates greater risk management and compliance efforts, as financial and clinical information can be analyzed, which we believe helps promote accountability across the company. Across the company, we use insights from our data management tools to benchmark performance, manage expenses, monitor risk, and manage compliance.

We believe PACS Services provides technology systems and support infrastructure that can enable seamless integration of new facilities and help to reduce risk when we acquire new facilities.

Clinical and Operational Leadership

We believe we are an employer-of-choice in the SNF industry and have attracted highly qualified local leadership and clinicians. Our facility-forward model helps attract and retain motivated professionals whom we provide with extensive training, professional guidance by seasoned experts, and access to best practices. We offer challenging and fulfilling opportunities for clinicians to gain meaningful experience treating higher acuity patients. Through work-education programs, we also offer many of our clinicians the opportunity to improve or enhance their clinical licenses with sponsored certification programs. We believe we are at the forefront of enabling operators and clinicians to operate in their highest value capacity and at the best of their professional capabilities.

Our Administrator-in-Training program, geared towards recent college graduates, and our PACS Professional Program for experienced nursing home administrators, both provide valuable, intensive training and mentorship to help aspiring PACS administrators build important skills, such as operational systems management, administrative effectiveness, and leadership and people development. Our placement process assesses skill sets, qualifications, and career interests in order to pair leaders with the facilities and teams that will be a good fit.

Our frontline CNAs, LPNs, and RNs are also encouraged to participate in our internal continuing education programs, as well as outside programs, to help them continue to develop their skills and to meet any mandated continuing education requirements. We also offer our clinicians and other personnel educational assistance to enable them to sharpen their skills and enhance their capabilities.

Disciplined Acquisition Playbook

We have an established track record of successful acquisitions. Our significant historical growth has been primarily driven by implementing our expertise in acquiring underperforming long-term custodial care focused SNFs and converting them into higher acuity, high value-add short-term transitional care focused SNFs. In pursuing each acquisition opportunity, we employ a disciplined evaluation process to identify facilities that meet our acquisition criteria and strategic priorities. We believe our framework and focused approach for acquisitions has contributed to our overall success. Our approach involves:

- **Sourcing and evaluation.** We have developed specific acquisition criteria to drive efficient sourcing and growth, and we continually monitor our pipeline of suitable acquisition targets. We believe we have a reputation as an acquiror-of-choice, which has led to regular inbound opportunities from small operators, larger platforms, and industry partners, such as landlords, brokers, and REITs.

- **Integration and execution.** Prior to and following closing of an acquisition, we perform a full facility evaluation focused on operational, clinical, financial, and administrative functions. Through this evaluation, we develop a detailed action plan with goals for IT integration and implementation of best practices led by facility administrators. We believe that administrators can create immediate additional value through technology integrations and then drive continued growth over time with improvements to clinical quality, operations, and financial performance. Our facilities generally undergo a three-year post-acquisition transition period. During this period, our integration efforts and implementation of best practices often result in significant improvements to clinical quality and other operational metrics. We believe the results of our strategy are demonstrated by our high average QM Star rating and occupancy rate for Mature facilities of 4.4 and 95%, respectively, as of December 31, 2025. By comparison, the average QM Star rating and occupancy rate for New facilities was 3.5 and 81%, respectively, as of December 31, 2025.

Our Diversified Portfolio of Properties

We have a diverse portfolio of facilities that are located in selected attractive markets. A majority of our facilities are leased and are accounted for as either operating leases or finance leases. Our remaining facilities are either wholly-owned

or partially-owned through joint ventures managed by third parties. Real-estate ownership is a key component of our growth strategy as it can provide balance sheet support as an inflationary hedge, provide capital flexibility as a source of asset collateral, reduce the burden of leases and restrictive agreements, and provide us opportunities to create additional value in improving distressed assets.

The following is a summary of our leased and owned facilities:

- ***Leased Properties.*** As of December 31, 2025, we had 268 leased facilities. The majority of these leased facilities are in California, with the remainder in Alaska, Arizona, Colorado, Idaho, Kansas, Kentucky, Missouri, Montana, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington. We often leverage our financial and operational condition to negotiate favorable lease terms, including low annual rent escalators, long expiration dates, and purchase options. As of December 31, 2025, our weighted average annual lease escalator was 2%, our average monthly lease expense was $954 per bed, our average remaining lease term across our portfolio was approximately 13 years, and we had 37 total purchase options at our discretion and 5 rights of first refusal that we may exercise in future years.

- ***Owned Properties.*** We have historically purchased the real-estate assets for certain of the post-acute care facilities we operate. Many of our owned properties were acquired with limited cash outlay while in a distressed state, or through the exercise of a purchase option that was originally negotiated while in a distressed state. We seek to create value in our properties by purchasing these distressed facilities and making improvements under our operations and ownership. As of December 31, 2025 we owned 53 post-acute care facilities, and we have investments in joint ventures that own the underlying real estate and related improvements of 49 post-acute care facilities that are operated by PACS Group subsidiaries. The majority of our owned real-estate properties are located in California, with the remainder in Colorado, Kentucky, Missouri, Nevada, Pennsylvania, South Carolina, and Texas. We have also explored facility ownership through de-novo, or new-build, facilities where we construct facilities and own them. Since 2013, we have opened or are in the process of opening 8 de-novo facilities.

We classify each of our facilities into three distinct categories based on the amount of time that has passed since acquisition: Mature, Ramping and New. Mature facilities are defined as facilities purchased more than 36 months prior to a respective measurement date. Ramping facilities are defined as facilities purchased within 18 to 36 months prior to a respective measurement date. New facilities are defined as facilities purchased less than 18 months prior to a respective measurement date. As of December 31, 2025, we operated 150 Mature facilities, 102 Ramping facilities, and 69 New facilities. For the year ended December 31, 2025, our Mature, Ramping, and New facilities generated skilled nursing services revenue of $2.9 billion, $1.1 billion, and $1.2 billion, respectively.

We believe our success in improving our acquired properties is reflected in the average QM Star rating, occupancy rate, and skilled mix by revenue for each of our Mature, Ramping and New facilities, depicted in the table below for the year ended December 31, 2025:

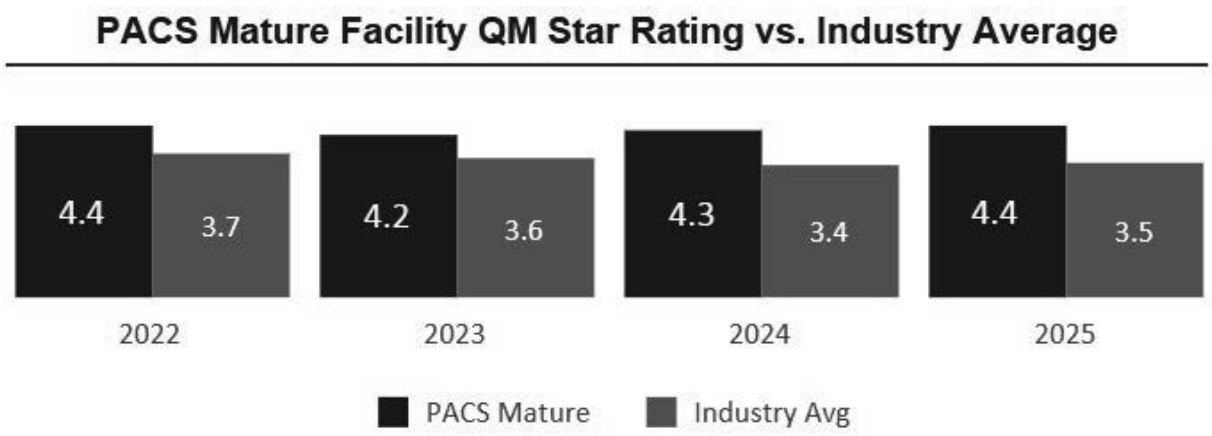
	Year Ended December 31, 2025		
	Mature facilities	Ramping facilities	New facilities
Average QM Star rating	4.4	4.1	3.5
Occupancy rate (operational beds)	95 %	86 %	81 %
Skilled mix by revenue	56 %	42 %	38 %

As of December 31, 2025, our full portfolio had an average QM Star rating of 4.1 Stars compared to the industry average of 3.5 Stars, and an average occupancy rate of 89% compared to the industry average occupancy rate of 79%. See the section titled “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations—Key Skilled Services Metrics and Non-GAAP Financial Measures.” We believe our strategy drives these results and is central to our ability to develop acquired facilities into higher performing facilities over time.

We believe the success of our strategy is further exemplified by our historical ability establish and maintain a QM Star rating for our Mature facilities that is higher than the industry average, The graphic below sets forth our QM Star rating

over time for our Mature facilities, as well as the industry average QM Star rating for buildings of all maturities, for the periods indicated.

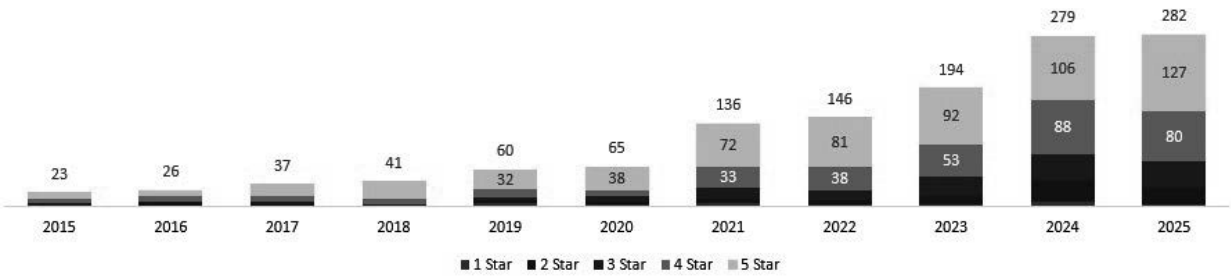
QM Star Ratings Over Time for PACS Mature Facilities vs. Industry Average[1]



(1) Source: CMS SNF Provider Information (Nov. 2024); PACS data for facilities with CMS certification and QM Star rating.

Execution of our strategy has also increased our number of facilities with QM Star ratings of 4 or 5 Stars over time. The graphic below sets forth our number of facilities by QM Star rating from 2015 through 2025.

QM Star Ratings Over Time for PACS Facilities[1]



(1) Facility count shown excludes facilities with unreported QM star rating for period and excludes ALF facilities with no QM Star ratings.

Our Value Proposition

We believe that our operating model creates meaningful value for patients and their families, our referring providers, our payors, and our administrators and clinicians.

Value Proposition for Patients and Families

- ***Coordinated care.*** We empower team members at every level through skillful training, shared resources, and a collaborative spirit. We help deliver coordinated care before, during, and after a patient's stay with us. Prior to admission, our administrators or other facility leaders meet with patients and their families, as well as hospital discharge planners, to plan for the patient's discharge and enable a seamless transition to our facility. During a stay with us, our local facility team coordinates closely with physicians to deliver high-touch, high-quality care for patients. As care nears completion, we meet with our patients, their families, home health agencies and downstream care providers to plan for and ensure a smooth transition.

- ***Outstanding patient experience.*** Our goal is to provide each patient with superior care and an outstanding experience. When patients arrive at our facilities they are greeted by a warm, inviting, and modern environment. We often upgrade facility infrastructure shortly after acquisition and perform periodic refreshes, to ensure our

facilities are comfortable and well-equipped to serve patients across a wide range of acuities with a primary focus on high acuity patients. High acuity patients generally require higher levels of medical care or monitoring due to conditions or complications that cannot be easily managed, and often need more nursing resources and attention to maintain their quality of life. We believe our investment in modern equipment and technology enables our facility care teams to identify and respond to patient needs and provide them high quality care in a timely manner. Moreover, our clinicians are highly trained, have significant experience, and are able to leverage bespoke care plans to help ensure that patients receive care tailored to their particular needs.

Value Proposition for Referring Providers

- ***Strategic and seamless transitions.*** Our administrators and their interdisciplinary teams seek to become a preferred partner by developing a deep understanding of local referring providers' and their patients' needs. Administrators often visit with patients and their families prior to hospital discharge to plan for and map out a smooth admission to our facility. Once a plan is set, the facility team endeavors to quickly and seamlessly transition new patients to the facility with a focus on ensuring continuity of care in the transition. We believe that hospitals and other referral sources consider our facilities to be attractive discharge options because we are able to care for a wide variety of patient needs, and are often able to accept admissions on short notice, including on nights and weekends. Our flexibility helps hospitals maintain adequate bed availability to meet their other patients' needs.

- ***Trusted partner with quality care.*** Our ability to care for higher acuity patients enables referring providers to have confidence that we will be able to adequately care for their patients and assist them in their recovery. Our facilities seek to work with patients' doctors to create personalized care plans to help ensure that patients stay on track in their recovery and to reduce the likelihood of their readmission to the hospital. Our facility teams also seek to coordinate closely with a patient's home health agency or other post-SNF caregivers to try to ensure the patient's transition home or to their next care setting is successful. This close coordination enables us, where warranted, to directly readmit patients back to our facility who would have otherwise been readmitted to an acute care hospital in the event they have a change of condition after leaving our facility.

Value Proposition for Payors

- ***Higher value site of care.*** We believe we provide high acuity care in a cost-effective setting and are able to quickly transition patients from the acute care setting, reducing length of stay and delivering more overall value for payors. Moreover, we believe we provide payors with a high-quality alternative to higher cost post-acute sites of care. For example, according to MedPAC, SNFs are the lowest cost facility-based post-acute healthcare, costing an average of $577 per covered day compared to $1,957 and $1,788 per covered day for inpatient rehabilitation facilities and long-term acute care hospitals, respectively.

- ***Culture of compliance.*** We focus on instilling a unified, cohesive culture of innovation and compliance that we believe provides consistency in our results and confidence in our facilities as an attractive care option for patients. Our emphasis on billing integrity, our independent internal compliance function, and our regular facility billing audits are intended to provide a foundation of trust and collaboration that makes us a natural choice for payors.

Value Proposition for Administrators and Clinicians

- ***Autonomy and aligned compensation.*** Each facility administrator is, in effect, the local "CEO" and dedicated leader of their facility. Alongside their local interdisciplinary team, they are empowered to make real-time decisions locally around all aspects of their business and to manage their individual facility in a way that they believe is best suited to address their local market and its needs, subject to compliance with company policies and procedures. We have designed a transparent incentive model for our administrators that is intended to align their compensation with operational and financial performance and with the quality of care of their facility. We provide them the tools and the autonomy to optimize the performance of their facility, and we reward them for success in their efforts. We believe that a well-performing facility is the result of providing quality care in an environment of healing and caring and one that is appropriately staffed, supplied, and equipped to meet the needs of its patients. This dedicated focus by our administrators and their local teams on patient outcomes drives demand for our services and can ultimately result in higher patient census and profitability.

- ***Robust technology enabled operating infrastructure.*** We developed PACS Services to reduce the managerial and operational burden on our administrators, enabling them to focus on leading their facilities and spending more time with patients and staff. PACS Services includes a robust suite of technology tools that provide detailed real-time data and trends that local clinicians and leadership teams can use to monitor and improve operational performance. PACS Services also includes regional support teams that leverage their deep tenure and experience across markets to provide higher-level support to local leaders on complex issues, including billing and cost reporting practices and regulatory compliance obligations. The regional teams are connected to and support the facilities within their designated region, which enables them to identify best practices and trends within the region, communicate those across their region, and provide facility-level support as needed.

- ***Highly entrepreneurial career development.*** By providing our administrators with autonomy in the operation of their facility, we believe we create a highly entrepreneurial environment that encourages and rewards leaders to optimize operational performance. We empower our clinicians to do the same and provide top performers the opportunity to progress via training for higher skill licenses and certifications. People are provided the opportunity to advance to become an administrator through our Administrator-in-Training program, and to join a regional leadership team. For example, in the year ended December 31, 2025, we promoted 56 of our administrators from within our organization after participating in our Administrator-in-Training program, and 18 of our RVPs were previously successful administrators with us.

Our Competitive Strengths

We believe our success is driven by the following competitive strengths:

Superior Overall Quality

Excellence in clinical quality and experience for our patients is at the forefront of our mission and is reflected in our above-industry average QM Star rating and occupancy rate. Our facilities employ skilled administrators and clinicians and equip them with purpose-built technology and support so they can operate at the top of their professional capacity and deliver high-quality care for patients. We continuously invest in our people, processes, and facilities to promote an excellent patient experience. We believe we deliver superior overall quality that has contributed to our reputation as a provider-of-choice in our communities, driving greater referral volumes from referring providers who value our high standards.

Locally Led Market-Driven Operating Model

Our locally led, centrally supported model is decentralized and emphasizes local operational autonomy. We believe that placing decision-making power at the local level with teams who understand the needs of their patients and their communities facilitates responsiveness and adaptability to evolving patient needs and facility and community factors. We believe the empowerment of local leadership promotes improved quality care for patients, greater referral volumes and higher occupancy rates. Our operating model is highly transferable to new markets, and enable us to quickly integrate and enhance new facilities.

Transparent and Meritocratic Leadership Culture

We have built a transparent, competitive, and collegial culture that promotes individual growth both personally and professionally and prioritizes a deep commitment to our patients, families, and team members. We promote transparency in performance, which we believe encourages collaboration and healthy competition among local leadership that in turn drives best practices. We believe this meritocratic culture, supported by highly seasoned industry veterans, helps optimize clinical and financial outcomes at facilities and instills accountability throughout the organization. This leadership mindset has empowered us to develop a deep bench of leaders capable of supporting our existing and future facilities.

Employer-of-Choice with Directly Aligned Incentive Model

We believe that we are an employer-of-choice in the post-acute care industry, which enables us to attract and retain highly motivated, entrepreneurial individuals who value operational independence and financial opportunity. This has enabled us to attract enterprising individuals from diverse backgrounds who may not have otherwise considered careers in skilled nursing. Our compensation model is designed to align local individual incentives with the long-term clinical quality and operational performance of the facility, which we believe fosters a shared ownership mentality. We believe this

directly aligned incentive model has played a critical role in successfully attracting, incentivizing, and retaining our industry veterans.

Robust Suite of Technology-Enabled Services

Our technology focus delivers real-time data access to caregivers and administrators, facilitating delivery of the right care at the right time. Our technology tools enable our local leadership teams to focus on their first priority, providing the highest quality care possible to patients. We believe our suite of technologies helps drive decision-making and enhances operating efficiencies that can improve clinical quality, operational metrics, and the financial performance of our facilities. While other facility administrators may spend considerable time on paperwork and low-value activities, we strive to reduce the administrative burden on our facility administrators so they can walk the halls, personally meet patients, and provide a bespoke, concierge-level customer service experience. We equip our clinicians with industry-leading technology, including point-of-care and digital charting technologies, which streamlines charting and paperwork, so they can spend more time with patients and focus on providing high quality care. We believe our technology and internally developed dashboards help to facilitate better patient care, risk management, regulatory compliance, staffing, and resource allocation. We have designed our technology to be easily integrated into new facilities and enable us to scale quickly and efficiently.

Differentiated, Multi-faceted, and Disciplined Acquisition Playbook

Since founded, we have demonstrated the effectiveness of our disciplined, multi-faceted playbook of acquiring and improving underperforming facilities, having successfully acquired and integrated over 300 facilities to date. We believe we have established a reputation as an acquiror-of-choice, which has led to several inbound opportunities, and has helped us build an extensive opportunity pipeline. Our balanced approach to evaluation enables us to selectively pursue opportunities that meet our strategic priorities and criteria and grow in a responsible manner. Through our investment into facilities and our integration process, we are able to transition new underperforming facilities to higher-value short-term transitional care facilities. We believe our success is evidenced by our robust QM Star ratings, occupancy rates, and profitability at our Mature facilities.

Our High-Quality Facilities

We are committed to providing a high-quality experience for all of our patients, which is why we invest in capital improvements and ongoing maintenance to all of our facilities, regardless of whether we lease or own. Our investment into facilities is differentiated from traditional industry operators who we believe are often hesitant to make physical plant investments into facilities and who often seek to extract value through cost-cutting or other limitations on facility resources. Our renovations are intended to improve the look and feel of facilities in order to provide an excellent experience. Our investments into medical beds, vitals monitors, physical therapy equipment, and other improvements enables us to provide services to higher acuity patients. We believe our high-quality facilities lead to sustained referral volumes, more admissions, and high skilled mix at our facilities, ultimately leading to higher occupancy rates and revenue per patient day. We also believe our investment into leased facilities makes us a preferred tenant with our landlords and provides us leverage in negotiating favorable lease terms.

Our Size and Scale

We believe our market density in key regions offers strategic advantages, such as brand recognition with referring providers, including hospitals and health systems, and consistency and continuity of referrals of patients. For example, our ability to accommodate a high volume of patients within our markets enables us to accept referrals without turning patients away to competitors, and can also further our reputation as a reliable, go-to provider of care for referring providers. We also believe our size and scale has provided us with the ability to negotiate favorable contracts with managed care and other payor sources, the ability to navigate stringent regulatory compliance obligations and withstand potential reimbursement and regulatory industry dynamics, and the ability to leverage real estate value for liquidity and growth.

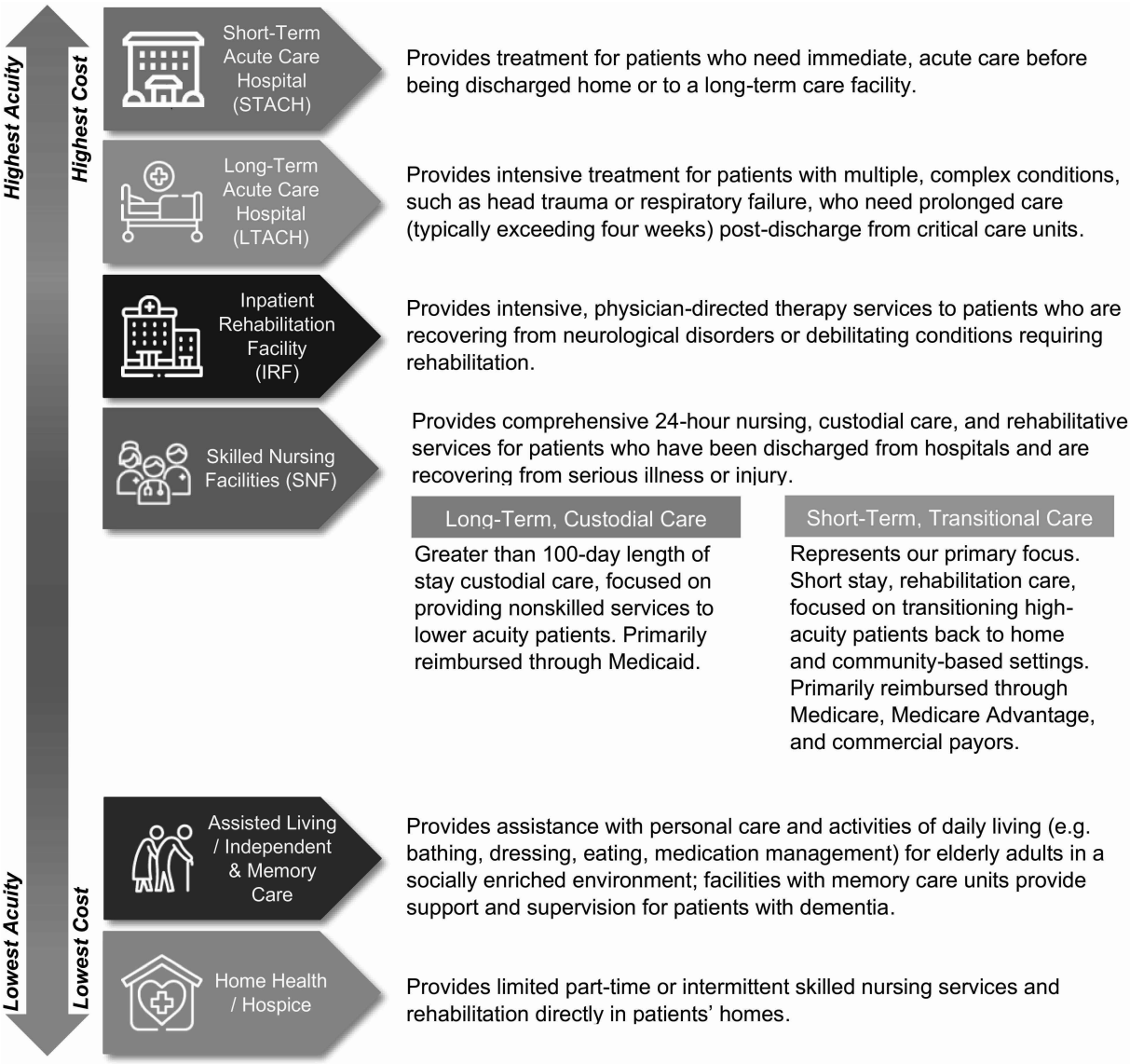
Industry Overview and Market Opportunity

The Post-Acute Care Continuum is Essential to the Healthcare Ecosystem

We operate in the post-acute care industry, which is an essential component of the healthcare delivery ecosystem, serving high need, medically fragile patients. Post-acute care encompasses multiple care settings outside of acute care hospitals that are differentiated by the acuity level of patients and the services they require. While services may overlap

across each distinct post-acute offering, post-acute rehab or SNFs provide the most comprehensive array of services. Upstream care providers, such as acute care hospitals, generally discharge patients to post-acute facilities where patients can receive key services at lower costs. For example, according to MedPAC, SNFs cost an average of $577 per covered day compared to $3,100 for short-term acute care hospitals.

Post-Acute Care Continuum



SNFs are an Integral and Essential Part of the Post-Acute Care Continuum

SNFs play an essential role in post-acute patient care. SNFs provide higher-acuity skilled nursing care to patients that cannot be adequately treated in community-based care settings, such as assisted living or independent living facilities, and who are no longer appropriate candidates for hospital care. Patients referred to a SNF are typically recovering from surgery or non-critical conditions, such as strokes, joint replacements, and acute infections, and are admitted to a SNF within 30 days of being discharged from a hospital where they spent at least three days as an inpatient. In many instances, patients are treated at SNFs prior to receiving home health nursing care and therapy services. The majority of SNF patients are aged 65 years or older. Despite the wide array of services and variety of needs addressed, MedPAC reports that SNFs are the lowest cost facility-based post-acute healthcare, costing on average $577 per covered day compared to $1,957 and $1,788 per covered day for inpatient rehabilitation facilities and long-term acute care hospitals, respectively. According to MedPAC data, SNFs accounted for approximately 50% of the total post-acute care continuum spend in 2023. According to CMS Inpatient Hospital discharge data, in the first half of 2023, approximately 24% of Medicare patients over 65 years old were

discharged to SNFs, representing more than any other facility type, including inpatient rehabilitation facilities and long-term acute care hospitals (approximately 6%), and more than home health nursing care (22%) or hospice (5%). As reimbursement and coverage continues to shift toward value-based models with greater emphasis on controlling costs, SNFs are integral to post-acute care and can continue to drive high-quality outcomes in low-cost settings.

The skilled nursing industry can be classified into two main sub verticals: A) long-term custodial care and B) short-term transitional care. Long-term custodial care predominantly focuses on lower acuity, Medicaid-eligible patients and provides institutional, custodial care services, including nonskilled, personal care services such as assistance with bathing, dressing, or eating. Short-term transitional care predominantly treats higher acuity, Medicare-eligible patients and primarily provides short-term inpatient-level skilled nursing care such as rehabilitation, physical therapy services, and intravenous injections.

Large, Fragmented Industry Comprised of Mostly Small and Independent Operators

According to the National Center for Health Statistics (NCHS) 2020 National Post-acute and Long-term Care Study, the SNF industry in the United States encompasses approximately 15,000 facilities and serves approximately 1.3 million patients annually. The industry is highly fragmented, with the top 10 operators, each having greater than approximately 100 facilities, representing approximately 11% of total number of SNFs in the United States, according to CMS data as of September 2024, and approximately 5,000 smaller and independent operators of less than 100 facilities making up the remainder. According to such data, approximately 73% and 27% of SNFs are located in urban and rural areas, respectively. In addition, approximately 73%, 21%, and 6% of SNFs are operated as for-profit, non-profit, and by the government, respectively, according to such data. We believe this fragmented landscape creates opportunities for larger providers with greater scale to serve patients better and meet regulatory requirements nation-wide by effectively addressing staffing, quality standards, and billing processes. Moreover, many small and independent operators face pressure due to billing requirements, regulations, competition on quality of care and facilities, staffing shortages and competition, and the cessation of COVID-related provider relief funding, which has led them to pursue sales of their facilities or businesses. This provides additional opportunity for well-managed, high-quality operators to grow through acquisitions.

Growing Demand Outpacing Supply of Skilled Nursing Facilities

The demand for healthcare services in the United States has increased in recent years and is expected to continue growing, largely due to a rapidly aging population and an increasing prevalence of chronic conditions. According to the U.S. Census Bureau, the U.S. population aged 65 and older is expected to nearly double from 2020 to 2060 and reach 95 million in 2060, which exceeds the expected increase in the general population during that same period, and comprise one fifth of the total U.S. population in 2030. Moreover, according to the U.S. Census Bureau, the U.S. population aged 85 and older is expected to nearly triple from 2020 to 2060 and reach 19 million in 2060. Additionally, according to an article published in Frontiers in Public Health in 2022, the percentage of people in the United States aged 50 and older with at least one chronic condition is estimated to increase by 99.5% from 2020 to 2050. According to CDC data as of 2022, approximately 83% of SNF patients were 65 years of age or older.

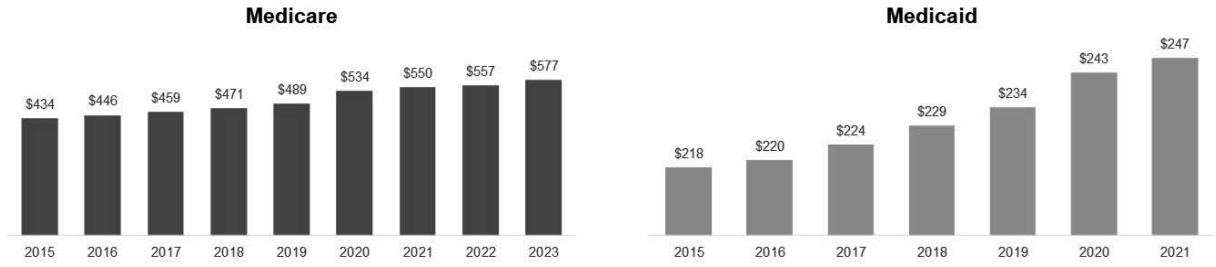
As demand has increased for SNFs, the number of SNFs has declined in recent years from approximately 15,650 in 2017 to approximately 14,740 in 2025. We believe this is due to a variety of factors, including an inability of many facilities to comply with quality standards, rigorous staffing, and billing requirements, and a lack of technology and sophistication at small and independent operators. Furthermore, new operators face multiple barriers to entry, including the requirements to obtain a Certificate of Need, complex licensure requirements, lack of operating experience, and significant capital requirements. As a result, the addition of new SNFs has not kept pace with the number of SNFs exiting the market, amplifying the need for skilled nursing to serve an aging population.

Favorable Reimbursement Environment

According to CMS, approximately 72% of SNF revenue in 2022 was derived from government sources, including Medicare and Medicaid. Medicare represents 21% of industry revenue, while Medicaid represents approximately 51%. The remainder comprises managed care, private pay, and other payors. Medicare and Medicaid reimbursement has steadily increased over the past few years. Medicare reimbursement per patient day increased at a CAGR of approximately 3.4% from 2012 to 2023, while Medicaid reimbursement per patient day increased at a CAGR of approximately 1.9% from 2012 to 2021. During that time, the industry experienced continued growth in reimbursement rates.

The following charts depict the increase in Medicare Fee for Service reimbursement per patient day from 2015 through 2023 and the increase in Medicaid Fee for Service reimbursement per patient day from 2015 through 2021, as reported by CMS.

Medicare and Medicaid Reimbursement Per Patient Day



Regulatory Environment

The SNF industry is highly regulated with stringent regulatory compliance obligations. In the ordinary course of business, providers are subject to federal, state and local laws and regulations relating to, among other things, billing and reimbursement, relationships with vendors, business relationships with physicians and other healthcare providers and facilities, as well as licensure, accreditation, enrollment, quality, adequacy of care, physical plant, life safety, personnel, staffing and operating requirements. Changes in law or new interpretations of existing laws and regulations may have a significant impact on revenue, costs and business operations of providers and other industry participants. In addition, governmental and other authorities periodically inspect the SNFs, senior living facilities and outpatient rehabilitation agencies to verify continued compliance with applicable regulations and standards and may impose citations and other regulatory penalties for regulatory deficiencies. Such regulatory penalties include but are not limited to civil monetary penalties, temporary payment bans, suspension or revocation of a state operating license and loss of certification as a provider in the Medicare or Medicaid program, which may be temporary or permanent in nature. This regulatory environment and related enforcement can have an adverse effect on providers and other industry participants. See the section titled “Business—Regulatory Matters.”

Our Market Opportunity

Despite the decline in the number of SNFs, the industry is large and growing, with CMS expecting total industry expenditures to increase from $193.6 billion in 2022 to $283.3 billion in 2031, representing a CAGR of 4.3%. Based on the number of facilities as reported by CMS, we are one of the largest SNF operators in the United States and believe our scale and other competitive strengths uniquely position us to capitalize on the current underlying trends within the SNF industry and capture a growing portion of this expected growth.

Our Growth Strategy

We have built a multi-faceted growth strategy with multiple organic and inorganic levers to help drive our growth and capitalize on the favorable industry dynamics. To continue our growth, we intend to:

- ***Expand our presence in existing and new markets.*** We have a robust pipeline of potential single-facility tuck-in acquisitions, larger multi-facility portfolio acquisitions and select new facility builds across existing and new markets. We have historically completed an average of approximately 25 acquisitions and one de-novo, or new-build, facility per year, but have the flexibility to increase or decrease this cadence from period to period in line with our business priorities and as strategic opportunities arise. We plan to continue to strategically pursue opportunities within our pipeline to supplement our organic growth. While we expect to continue to execute on this strategy, we do not have binding agreements or commitments for any material investments at this time.

- ***Leverage operational upside within our existing footprint.*** Our portfolio has a healthy foundation for strong embedded organic growth. We are focused on driving higher occupancy and increasing skilled mix in an effort to fill unused capacity with higher acuity patients, which can improve our revenue per patient day and our profitability, which in turn drive growth. Historically, we have found that it takes up to 3 years for a New facility

to scale to performance similar to that of a Mature facility. As of December 31, 2025, we had 69 New and 102 Ramping facilities, which we believe provides us some degree of near-term visibility into expected organic growth within our footprint.

- ***Continue to grow our pipeline of leaders.*** Our rapid growth in size and scale can be attributed to our deep bench of talented leaders. Our administrators in training provide us with leadership resources that we can use to quickly staff new facilities with qualified operators. Similarly, our RVPs enable us to scale within regions. We intend to invest heavily in training existing leaders and expanding our bench of new administrators and RVPs and to support our future growth.

- ***Extract embedded value from real estate ownership.*** We plan to continue to evaluate our real estate purchase options in an effort to reduce our rent burden and grow the underlying earnings of our business. Throughout the history of the Company, we have selectively exercised various purchase options, and had 37 additional options available to us as of December 31, 2025. We intend to continue to selectively exercise purchase options and continue structuring additional purchase options to provide an additional lever to grow net margins and enhance stockholder value. Moreover, we believe that our real estate ownership provides balance sheet support as an inflationary hedge, provides capital flexibility as a source of asset collateral, reduces the burden of leases and restrictive agreements, and provides us opportunities to create additional value by improving distressed assets.

- ***Ancillary opportunities.*** We have identified and continue to evaluate multiple investment opportunities that have the potential to improve our post-acute patient experience by augmenting the services we provide. We may capitalize on these investment opportunities that are ancillary to our core business, such as pharmacy services, laboratory services, transportation, and imaging, which have the potential to be additional sources of revenue and operating income over time. We refer to these efforts to build a strategic mix of investments in ancillary business lines as "PACS Ventures." We continue to evaluate opportunities to in-source, acquire, and commercialize these ancillary opportunities. Additionally, we may choose to monetize our PACS Services by offering it to third-party SNF operators in the future.

- ***Expand into other post-acute sites of care.*** We believe that our proven operational playbook and focus on delivering high-quality care have the potential to be utilized in additional post-acute sites of care, including home health and hospice as well as within broader senior living communities. As of December 31, 2025, we had two independent living facilities and 28 assisted living facilities which provide a foundation for further expansion.

Human Capital Resources

Our Culture and Values

Our leading culture of collegiality and committed focus on quality is driven from the top with entrepreneurial, passionate leaders who are determined to deliver a superior experience for patients and staff. Our culture of transparency across our regions and facilities fosters an environment where best-practices are shared among regions which promotes healthy competitiveness and constant improvement across our facilities.

Our culture is centered on the following core values:

- **Love.** We recognize that love is the foundation for providing care to the vulnerable. We support our clients as they build a culture of loving care within and beyond their communities.

- **Excellence.** We look for and act on opportunities to improve every day.

- **Trust.** We act with integrity and expect the same of others.

- **Accountability.** We seek responsibility for our actions, attitudes, and mistakes.

- **Mutual respect.** We treat others the way they want to be treated.

- **Commitment.** We are committed to providing exemplary, compassionate care to our residents and patients, and finding joy and satisfaction in our work as a team.

Our Employees

As of December 31, 2025, we had 47,455 employees working across 321 post-acute care facilities in 17 states and at our corporate headquarters in Salt Lake City, Utah. Of our 47,455 employees, 27,696 are clinicians, including approximately 3,750 RNs including DONs, approximately 6,806 LPNs, and approximately 17,140 CNAs. Approximately 19,759 of our employees work in non-clinical functions and administrative / support functions, including 21 RVPs, 256 facility administrators, 25 senior living executive directors, 224 clinical and compliance support, 90 information technology support, and approximately 19,143 additional administrative and support staff. We also employ a dedicated team specifically focused on ensuring smooth functioning and support for our point-of-care including the clinical and compliance support, information technology support above. Additionally, 6,313 of our employees were represented by unions under collective bargaining agreements as of December 31, 2025.

Our senior management team boasts extensive experience, totaling an average of over 11.1 years with us and 21.1 years within the SNF industry as of December 31, 2025. As of December 31, 2025, our RVPs had a combined average of 7.2 years of experience with the Company, our administrators an average of 3.0 years and our Directors of Nursing an average of 3.2 years.

Competition

The post-acute care industry is highly competitive and fragmented and we compete with numerous local and regional providers, in addition to large national providers that have achieved geographic diversity and economies of scale. We expect that the industry will become increasingly competitive in the future. Our independently operated facilities also compete with inpatient rehabilitation facilities and long-term acute care hospitals. Increasingly, we are competing with home health and community-based providers who have developed programs designed to provide services to seniors outside a facility-based setting, potentially decreasing the time they need the higher level of care provided in a SNF. Competitiveness may vary significantly from location to location, depending upon factors such as the number of competing facilities, availability of services, expertise of staff, and the physical appearance and amenities of each location. We believe that the primary competitive factors in the post-acute care industry are:

- ability to attract and to retain qualified management and clinicians;
- reputation and achievements of quality healthcare outcomes;
- attractiveness and location of facilities;
- ability to charge competitive prices;
- the expertise and commitment of the management team and employees; and
- community value, including amenities and ancillary services.

We seek to compete effectively in each market by establishing a reputation within the local community as a preferred provider of post-acute care services. This means that the facility administrators are generally free to discern and address the unique needs and priorities of referring providers, patients, payors and other stakeholders in the local community or market, and then create a superior service offering and reputation for that particular community or market that is calculated to encourage prospective patients and referral sources to choose or recommend the facility.

Increased competition could limit our ability to attract and retain patients, qualified management and caregivers, maintain or increase rates or to expand our business. Some of our competitors have greater financial and other resources than we have, may have greater brand recognition and may be more established in their respective communities than we are. Competing companies may also offer lower costs, newer facilities or different programs or services than we offer, and may therefore attract individuals who are currently patients of our facilities, potential patients of our facilities, or who are otherwise receiving our healthcare services. Other competitors may have lower expenses or other competitive advantages than us and, therefore, provide services at lower prices than we offer.

Regulatory Matters

Healthcare

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 revenue, costs and business operations. Our independent operating facilities that provide healthcare services are subject to federal, state and local laws relating to, among other things, licensure, accreditation, enrollment, quality, adequacy of care, physical plant, life safety, personnel, staffing and operating requirements. In addition, these facilities are subject to federal and state laws that govern billing and reimbursement, relationships with vendors, business relationships with physicians and other healthcare providers and facilities, and workplace protection for healthcare staff.

Governmental and other authorities periodically inspect the SNFs, senior living facilities and outpatient rehabilitation agencies 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. The operations can only participate in these third-party payment programs if 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. These statements of deficiency may require corrective action to regain and maintain compliance. In some cases, federal or state regulators may impose other remedies including imposition of civil monetary penalties, temporary payment bans, loss of certification as a provider in the Medicare or Medicaid program, or suspension or revocation of a state operating license.

The regulatory environment surrounding the healthcare industry subjects providers to significant scrutiny. In the ordinary course of business, we and other 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 United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG), the United States Department of Justice (DOJ), state Medicaid agencies, state Attorney Generals, local and state ombudsman offices and 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 the Medicare and Medicaid 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.

As discussed in more detail in Part I. Item 3 “Legal Proceedings,” we have received two Civil Investigative Demands from the U.S. Department of Justice (“DOJ”) and one from the U.S. Attorney’s Office requesting information and documentation relating to investigations to determine if we have violated the Federal False Claims Act by improperly inducing patient referrals or by submitting false claims to Medicare. We have also received a subpoena from the DOJ Criminal Division per the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) relating to an investigation into possible violations of various sections of 18 U.S.C. that prohibit the making of fraudulent or false statements to any branch of the government of the United States, and a subpoena from the Respiratory Care Board of California (the “RCB”) relating to an investigation to determine if a Respiratory Care Practitioner (“RCP”) fraudulently documented providing respiratory treatments to two patients at one of our facilities. While we are cooperating with each of these investigations, we cannot predict their outcome and there are significant legal and other expenses involved that consume financial and personnel resources. Expansion of enforcement activity could have an adverse effect on our business, financial condition, or results of operations.

Medicare and Medicaid Reimbursement and Requirements

Medicare and Medicaid represent our largest sources of revenue and accounted for 33.7% and 40.5% of our routine revenue for the year ended December 31, 2025, respectively. The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. The Medicare program and state Medicaid programs and their reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare and state Medicaid programs reimburse us for our services. Budget pressures often lead the federal government to reduce or place

limits on reimbursement rates under Medicare and Medicaid. We cannot predict the extent to which such proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and legislation will have on us. Historically, adjustments to reimbursement under Medicare and Medicaid programs, due to such changes or government actions, have had a significant effect on our revenue.

Medicaid - In March of 2020, the Families First Coronavirus Response Act (FFCRA) provided a 6.2% increase to the Federal Medical Assistance Percentage (FMAP) during the PHE. In addition to this funding increase, the FFCRA imposed conditions restricting the disenrollment and standards for re-enrolling Medicaid beneficiaries to promote continuous care of beneficiaries during the PHE. The bipartisan omnibus spending plan passed by Congress and signed into law by the President on December 29, 2022, amended these Medicaid enrollment protections and increased FMAP funding provided in the FFCRA. The FMAP increase CMS provided to states was subject to reductions in 2023. The ultimate amount of funding from each state varied substantially based on that states' policies.

Medicare Annual Payment Rule and Updates - The Balanced Budget Act of 1997 required the implementation of a per diem prospective payment system (PPS) for SNFs covering all costs related to the provision of services to Medicare Part A beneficiaries. The SNF PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of furnishing covered SNF services (routine, ancillary, and capital-related costs). CMS is required to calculate an annual Medicare market-basket update to the payment rates, which is an inflation measure of SNF input prices.

On July 31, 2025, CMS issued the final rule for Fiscal Year (FY) 2026, which is in effect from October 1, 2025 through September 30, 2026. The SNF PPS FY 20206 Final Rule updates SNF PPS rates by 3.2% 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 include the SNF Value-Based Purchasing (VBP) Program reductions for certain SNFs subject to the net reduction in payments under the SNF VBP. In addition to updating payment rates, the FY 2026 SNF PPS Final Rule also included updates to ICD-10 code mapping, the VBP program, and quality reporting program. The SNF PPS FY 2025 Final Rule included significant enhancements to CMS' enforcement capabilities within nursing homes, aiming to reinforce the safety and quality of care. The final rule broadened CMS's ability to levy financial penalties as a means to ensure sustained remediation of health and safety infractions. The final rule eliminated certain restrictions on the imposition of per instance (PI) civil monetary penalties (CMPs) and per day (PD) CMPs, allowing for more flexible imposition of both PD and PI penalties within statutory dollar amounts. In addition, the revisions enabled the imposition of CMPs for any noncompliance that was previously cited in the past three standard surveys for which no CMP was yet imposed. These changes are intended to provide CMS with enhanced tools to address violations more effectively and reflect the severity of the impact on residents' health and safety. The expanded enforcement policies became effective on October 1, 2024, and operationalized beginning March 3, 2025.

Patient-Driven Payment Model (PDPM) - The PDPM, a case-mix classification model used in the SNF PPS for classifying SNF patients in a stay covered under Medicare Part A, became effective October 1, 2019. PDPM classifies patients into payment groups based on the patient's condition (clinically relevant factors) and resulting care needs, rather than on the volume of services provided, to determine Medicare reimbursement. PDPM utilizes five case-mix adjusted payment components: physical therapy, occupational therapy, speech language pathology, nursing and social services and non-therapy ancillary services. It also uses a sixth non-case mix component to cover utilization of SNFs' resources that do not vary depending on resident characteristics. In the FY 2026 SNF PPS Final Rule, CMS finalized several changes to the PDPM ICD-10 code mappings to allow providers to provide more accurate, consistent, and appropriate primary diagnoses that meet the criteria for skilled intervention during a Part A SNF stay. These updates are intended to improve coding accuracy and better reflect patients' primary diagnoses during SNF stays, potentially impacting reimbursement levels and case-mix classifications for the skilled nursing facilities operated by our independent subsidiaries.

Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program - All SNFs that receive reimbursement under the SNF PPS are also subject to the SNF Value Based Purchasing (VBP) Program. CMS withholds 2% of SNFs' Medicare FFS Part A payments to fund the SNF VBP Program, and CMS is then required to redistribute 50-70% of this amount to SNFs as incentive payments based on their performance in the SNF VBP Program. For the FY 2025 Program year, performance in the SNF VBP Program is based on a single measure of all-cause hospital readmissions. Beginning in the FY 2026 program year, the measures will be expanded to also include (1) Skilled Nursing Facility Healthcare Associated Infections Requiring Hospitalization (SNF HAI), (2) Total Nursing Hours per Resident Day Staffing (Total Nurse Staffing), and (3) Total Nursing Staffing Turnover. Beginning in the FY 2027 program year, the measures will be further expanded to include Discharge to Community—Post-Acute Care Measure for Skilled Nursing Facilities (DTC PAC SNF), (2) Percent of Residents Experiencing One or More Falls with Major Injury, (3) Discharge Function Score for SNFs, and (4) Number of Hospitalizations per 1,000 Long Stay Residents Days. In FY 2028, the measures will be expanded to include

Skilled Nursing Facility Within-Stay Potentially Preventable Readmission. The FY 2025 SNF PPS final rule also adopted several operational and administrative updates to the SNF VBP Program, including a policy to select, retain and remove measurements to ensure the VBP Program's evaluation metrics remain relevant and effective for assessing care quality, as well as policies for updating technical measures and policies for reviewing and correcting data CMS relies upon to calculate its measures. In the FY 2026 SNF PPS Final Rule, CMS finalized a series of operational and administrative proposals for the SNF VBP Program. Operationally, this includes establishing performance standards for fiscal years 2028 and 2029, applying the scoring methodology for the SNF Within-Stay Potentially Preventable Readmission measure, and removing the VBP program's health equity adjustment from the scoring methodology. Administrative updates include the adoption of a new reconsideration process for the review and correction of disputes, as well as technical updates to the program's regulation text.

Skilled Nursing Facility – Quality Reporting Program (SNF QRP) - The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) created data reporting requirements for certain Post-Acute-Care (PAC) providers. The IMPACT Act requires that each SNF submit its quality data and standardized patient assessment data elements in connection with the Quality Reporting Program (QRP). If a SNF does not submit required quality data, the SNF's annual payment update rates are reduced by 2.0% for each noncompliant fiscal year. Beginning in FY 2027, CMS will require participation in a process to validate data submitted under the SNF QRP. In the FY 2026 SNF PPS Final Rule, CMS finalized its proposal to update the process for a SNF to request reconsideration of an initial determination of non-compliance with the SNF QRP reporting requirements, and will allow SNFs to request an extension to the deadline to file a request for reconsideration, and expands the bases on which CMS can grant a reconsideration request. CMS also summarized comments on future measure concepts for the SNF QRP, potential revisions to the data submission deadlines for assessment data collected for the SNF QRP from 4.5 months after the end of each quarter to 45 days after the end of each quarter, and advancing digital quality measurement in SNFs.

2025 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. For example, the 2025 Home Health PPS final rule requires long-term care facilities, including SNFs, to make at least weekly reports to CMS regarding respiratory illnesses, including 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 a 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. Due to subsequent legislative amendments to the statute, the sequestrations will remain in effect through 2032, with the exception of a temporary suspension from May 1, 2020 through March 31, 2022.

Medicare Part B Requirements - Some of our revenue is paid by the Medicare Part B program under a fee schedule. Medicare Part B provides reimbursement for certain physician services, limited drug coverage, and other outpatient services outside of a Medicare Part A covered patient stay. Although certain therapy services were historically subject to a payment cap, the Bipartisan Budget Act of 2018 (BBA) repealed those caps while retaining and adding additional limitations to ensure appropriate therapy services. The BBA also establishes coding modifier requirements and retains the targeted medical review process established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) at a threshold amount of $3,000. The Current Year (CY) 2025 Physician Fee Schedule (PFS) Final Rule reduced the conversion factor (i.e., the number by which CMS determine all current procedural terminology code payments) by 2.83% from the CY 2024 conversion factor. This changed lowered the overall payment rate under the PFS by 2.93% in CY 2024 compared to CY 2023. On July 14, 2025, CMS issued the CY 2026 PFS Proposed Rule, which contains updates to payment methods and models, encourages care coordination, reduces collection and reporting of data measurements, and continues certain telehealth flexibilities that began during the COVID-19 pandemic. Beginning in CY 2026, there will be two separate conversion factors for qualifying alternative payment model (APM) participants (QPs) and one for physicians and practitioners who are not QPs. CMS proposes an APM conversion factor of 0.75% for QPs and 0.25% for non-QPs, with a one-year statutory 2.5% increase for 2026. The proposed APM conversion factors represents a projected increase of 3.8% for QPs from the current conversion factor, and a projected increase of 3.3% for non-QPs from the 2025 level.

Programs of All-Inclusive Care for the Elderly

Programs of All-Inclusive Care for the Elderly (PACE) provides medical and social services to elderly individuals who qualify for nursing home care but, at the time of enrollment, can still live safely in the community. CMS conducts a comprehensive annual review of the PACE organization's operation of the PACE program during a 3-year trial period to

assure compliance with all significant requirements. For example, each PACE organization must establish an interdisciplinary team that, among other responsibilities, comprehensively assesses the individual needs of each participant and assigns each participant to an interdisciplinary team. On April 12, 2023, CMS published updates to the PACE program, including to the determination of a contract year and the types of contracted services. In addition, effective January 1, 2025, PACE organizations must comply with new prescription drug event (PDE) reporting requirements to receive manufacturer discounts for drugs provided through Medicare Part D as provided for in the Inflation Reduction Act of 2022 (IRA).

Federal Healthcare Reform

Patient Protection and Affordable Care Act - In recent years, there have been, and we expect there will continue to be, a number of legislative and regulatory changes to the U.S. healthcare system, many of which are intended to contain or reduce healthcare costs. For example, the Affordable Care Act (ACA) affects how healthcare services are covered, delivered and reimbursed, and it expanded health insurance coverage through a combination of public program expansion and private sector health insurance reforms. 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. These reforms include modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. Since its enactment, there have been judicial, executive and Congressional challenges to certain aspects of the ACA and, on June 17, 2021, the U.S. Supreme Court dismissed the most recent judicial challenge to the ACA brought by several states without specifically ruling on the constitutionality of the ACA.

In August of 2022, Congress passed and the Biden Administration signed into law the Inflation Reduction Act of 2022 (IRA), which continued and expanded certain provisions of the ACA. Among other things, the IRA extended premium subsidies in the form of advanced premium tax credits paid by the federal government through the end of 2025, resulting in subsidies being available to offset or reduce the costs of private health insurance policies for older persons on fixed incomes or with limited savings. This may aid older patients in obtaining or keeping their health insurance in order to pay for long-term care services. However, if Congress does not take action, the enhanced subsidies will expire at the end of 2025, and insurance coverage could become unaffordable for certain individuals. Other healthcare-related provisions of the IRA include phased-in provisions for Medicare to negotiate the prices of certain prescription drugs, limiting the out-of-pocket cost of prescribed drugs to Medicare Part D recipients to $2,000 per year (in addition to a monthly cap on out-of-pocket prescription drug expenses) and limiting the monthly cost of insulin to $35.

The One Big Beautiful Bill Act – The One Big Beautiful Bill Act (OBBBA), which was enacted in July 2025, imposes significant reductions in the funding of the Medicaid program. The law requires states to establish work requirements and conduct more frequent participant eligibility redeterminations, among other modifications. Although the full impact of the OBBBA is uncertain at this time, these changes are expected to reduce enrollment in state Medicaid programs. The timing and magnitude of the reductions may vary by state depending on how quickly states implement the changes, how states may adapt their future tax and Medicaid funding policies in response, as well as other macroeconomic factors. The law also limits payments to Medicaid providers to 100% of the mandated Medicare rate for expansion states and 110% of the Medicare rate for non-expansion states. The following provisions of the OBBBA are expected to impact particularly impact Medicaid reimbursement mechanisms and enrollment dynamics relevant to our business.

Many states use financial arrangements referred to as provider taxes, which are state taxes assessed on healthcare providers or facilities, to generate funds to help pay for the non-federal share of Medicaid costs, including payments to SNFs. Under the Patient Protection and Affordable Care Act (ACA), provider taxes were capped at 6% of a provider's net patient revenue. Existing federal law prohibits state Medicaid programs from guaranteeing providers that they will receive their provider taxes paid back - this is known as the hold harmless provision. The OBBBA prohibits states from imposing new provider taxes or increasing existing provider tax rates or tax bases, except for nursing facilities and intermediate care facilities. The OBBBA 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.

Beginning in the first quarter of 2027, the OBBBA dictates that states must conduct Medicaid eligibility redeterminations every six months, rather than annually, for individuals enrolled under Medicaid. Additionally, the OBBBA includes a provision to reduce Medicaid retroactive eligibility from 90 days to 30 days for most enrollees, but allows for 60 days for long-term care residents and traditional Medicaid enrollees. We believe that delays in confirming

eligibility or coverage under these provisions can create the conditions for coverage interruptions, potential delays or denied payments.

Prior to the OBBBA'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 OBBBA 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 OBBBA's implementation are grandfathered by the OBBBA, 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 OBBBA limits SDPs to the Medicaid fee-for-service payment rate.

The OBBBA 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.

Beginning in fiscal year 2030, the OBBBA 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 OBBBA expanded the scope of these improper payments to include payments where insufficient information is available to confirm the recipient's eligibility for payment.

The OBBBA 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 OBBBA 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.

It is uncertain at this point how the overall budgets of states will be impacted by the OBBBA due to reduced federal Medicaid contributions. However, one potential risk to our revenue is due to the fact that the states will simply have less money in general. Therefore, we anticipate states being forced to make difficult decisions in the future about where those funds are directed. We will continue to monitor any such developments and advocate accordingly at the federal, state and local levels.

Program Integrity Rules – In June 2025, the Department of Health and Human Services (HHS) finalized the Marketplace Program Integrity and Affordability Rule. The rule, among other changes, shortens the open enrollment period starting in 2027, eliminates the special enrollment period for people with incomes at or below 150% federal poverty level, and tightens eligibility verification requirements for all enrollees. HHS expects the regulation to reduce Marketplace enrollment in 2026 predominantly in states that did not expand Medicaid. Its long term impacts are uncertain as many of the provisions sunset at the end of 2026 and some do not apply to state-based Marketplaces.

Five-Star Quality Reporting Metrics - CMS created the Five-Star Quality Rating System, which assigns each a nursing home a rating between one and five stars, as a resource to assist consumers with comparing nursing homes. Each nursing home receives an overall rating, as well as separate ratings for health inspections, staffing and quality measures. In part due to the competitive nature of the system, achieving a four- or five-star ranking can be challenging. The results of the Five-Star Quality Rating System are published on CMS's public website, Care Compare. CMS also displays a consumer alert icon next to nursing homes that have been cited for incidents of abuse, neglect, or exploitation, which is updated monthly with CMS's refresh of survey inspection results on that website. In June 2025, CMS announced changes to Nursing Home Care Compare and the Five Star Quality Rating system. Starting July 30, 2025, CMS will publish aggregated five-star performance metrics for nursing home chains to increase transparency of nursing homes' ownership and control for consumers. In addition, CMS shifted the methodology for calculating the health inspection rating from including the third most recent standard health survey to including only the two most recent surveys. Effective October 29, 2025, CMS will update the long-stay antipsychotic measure to incorporate Medicare and Medicaid claims and Medicare Advantage encounter data, which CMS expects will increase national antipsychotic rates from approximately 14.64% to 17.98%. We expect that these changes will result in varying changes to individual facilities' ratings. In connection with improvements to its data infrastructure, CMS temporarily paused monthly updates to the Nursing Home Care Compare

Five Star Rating System as of July 30, 2025. Although CMS started to update certain limited information as of September 24, 2025, the government shutdown delayed updates to the Care Compare website until late November of 2025. CMS' January 2026 refresh was delayed and is expected to be published on or around February 5, 2026.

Proposed and Enacted Federal and State Legislation - The U.S. Congress has introduced various bills intended to improve quality of care and oversight in nursing homes. For example, on August 10, 2021, the Nursing Home Improvement and Accountability Act of 2021 was introduced in the U.S. Senate and proposed to reduce SNF payments for inaccurate submission of certain data, provide federal funding to carry out SNF data validation and ensure accuracy of cost report information, and mandate staffing requirements for SNFs. Although this bill was not approved by Congress, similar proposed legislation may be introduced in the future.

In addition to proposed legislation at the federal level, state legislatures have introduced and enacted legislation to address quality of care and oversight in nursing homes. For example, California enacted the Skilled Nursing Facility Ownership and Management Reform Act of 2022, which took effect on July 1, 2023, increasing the oversight authority of the California Department of Public Health and changing several provisions regarding SNF licensing. We expect for states to continue to introduce and pass legislation that increases the regulation of SNFs.

Quality of Care Initiatives - on April 22, 2024, CMS issued a final rule that creates minimum staffing standards for skilled nursing facilities and nursing facilities and requirements for states to report the percent of Medicaid payments spent on compensation to direct care workers and support staff at each nursing facility and each intermediate care facility for individuals with intellectual disabilities. Certain provisions of the staffing requirements have been subject to legislative and judicial challenges and were repealed in December 2025. For further discussion, see the section titled "CMS Minimum Staffing Standards and Final Rule." Although there has been a trend in recent years of administrative, regulatory, and legislative efforts at the federal and state level to monitor and regulate LTC facilities, we are not able to predict whether the current administration will prioritize regulation applicable to LTCs.

CMS Ownership Transparency Final Rule - CMS' final rule published in November 2023 requires SNFs to publicly disclose certain additional information regarding their ownership and managerial relationships, including the identity of any person or legal entity that: (1) exercises financial, operational, or managerial control over a facility or part of a facility, or provides policies and procedures or financial or cash management services to a facility; (2) leases or subleases real property to the facility, or owns 5% or more of the real property's total value; and (3) provides any management or administrative services (or consults regarding the same), or provides accounting or financial services to SNFs. The rule also expands ownership and control interest disclosures to include information about each member of the facilities governing body, individuals or entities serving as officers, directors, members, partners or managing employees, and 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. In addition to the federal requirements, certain states have also adopted laws requiring disclosure of ownership information and other financial and ownership transparency requirements for SNFs.

CMS Minimum Staffing Standards Final Rule Repeal & Reinstatement of Pre-2024 Staffing Requirements - On April 22, 2024, CMS issued a final rule establishing new federal minimum staffing standards for skilled nursing facilities (SNFs) (2024 Staffing Rule). On July 4, 2025, the OBBBA was signed into law, which prohibits HHS from implementing, administering, or enforcing the Staffing Rule until October 1, 2034. On December 2, 2025, HHS issued an interim final rule repealing provisions of the Staffing Rule (Interim Final Rule). The Interim Final Rule repealed the requirement for nursing homes to provide certain minimum numbers of hours of nursing care per resident day and have a registered nurse (RN) onsite 24/7. In addition, CMS reinstated the minimum RN staffing requirement that were in existence prior to the 2024 Staffing Rule for facilities to use the services of an RN for at least eight consecutive hours a day, seven days a week and to designate an RN to serve as the director of nursing on a full-time basis except when waived. The repeal and reinstatement were effective on February 2, 2026. Although implementation of the 2024 Staffing Rule has been delayed under the OBBBA and some staffing requirements have been modified through the Interim Final Rule, future Presidential Administrations and HHS and CMS, under new leadership, could impose more stringent requirements for staffing.

Medicare and Medicaid Enrollment and Participation Requirements - Healthcare providers, including SNFs and other LTC facilities, must comply with certain requirements in order to participate in the Medicare and Medicaid Programs. Examples include requirements related to resident rights, admission, transfer and discharge, resident assessments, care planning, availability of certain services, administration and governance, emergency preparedness, quality assurance and

performance improvement programs, infection control, compliance and ethics programs, physical environment, and training requirements. Compliance with 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 LTC facilities. CMS has issued guidance and direction around arbitration, to include: the facility must not require signing of an arbitration agreement as a condition of admission or a requirement to continue to receive care at the facility, and the agreement must expressly contain language to this effect; the facility must inform the resident or the resident's representative of the right not to sign the agreement; the facility must confirm that the agreement is explained in a manner that can be understood and that the resident or their representative acknowledges their understanding of the agreement; the agreement must provide for the right to rescind the agreement within 30 calendar days of signing; and the agreement may not contain language that prohibits or discourages communications with federal, state, or local officials, including federal and state surveyors, other federal or state health department employees, and representatives of the Office of the State Long-Term Care Ombudsperson. Congress has routinely introduced, but not passed, legislation addressing the issue of arbitration agreements used by LTC facilities. While legislative action is possible in the future, federal regulations and state/federal laws remain our primary source of authority over the use of pre-dispute binding arbitration agreements.

The requirements of participation serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid. CMS has updated its guidance for surveyors and state agencies in order to, among other things, enhance responses to resident complaints and reported incidents. The guidance focuses on the following topics: (1) resident abuse and neglect (including reporting of abuse); (2) admission, transfer and discharge; (3) mental health and substance abuse disorders; (4) nurse staffing and reporting of payroll to evaluate staffing sufficiency; (5) residents' rights (including visitation); (6) potential inaccurate diagnoses or assessments; (7) prescription and use of pharmaceuticals, including psychotropics and drugs that act like psychotropics; (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 to improve consistency in the application of standards among various states. In 2022, CMS published the survey resources CMS and state surveyors would be using to evaluate LTC facilities' compliance with vaccination and reporting requirements. These updates provided more information for state surveyors to utilize when evaluating LTC facilities' 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 has also made significant software enhancement, including those used to measure and evaluate LTC facility compliance with the Medicare Requirements of Participation.

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."

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 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. 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.

Licensure and Certification

Our facilities and healthcare professionals are subject to various federal, state, and local licensure and certification requirements in connection with our provision of healthcare services. Certain states in which we operate have certificate of need or similar programs regulating the establishment or expansion of healthcare facilities. The initial and continued licensure of our facilities and certification to participate in government healthcare programs depends upon many factors including various state licensure regulations relating to quality of care, environment of care, equipment, services, minimum staffing requirements, staff training, administrators, personnel, and the existence of adequate policies, procedures, and

controls. In addition to facility licensure requirements, states also impose licensing requirements on the healthcare professionals who provide services at our facilities. States may impose restrictions on, or revoke, licenses of healthcare providers for, among other things, improper clinical conduct and delegation of such services, patient mistreatment, ethical violations and substance abuse, or aiding and abetting the unlicensed practice of medicine.

Federal, state, and local agencies survey our facilities on a regular basis to determine whether the facilities are in compliance with regulatory operating and health standards and conditions for participating in government healthcare programs. 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 facilities, 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 operating 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.

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) initiative. 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 program once it demonstrates significant improvements in quality of care that are continued over a defined period of time. On October 21, 2022, CMS issued a Memorandum announcing updates to the oversight of those facilities that fall under the SFF Program. These measures included increasing 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. In October 2025, the OIG issued a report reviewing the SFF program and concluded that the SFF program has not yielded lasting improvements because nursing homes that graduate from the program do not maintain the improvements over time. The OIG stated that the SFF program relies too heavily on financial penalties that do not require changes in nursing home operations, and recommended that CMS (1) impose more nonfinancial enforcement remedies that encourage sustained compliance; (2) assess the extent to which it took enhanced enforcement actions for SFF graduates and the effectiveness of those actions, particularly for graduates that received a deficiency for staffing; and (3) incorporate nursing home ownership information into the SFF program, such as in selecting SFFs and identifying patterns of poor performance. CMS concurred with OIG’s second recommendation and did not concur with the first and third recommendations, noting that actions have already been taken to address those recommendations.

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. 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.

Civil and Criminal Fraud and Abuse Laws and Enforcement

The U.S. healthcare industry is heavily regulated by federal, state and local governments. We are subject to federal and state laws that regulate our relationships with physicians and other healthcare providers, the manner in which our facilities provide and bill for services and collect reimbursement from governmental programs and private payors, our marketing activities, and other aspects of our operations.

The federal Anti-Kickback statute (AKS) prohibits, among other things, knowingly and willfully offering, paying, soliciting or receiving remuneration, directly or indirectly, in cash or kind, to induce or reward either the referral of an individual for, or the purchase, order or recommendation of, any good or service, for which payment may be made under federal and state healthcare programs such as Medicare and Medicaid. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it in order to have committed a violation. The AKS includes statutory exceptions and regulatory safe harbors that protect certain arrangements. Failure to meet the requirements of the safe

harbor, however, does not render an arrangement illegal. Rather, the government may evaluate such arrangements on a case-by-case basis, taking into account all facts and circumstances, including the parties' intent and the arrangement's potential for abuse, and may be subject to greater scrutiny by enforcement agencies.

Additionally, the federal physician self-referral law (Stark Law) prohibits a physician from referring 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 an exception applies. Designated health services include inpatient and outpatient hospital services, physical therapy, occupational therapy, speech language pathology services, durable medical equipment, prosthetics, orthotics and supplies, diagnostic imaging, and enteral and parenteral feeding and supplies 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 prohibited from submitting or claiming payment under the Medicare or Medicaid programs or from collecting from the patient or other payor.

The federal False Claims Act (FCA) prohibits a person from knowingly presenting, or caused to be presented, a false or fraudulent request for payment from the federal government, or from making a false statement or using a false record to have a claim approved. The FCA further provides that a lawsuit thereunder may be initiated in the name of the government by an individual referred to as a "whistleblower." Moreover, the government may assert that a claim including items and services resulting from a violation of the AKS or the Stark Law constitutes a false or fraudulent claim for purposes of the civil FCA. Penalties for a violation of the FCA include fines for each false claim, plus up to three times the amount of damages caused by each false claim.

Further, the Civil Monetary Penalties Statute authorizes the imposition of civil monetary penalties, assessments and exclusion against an individual or entity based on a variety of prohibited conduct, including, but not limited to offering remuneration to a federal healthcare program beneficiary that the individual or entity knows or should know is likely to influence the beneficiary to order or receive healthcare items or services from a particular provider.

Many states have also adopted or may adopt similar anti-kickback, self-referral, false claim, and fraud and abuse laws as described above. The scope of these laws and the interpretations of them vary by jurisdiction and are enforced by local courts and regulatory authorities, each with broad discretion. Some state fraud and abuse laws apply to items or services reimbursed by any third-party payor, including commercial insurers, and to funds paid out of pocket by a patient.

Violation of any of these laws or any other governmental regulations that apply may result in significant penalties, including, without limitation, administrative civil and criminal penalties, damages, fines, additional reporting requirements and compliance oversight obligations, contractual damages, the curtailment or restructuring of operations, exclusion from participation in governmental healthcare programs and/ or imprisonment.

In the ordinary course of business, we and other 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, as well as commercial payors. As discussed in more detail in Part I. Item 3 "Legal Proceedings," we have received two Civil Investigative Demands from the DOJ and one from the U.S. Attorney's Office requesting information and documentation relating to investigations to determine if we have violated the Federal False Claims Act by improperly inducing patient referrals or by submitting false claims to Medicare. We have also received a subpoena from the DOJ Criminal Division per the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to an investigation into possible violations of various sections of 18 U.S.C. that prohibit the making of fraudulent or false statements to any branch of the government of the United States, and a subpoena from the Respiratory Care Board of California (the "RCB") relating to an investigation to determine if a Respiratory Care Practitioner ("RCP") fraudulently documented providing respiratory treatments to two patients at one of our facilities. While we are cooperating with each of these investigations, we cannot predict their outcome. In response to these investigations and any other inquiries, investigations and audits we may receive, federal and state agencies and other payors may impose citations for regulatory deficiencies and other regulatory penalties, including demands for refund of overpayments, civil monetary penalties, payment bans and terminations from the Medicare and Medicaid programs, which may be temporary or permanent in nature.

In recent years, there has been increased regulatory scrutiny into post-hospital SNF care. For example, in November 2019, the OIG released a report of its investigation into overpayments to hospitals that did not comply with Medicare's post-acute care transfer policy. Hospitals violating this policy transferred patients to certain post-acute care settings, such as SNFs, but claimed the higher reimbursements associated with discharges to homes. A similar OIG audit report released in September 2023 identified over $563 million in overpayments to hospitals that did not comply with Medicare's post-acute

care transfer policy. Another similar OIG audit report, released in February 2019, focused on improper payments for SNF services when the Medicare three-day inpatient hospital stay requirement was not met. In 2021, the OIG released the result of an audit finding that Medicare overpaid millions of dollars of chronic care management (CCM) services. The OIG's 2021 report found that in calendar years 2017 and 2018, Medicare overpaid millions of dollars in CCM claims. In 2022, the OIG released an audit revealing that CMS had not collected $226 million, or 45%, of identified overpayments within that period, potentially affecting SNFs. Other ongoing OIG audits include an a review of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, a review of whether and how states used 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 a review of Medicare Advantage Organizations' use of prior authorization for post-acute care.

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 Payroll-Based Journal (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, in April 2025, 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. In an audit announced in May 2025, OIG stated it 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. 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.

On numerous occasions, CMS has indicated its intent to vigilantly monitor overall payments to SNFs, paying particular attention to facilities that have high reimbursements for ultra-high therapy, therapy resource utilization groups with higher activities of daily living scores and long average lengths of stay. The OIG recognizes that there is a strong financial incentive for facilities to bill for higher levels of therapies, even when not needed by patients. We cannot predict the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. We expect for regulators to continue to focus on post-hospital SNF care, which may result in additional oversight or stricter compliance standards.

Data Privacy and Security Laws

In the United States, numerous federal and state laws and regulations, including data breach notification laws, health information privacy and security laws and consumer protection laws and regulations govern the collection, use, disclosure, and protection of health-related and other personal information. Privacy and security laws, regulations, and other obligations are constantly evolving, may conflict with each other to complicate compliance efforts, and can result in investigations, proceedings, or actions that lead to significant civil and/or criminal penalties and restrictions on data processing.

Additional Information and Website Disclosure

Our website is www.pacs.com. On our Investor Relations website, www.ir.pacs.com, we make available free of charge a variety of information for investors, including our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and any amendments to those reports, as soon as reasonably practicable after we electronically file that material with, or furnish it to, the SEC. The SEC also maintains a website at *http://www.sec.gov*, which contains annual, quarterly and current reports, proxy and information statements and other information regarding issuers that file electronically with the SEC. The information found on our website is not part of this or any other report that we file with, or furnish to, the SEC.

Item 1A RISK FACTORS

Our business involves a high degree of risk. You should carefully consider each of the following risk factors and all other information set forth in this report and our other filings with the SEC. Based on the information currently known to us, we believe that the following information identifies the most significant risk factors affecting our company. In addition, past financial performance may not be a reliable indicator of future performance and historical trends should not be used to anticipate results or trends in future periods.

If any of the following risks and uncertainties develops into actual events or circumstances, they could have a material adverse effect on our business, financial condition and results of operations. You should carefully read the following risk factors, together with our combined/consolidated financial statements and the related notes and all other information included in this report and our other filings with the SEC. This report contains forward-looking statements that contain risks and uncertainties.

Risks Related to Our Business and Industry

We depend 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 facilities as well as changes in payor mix and payment methodologies and new cost containment initiatives by third-party payors.

Our revenue is affected by the percentage of the patients of our operating subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients or skilled 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 revenue. Changes to federal law affecting Medicaid funding and availability, including the enactment of the OBBBA, may materially affect our business and the operations of our independent subsidiaries. Because high acuity patients require more skilled nursing services and a higher level of care, we generally receive higher reimbursement rates for providing care to them. Lower acuity patients, who are typically Medicaid beneficiaries, typically require fewer skilled nursing services and thus we are typically paid lower rates by Medicaid for caring for them, sometimes at rates that do not cover our costs of providing care to the patient. Reimbursement rates provided for caring for skilled patients are more likely to meet or exceed the costs of providing care to those patients, thus enabling the facility to be fiscally sustainable. Given the generally predetermined nature of the reimbursement rates that we are paid for caring for patients, depending on their acuity level, if our labor or other operating costs increase disproportionately compared to the reimbursement rates we are paid for providing services, particularly with Medicaid patients, we will generally be unable to recover the increased costs from payors unless and until reimbursement rates are adjusted, and even then they may not be adjusted in full, in a timely manner, and are typically only adjusted on a prospective basis. 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 operating subsidiaries for whom we receive Medicaid reimbursement, it could have a material adverse effect on our business, financial condition, and results of operations.

Initiatives undertaken by major insurers and managed care companies, including companies who run plans commonly referred to as Managed-Medicare and Managed-Medicaid, to reduce their costs and the amounts they pay providers 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 their lower offered rates. Additionally, some payors have used the federal "No Surprises Act" or similar state legislation as a means to initiate 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. 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.

We may not be fully reimbursed for all services for which each facility bills through consolidated billing or bundled payments, which could have an adverse effect on our revenue, financial condition and results of operations.

In connection with the per diem prospective payments paid to SNFs, SNFs are required to perform consolidated billing for certain items and services furnished to patients and residents. Consolidated billing generally requires the SNF to bill a single daily amount for the entire package of care that its patients receive during a SNF stay covered by Medicare Part A or Medicare Advantage plans. Given the generally predetermined nature of the reimbursement rates that SNFs are paid for

caring for patients, if our operating costs increase disproportionately compared to the reimbursement rates we are paid for providing services under consolidated billing, there could be a material adverse effect on our business, financial condition, and results of operations.

In addition, CMS has implemented certain payment initiatives that bundle acute care and post-acute care reimbursement. Post-hospitalization skilled nursing services must be "bundled" into the hospital's diagnostic related group payment in certain limited circumstances, in which case the hospital and SNF must effectively divide the payment that otherwise would have been made to the hospital and no additional funds are paid by Medicare for the skilled nursing care of the patient. Although this practice applies to only a limited number of DRGs and is uncommon at our SNFs currently, it could adversely affect SNF utilization and payments, whether due to the practical difficulty of this apportionment or hospitals being reluctant to lose revenue by discharging patients to a SNF. If more payments are required to be bundled in the future, or if there is any significant increase in patients for whom we receive bundled payments, our SNFs may not receive full reimbursement for all the services they provide, which could have a further adverse effect on SNF utilization and our revenue, financial condition and results of operations.

Increased competition for, or a shortage of, nurses, nurse assistants 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 and other skilled personnel, such as registered nurses, licensed vocational nurses, licensed practical nurses, 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 administrator who is ultimately responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Each facility administrator leads a team of facility staff who are directly responsible for day-to-day care of the facility residents, as well as other operational functions of the facility including 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. We also compete with businesses outside of healthcare in our efforts to attract and retain talented employees.

Our subsidiaries operate SNFs in Alaska, Arizona, California, Colorado, Idaho, Kansas, Kentucky, Missouri, Montana, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington as of December 31, 2025. Some states have established minimum staffing requirements for facilities operating in that state, and other states may do the same in the future, or existing requirements may become more stringent. The federal government adopted minimum staffing requirements in mid-2024, which were partially repealed in late 2025. For further discussion of federal minimum staffing requirements, see the section titled "CMS Minimum Staffing Standards Final Rule." Failure to comply with minimum staffing requirements due to competition for, a shortage of or an inability to hire required personnel can, among other things, jeopardize a facility's compliance with the conditions of participation under relevant state and federal healthcare programs. The shifting regulatory framework presents separate compliance challenges. 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, and may also disqualify the facility from participation in state programs that reward facilities for meeting applicable quality criteria.

If federal or state governments were to materially change the way compliance with applicable staffing standards is calculated or enforced, our labor or other operating costs could increase and the current shortage of healthcare workers could impact us more significantly. The local labor markets where we compete are sometimes in a state of disequilibrium where the needs of businesses such as ours outstrip the supply of available and willing workers, which can make it challenging to hire sufficient quantities of staff locally and may require us to use third-party staffing companies to provide healthcare workers at an even higher cost. There is additional upward pressure on wages in many of our markets from different industries and more generally due to the current rate of inflation. Some of these industries compete with us for labor, 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, in addition to our increasing fixed and variable costs. Due to the generally limited supply of qualified applicants who seek or are willing to accept employment in certain of our markets, these broader trends 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, or limit our ability to admit all residents who would like to receive care at our facilities.

Existing or future federal, state or local 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. Although implementation of the Staffing Rule has been delayed under the OBBBA, future Presidential Administrations and HHS and CMS, under new leadership, could impose more stringent requirements for staffing. Due to labor shortages and other opportunities available to qualified workers, there can also be no assurance that sufficient numbers of applicants will be available to fulfill any staffing requirements that may be imposed, whether at pay rates that companies can afford or otherwise. Furthermore, CMS and some states have published guidance to surveyors addressing topics that specifically include nurse staffing and collection of payroll data to evaluate staffing levels, which may lead to future regulation that increase our staffing requirements and labor costs or lower revenues.

Increased competition for, or a shortage of, nurses or other qualified personnel, or general ongoing inflationary pressures may require that we enhance our pay and benefits packages, potentially beyond what we can afford in light of applicable reimbursement rates and other cost pressures, to compete effectively for such personnel. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from market to market and facility to facility, and may adversely affect the applicable facilities' quality and other ratings based on data reported to CMS. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations could be harmed.

State efforts to regulate or deregulate the healthcare services industry or the construction, expansion, or acquisition 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, commonly 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.

Some other states that do not require certificates of need have effectively limited 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, excessively time-consuming or otherwise unfeasible. In addition, some states require the approval of the state Attorney General for acquisition of a facility being operated by a non-profit organization.

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 or acquisitions. 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.

If we fail to attract patients and residents and to compete effectively with other healthcare providers, our revenue and profitability may decline and we may incur losses.

We rely significantly on appropriate referrals from physicians, hospitals and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our facilities. 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. The establishment of joint ventures or networks between referral sources, such as acute-care hospitals, and other post-acute providers may hinder patient referrals to us. The growing emphasis on integrated care delivery across the healthcare continuum increases that risk. 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.

The healthcare services industry is highly competitive. Our skilled nursing facilities compete primarily on a local and regional basis with other skilled nursing facilities and with assisted/senior living facilities, from national and regional chains to smaller providers owning as few as a single facility. Competitors include other for-profit providers as well as non-profits, religiously-affiliated facilities, and government-owned facilities. We also compete under certain circumstances with inpatient rehabilitation facilities and long-term acute care hospitals. Our ability to compete successfully varies from location to location and depends on a number of factors, including the number of competing facilities in the local market and the types of services available at those facilities, our local reputation for quality care of patients, the commitment and expertise of our caregivers, our local service offerings and treatment programs, the cost of care in each locality, and the physical appearance, location, age and condition of our facilities. If we are unable to attract patients to our facilities and agencies, particularly high-acuity patients, then our revenue and profitability will be adversely affected. Some of our competitors may have greater recognition and be more established in their respective communities than we are, and may have greater financial and other resources than we have. Competing long-term care companies may also offer newer facilities or different programs or services than we do, which, combined with the foregoing factors, may result in our competitors being more attractive to our current patients, to potential patients and to referral sources. Furthermore, while we budget for routine capital expenditures at our facilities to keep them competitive in their respective markets, to the extent that competitive forces cause those expenditures to increase in the future, our financial condition may be negatively affected.

Our policy is to comply with laws prohibiting kickbacks and referral payments to referral sources. If our competitors use more aggressive methods than we do with respect to obtaining patient referrals, our competitors may from time to time obtain patient referrals that are not otherwise available to us.

The primary competitive factors for our assisted and senior living services are similar to those for our skilled nursing businesses and include reputation, the cost of services, the quality of services, responsiveness to patient/resident needs and the ability to provide support in other areas such as third-party reimbursement, information management and patient recordkeeping. Furthermore, given the relatively low barriers to entry and continuing healthcare cost containment pressures, we expect that the markets we service will become increasingly competitive in the future. Increased competition in the future could limit our ability to attract and retain patients and residents, maintain or increase our fees, or expand our business.

We review and audit the care delivery, recordkeeping and billing processes of our operating subsidiaries. These reviews from time to time detect instances of noncompliance that we attempt to correct, which in some instances requires reduced or repayment of billed amounts or other costs.

Under our locally led, centrally supported model, each of operating subsidiaries is responsible for ensuring its compliance with the broad range of applicable federal and private healthcare regulatory requirements. PACS Services offers internal compliance professionals and invest in other resources to help us and our operating subsidiaries comply with these requirements. To further assist, we adopted a company-wide compliance program that includes, among other things, (1) policies and procedures that take into account applicable laws, regulations, sub-regulatory guidance and industry practices and customs that govern the clinical, reimbursement and operational aspects of our operating subsidiaries; (2) training about our compliance process for employees throughout our organization, 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; (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) and (4) a compliance hotline that permits the anonymous reporting of potential compliance matters. Recently, with the assistance of outside counsel, we engaged in a detailed review of our compliance program and its implementation at our operating subsidiaries. As a result of that review we have or are implementing various changes to further assist us and our operating subsidiaries in evaluating and maintaining compliance with the various federal and state regulations that impact our business and that of our operating subsidiaries. Some of these changes include: retained a new Chief Compliance Officer with extensive experience in designing, implementing and monitoring a robust compliance program; regularly updating our policies and procedures library; updating our compliance hotline to facilitate the reporting and tracking of potential compliance issues; expanding our education and training programs; and increasing our monitoring for compliance and corrective actions.

Given our operations are subject to highly complex compliance requirements, our systems and internal controls regularly highlight potential compliance issues, which we investigate as they arise. We similarly investigate concerns that

are reported to us by employees or other persons. In some cases, these potential compliance issues overlap with allegations in the ongoing government investigations identified in Part I, Item 3 "Legal Proceedings". When errors or compliance failures are identified, we seek to rectify them as appropriate. Depending on the circumstances, in order to rectify a failure, we may be required to take certain actions, including but not limited to self-reporting them to applicable federal and state regulators, government agencies or other third parties, disgorging or paying money to the government or other third parties, and implementing changes to systems, personnel or other resources in order to mitigate the risk of recurrence, all of which could result in significant costs. Such issues, and any failure to properly remediate such issues or to timely identify and refund overpayments, for instance, could result in potential federal False Claims Act (FCA) liability and could have a material adverse effect on our business, financial condition and results of operations. Other significant compliance failures could have similar negative impacts.

We are subject to various governmental inspections, audits, and investigations, including civil investigative demands (CIDs) and criminal subpoenas such as the ones discussed in more detail in Part I. Item 3 "Legal Proceedings" relating to alleged violations of the Federal False Claims Act and the making of false or fraudulent statements under HIPAA. We cannot predict the outcome of these ongoing investigations, or any government inspection, audit or investigation. We could be forced to expend considerable resources responding to these investigations and to any other investigations, audits and other enforcement actions that we may receive, which could divert material time, resources and attention away from our management team and our staff. Additionally, an adverse finding in any such matters could lead to the imposition of damages, fines, penalties, restitution, other monetary liabilities, sanctions, settlements or changes to our business practices or operations that could have a material adverse effect on our business, financial condition or results of operations.

We are subject to litigation, which is commonplace in our industry, which could result in significant legal costs and large settlement amounts or damage awards, and our self-insurance programs may expose us to significant and unexpected costs and losses.

The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents of our operating subsidiaries and the services we provide, and malpractice and other lawsuits against providers in our industry are endemic. The industry has experienced an increased trend in the number and severity of litigation claims, particularly patient-related litigation, 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 that they allege led to patient harm, including for state healthcare survey deficiencies received, allegations of insufficient staffing, allegations of insufficient training, allegations that companies put financial considerations over patient needs, and other claims. 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. Increased caps on damages that may be awarded in such actions has and may continue to lead to a larger frequency and severity of these lawsuits against our independent operating subsidiaries, particularly those who operate in California and other states that adopt similar legislation. We, and others in the industry, have been, and continue to be, subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, patient abuse or neglect, elder abuse, wrongful death or other related claims. For instance, in early 2023, we were subject to approximately $36.0 million in damages and fees awarded in a California jury verdict in a patient-care case that we inherited as part of an acquisition in 2021. There can be no assurance that we will not be subject to similar or larger verdicts in the future, particularly in light of the fact that large tort verdicts have become somewhat common throughout the United States, particularly in comparatively litigious states such as California and Kentucky. We may in the future do business in similarly or more litigious states as well. The defense of lawsuits has in the past, and may in the future, result in significant legal costs, regardless of the outcome, particularly as we and other providers have had to take on higher insurance deductibles and premiums. Additionally, increases to the frequency and/or severity of losses from such claims and suits may result in increased liability insurance premiums, increases in deductibles, a decline in available insurance coverage levels, or other negative impacts on the availability and cost of insurance, which could materially and adversely affect our business, financial condition and results of operations. In addition to carrying third-party liability insurance, starting in January 2022, we formed a wholly-owned captive insurance subsidiary, Welsch Insurance Ltd. (Welsch), that provides professional liability and general liability insurance to various consolidated operating subsidiaries. See the risk factor titled "Our self-insurance programs may expose us to significant and unexpected costs and losses."

Furthermore, class action claims related to patient care, employment practices or other matters have been and in the future could be brought alleging legal violations that may materially affect our business, financial condition and results of operations. These types of claims have been filed against us and other companies in our industry in the past, and are likely to continue. For example, in recent years there has been a general increase in the number of suits filed against us and other companies in California, across industries, that purport to be wage and hour class action claims. They are typically based

on alleged failures to permit or properly compensate for meal and rest periods, failure to pay for all time worked, and other alleged failures of California's extensive wage and hour laws and regulations. While we have not had a similar experience in other states, circumstances could change in those states, or we could in the future operate in other states with litigation risks similar to California. 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.

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 successful plaintiff might attempt to hold us or one or more of our other subsidiaries 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 and find that we or other entities are vicariously liable, the resulting judgment could increase our liability and adversely affect our financial condition and results of operations.

Our independently operating subsidiaries offer arbitration agreements to residents on admission, and require employees to enter into arbitration agreements as a condition of employment. While arbitration agreements have generally been favored by the courts, have been validated by the United States Supreme Court, and are believed to streamline the dispute resolution process and reduce the parties' exposure to excessive legal fees and jury awards, courts in some states, as well as regulators in some states and on the federal level, have showed increasing opposition to the use and enforcement of arbitration agreements, particularly in consumer and employment contexts. Current CMS regulations prohibit nursing facility providers from requiring patients to enter into arbitration agreements as a condition of admission, and there have been prior legislative efforts on both state and federal levels to codify similar prohibitions. Furthermore, prior CMS proposals sought to prohibit any use of arbitration agreements between nursing homes and their patients. In light of its continuing negative view on arbitration, CMS has identified arbitration agreements as an area of focus and has 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. If we are not able to secure voluntary pre-admission arbitration agreements from our patients, 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. We would be subject to similar risks if we are at some point prohibited from requiring employees to enter into arbitration agreements.

Our business may be affected by the evolving regulatory framework for AI Technologies.

The regulatory framework for artificial intelligence ("AI"), machine learning, and automated decision-making technologies (collectively, "AI Technologies") is rapidly evolving as many federal and state government bodies and agencies have introduced or are currently considering additional laws and regulations. Additionally, existing laws and regulations may be interpreted in ways that would affect the operation of our AI Technologies.

It is possible that new laws and regulations will be adopted, or that existing laws and regulations may be interpreted in ways that would limit our ability to use AI Technologies for our business, or require us to change the way we use AI Technologies in a manner that negatively affects the performance of our services and the way in which we use AI Technologies. We may need to expend resources to adjust our services in certain jurisdictions if the laws, regulations, or decisions are not consistent across jurisdictions. Further, the cost to comply with such laws, regulations, or decisions and/or guidance interpreting existing laws, could be significant and would increase our operating expenses (such as by imposing additional reporting obligations regarding our use of AI Technologies). Such an increase in operating expenses, as well as any actual or perceived failure to comply with such laws and regulations, could adversely affect our business, financial condition and results of operations.

If we are unable to provide consistently high quality of care, or if our employees or staff members engage in conduct (or fail to take action) that impacts our patients' health, safety, welfare or clinical treatment, our business will be adversely impacted and we may be subject to civil or criminal penalties, fines or other actions.

Providing quality patient care is fundamental to our business. Many of our patients have complex medical conditions or special needs, are vulnerable, and often require a substantial level of care and supervision. Our patients have in the past and could in the future be harmed by one or more of our employees or staff members, either intentionally, by accident, or through negligence, neglect, error, poor performance, mistreatment, assault, abuse, failure to provide proper care, failure to

properly document or monitor or report information, failure to address risks to patients' health or safety, failure to maintain appropriate staffing, failure to implement appropriate interventions or other actions or inaction. Employees and staff members have engaged in conduct (including failing to take action) that has impacted, and may in the future engage in conduct that impacts, our patients or their health, safety, welfare, or clinical treatment.

If one or more of our facilities experiences an adverse patient incident or is found to have failed to provide appropriate patient care (including as a result of a staffing shortages or the actions or inactions of our employees or staff members), governmental or regulatory authorities may take action against us or our employees or staff members, including an admissions ban, admissions hold, reduction in census, loss of accreditation, license revocation, administrative or other order, other adverse regulatory action, a settlement or other agreement requiring corrective actions or requiring us or a specific facility to demonstrate substantial compliance with licensure or other requirements, and the imposition of certain requirements. If such an action or a closure of a facility were to occur and result in the improper termination of patient care, we or our employees or staff members may be exposed to governmental or regulatory inquiries, investigations, liability, and litigation, including claims of patient abandonment. Certain of our independently operating subsidiaries have been, and may continue to be, subject to findings of quality of care deficiencies or practices, incidents of patient abuse or neglect, and claims regarding services rendered that do not meet the standard of care, which have resulted, and in the future may result, in civil or criminal penalties, fines and other actions.

Any such patient incident, adverse regulatory action, self-disclosure, self-report, claim or other event, action or inaction has in the past, and could in the future, result in governmental investigations, judgments, or fines and have a material adverse effect on our business, financial condition, and results of operations. While such enforcement actions are typically taken against individuals, we cannot predict how law enforcement or governmental or regulatory authorities will enforce the laws or whether governmental or regulatory authorities will assert that we or any of our employees or staff members are responsible for such actions, or should have known about such actions. In addition, we have been and could become the subject of negative publicity or unfavorable media attention or governmental or regulatory scrutiny, regardless of whether the allegations are substantiated, that could have a significant, adverse effect on the trading price of our common stock or adversely impact our reputation, our relationships with referral sources and payors, whether patients and their family members choose us, and whether our referral sources choose other providers.

We rely significantly on information technology, and any failure, inadequacy or interruption of that technology could harm our ability to effectively operate our business.

We collect and maintain information in digital form that is necessary to conduct our business, and we are increasingly dependent on information technology systems and infrastructure to operate our business. Our ability to effectively manage our business depends significantly information systems, including those operated by certain of our third-party partners. In the ordinary course of our business, we collect, store and transmit large amounts of confidential information, including intellectual property, proprietary business information, health-related information and personal information (collectively, "Confidential Information") of customers and our employees and contractors. It is critical that we do so in a secure manner to maintain the confidentiality and integrity of such Confidential Information.

Our information technology systems and those of our third-party service providers, strategic partners and other contractors or consultants are vulnerable to attack, damage and interruption from. We also heavily rely on information systems to process financial and accounting information for financial reporting purposes. Any of these information systems could fail or experience a service interruption for a number of reasons, including computer viruses and malware (e.g., ransomware), misconfigurations, "bugs" or other vulnerabilities, malicious code,terrorism, war, telecommunication and electrical failures,programming errors, hacking or other cyberattacks, phishing attacks, and unlawful activities, natural disasters, or our failure to properly maintain system redundancy or protect, repair, maintain or upgrade our systems, employee theft or misuse, human error, fraud, denial or degradation of service attacks, and sophisticated nation-state and nation-state-supported actors or unauthorized access or use by persons inside our organization, or persons with access to systems inside our organization. We have also outsourced elements of our information technology infrastructure, and as a result a number of third-party vendors may or could have access to our confidential information.The failure of our third-party partners' information systems to operate effectively or to integrate with other systems, or a breach in security of these systems, could negatively impact our financial results.

If we experience any significant disruption to our financial information systems that we are unable to mitigate, our ability to timely report our financial results could be impacted, which could negatively impact our stock price. We also communicate electronically throughout the United States with our employees and with third parties, such as patients. A service interruption or shutdown could have a materially adverse impact on our operating activities and could result in

reputational, competitive, and business harm. Furthermore, remediation and repair of any failure, problem or breach of our key information systems could require significant capital investments.

We calculate certain operational metrics using internal systems and tools and do not independently verify such metrics. Certain metrics are subject to inherent challenges in measurement, and real or perceived inaccuracies in such metrics may harm our reputation and negatively affect our business.

We refer to a number of operational metrics, including, but not limited to, skilled mix, average daily rates, occupancy percentage, and other metrics. We use these metrics to monitor and evaluate our business as well as the various facilities that we own and operate, and these metrics have an influence on our strategy, operational decision-making, budgeting, and planning. We calculate these metrics using internal systems and tools that are not independently verified by any third-party. These metrics may differ from estimates or similar metrics published by third parties or other companies due to differences in sources, methodologies or the assumptions on which we rely. Our internal systems and tools have a number of limitations, and our methodologies for tracking these metrics may change over time, which could result in unexpected changes to our metrics, including the metrics we publicly disclose on an ongoing basis. If the internal systems and tools we use to track these metrics under count or over count performance or contain algorithmic or other technical errors, the data we present may not be accurate. While these numbers are based on what we believe to be reasonable estimates of our metrics for the applicable period of measurement, there are inherent challenges in measuring savings, the use of our solutions, services and offerings and other metrics. In addition, limitations or errors with respect to how we measure data or with respect to the data that we measure may affect our understanding of certain details of our business, which would affect our long-term strategies. If our operating metrics or our estimates are not accurate representations of our business, or if investors do not perceive our operating metrics to be accurate, or if we discover material inaccuracies with respect to these figures, our reputation may be significantly harmed, and our operating and financial results could be adversely affected.

We may be unable to complete future facility 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 operating subsidiaries, which would decrease our revenue.

To date, our revenue growth has been significantly impacted by our acquisition of new facilities and properties. 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 property acquisition opportunities that are consistent with our strategic objectives.

We face competition for the acquisition of facilities and properties and expect this competition to continue and potentially increase. Based upon factors such as our ability to identify suitable acquisition candidates, future regulations affecting our ability to acquire new facility operations and related real estate, the purchase or lease 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 and profitability.

We have also previously acquired facilities, which over time became non-strategic or less desirable, and have divested them. In the future we may consider divesting similar facilities that we determine at that time to be non-strategic or less desirable. Divesting facilities will typically negatively impact our revenue, may divert management and other resources from acquisitions or other efforts, and may have other adverse effects on our business, financial condition and results of operation.

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

We may not be able to successfully or efficiently integrate new acquisitions with our existing operating 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. Integrating larger portfolios of acquired facilities concurrently may present similar but more acute challenges than integrating fewer facilities. 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

operating 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 operating subsidiaries we acquire, we will not realize the anticipated benefits and we may experience lower than anticipated profits, or even losses.

During the years ended December 31, 2025, 2024, and 2023, we added eight, 106, and 58 stand-alone skilled nursing, assisted living, and subacute facilities, respectively. This growth, as well as growth in the current year and future years, 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 facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services at the facilities, and if we are unable to improve them 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, which could have an adverse effect on our business, financial condition and results of operation.

In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations, and we may not be able to successfully integrate acquired facilities and properties into our operations, or achieve the benefits we expect from any of our facility acquisitions.

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those facilities, against whom we may have little or no recourse. Many facilities we have historically acquired were underperforming financially and had issues, including but not limited to, clinical, regulatory and litigation, prior to and at the time of acquisition. Even where we have improved patient care and operations at facilities that we have acquired, 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 facilities into substantial compliance with applicable healthcare regulations. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for operational and financial improvement, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities 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 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 facilities, including contingent liabilities. For example, when we acquire a facility, we generally assume the facility's existing Medicare provider number for purposes of billing Medicare for services. If CMS later determines that the prior owner of the facility had received overpayments from Medicare for the period of time during which it operated the facility, or had incurred fines in connection with the operation of the facility, CMS could hold us liable for repayment of the overpayments or fines.

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 and 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. 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.

We may have difficulty completing partnerships that increase our capacity consistent with our growth strategy.

We may selectively pursue strategic acquisitions of, and we frequently pursue partnerships with, other healthcare providers. We may face limitations on our ability to identify sufficient partner, acquisition or other development targets and to complete those transactions to meet goals. These partnerships may not be profitable or may not achieve the profitability that justifies the investments made. Furthermore, the nature of a partnership requires us to consult with and share certain decision-making powers with unaffiliated third parties, some of which may be not-for-profit health systems. We do not manage any of the partnerships in which we invest, and operational and strategic decision making power is held by entities that we do not control. If our partners do not fulfill their obligations, the affected partnership may not be able to operate according to its business or strategic plans, which could have a material adverse effect on our results of operations, or require us to increase our level of financial commitment to the partnership. Moreover, differences in economic or business interests or goals among partnership participants could result in delayed decisions, failures to agree on major issues and even litigation. If these differences cause the partnerships to deviate from their business or strategic plans, or if our partners take actions contrary to our policies, objectives or the best interests of the partnership, it could have a material adverse effect on our business, financial condition and results of operations.

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

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 commonly known as the Five-Star Quality Rating System. It gives each nursing home a rating of between one and five stars in various categories, with five-star ratings becoming harder to obtain over time. The ratings are available on a publicly available website maintained by CMS currently called Care 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. Some of the ratings include a multi-year lookback period, which causes the prior operator's data to be factored into our ratings for some period of time. Based on CMS's guidance and regulations, we expect more data to be collected by CMS and reported on their website in the future.

CMS continues to increase quality measure thresholds, making it more difficult to achieve upward and five-star ratings. For instance, CMS increased its quality measure thresholds in October of 2022, making it more difficult for facilities to obtain or maintain four- and five-star ratings, allowing only 10% of nursing facilities within a state to receive a five-star rating. CMS discloses the increasing standards for four- and five-star ratings in its star rating cut point table, which discloses the points needed for each star rating within every state. CMS has indicated that it will increase these quality measure thresholds every six months. 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 affected facilities may decline even as their quality measures remain unchanged or improve. Additionally, CMS displays on the Care Compare website a consumer alert icon for nursing homes that have been cited on inspection reports for incidents of abuse, neglect, or exploitation. If our facilities fail to have attractive or otherwise acceptable ratings on the Care Compare website it could negatively impact their operations, including their ability to attract or retain patients and an increase in expenses to improve such ratings.

Providing quality patient care is the cornerstone of our business. We believe that patients and their families choose our facilities, and hospitals, physicians and other referral sources refer patients to us, in large part because of our facilities' reputation for delivering quality care. If our facilities fail to achieve their rating goals or otherwise maintain positive reputations in their local communities, due to nursing and administrative staffing and turnover or otherwise, or if they receive a consumer alert icon for incidents of abuse, neglect, or exploitation or other negative ratings on Care Compare, it may affect our ability to attract patients, 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;

- we receive survey deficiencies or citations of higher-than-normal scope or severity or experience higher-than-expected number of deficiencies or citations;

- we acquire especially troubled operations or facilities that present unattractive risks to current or prospective insurers;

- 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 require us to significantly increase our self-insured retention or deductible 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. 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, workers compensation and employee health insurance costs have also increased markedly in recent years. 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.

We do not carry insurance for all categories of risk that our business may encounter. Some of the policies we currently maintain include property, general liability, employment benefits liability, business automobile, workers' compensation, and directors' and officers', employment practices and fiduciary liability insurance. We do not know, however, if we will be able to maintain insurance with adequate levels of coverage. Any significant uninsured liability may require us to pay substantial amounts, which would have an adverse effect on our financial condition and results of operations.

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

We are self-insured up to certain limits for workers compensation, property and casualty, automobile, employment practices liability, directors and officers liability, employee healthcare and general and professional liability coverages. The types and amounts of self-insurance may vary from time to time based on our decisions with respect to risk retention and regulatory requirements. We establish the insurance loss reserves based on an estimation process that uses information obtained from both company-specific and industry data. Estimated costs are subject to a variety of assumptions and other factors including the severity, duration and frequency of claims, legal costs associated with claims, healthcare trends and projected inflation of related factors. Material increases in the number of insurance claims, changes to healthcare costs, accident frequency and severity, legal expenses and other factors could result in unfavorable difference between actual self-insurance costs and our reserve estimates. As a result, our self-insurance costs could increase which may have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

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

Our facilities located in California account for a majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature 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 approximately 48% of our skilled nursing beds are located in California as of December 31, 2025, 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.

In addition, our facilities in certain states, such as Kansas, Kentucky, South Carolina, Missouri, Ohio and Texas are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, tornadoes and flooding. These acts of nature may cause disruption to us, the employees of our operating subsidiaries and our facilities, which could have an adverse impact on the patients of our operating subsidiaries and our business. In order to provide care for the patients of our operating subsidiaries, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our facilities, and the availability of qualified employees to provide services at our facilities. If the delivery of goods or the ability of employees to reach our facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our facilities 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. Furthermore, due to the concentration of our operations in these states, our business may be adversely affected by economic conditions, contagious disease outbreaks, political unrest, and other conditions over which we have no control that disproportionately affect these states as compared to other states. Such events could harm the patients and employees of our operating subsidiaries, severely damage or destroy one or more of our facilities, adversely affect our business, reputation and financial condition, or otherwise cause our business to suffer in ways that we currently cannot predict.

The actions of national labor unions may adversely affect our revenue and our profitability.

Some of our facilities are parties to collective bargaining agreements with labor unions, and we anticipate that additional facilities will enter into collective bargaining agreements in the future. The Biden-Harris Administration requested that HHS and CMS study and issue proposed rules regarding care-based careers that may increase the likelihood of employee unionization due to increased emphasis on care-based careers in SNF facilities, however the current political landscape has reduced the likelihood of federal action that forces unionization in SNF facilities. If employees 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 our facilities, 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 have an adverse effect on our business, financial condition and results of operations.

As of December 31, 2025, we leased 268 or 83% of our facilities (including 49 leased facilities partially owned through our joint ventures managed by third parties). 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). Some of our leases cover more than one facility, including some leases that cover 25 or more facilities on a single master lease. 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. For leases of certain facilities, our landlord could require us to purchase the associated real estate. Termination of a lease could result in a default under our debt agreements and could have an adverse effect on our business, financial condition and 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. Furthermore, there may be disputes with landlords regarding the obligations under such lease, or the ability of the landlord to terminate the lease, which could disrupt our business operations and increase expenses.

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

We may not generate sufficient cash flow from operations to cover interest, principal and lease payments. Additionally, under the terms of our credit facility with Truist Bank and a syndicate of lenders (Amended and Restated Credit Facility), we are subject to certain affirmative and negative covenants customary for credit facilities of this type as well as two financial covenants, a total leverage financial covenant and a fixed charge coverage ratio financial covenant. These restrictions may limit our ability to obtain additional advances under our Amended and Restated 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. See the section titled "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity & Capital Resources—Credit Facilities."

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 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 leases.

Because our mortgages and lease obligations are fixed expenses and secured by specific assets, and because our obligations under the Amended and Restated Credit Facility are secured by virtually all of our assets, including real property, subject to customary exceptions, 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 leases depends upon our future performance, which will be subject to general economic conditions, industry cycles and financial, business and other factors affecting our operating 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 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 leases. The failure to make required payments on our debt or 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.

Our founders have personal guarantees under certain of our leases, which subjects them to increased risk of default.

Our founders have provided personal guarantees under certain of our leases using their personal property. Under the personal guarantees provided by our founders, our founders have agreed to satisfy our obligations under the leases in the event that we are unable to perform our obligations thereunder. In the event that the guarantee is enforced against either or both of our founders, they could be obliged to use their personal property to fulfill their obligations under the leases. If our founders are subject to personal bankruptcy or refute the guarantees, we may be subject to an increased risk of default under our leases. Our founders owe a fiduciary duty of loyalty to us. However, there is potential for conflicts of interest between each of their personal interests and ours whether their respective guaranty is called upon or not. No assurance can be given that material conflicts will not arise that could be detrimental to our operations and financial prospects.

We may need additional capital to fund our operating 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 operating subsidiaries and facilities 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 facilities 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, and to otherwise make our facilities more attractive in their local markets. 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 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 OBBBA may impose further strain and limitation of funds available through the Medicaid programs in the states where our independent subsidiaries operate. In addition, third-party payors may not make timely payment to us. 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. Delays also happen from time to time with managed care organizations and other insurance companies who are payors for our patients.

Some states in which we operate are operating with budget deficits or could have budget deficit 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 many states, including some of the largest where we operate, including California, state Medicaid benefits are administered through MCOs. Typically, these MCOs manage commercial health and federal Medicare Advantage benefits under a managed care contract.

MCOs and other third-party payors have continued to consolidate in order to enhance their ability to influence the delivery and cost structure of healthcare services. Consequently, the healthcare needs of a large percentage of the U.S. population are increasingly served by a smaller number of managed care organizations. These organizations generally enter into service agreements with a limited number of providers for needed services. In addition, third-party payors, including managed care payors, increasingly are demanding discounted fee structures.

Nationally, MCOs cover increasingly large numbers of Medicaid and Medicare Advantage beneficiaries. 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 OBBBA may result in MCOs becoming more aggressive in the denial of claims 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 operating subsidiaries, and additional avenues for risks that include fines and other sanctions, including suspension or exclusion from participation in various governmental programs. To the extent that these organizations terminate us as a preferred provider, engage our competitors as a preferred or exclusive provider, demand discounted fee structures, limit the patients eligible for our services, or seek our assumption of all or a portion of the financial risk through a prepaid capitation arrangement, it could have a material adverse effect on our business, financial condition, results of operations and liquidity.

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

Certain of our facilities 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 those monies, and we may be subject to citations, fines and penalties.

Each of our facilities 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 misappropriated money. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse those monies, and we may also be subject to citations, fines and penalties pursuant to federal and state laws.

Security breaches, cybersecurity incidents, or our inability to effectively integrate, manage and keep our information systems secure and operational could violate security laws, disrupt our operations, 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. Our business is dependent on the proper functioning and availability of our computer systems and networks. While we have taken steps to protect the safety and security of our information systems and the patient health information and other data maintained within those systems, 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. We may also experience security breaches that may remain undetected for an extended period. Even if identified, we may be unable to adequately investigate or remediate incidents or breaches due to attackers increasingly using tools and techniques – including artificial intelligence – that are designed to circumvent controls, to avoid detection, and to remove or obfuscate forensic evidence. 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.

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. If we or our third-party vendors were to experience a significant cybersecurity breach of our or their information systems or data, the costs associated with the investigation, remediation and potential notification of the breach to counter-parties and data subjects could be material. In addition, our remediation efforts may not be successful. If we do not allocate and effectively manage the resources necessary to build and sustain the proper technology and cybersecurity infrastructure, we could suffer significant business disruption. There can also be no assurance that our and our third-party service providers', strategic partners', contractors', consultants', and subcontractors'cybersecurity risk management program and processes, including policies, controls or procedures, will be fully implemented, complied with or effective in protecting our systems, networks and confidential information.

A cyberattack 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. We and certain of our service providers are from time to time subject to cyberattacks and security incidents. While we do not believe that we have experienced any significant system failure, accident or security breach to date, if such an event were to occur and cause interruptions in our operations,

It could also result in the theft, destruction, loss, misappropriation or release of confidential information or intellectual property, could cause operational or business delays that may materially impact our ability to provide various healthcare services and otherwise conduct our business operations, and could require us to expend significant costs to remediate the breach and retrieve our data or access to our systems. If a security breach or other incident were to result in the unauthorized access to or unauthorized use, disclosure, release or other processing of personal information, it may be necessary to notify individuals, governmental authorities, supervisory bodies, the media and other parties pursuant to

privacy and security laws. Any security compromise affecting us, our service providers, strategic partners, other contractors, consultants, or our industry, whether real or perceived, could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties, erode confidence in the effectiveness of our security measures, and lead to regulatory scrutiny. To the extent that any disruption or security breach were to result in a loss of, or damage to, our data or systems, or inappropriate disclosure of confidential or proprietary or personal information, we could also incur liability and become subject to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to, disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, Office of Civil Rights, the Office of the Inspector General (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 condition, results of operations and liquidity.

Further, our insurance coverage may not be sufficient to cover the financial, legal, business or reputational losses that may result from an interruption or breach of our systems.

If we are unable to obtain, maintain and enforce intellectual property protection for our technology or if the scope of our intellectual property protection is not sufficiently broad, our ability to successfully compete and utilize our technology may be adversely affected.

Our business depends, in part, on internally developed technology and content, including software and know-how, the protection of which is important to the success of our business and strategy. We rely on a combination of trademark, trade-secret, and copyright laws and confidentiality procedures and contractual provisions to protect our intellectual property rights. We may, over time, increase our investment in protecting our intellectual property through additional trademark, patent and other intellectual property filings. These measures, however, may not be sufficient to offer us meaningful protection. If we are unable to establish or protect our intellectual property and other rights, our competitive position and our business could be harmed, as third parties may be able to develop technologies that are substantially the same as ours or challenge our ability to use our existing technologies.

Also, some of our services rely on technologies and software developed by or licensed from third parties, and we may not be able to maintain our relationships with such third parties or enter into similar relationships in the future on reasonable terms or at all. Our failure to obtain, maintain and enforce our intellectual property rights could have a material adverse effect on our business, financial condition and results of operations.

We are a holding company with no operations and rely upon our multiple independent operating subsidiaries to 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 facilities is operated through a separate, wholly owned, independent subsidiary, which has its own local 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. If the cash distributions we receive from our subsidiaries are insufficient for us to fund our financial obligations, we may be required to raise cash through the incurrence of debt, the issuance of equity or the sale of assets to fund. However, there is no assurance that we would be able to raise cash by these means. If the ability of any of our subsidiaries to pay dividends or make distributions or payments to us is materially restricted by regulatory or legal requirements, bankruptcy or insolvency, or our need to maintain our financial strength ratings, or is limited due to operating results or other factors, it could adversely affect our ability to meet our financial obligations and to pay dividends or make distributions to our stockholders.

Our future success depends on the continuing efforts of our management and key employees, and on our ability to attract and retain highly skilled personnel and senior management.

We depend on the talents and continued efforts of our senior management and key employees. The loss of members of our management or key employees may disrupt our business and harm our results of operations. Furthermore, our ability to manage further expansion will require us to continue to attract, motivate, and retain additional qualified personnel. Competition for this type of personnel is intense, and we may not be successful in attracting, integrating, and retaining the personnel required to grow and operate our business effectively. There can be no assurance that our current management team or any new members of our management team will be able to successfully execute our business and operating strategies.

Risks Related to Government Regulation

We rely on payments from third-party payors, including Medicare, Medicaid and other governmental healthcare programs and private insurance organizations. If coverage or reimbursement for services are changed, reduced or eliminated, including through cost-containment efforts, spending requirements are changed, data reporting, measurement and evaluation standards are enhanced and changed, our operations, revenue and profitability could be materially and adversely affected.

We derive substantial revenue from government healthcare programs, primarily Medicare and state Medicaid programs. Medicare and Medicaid are our largest sources of total revenue. Medicare accounted for 33.7%, 33.8%, and 38.6% of total revenue for the years ended December 31, 2025, 2024, and 2023, respectively. Medicaid accounted for 40.5%, 40.4%, and 37.6% of our total revenue for the years ended December 31, 2025, 2024, and 2023, respectively. 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, Medicaid and other third-party payors payments, it could have a material adverse effect on our business, financial condition and results of operations.

Congress and the CMS often change the rules governing the Medicare program, including those governing reimbursement. Payments received from state Medicaid programs vary from state to state. These payments and programs are subject to statutory and regulatory changes, administrative rulings, interpretations, budgetary and funding constraints, and changes to the methods of calculating payments and reimbursements and requirements to participate in the programs. When these changes are implemented, we must also modify our operations and internal billing processes and procedures accordingly, which can require significant time and expense. As federal healthcare expenditures continue to increase and state governments may face budgetary shortfalls, federal and state governments have made, and may continue to make, significant changes to the Medicare and Medicaid programs and reimbursement received for services rendered to beneficiaries of such programs. The U.S. federal budget is subject to change, including reductions in federal spending, and the Medicare program is frequently mentioned as a target for spending cuts. The full impact on our business of any changes is uncertain. Changes to the Medicare program, state Medicaid programs and other third-party payor program that could adversely affect our business include:

- statutory and regulatory changes and executive actions, including policy interpretations and changes that impact state reimbursement programs, particularly Medicaid reimbursement and managed care payments;
- administrative or legislative changes to base rates or the bases for payment;
- the reduction or elimination of annual rate increases, or the end of the reduced payments deferment;
- 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;
- payment or other delays by fiscal intermediaries, carriers or payors;
- redefining enrollment standards and participation in government healthcare programs;
- changes in staff requirements as a condition of payment or eligibility for Medicare reimbursement;

- reduced reimbursement rates and changes in coverage under commercial and managed care contracts;
- changes in reimbursement rates, methods, or timing under governmental reimbursement programs, including reductions in annual reimbursement updates due to budgetary or other pressures;
- interruption or delays in payments due to any ongoing governmental investigations and audits or due to a partial or total federal or state government shutdown for a prolonged period of time;
- an increase in co-payments or deductibles payable by beneficiaries;
- recoupment efforts and recovery of overpayments;
- federal, state, and local litigation, administrative proceedings, and enforcement actions, including those relating to false claims, pandemics and the failure to satisfy the terms and conditions of financial relief; and
- reputational harm of publicly disclosed enforcement actions, audits, or investigations related to quality of care, patient harm and abuse, billing and reimbursement.

The healthcare industry broadly, including government and commercial payors, is initiating cost containment efforts. 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. 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. 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. Additionally, both government and private payors are increasingly looking to value-based purchasing to contain costs. Value-based purchasing focuses on quality of outcomes and efficiency of care, rather than quantity of care. The shifting regulatory framework presents separate compliance challenges. Reductions in reimbursement rates or the scope of services being reimbursed could have a material, adverse effect on our business, financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating costs.

In addition, CMS may make future adjustments to reimbursement levels and underlying reimbursement formulas as it continues to monitor the impact of current payments system on patient outcomes and budget neutrality.

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. 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 majority of our total revenue is generated from our skilled nursing operating subsidiaries in California, any budget reductions or delays in California could adversely affect our net patient service revenue and profitability. Despite present state budget surpluses in many of the states in which we operate, we can expect continuing cost containment pressures on Medicaid outlays for SNFs, and any such decline could have an adverse effect on our business 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. Moreover, the OBBBA imposes significant reductions in the funding of the Medicaid program, such reductions are expected to decrease the number of persons enrolled in Medicaid and reduce the services covered by Medicaid.

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 OBBBA'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' net patient 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. The changes to the Medicaid program enacted in the OBBBA 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 could have a significant and adverse effect on states' Medicaid expenditures or delays in eligibility or coverage, and as a result could have a material adverse effect on our business, financial condition or results of operations.

The CAA 2023 provided for the gradual wind-down and termination of increased Federal Medicaid Assistance Percentage (FMAP) payments under the Families First Coronavirus Relief Act (FFCRA) in 2023, and also provided for the disenrollment of Medicaid beneficiaries who have participated in the program since early in the COVID-19 pandemic.

Beginning on April 1, 2023, states were allowed to begin disenrolling Medicaid beneficiaries and our understanding is that states have now substantially completed their unwinding processes. Data from CMS on Medicaid redeterminations showed substantial increases in ACA plan enrollments among consumers in 2023 and 2024 who lost Medicaid or CHIP coverage, as well as decreases in Medicaid enrollment from 2023 to 2024. As a result of decreases in enrollment, there may be fewer current or potential patients able to pay for our operating subsidiaries' services, and increased competition for Medicaid beneficiaries able to provide reimbursement for those services. In addition, states risk losing federal Medicaid matching funds for non-compliance with CMS's instructions, which could result in reduced Medicaid funds available for timely reimbursement of our operating subsidiaries for their operations.

Medicare and Medicaid nursing facilities are required to disclose data about the facility's ownership, management and the owners of real property lessors upon initial enrollment and revalidation. In addition, the nursing facilities are required to timely report any changes, including in connection with any change of ownership. CMS defines the disclosable parties to include members of the facility's governing body, persons or entities who are an officer, director, member, partner, trustee or managing employee of the facility, persons or entities that exercise operational, financial or managerial control, lease or sublease real property to the facility, own a direct or indirect interest of five percent or greater of the real property or provide management or administrative services to the facility. Additionally, for any disclosable party that is a corporation, the disclosure must include the stockholders who have a five percent or greater direct or indirect ownership interest. Additionally, facilities will be required to disclose whether any entity on the form is a private equity company or real estate investment trust (REIT). CMS makes the information that is provided publicly available. This new disclosure requirement involves reporting extensive information and may complicate our efforts to comply with Medicare and Medicaid requirements. Failure to comply with the new disclosure requirements could affect our participation in Medicare and state Medicaid programs and adversely impact our business and financial condition.

Medicaid is an important source of funding for our independent operating subsidiaries. We may be adversely affected by the disenrollment of Medicaid beneficiaries, which may lead to a reduction in reimbursement that may adversely impact our revenue and profit. Although CMS announced in 2024 that all unwinding-related renewals for beneficiaries enrolled in Medicaid must be completed no later than December 31, 2025, the majority of states have now substantially completed their unwinding processes. The ultimate impact of Medicaid disenrollment on our finances and operations will depend on individual states' specific circumstances and actions. See Part I, Item 1 "Business--Regulatory Matters."

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

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 most recently, new rules regarding the implementation of the anti-discrimination provisions and new rules requiring the 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 Inflation Reduction Act of 2022 (IRA) in August of 2022, Congress continues to expand and supplement 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.

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. In the event that the ACA is repealed or any elements of the ACA that are beneficial to our business are materially amended or changed, 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. However, any material changes to the ACA or its implementing regulations may negatively impact our operations.

Most recently, the OBBBA was enacted in July 2025, which imposes significant reductions in the funding of the Medicaid program. The law requires states to establish work requirements and more frequent redeterminations, among other modifications, and these changes are expected to reduce enrollment in state Medicaid programs. The timing and magnitude of the reductions may vary by state depending on how quickly states implement the changes. The law also reduces limits on payments to Medicaid providers to 100 percent of the mandated Medicare rate for expansion states and 110 percent of the Medicare rate for non-expansion states. Their impact is uncertain at this time and will depend on how states may adapt their future tax and Medicaid funding policies in response.

While it is not possible to predict whether and when any such healthcare reform initiatives or changes to the ACA will occur, specific proposals, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. 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, and a new administration could make changes impacting the implementation and enforcement of the ACA, which could harm our business, operating results and financial condition. We have already seen this with regulatory activity promulgating rules regarding anti-discrimination under Section 1557 of the ACA and the disclosure of SNF ownership and service providers under Section 6101 of the ACA. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

Since the ACA, there have been healthcare reform proposals and we expect that other healthcare reform legislative and regulatory changes will be proposed and enacted, including reductions in payments to SNFs and impose the staffing and reporting requirements. We cannot predict what effect future reforms to the U.S. healthcare system will have on our business, including the demand for our services, the cost of our operations, 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. See Part I, Item 1 “Business-Regulatory Matters.”

We are subject to various government and third-party payor 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 or other third-party payor programs.

Regulators and third-party payors are increasing scrutiny of claims, which may require additional resources to response to audits and may cause additional delays or denials in receiving payment. As a result of our participation in the Medicaid and Medicare programs, we and other program participants are subject to various governmental reviews, audits and investigations to verify compliance with the rules associated with these programs and related applicable laws and regulations, including 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. 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. Managed care and other third-party payors also often reserve the right to conduct audits and do on a regular basis.

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 or admission bans or moratoriums;
- protracted regulatory oversight, including 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;
- an increase in private litigation against us; and
- damage to our reputation in the geographies served by our independent operating subsidiaries.

Both federal and state government continue to pursue intensive enforcement polices resulting in a significant number of investigations, audits, citations or regulatory deficiencies and other regulatory actions. Federal and state agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing audits, inquiries and 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; and the medical necessity of rendered services. In 2023, CMS announced a nationwide audit, the "SNF 5-Claim Probe & Educate Review," in which the Medicare Administrative Contractors 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.

If we fail to comply with these extensive laws, regulations and prohibitions to our business, we and certain officers could become subject to demands for refund of alleged overpayments, civil and criminal penalties, termination, exclusion or payment suspensions from the Medicare and Medicaid program, loss of Medicare or Medicaid certification, bans on Medicare and Medicaid payments for new admissions, admission moratoriums. We may also become subject to corporate integrity agreements or extensive monitoring by regulatory agencies. For example, we are subject to various legal proceedings, claims, and governmental inspections, audits, and investigations, including civil investigative demands (CIDs) and criminal subpoenas such as the ones discussed in more detail in Part I. Item 3 "Legal Proceedings" relating to alleged violations of the Federal False Claims Act and the making of false or fraudulent statements under HIPAA. We cannot predict their outcome of these investigations. We could be forced to expend considerable resources responding to these investigations and to any other investigations, audits and other enforcement actions that we may receive, which could divert material time, resources and attention away from our management team and our staff. Additionally, an adverse finding in any such matters could lead to the imposition of damages, fines, penalties, restitution, other monetary liabilities, sanctions, settlements or changes to our business practices or operations that could have a material adverse effect on our business, financial condition or results of operations.

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.

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, the manner in which we provide and bill for services and collect reimbursement from governmental programs and private payors, and our interactions with patients, healthcare providers and referral sources, our marketing activities, and other aspects of our operations. These laws and regulations are subject to frequent change. 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. Restrictions under applicable federal and state laws and regulations that may affect our ability to operate include the following:

- the federal Anti-Kickback Statute (AKS) that prohibits the knowing and willful offer, payment, solicitation or receipt of any bribe, kickback, rebate or other remuneration for referring an individual, in return for ordering, leasing, purchasing or recommending or arranging for or to induce the referral of an individual or the ordering, purchasing or leasing of items or services covered, in whole or in part, by any federal healthcare program, such as Medicare and Medicaid. "Remuneration" includes the transfer of anything of value, in cash or in kind and directly or indirectly. A person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;

- the federal physician self-referral law (Stark Law), that, subject to limited exceptions, prohibits physicians, which includes a doctor of medicine, from referring Medicare or Medicaid patients to an entity for the provision of certain designated health services if the physician or a member of such physician's immediate family has a direct or indirect financial relationship (including an ownership interest or a compensation arrangement) with the entity, and prohibit the entity from billing Medicare or Medicaid for such designated health services. Unlike the AKS, the Stark Law is violated if the financial arrangement does not meet an applicable exception, regardless of any intent by the parties to induce or reward referrals or the reasons for the financial relationship and the referral;

- the federal False Claims Act (FCA), that imposes civil and criminal liability on individuals or entities that knowingly submit false or fraudulent claims for payment to the government or knowingly making, or causing to be made, a false statement in order to have a false claim paid. There are many potential bases for liability under the FCA. The government has used the FCA to prosecute Medicare and other government healthcare program fraud such as coding errors, billing for services not provided, and providing care that is not medically necessary or that is substandard in quality. In addition, the government may assert that a claim including items or services resulting from a violation of the federal AKS or Stark Law constitutes a false or fraudulent claim for purposes of the FCA. Actions under the FCA may be brought by the Attorney General, the U.S. Department of Justice (DOJ), the United States Attorney Offices, or as a qui tam action by a private individual in the name of the government. These private parties, often referred to as relators or whistleblowers, are entitled to share in any amounts recovered by the government through trial or settlement, and these qui tam cases are sealed by the court at the time of filing;

- the criminal healthcare fraud provisions of HIPAA and related rules that prohibit knowingly and willfully executing a scheme or artifice to defraud any healthcare benefit program or falsifying, concealing or covering up a material fact or making any materially false, fictitious or fraudulent statement in connection with the delivery of or payment for healthcare benefits, items or services. Similar to the AKS, a person or entity does not need to have actual knowledge of the statute or specific intent to violate it to have committed a violation;

- similar state law provisions pertaining to anti-kickback, self-referral and false claims issues, some of which may apply to items or services reimbursed by any payor, including patients and commercial insurers;

- state corporate practice and fee-splitting laws that prohibit general business corporations such as us, from practicing medicine or other healthcare professionals, controlling licensed healthcare professionals' medical decisions or engaging in some practices, such as spitting fees with licensed healthcare professionals;

- laws that regulate debt collection practices;

- federal and state antitrust laws that prohibit or limit exclusive contracting relationships with healthcare providers, prohibit or limit the sharing of cost and pricing data, prohibit competitors from taking collective action to set commercial payer reimbursement rates, and determine when a joint venture or healthcare network is sufficiently integrated, by either sharing substantial financial risk or substantial clinical integration, to jointly contract with commercial payers;

- laws that impose criminal penalties on healthcare providers who fail to disclose or refund known overpayments;

- laws that require maintenance of licensure, certification and accreditation;

- laws relating to adequacy and quality of healthcare services, quality and maintenance of medical equipment and facilities;

- laws that impose reporting, transparency and disclosure requirements of the ownership, management. managing employees and the owners of real property lessors or sublessors, including any private equity companies or REITs;

- laws relating to staffing levels and qualifications and vaccination (including boosting) of healthcare and support personnel;

- confidentiality, maintenance and security issues associated with medical records and claims processing; and

- constraints on protective contractual provisions with patients and third-party payors.

These laws and regulations are complex, and we do not always have the benefit of significant regulatory or judicial interpretation of these 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. 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, operations, capital expenditure programs and operating expenses. Our efforts to comply with these laws and regulations could be costly and result in diversion of management time and effort and may still not guarantee compliance. Regulators continue to increase their scrutiny of compliance with these obligations, which may require us to further revise or expand our compliance program. While we diligently strive to maintain compliance with these laws, 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. For example, we are subject to various governmental inspections, audits, and investigations, including civil investigative demands (CIDs) and criminal subpoenas such as the ones discussed in more detail in Part I. Item 3 “Legal Proceedings” relating to alleged violations of the Federal False Claims Act and the making of false or fraudulent statements under HIPAA. We cannot predict the outcome of these ongoing investigations and any future legal proceeding, government inspection, audit or investigation. We could be forced to expend considerable resources responding to these investigations and to any other investigations, audits and other enforcement actions that we may receive, which could divert material time, resources and attention away from our management team and our staff.

Any adverse finding in these ongoing matters, or in any similar matter that may arise in the future, could subject us to civil or criminal penalties, sanctions, remedial measures 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. In addition, if we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations and enter into a corporate integrity agreement, deferred prosecution or similar agreements with state or federal government agencies. 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.

We face and are currently subject to surveys, investigations, and other proceedings relating to our licenses and certification and potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations. Public and government calls for increased survey and enforcement efforts toward SNFs, and potential rulemaking that may result in enhanced enforcement and penalties, could result in increased scrutiny by state and federal survey agencies.

Our facilities must comply with required conditions of participation in the Medicare program and state Medicaid programs and state licensure requirements. We are subject to surveys and investigations from federal and state agencies as well as accreditation organizations. We receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. If we fail to meet the conditions of participation or licensure standards, we may receive a notice of deficiency from the applicable surveyor. 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.

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 facilities. No material remedial actions have been taken against us to date, however, we have had facilities placed on special focus facility (SFF) status in the past, continue to have some

facilities on this status currently and other operating subsidiaries may be identified for such status in the future. In particular, as our strategy includes the targeted acquisition of underperforming SNFs, we from time to time acquire facilities with special focus facility status. As of December 31, 2025, we had four facilities with special focus facility status. Three such facilities were acquired with this status and one was placed on such status following our acquisition of the facility. These facilities received such status as a result of accumulating an above average number survey deficiency points over the course of multiple surveys, some of which occurred prior to their acquisition. Survey deficiency points are issued by the government survey agency when inspecting a nursing facility to reflect the deficiencies that the facility is cited for in the survey, which include, but are not limited to, quality of life and care, freedom from abuse, neglect and exploitation deficiencies.

If a facility then fails to institute an acceptable plan of correction to remediate the deficiency within the correction period provided by the state surveyor, that facility could be subject to remedial action. These actions include the imposition of fines, imposition of a license to a conditional or provisional status, admission holds, suspension or revocation of a license, payment suspension, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including civil monetary penalties and criminal penalties. Termination of one or more of our facilities from the Medicare or state Medicaid programs for failure to satisfy conditions of participation, or the imposition of alternative sanctions, could disrupt operations, require significant attention by management or have a material adverse effect on our business and reputation and consolidated financial condition, results of operations and cash flows.

From time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state 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 voluntary 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.

Furthermore, in some states, citation of one affiliated facility could negatively impact other facilities 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, 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.

As CMS turns its attention to enhancing enforcement activities towards SNFs, state survey agencies will have more accountability for their survey and enforcement efforts. Effective October 1, 2024, CMS finalized expanded authority to impose multiple per day and per instance CMPs on facilities for non-compliance identified in surveys, with a look back period of three standard surveys. Although we are not able to predict whether the new administration will continue to prioritize regulation applicable to LTCs, the measures implemented under the Biden administration may result more frequent surveys of our facilities, with more substantial penalties, fines and 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. Additionally, CMS recently updated the survey resources that CMS and state surveyors use in evaluating our SNFs' compliance with federal Requirements for Participation. 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 operating subsidiaries.

Actual or perceived failures to comply with applicable data protection, privacy and security laws, regulations, including HIPAA, standards and other requirements could adversely affect our business, results of operations, and financial condition.

The data protection landscape is rapidly evolving, and we are or may become subject to numerous federal and state laws, requirements and regulations governing the collection, use, disclosure, retention, and security of health-related and other personal information. Implementation standards and enforcement practices are likely to remain uncertain for the foreseeable future, and we cannot yet determine the impact future laws, regulations, standards, or perception of their requirements may have on our business. This evolution may create uncertainty in our business, affect our ability to operate in certain jurisdictions or to collect, store, transfer use and share personal information, necessitate the acceptance of more onerous obligations in our contracts, result in liability or impose additional costs on us. The cost of compliance with these

laws, regulations and standards is high and is likely to increase in the future. Any failure or perceived failure by us to comply with federal or state laws or regulations, our internal policies and procedures or our contracts governing our processing of personal information could result in negative publicity, government investigations and enforcement actions, claims by third parties and damage to our reputation, any of which could have a material adverse effect on our business, results of operation, and financial condition.

HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act, and regulations implemented thereunder, or collectively HIPAA, imposes privacy, security and breach notification obligations on certain healthcare providers, health plans, and healthcare clearinghouses, known as covered entities, as well as their business associates that perform certain services that involve creating, receiving, maintaining or transmitting individually identifiable health information for or on behalf of such covered entities, and their covered subcontractors. HIPAA requires us to adopt and maintain policies, procedures and systems designed to protect the privacy, security and integrity of patients' individually identifiable health information, including the adoption of administrative, physical and technical safeguards to protect such information, and certain notification requirements in the event of a breach of unsecured PHI.

Additionally, under HIPAA, covered entities must report breaches of unsecured PHI to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a covered entity or its agents. Notification also must be made to the U.S. Department of Health and Human Services Office for Civil Rights, or OCR, and, in certain circumstances involving large breaches, to the media. Business associates must report breaches of unsecured PHI to covered entities within 60 days of discovery of the breach by the business associate or its agents. A non-permitted use or disclosure of PHI is presumed to be a breach under HIPAA unless the covered entity or business associate establishes that there is a low probability the information has been compromised consistent with requirements enumerated in HIPAA. Recently, the OCR has targeted investigative and enforcement efforts on violations of patients' rights of access, imposing significant fines for violations largely initiated from patient complaints.

Entities that are found to be in violation of HIPAA as the result of a breach of unsecured PHI, a complaint about privacy practices or an audit by the U.S. Department of Health and Human Services, or HHS, may be subject to significant civil, criminal and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance. HIPAA also authorizes state Attorneys General to file suit on behalf of their residents. Courts may award damages, costs and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI. Furthermore, the Federal Trade Commission ("FTC") and many state Attorneys General continue to enforce federal and state consumer protection laws against companies for online collection, use, dissemination and security practices that appear to be unfair or deceptive.

We must also comply with state privacy laws to the extent that they are more protective of healthcare information or provide additional protections not afforded by HIPAA. Certain states have also adopted comparable privacy and security laws and regulations, which govern the privacy, processing and protection of health-related and other personal information. Such laws and regulations will be subject to interpretation by various courts and other governmental authorities, thus creating potentially complex compliance issues for us and our future customers and strategic partners. For example, the California Consumer Privacy Act of 2018, as amended by the California Privacy Rights Act (collectively, the "CCPA") requires covered businesses that process the personal information of California residents to, among other things: (i) provide certain disclosures to California residents regarding the business's collection, use, and disclosure of their personal information; (ii) receive and respond to requests from California residents to access, delete, and correct their personal information, or to opt out of certain disclosures of their personal information; and (iii) enter into specific contractual provisions with service providers that process California resident personal information on the business's behalf. Additional compliance investment and potential business process changes may also be required. Similar laws have been passed in other states, and are continuing to be proposed at the state and federal level, reflecting a trend toward more stringent privacy legislation in the United States. For example, Washington State enacted the Washington My Health My Data Act, which broadly defines consumer health data, creates a private right of action to allow individuals to sue for violations of the law, imposes stringent consent requirements, and grants consumers certain rights with respect to their health data, including to request deletion of their information. The enactment of such laws could have potentially conflicting requirements that would make compliance challenging. In the event that we are subject to or affected by HIPAA, the CCPA, or other domestic privacy and data protection laws, any liability from failure to comply with the requirements of these laws could adversely affect our financial condition.

We send short message services ("SMS") text messages to patients. While we obtain consent from these individuals to send text messages, federal or state regulatory authorities or private litigants may claim that the notices and disclosure we provide, form of consent we obtain or our SMS texting practices are not adequate or violate applicable law. In addition, we must ensure that our SMS texting practices comply with regulations and agency guidance under the Telephone Consumer Protection Act (the "TCPA"), a federal statute that protects consumers from unwanted telephone calls, faxes and text messages. While we strive to adhere to strict policies and procedures that comply with the TCPA, the Federal Communications Commission ("FCC"), as the agency that implements and enforces the TCPA, may disagree with our interpretation of the TCPA and subject us to penalties and other consequences for noncompliance. Determination by a court or regulatory agency that our SMS texting practices violate the TCPA could subject us to civil penalties and could require us to change some portions of our business. Even an unsuccessful challenge by patients or regulatory authorities of our activities could result in adverse publicity and could require a costly response from and defense by us. Moreover, if wireless carriers or their trade associations, which issue guidelines for texting programs, determine that have violated their guidelines, our ability to engage in texting programs may be curtailed or revoked, which could impact our operations and cause us to incur costs related to implementing a workaround solution.

HIPAA and other comparable state and federal laws and regulations change periodically. If we fail to comply with these state and federal laws and regulations, 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. As described in more detail in Part I. Item 3 "Legal Proceedings", we are currently subject to a criminal investigation relating to the alleged making of false or fraudulent statements under HIPAA. We cannot predict the outcome of this investigation.

If we fail to comply with applicable data interoperability and information blocking rules, its consolidated results of operations could be adversely affected.

In March 2020, the Office of the National Coordinator for Health Information Technology, or ONC, which is now known as the Assistant Secretary for Technology Policy, or ASTP, released a final rule implementing the information blocking prohibition of the 21st Century Cures Act, which went into effect on April 5, 2021. The rule, which applies to almost all health care providers, is designed to create a more interoperable health care system that supports seamless data exchange, improves care coordination, and removes barriers to the use and exchange of electronic health information, or EHI,between providers and plans and as directed by patients. "Information blocking" refers to activities that unreasonably limit the availability and use of EHI. The rule prohibits information blocking of EHI unless it is required by law or meets one of eight narrowly applied exceptions. ONC has delegated oversight and compliance monitoring to the Office of Inspector General, and a provider may be subject to significant financial penalties if it fails to comply with these new rules. Any individual can submit a complaint alleging that a provider has engaged in information blocking through an online portal made available by ONC. Any failure to comply with these rules could have a material adverse effect on our business, results of operations and financial condition.

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

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 Multiple Procedure Payment Reduction (MPPR), institution of annual caps, mandatory medical reviews for annual claims beyond a certain monetary threshold, and a reduction in reimbursement rates for therapy assistant claim modifiers. Of specific concern has been CMS's recent efforts to lower Medicare Part B reimbursement rates for outpatient therapy services. Such cost-containment measures and ongoing payment changes could have an adverse effect on our revenue. The Office of the Inspector General (OIG) 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.

The OIG regularly conducts investigations regarding certain payment or compliance issues within the healthcare industry. The OIG identified SNF compliance as an issue of concern in recent semi-annual reports to Congress, and its January 2023 study regarding SNF emergency preparedness identified the need for further oversight and addition of SNF emergency readiness to the OIG's 2023 work plan. Nursing homes were also a topic of discussion in the OIG's 2023 semi-annual report to Congress, which emphasized the continued protection and oversight of care that nursing facilities provide to residents. Among other things, the OIG 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, although it is unknown whether the current presidential administration will seek further or escalating scrutiny of SNFs.

Our business model, like those of some other for-profit operators, is based in part on attracting higher-acuity patients whom we believe provide us more opportunity to be profitable due to the higher level of services they need and accordingly higher reimbursement rates, and over time our overall patient mix has consistently shifted to higher-acuity and higher-resource utilization patients in most facilities we operate. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

Newly enacted and proposed legislation in the states where our independently operating entities are located may affect our operations in terms of individual litigation and the broader regulatory environment.

A bill in the State of California, where a significant majority of our facilities are located, was signed into law which increases the cap of non-economic damages awarded to plaintiffs who are successful in medical malpractice litigation. The cap increased from $250,000 to $350,000 beginning on January 1, 2023, then increases over the following 10 years until the cap reaches a maximum of $750,000, with further adjustments for inflation. In wrongful death cases, the cap increased from $250,000 to $500,000 on January 1, 2023, with incremental increases over the following 10 years until the cap reaches a maximum of $1,000,000, with adjustments for inflation. Due to California's influence on other states, other jurisdictions where we operate may enact similar laws. Similar to the potential incentive of increased damages caps, the Supreme Court's recent decision in Health and Hospital Corporation of Marion City v. Talevskimay increase public interest in potential claims against SNFs, 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 operating subsidiaries.

As another example, California's adoption of the Skilled Nursing Facility Ownership and Management Reform Act of 2022 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 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 facilities in the event they are not compliant with these new licensure application requirements. As a result, this law may delay or impede growth within California. As with the law 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.

More recently, California's legislature has proposed, among other things, bills related to increasing the minimum wage for workers, spending requirements and increased disclosure. These and other bills would create new and costly obligations on our independent operating subsidiaries if they became law and if enacted, would adversely affect our business, operations, and profitability. In October 2023, California adopted legislation that requires, if and when a minimum spending bill is later enacted with respect to skilled nursing facilities, workers at skilled nursing facilities, as well as most other healthcare facilities throughout the state, be paid a minimum wage that begins at $21 per hour beginning June 1, 2024, increasing to $23 per hour beginning June 1, 2026, and then increasing to $25 per hour beginning June 1, 2028. While California's state Medicaid reimbursement program will, barring intervening changes to the program, reimburse providers for some of the increased operating costs, there can be no assurance that they will be reimbursed for the full increase, or that they will be reimbursed in a timely manner.

On April 24, 2024, the California Department of Health Care Access and Information (HCAI) announced that the Office of Health Care Affordability's Board approved a statewide healthcare spending target of 3%, which represents a long-term reduction of current levels of statewide healthcare spending. The spending target will be phased in over time, initially starting at 3.5% for 2025 and 2026, the target will be lowered to 3.2% for 2027 and 2028 before ultimately reaching 3% for 2029 and beyond.

As another example, Texas passed a bill which partially restored Medicaid state relief funding for SNFs through August 31, 2023. Texas also enacted regulations effective September 1, 2023 that provide rate increases for direct care staff, which may provide financial relief to our independent operating subsidiaries in Texas. Other states may continue to propose bills impacting skilled nursing facilities, 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 operating 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, the Americans with Disabilities Act (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 U.S. Equal Employment Opportunity Commission (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.

On June 5, 2023, CMS published the Omnibus Final Rule, withdrawing the COVID-19 vaccination IFR 60 days after the rule's publication. At present, there is no nationally significant litigation concerning such mandates. The effects of the COVID-19 vaccination IFR's withdrawal on our operations and the labor pool for nursing and administrative staff is unknown, but may have an impact on our business, operations, and profitability.

Furthermore, the Biden Administration requested 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 new administration 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 new Administration and its new leaders of HHS and CMS.

The compliance costs associated with these laws and evolving regulations could be substantial. By way of example, all of our facilities 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. While we are insured for these types of claims, we could be subject to damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

In addition, California has adopted a law phasing in a minimum wage increase for healthcare workers that will reach $25 per hour for certain employees over the next several years. The first increases took effect in 2024 and additional increases are scheduled to continue through 2026 and beyond. As of December 31, 2025, approximately 48% of our skilled nursing beds are located in California. If similar legislation is proposed or adopted in other states in which we operate or into which we expand, our labor costs could increase significantly, which could have a material adverse effect on our business, financial condition, and results of operations.

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 operating 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 certificate of need boards, licensing agencies, Medicare and Medicaid as well as third-party payors. Rules regarding the disclosure of SNF facility ownership 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.

In recent years, states have become increasingly interested in the review of healthcare transactions for impacts on costs, access to care and quality, and certain states are particularly focused on transactions involving private equity investments. Transactions involving single multi-state organizations with hundreds of healthcare providers and facilities across the country are and may be in the future subject to state reviews because one or more providers or facilities derive revenue from patients within the state. Certain state review processes can involve lengthy review and approval periods, require enhanced disclosure obligations and impact analysis, public notices and hearings, and approval conditions and post-

closing oversight, including ongoing reporting obligations. Overall, these state laws regulating costs, access to care and quality, in effect and those that may go into effect in the future, may delay or burden our transactions, including future add-on acquisitions, increase costs associated with expansion, require intrusive disclosures, and impose onerous, ongoing reporting obligations.

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 facilities. Additionally, the Fair Housing Act and other similar state laws require that we advertise our services in such a way that we promote diversity and not limit it. We may be required, among other things, to change our marketing techniques to comply with these requirements.

In addition, we are required to operate our facilities 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 affiliated 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.

Our operations are subject to environmental and occupational health and safety regulations, which could subject us to fines, penalties and increased operational costs.

We are subject to a wide variety of federal, state and local environmental and occupational health and safety laws and regulations. Regulatory requirements faced by healthcare providers such as us include those relating to air emissions, wastewater discharges, air and water quality control, occupational health and safety (such as standards regarding blood-borne pathogens and ergonomics), management and disposal of low-level radioactive medical waste, biohazards and other wastes, management of explosive or combustible gases, such as oxygen, specific regulatory requirements applicable to asbestos, lead-based paints, polychlorinated biphenyls and mold, other occupational hazards associated with our workplaces, and providing notice to employees and members of the public about our use and storage of regulated or hazardous materials and wastes. Failure to comply with these requirements could subject us to fines, penalties and increased operational costs. Moreover, changes in existing requirements or more stringent enforcement of them, as well as discovery of currently unknown conditions at our owned or leased facilities, could result in additional cost and potential liabilities, including liability for conducting cleanup, and there can be no guarantee that such increased expenditures would not be significant.

Risks Related to Ownership of Our Common Stock

The market price of our common stock may be volatile or may decline steeply or suddenly regardless of our operating performance, which could result in substantial losses for owners of our common stock, and we may not be able to meet investor or analyst expectations.

The market price of our common stock may be highly volatile and fluctuate or decline significantly in response to numerous factors, many of which are beyond our control, including:

- variations between our actual operating results, or those of companies that are perceived to be similar to us, and the expectations of securities analysts, investors and the financial community;

- any forward-looking financial or operating information we may provide to the public or securities analysts, any changes in this information or our failure to meet expectations based on this information;

- actions of securities analysts who initiate or maintain coverage of us, changes in financial estimates by any securities analysts who follow our Company or our failure to meet these estimates or the expectations of investors;
- additional shares of our common stock being sold into the market by us or our existing stockholders;
- hedging activities by market participants;
- announcements by us or our competitors of significant features, technical innovations in facilities, acquisitions, strategic partnerships, joint ventures or capital commitments;
- changes in operating performance and stock market valuations of companies in our industry, including our competitors;
- changes in third-party payor reimbursement policies;
- an inability to obtain additional funding;
- general economic, political, industry and market conditions, including rising inflation, high interest rates, capital market disruptions, and price and volume fluctuations in the overall stock market;
- lawsuits threatened or filed against us;
- developments in new legislation and pending lawsuits or regulatory actions, including interim or final rulings by judicial or regulatory bodies; and
- other events or factors, including those resulting from political conditions, election cycles, pandemics, war or incidents of terrorism, or responses to these events, many of which are outside of our control.

Furthermore, short sellers may engage in activity intended to drive down the market price of our common stock, which could also result in related regulatory and governmental scrutiny, among other effects. Short selling is the practice of selling securities that the seller does not own but rather has borrowed or intends to borrow from a third party with the intention of later buying lower priced identical securities to return to the lender. Accordingly, it is in the interest of a short seller of our common stock for the price to decline. At any time, short sellers may also publish, or arrange for the publication of, opinions or characterizations that are intended to create negative market momentum in our common stock. Short selling reports can cause downward pressure and increased volatility in an issuer's stock price. For example, on November 4, 2024, a short-seller report was published about us, which contained certain allegations related to components of our operating results and other strategic matters. As a result, our Audit Committee completed an independent investigation to review the matters referenced in the report, which resulted in the identification of material weaknesses in internal control over financial reporting and the restatement of our interim financial statements for the quarters ended March 31, 2024 and June 30, 2024. The publication of the short-seller report resulted in a significant decline in the market price of our common stock, from which it has not fully recovered, and has led to securities class action and derivative litigation as described in "Legal Proceedings."

In addition, extreme price and volume fluctuations in the stock markets have affected and continue to affect many healthcare companies' stock prices. Stock prices often fluctuate in ways unrelated or disproportionate to the companies' operating performance. Following the publication of the short-seller report about us in November 2024 and following the significant decline in the market price of our common stock, we and certain of our executive officers were named as defendants in a securities class action discussed in more detail in Part I, Item 3. "Legal Proceedings". Securities litigation has and could continue to subject us to substantial costs, divert resources and the attention of management from our business and seriously harm our business.

Moreover, because of these fluctuations, comparing our operating results on a period-to-period basis may not be meaningful. This variability and unpredictability could also result in our failure to meet the expectations of industry or financial analysts or investors for any period. If our revenues or operating results fall below the expectations of analysts or investors or below any forecasts we may provide to the market, or if the forecasts we provide to the market are below the expectations of analysts or investors, the price of our common stock could decline substantially. Such a stock price decline could occur even when we have met any previously publicly stated revenue or earnings forecasts that we may provide.

We are subject to a securities class action litigation and derivative lawsuit.

Securities class action litigation is often been brought against companies following a decline in the market price of their securities, and is often followed by derivative litigation. Following the publication of the short-seller report about us in November 2024, the market price of our common stock declined significantly and we and certain of our executive officers were named as defendants in a securities class action and derivative lawsuits discussed in more detail in Part I, Item 3. "Legal Proceedings". These lawsuits and any future lawsuits to which we may become a party are subject to inherent uncertainties and will likely be expensive and time-consuming to investigate, defend and resolve, and will divert our management's attention and financial and other resources. The outcome of litigation is necessarily uncertain, and we could be forced to expend significant resources in the defense of these and other suits, and we may not prevail. Any litigation to which we are a party may result in an onerous or unfavorable judgment that may not be reversed upon appeal or in payments of substantial monetary damages or fines, or we may decide to settle this or other lawsuits on similarly unfavorable terms, which could adversely affect our business, financial condition, results of operations or stock price.

There can be no assurance that we will be able to comply with the continued listing standards of the New York Stock Exchange.

We did not timely file our Quarterly Report on Form 10-Q for the quarter ended September 30, 2024, Annual Report on Form 10-K for the year ended December 31, 2024, Quarterly Report on Form 10-Q for the quarter ended March 31, 2025, and Quarterly Report on Form 10-Q for the quarter ended June 30, 2025, due to an independent investigation by the Company's independent Audit Committee and the process of restating of our consolidated financial statements for the periods ended March 31 and June 30, 2024. As a result of these delinquent filings, we were out of compliance with NYSE Listing Rule 802.01E. We have since filed all delinquent reports and have regained compliance with the New York Stock Exchange (NYSE) continued listing standards. However, there can be no assurance that we will be able to maintain compliance with the NYSE's continued listing standards in the future. If we fail to satisfy the NYSE's continued listing requirements, including as a result of future delays in our SEC filings, we could be subject to delisting. The delisting of our common stock from NYSE would likely have a negative effect on the price of our common stock, impair our stockholders' ability to sell or purchase our common stock, lead to a limited amount of analyst coverage and may make it more difficult for us to raise capital on favorable terms in the future. In addition, delisting could subject us to additional litigation or regulatory investigation or enforcement.

An active trading market for our common stock may not be sustainable, and you may not be able to resell your shares at or above the price you pay.

Although our common stock is listed on the New York Stock Exchange under the symbol "PACS," an active trading market for our common stock may not be sustained. In the absence of an active trading market for our common stock, you may not be able to sell your shares of our common stock when desired or at or above the price you paid. An inactive market may also impair our ability to raise capital by selling shares and may impair our ability to acquire other businesses or properties using our shares as consideration, which, in turn, could materially and adversely affect our business.

Our founders, Jason Murray and Mark Hancock, have substantial control over us and hold a substantial portion of our outstanding common stock, and their interests may conflict, or appear to conflict, with our interests and the interests of other stockholders.

Our founders, Jason Murray and Mark Hancock, collectively beneficially own approximately 69.8% of the voting power of our common stock. In addition, pursuant to the terms of our Amended and Restated Charter, our founders are able to control corporate matters for the foreseeable future. For example, each founder has the right to designate (i) up to two individuals for inclusion in our slate of director nominees if such founder beneficially owns at least 20% of the aggregate number of shares of common stock outstanding immediately following the completion of our initial public offering (IPO) or (ii) one individual for inclusion in our slate of director nominees if such founder beneficially owns less than 20% but at least 10% of the aggregate number of shares of common stock outstanding immediately following the completion of our IPO. Accordingly, each founder currently has the right to designate two directors and collectively have the right to designate four directors, which represents four out of our five-member board of directors.

In addition, pursuant to the terms of our Amended and Restated Charter, for so long as Messrs. Murray and Hancock beneficially own, in the aggregate, the majority of the voting power of our outstanding shares of voting stock, they are able to remove any of our directors at any time with or without cause and may take action by written consent without a meeting of stockholders. As a result, Messrs. Murray and Hancock are able to determine or significantly influence our management,

business plans, policies, and governance for the foreseeable future. This concentrated control of the composition of the board of directors and voting power of our common stock will preclude your ability to influence corporate matters for the foreseeable future, including with respect to the composition of our board of directors, the election and removal of directors, the authorization and issuance of additional shares of our common stock that would be dilutive to you, the issuance of shares of preferred stock that could be dilutive to you and could have disparate voting rights, amendments to our organizational documents, and any merger, consolidation, sale of all or substantially all of our assets, or other major corporate transaction requiring stockholder approval. In addition, this may prevent or discourage unsolicited acquisition proposals or offers for our capital stock that you may feel are in your best interests as one of our stockholders and may deprive us of what we perceive as an attractive business combination opportunity. These limitations could deprive you of an opportunity to receive a premium for your shares of common stock as part of a sale of our company and ultimately might affect the market price of our common stock.

Even when the parties to our Stockholders Agreement cease to own shares of our stock representing a majority of the total voting power, for so long as such parties continue to own a significant percentage of our stock, they will still be able to significantly influence or effectively control the composition of our board of directors and the approval of actions requiring stockholder approval through their voting power. Accordingly, for such period of time, the parties to our Stockholders Agreement will have significant influence with respect to our management, business plans, policies, and governance.

Future sales, or the perception of future sales, of shares of common stock by existing stockholders could cause the market price of our common stock to decline.

If our existing stockholders sell, or indicate an intention to sell, substantial amounts of our common stock in the public market after the lock-up and legal restrictions on resale lapse, the trading price of our common stock could decline.

As of February 23, 2026, we had a total of 157,165,029 shares of our common stock outstanding. Of these shares, 46,835,808 shares of common stock are freely tradable, without restriction, in the public market unless purchased by our affiliates. The remaining shares are held by our directors, executive officers and other affiliates and may be sold in the public markets subject to volume limitations under Rule 144 of the Securities Act (Rule 144), and various vesting agreements. Sales of a substantial number of such shares or the perception that such sales may occur, could cause our market price to fall or make it more difficult for you to sell your common stock at a time and price that you deem appropriate. Messrs. Murray and Hancock are additionally entitled to rights with respect to the registration of all of their shares and they may be able to sell their shares outside of the volume limitations imposed by Rule 144.

Additionally, the shares of our common stock registered on our registration statement on Form S-8 under the Securities Act and issuable or reserved for issuance under our 2024 Incentive Award Plan (2024 Plan) and our 2024 Employee Stock Purchase Plan (2024 ESPP) are eligible for sale in the public market, subject to Rule 144 limitations applicable to affiliates. If these additional shares are sold, or if it is perceived that they will be sold in the public market, the trading price of our common stock could decline.

If our estimates or judgments relating to our critical accounting policies are based on assumptions that change or prove to be incorrect, our operating results could fall below our publicly announced guidance or the expectations of securities analysts and investors, resulting in a decline in the market price of our common stock.

The preparation of combined/consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in our combined/consolidated financial statements and the accompanying notes thereto. We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances, the results of which form the basis for making judgments about the carrying values of assets, liabilities, equity, revenue and expenses that are not readily apparent from other sources. It is possible that interpretation, industry practice and guidance involving estimates and assumptions may evolve or change over time. If our assumptions change or if actual circumstances differ from our assumptions, our operating results may be adversely affected and could fall below our publicly announced guidance or the expectations of securities analysts and investors, resulting in a decline in the market price of our common stock.

We are a "controlled company" within the meaning of the corporate governance standards of the New York Stock Exchange. As a result, we may elect to rely on exemptions from certain corporate governance standards and you may not have the same protections afforded to stockholders of companies that are subject to such requirements.

Jason Murray and Mark Hancock collectively control a majority of the voting power of shares eligible to vote in the election of our directors. Because more than 50% of the voting power in the election of our directors is held by an individual, group, or another company, we are a "controlled company" within the meaning of the corporate governance standards of the New York Stock Exchange. As a controlled company, we may elect not to comply with certain corporate governance requirements, including the requirements that, within one year of the date of the listing of our common stock:

- a majority of our board of directors consists of "independent directors," as defined under the rules of the New York Stock Exchange;
- our board of directors has a compensation committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities;
- our board of directors has a nominating and corporate governance committee that is composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities; and
- there will be an annual performance evaluation of the nominating and corporate governance and compensation committees.

For so long as we remain a "controlled company," we may elect to rely on these exemptions. Accordingly, you may not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance requirements of the New York Stock Exchange rules.

Our principal stockholders and management own a significant percentage of our stock and will be able to exercise significant influence over matters subject to stockholder approval.

As of December 31, 2025, our executive officers, and directors beneficially owned 70.3% of our outstanding shares of common stock. Therefore, these stockholders (in particular, Messrs. Murray and Hancock) have the ability to influence us through this ownership position. The interests of these stockholders may not be the same as or may even conflict, or appear to conflict, with your interests. For example, these stockholders could attempt to delay or prevent a change in control of us, even if such change in control would benefit our other stockholders, which could deprive our stockholders of an opportunity to receive a premium for their common stock as part of a sale of us or our assets, and might affect the prevailing market price of our common stock due to investors' perceptions that conflicts of interest may exist or arise. In addition, these stockholders, acting together, will be able to significantly influence all matters requiring stockholder approval, including the election and removal of directors and any merger or other significant corporate transactions. As a result, this concentration of ownership may not be in the best interests of our other stockholders.

Delaware law and provisions in our Amended and Restated Charter and Amended and Restated Bylaws could make a merger, tender offer or proxy contest difficult, thereby depressing the trading price of our common stock.

Our Amended and Restated Charter and Amended and Restated Bylaws contain provisions that could depress the trading price of our common stock by acting to discourage, delay or prevent a change of control of our company or changes in our management that the stockholders of our company may deem advantageous. These provisions include the following:

- establishing a classified board of directors so that not all members of our board of directors are elected at one time;
- permitting our board of directors to establish the number of directors and fill any vacancies and newly-created directorships, subject to rights granted to Messrs. Murray and Hancock pursuant to our Amended and Restated Charter and the Stockholders Agreement;
- providing that directors may be removed at any time with or without cause by the affirmative vote of the holders of a majority of the voting power of the then outstanding shares of our voting stock; provided, however, that at any time when Messrs. Murray and Hancock beneficially own, in the aggregate, less than the majority of the voting power of our outstanding shares of voting stock, directors may only be removed for cause and only by the

affirmative vote of the holders of at least two-thirds of the voting power of all then outstanding shares of our voting stock;

- requiring the approval of holders of two-thirds of the total voting power of all then outstanding shares of our capital stock to amend certain provisions in our Amended and Restated Charter and our Amended and Restated Bylaws;

- authorizing the issuance of "blank check" preferred stock that our board of directors could use to implement a stockholder rights plan;

- prohibiting stockholders from calling special meetings of stockholders;

- providing that, at any time when Messrs. Murray and Hancock beneficially own, in the aggregate, at least a majority of the voting power of our outstanding shares of voting stock, our stockholders may take action by written consent without a meeting, and at any time when Messrs. Murray and Hancock beneficially own, in the aggregate, less than a majority of the voting power of our outstanding shares of voting stock, our stockholders may not take action by written consent, which has the effect of requiring all stockholder actions to be taken at a meeting of our stockholders;

- providing that the board of directors is expressly authorized to make, alter or repeal our Amended and Restated Bylaws;

- restricting the forum for certain litigation involving us to Delaware or federal courts, as applicable; and

- establishing advance notice requirements for nominations for election to our board of directors or for proposing matters that can be acted upon by stockholders at annual stockholder meetings.

Any provision of our Amended and Restated Charter or Amended and Restated Bylaws or Delaware law that has the effect of delaying or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock and could also affect the price that some investors are willing to pay for our common stock.

The provisions of our Amended and Restated Charter requiring exclusive forum in the Court of Chancery of the State of Delaware and the federal district courts of the United States for certain types of lawsuits may have the effect of discouraging lawsuits against our directors and officers.

Our Amended and Restated Charter provides that, unless we otherwise consent in writing, (A) (i) any derivative action or proceeding brought on our behalf, (ii) any action asserting a claim of breach of a fiduciary duty owed by any current or former director, officer, other employee or stockholder of us to the us or the our stockholders, (iii) any action asserting a claim arising pursuant to any provision of the Delaware General Corporation Law, our Amended and Restated Charter or our Amended and Restated Bylaws (as either may be amended or restated) or as to which the Delaware General Corporation Law confers exclusive jurisdiction on the Court of Chancery of the State of Delaware or (iv) any action asserting a claim governed by the internal affairs doctrine of the law of the State of Delaware shall, to the fullest extent permitted by law, be exclusively brought in the Court of Chancery of the State of Delaware or, if such court does not have subject matter jurisdiction thereof, the federal district court of the State of Delaware; and (B) the federal district courts of the United States shall be the exclusive forum for the resolution of any complaint asserting a cause of action arising under the Securities Act; however, there is uncertainty as to whether a court would enforce such provision, and investors cannot waive compliance with federal securities laws and the rules and regulations thereunder. Notwithstanding the foregoing, the exclusive forum provision shall not apply to claims seeking to enforce any liability or duty created by the Exchange Act or any other claim for which the federal courts of the United States have exclusive jurisdiction. The choice of forum provision may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our directors, officers or other employees and may also result in increased costs for stockholders to bring any such claim, which may discourage such lawsuits against us and our directors, officers, and other employees, although our stockholders will not be deemed to have waived our compliance with federal securities laws and the rules and regulations thereunder. Alternatively, if a court were to find the choice of forum provision contained in our Amended and Restated Charter to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could have an adverse effect on our business, financial condition and results of operations. Any person

or entity purchasing or otherwise acquiring or holding any interest in shares of our capital stock shall be deemed to have notice of and consented to the forum provisions in our Amended and Restated Charter (as may be amended or restated).

Non-U.S. Holders who own more than 5% of our common stock may be subject to U.S. federal income tax on gain realized on the sale or other taxable disposition of such common stock.

Because the determination of whether we are a "U.S. real property holding corporation" (USRPHC) for U.S. federal income tax purposes depends on the fair market value of our "U.S. real property interests" (USRPIs) relative to the fair market value of our non-U.S. real property interests and our other business assets, and because we have significant interests in real property located in the U.S., we may currently be, or may become in the future, a USRPHC. There can be no assurance that we do not currently constitute, or will not become, a USRPHC. As a result, a "Non-U.S. Holder" may be subject to U.S. federal income tax on gain realized on a sale or other taxable disposition of our common stock if such Non-U.S. Holder has owned, actually or constructively, more than 5% of our common stock at any time during the shorter of the five-year period ending on the date of the sale or other taxable disposition or the Non-U.S. Holder's holding period in such stock.

Risks Related to Being a Public Company

We continue to incur increased costs as a result of operating as a public company, and our management is required to devote substantial time to new compliance initiatives and corporate governance practices. Additionally, if we fail to maintain proper and effective internal controls, our ability to produce accurate financial statements on a timely basis could be impaired.

As a public company, we continue to incur significant legal, accounting, and other expenses that we did not incur as a private company. We are subject to the reporting requirements of the Exchange Act, the Sarbanes-Oxley Act, the Dodd-Frank Wall Street Reform and Protection Act, as well as rules adopted, and to be adopted, by the Securities and Exchange Commission (SEC), and the New York Stock Exchange. Our management and other personnel devote a substantial amount of time to these compliance initiatives. Moreover, these rules and regulations to substantially increase our legal and financial compliance costs and to make some activities more time-consuming and costly, which increases our operating expenses. For example, these rules and regulations make it more difficult and more expensive for us to obtain director and officer liability insurance and are required to incur substantial costs to maintain sufficient coverage. We cannot accurately predict or estimate the amount or timing of additional costs we may incur to respond to these requirements. The impact of these requirements could also make it more difficult for us to attract and retain qualified persons to serve on our board of directors, our board committees, or as executive officers.

In addition, as a public company we are required to incur additional costs and obligations in order to comply with SEC rules that implement Section 404 of the Sarbanes-Oxley Act. Under these rules, we are required to make a formal assessment of the effectiveness of our internal control over financial reporting, and we will be required to include an attestation report on internal control over financial reporting issued by our independent registered public accounting firm. To achieve compliance with Section 404 within the prescribed period, we engage in a process to document and evaluate our internal control over financial reporting, which is both costly and challenging. In this regard, we continue to dedicate internal resources, engage outside consultants and adopt a detailed work plan to assess and document the adequacy of our internal control over financial reporting, continue steps to improve control processes as appropriate, validate through testing that controls are designed and operating effectively, and implement a continuous reporting and improvement process for internal control over financial reporting.

The rules governing the standards that must be met for management to assess our internal control over financial reporting are complex and require significant documentation, testing, and possible remediation to meet the detailed standards under the rules. During the course of its testing, our management may identify material weaknesses, in addition to those described below, which may not be remedied in time to meet the deadline imposed by the Sarbanes-Oxley Act. Our internal control over financial reporting will not prevent or detect all errors and all fraud. A control system, no matter how well designed and operated, can provide only reasonable, not absolute, assurance that the control system's objectives will be met. Because of the inherent limitations in all control systems, no evaluation of controls can provide absolute assurance that misstatements due to error or fraud will not occur or that all control issues and instances of fraud will be detected.

We have identified material weaknesses in our internal control over financial reporting. If our remediation of such material weakness is not effective, or if we experience additional material weaknesses or otherwise fail to design and maintain effective internal control over financial reporting, our ability to accurately report our financial condition and results of operations in a timely manner or comply with applicable laws and regulations could be impaired, which may adversely affect investor confidence in us, subject us to litigation or significant financial or other penalties, and, as a result, affect the value of our common stock and our financial condition.

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or combined/consolidated financial statements will not be prevented or detected on a timely basis. In connection with the preparation of our combined/ consolidated financial statements for the year ended December 31, 2024 together with facts learned during the course of the Audit Committee's independent investigation, our management identified control deficiencies that, individually or in the aggregate, constitute a material weakness in our internal control over financial reporting. Specifically, we did not design and maintain an effective control environment commensurate with the financial reporting requirements of a public company, including sufficient processes to identify, assess, and communicate relevant risks to appropriate levels of the organization, including potential compliance issues received through the hotline process. In addition, we did not design and maintain adequate controls within the revenue process to appropriately recognize revenue for new services in accordance with ASC 606. In addition, in connection with the preparation of our consolidated financial statements for the year ended December 31, 2025, our management identified control deficiencies that, individually or in the aggregate, constitute material weaknesses in our internal control over financial reporting. Specifically, we did not design and maintain effective controls within the revenue process to address the completeness and accuracy of underlying data used to determine routine revenue. We also did not design controls to timely assess operational trends that could materially impact variable consideration estimates related to revenue recognition.

As described in Part II, Item 9A “Controls and Procedures”, the material weaknesses identified in 2024 resulted in a restatement of our previously issued interim condensed combined/consolidated financial statements as of and for the interim periods ended March 31, 2024 and June 30, 2024. Management is taking steps to remediate the material weaknesses in our internal controls, but we cannot assure you that the measures we have taken to date, and that we are continuing to implement, will be sufficient to remediate the material weaknesses we have identified or to avoid the identification of additional material weaknesses in the future. If the steps we take do not remediate the material weaknesses in a timely manner, or we identify new material weaknesses in the future, there could continue to be a reasonable possibility that these material weaknesses or others could result in a material misstatement of our annual or interim financial statements that would not be prevented or detected on a timely basis, any of which could diminish investor confidence in us and cause a decline in the price of our common stock. Furthermore, the steps to remediate any material weakness, including the ones described in Part II, Item 9A “Controls and Procedures”, could require additional remedial measures, including hiring additional personnel, which could be costly and time-consuming.

If, when required in the future, we are unable to assert that our internal control over financial reporting is effective, or if our independent registered public accounting firm is unable to express an unqualified opinion as to the effectiveness of our internal control over financial reporting, we may be unable to maintain compliance with securities law requirements regarding timely filing of periodic reports in addition to applicable stock exchange listing requirements, investors may lose confidence in the accuracy and completeness of our financial reports, the market price of our common stock could be adversely affected, and we could become subject to additional litigation or investigations by the stock exchange on which our securities are listed, the SEC, or other regulatory authorities, which could require additional financial and management resources. In any of these cases, there could be an adverse effect on our business, financial condition and results of operations.

The restatement of our condensed combined/consolidated financial statements has subjected us to a number of additional risks and uncertainties, including regulatory, stockholder or other actions, loss of investor confidence and negative impacts on the trading of our common stock.

We restated our condensed combined/consolidated financial statements as of March 31, 2024, and for the three months then ended, included in the Company’s Quarterly Report on Form 10-Q filed with the SEC on May 13, 2024 (as amended on May 21, 2024) and our condensed combined/consolidated financial statements as of June 30, 2024, and for the three and six months then ended, included in the Company’s Quarterly Report on Form 10-Q filed with the SEC on August 12, 2024. The preparation of our restated financial statements caused us to incur substantial expenses for legal, accounting, tax and other professional services and diverted our management’s attention from our business. In addition, as a result of the restatement, we failed to timely file multiple periodic reports and faced delisting from NYSE. This restatement or any

future restatement may cause investors to lose confidence in our operating results, the price of our common stock could decline and we could be subject to future, stockholder or other litigation or regulatory enforcement actions.

Our management team has limited experience managing a public company.

Most members of our management team have limited experience managing a publicly traded company, interacting with public company investors and complying with the increasingly complex laws pertaining to public companies. Our management team may not successfully or efficiently manage us as a public company that is subject to significant regulatory oversight and reporting obligations under the federal securities laws and the continuous scrutiny of securities analysts and investors. These new obligations and constituents require significant attention from our senior management and could divert their attention away from the day-to-day management of our business, which could have an adverse effect on our business, financial condition and results of operations.

Our disclosure controls and procedures may not prevent or detect all errors or acts of fraud.

As a public company, we are subject to the periodic reporting requirements of the Exchange Act. We must design our disclosure controls and procedures to reasonably assure that information we must disclose in reports we file or submit under the Exchange Act is accumulated and communicated to management, and recorded, processed, summarized, and reported within the time periods specified in the rules and forms of the SEC. Any disclosure controls and procedures or internal controls and procedures, no matter how well-conceived and operated, can provide only reasonable, not absolute, assurance that the objectives of the control system are met. These inherent limitations include the realities that judgments in decision-making can be faulty, and that breakdowns can occur because of simple error or mistake. For example, our directors or executive officers could inadvertently fail to disclose a new relationship or arrangement causing us to fail to make a required related party transaction disclosure. Additionally, controls can be circumvented by the individual acts of some persons, by collusion of two or more people or by an unauthorized override of the controls. Accordingly, because of the inherent limitations in our control system, misstatements due to error or fraud may occur and not be detected.

If securities or industry analysts either do not publish research about us or publish inaccurate or unfavorable research about us, our business or our market, or if they change their recommendations regarding our common stock adversely, the trading price or trading volume of our common stock could decline.

The trading market for our common stock is influenced in part by the research and reports that securities or industry analysts may publish about us, our business, our market or our competitors. If one or more analysts initiate research with an unfavorable rating or downgrade our common stock, provide a more favorable recommendation about our competitors or publish inaccurate or unfavorable research about our business, our common stock price would likely decline. For example, in November 2024 a short-seller published a report containing numerous allegations of wrongdoing within our business. As a result, the trading price of our common stock experienced a significant and immediate decline, from which it has yet to fully recover. If any analyst who may cover us were to cease coverage of us or fail to regularly publish reports on us, we could lose visibility in the financial markets, which in turn could cause the trading price or trading volume of our common stock to decline.

Regardless of accuracy, unfavorable interpretations of our financial information and other public disclosures could have a negative impact on our stock price. If our financial performance fails to meet analyst estimates, for any of the reasons discussed above or otherwise, or one or more of the analysts who cover us downgrade our common stock or change their opinion of our common stock, our stock price would likely decline.

Even if our common stock is actively covered by analysts, we do not have any control over the analysts or the measures that analysts or investors may rely upon to forecast our future results. Overreliance by analysts or investors on any particular metric to forecast our future results may lead to forecasts that differ significantly from our own.

General Risks

Global economic and financial market conditions, including severe market disruptions and the potential for a significant and prolonged global economic downturn, could impact our business operations in a number of ways, including, but not limited to, reduced demand in key customer end-markets.

The global economy can be negatively impacted by a variety of factors such as the spread or fear of spread of contagious diseases, man-made or natural disasters, actual or threatened war, terrorist activity, political unrest, civil strife

and other geopolitical uncertainty. If we or any of the third parties with whom we engage were to experience prolonged business shutdowns or other disruptions as result of any of the foregoing events, our ability to conduct our business in the manner and on the timelines presently planned could be materially and negatively affected, which could have a material adverse impact on our business, financial condition and results of operations. Furthermore, such adverse and uncertain economic conditions may impact the post-acute services industry and consumer demand for our services. Decreases in demand for our services without a corresponding decrease in our costs would put downward pressure on margins and would negatively impact our financial results. Prolonged unfavorable economic conditions or uncertainty may have an adverse effect on our sales and profitability.

Changes in the U.S. and global social, political, regulatory and economic conditions or in laws and policies governing foreign trade, manufacturing, development and investment could also adversely affect our business. For example, tariffs or other trade restrictions imposed by the U.S. government on imported goods, including pharmaceuticals, medical supplies, medical devices, and equipment, have and could continue to increase our operating costs. Even where we do not directly import goods, our suppliers may experience increased costs due to tariffs, which have and could continue to be passed through to us in the form of higher prices for medical supplies, consumables, and capital equipment. Because our reimbursement rates under Medicare and Medicaid are largely fixed and may not be adjusted promptly to reflect increased costs, we may be unable to recover the full amount of any tariff-related cost increases, which have and could continue to adversely affect our margins, financial condition, and results of operations. If global economic conditions remain volatile for a prolonged period or experience further disruptions, it could have a material adverse effect on our business, financial condition and results of operations.

We may acquire or invest in companies, which may divert our management's attention and result in additional dilution to our stockholders. We may be unable to integrate acquired businesses and technologies successfully or achieve the expected benefits of such acquisitions.

We may evaluate and consider potential strategic transactions, including acquisitions of, or investments in, businesses, technologies, services, products, and other assets in the future. An acquisition, investment or business relationship may result in unforeseen operating difficulties and expenditures. In particular, we may encounter difficulties assimilating or integrating the businesses, technologies, products, personnel, or operations of the acquired companies. Key personnel of the acquired companies may choose not to work for us, their software may not be easily adapted to work with ours, or we may have difficulty retaining the customers of any acquired business due to changes in ownership, management, or otherwise. We may also experience difficulties integrating personnel of the acquired company into our business and culture. Acquisitions may also disrupt our business, divert our resources and require significant management attention that would otherwise be available for development of our existing business. The anticipated benefits of any acquisition, investment, or business relationship may not be realized or we may be exposed to unknown risks or liabilities.

Negotiating these transactions can be time-consuming, difficult, and expensive, and our ability to close these transactions may often be subject to approvals that are beyond our control. Consequently, these transactions, even if undertaken and announced, may not close. For one or more of those transactions, we may:

- issue additional equity securities that would dilute our stockholders;
- use cash that we may need in the future to operate our business;
- incur debt on terms unfavorable to us or that we are unable to repay;
- incur large charges or substantial liabilities;
- encounter difficulties retaining key employees of the acquired company or integrating diverse software codes or business cultures; and
- become subject to adverse tax consequences, substantial depreciation, or deferred compensation charges.

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

We paid no dividends during the year ended December 31, 2025. For the years ended December 31, 2024 and 2023, we paid $33.7 million and $80.4 million, respectively, in cash dividends to holders of our common stock. We currently anticipate that we will retain future earnings for the development, operation and expansion of our business and do not

anticipate declaring or paying any cash dividends for the foreseeable future. Any return to stockholders will therefore be limited to any appreciation in the value of their stock. 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 Amended and Restated Credit Facility restricts our ability to pay dividends to stockholders, in certain instances, if we are in default under the agreement. The failure to pay or maintain dividends could adversely affect the market price of our common stock.

Item 1B. UNRESOLVED STAFF COMMENTS

None.

Item 1C. CYBERSECURITY

Cybersecurity Risk Management and Strategy

We have developed and implemented a cybersecurity risk management program intended to protect the confidentiality, integrity, and availability of our critical systems and information.

We design and assess our program based on the National Institute of Standards and Technology Cybersecurity Framework, or NIST CSF. This means that we use the NIST CSF as a guide to help us identify, assess, and manage cybersecurity risks relevant to our business. It does not, however, mean that we meet any technical standards, specifications, or requirements.

Our cybersecurity risk management program is part of our overall risk management program and shares similar governance processes and reporting channels that apply across the risk management program to financial, legal, compliance, and other operational risk areas.

Key elements of our cybersecurity risk management program and strategy include but are not limited to the following:

- Adhering to principles of Security by Design and Security by Default
- Conducting third-party vulnerability scans, and penetration testing
- Access controls enforcing principles of Least Privilege, Zero Trust, and Role-Based Access Controls with MFA requirements for critical systems and accounts
- Cybersecurity incident response plan that includes procedures for responding to cybersecurity incidents
- A third-party risk management evaluation process for key service providers based on our assessment of their criticality to our operations and respective risk profile, suppliers, and vendors with access to our information systems or data
- An employee cybersecurity awareness training program including awareness training and simulated attacks
- A dedicated team responsible for incident identification, management, and remediation
- Implementation of cybersecurity controls with ongoing monitoring and improvement internally, with assistance from external auditors
- Third-party security vendors and auditors, where appropriate, to assess, test and otherwise assist with aspects of our security processes.

We have not identified cybersecurity threats, including as a result of any prior cybersecurity incidents, that have materially affected us, including our operations, business strategy, results of operations, or financial condition. We face risks from cybersecurity threats that, if realized are reasonably likely to materially affect us, including our operations, business strategy, results of operations, or financial condition. See “Item 1A. Risk Factors – *Security breaches,*

cybersecurity incidents, or our inability to effectively integrate, manage and keep our information systems secure and operational could violate security laws, disrupt our operations, and subject us to significant liability."

Cybersecurity Governance

Our board of directors considers cybersecurity risk as part of its risk oversight function and has delegated to the Audit Committee (the Committee) oversight of cybersecurity risks, including oversight of management's implementation of our cybersecurity risk management program. The Committee receives quarterly reports from management on our cybersecurity risks. In addition, management updates the Committee, where it deems appropriate, regarding cybersecurity incidents it considers to be significant or potentially significant.

The Committee reports to the full board of directors regarding its activities, including those related to cybersecurity. The full board of directors also receives briefings from management on our cyber risk management program.

Our management team, including the Vice President of Technology, is primarily responsible for assessing and managing our material risks from cybersecurity threats. The team has primary responsibility for our overall cybersecurity risk management program and supervises both our internal cybersecurity personnel and our retained external cybersecurity consultants. Our Vice President of Technology has over 25 years of experience in the information technology space and over 20 years of management experience over IT operations, which includes management experience in a complex, multi-site, healthcare setting. We also leverage a third party cybersecurity team from FIT Solutions to assist with cybersecurity governance and operations. Our third party team has over 65 years of experience across cybersecurity leadership, information technology engineering, and operations. Further, both our internal and retained consultants have obtained industry certifications, including Certified Information Systems Security Professional (CISSP), Rapid7 Certified Security Analyst, GIAC Security Operation Center Analyst (GSOC), GIAC Certified Incident Handler (GCIH), GIAC Penetration Tester (GPEN), Microsoft Security Certifications, and AWS Practitioner, among others.

Our management team takes steps to stay informed about and monitor efforts to prevent, detect, mitigate, and remediate cybersecurity risks and incidents through various means, which may include: briefings from internal security personnel; threat intelligence and other information obtained from governmental, public or private sources, including external consultants engaged by us; and alerts and reports produced by security tools deployed in our IT environment.

Item 2. PROPERTIES

PACS Services. Our PACS Services' main office is located in Salt Lake City, Utah. The property consists of approximately 165,000 square feet of usable office space. A portion of the office building is subleased to third-party tenants. We also have PACS Services offices in Rocklin, California and Riverside, California.

Operating Facilities. As of December 31, 2025, we operated 321 post-acute care facilities in Alaska, Arizona, California, Colorado, Idaho, Kansas, Kentucky, Missouri, Montana, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington, with the operational capacity to serve 35,379 patients with 32,854 skilled nursing beds and 2,525 assisted living beds. Of these post-acute care facilities, we leased 219 facilities, directly owned the real estate at 53 facilities and had joint ventures for 49 facilities which we also leased. In addition, subsequent to December 31, 2025, we acquired three facilities (two owned facilities representing 144 assisted living beds in Alaska and one leased facility representing 86 assisted living beds in Idaho) and acquired the real estate for one facility in Arizona which we previously operated. Additionally, subsequent to December 31, 2025 we divested of one leased facility in Colorado which included 110 skilled nursing beds. A majority of our facilities are operated under long-term, triple-net lease arrangements pursuant to which we are responsible for property taxes, insurance, maintenance, and repairs. As of December 31, 2025, the average remaining lease term across our portfolio was 13 years for operating leases and 22 years for finance leases, and certain leases include purchase options, purchase obligations, and rights of first refusal. Our owned facilities are subject to mortgages and other customary encumbrances for similar properties. See Note 13, "Leases", to our audited combined/ consolidated financial statements for additional information.

We believe our facilities are suitable and adequate for their current needs. The following table provides summary information regarding the location of our post-acute care facilities and operational beds by property type as of December 31, 2025:

	Leased		Owned		Total	
	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
Alaska	1	102	—	—	1	102
Arizona	10	1,364	—	—	10	1,364
California	108	12,651	32	3,481	140	16,132
Colorado	19	2,236	1	242	20	2,478
Idaho	6	409	—	—	6	409
Kansas	2	258	—	—	2	258
Kentucky	5	596	2	340	7	936
Missouri	2	190	3	424	5	614
Montana	1	64	—	—	1	64
Nevada	9	787	3	325	12	1,112
Ohio	24	2,733	—	—	24	2,733
Oregon	21	1,572	—	—	21	1,572
Pennsylvania	4	593	4	602	8	1,195
South Carolina	21	2,355	6	663	27	3,018
Tennessee	12	1,287	—	—	12	1,287
Texas	3	300	2	282	5	582
Washington	20	1,523	—	—	20	1,523
	268	29,020	53	6,359	321	35,379

Item 3. LEGAL PROCEEDINGS

We are subject to various legal proceedings, claims, and governmental inspections, audits, and investigations that arise in the ordinary course of our business.

Regulatory Investigations

On April 8, 2024, Providence Administrative Consulting Services ("Providence") and Paradise Valley Healthcare Center ("Paradise Valley") received a Civil Investigative Demand ("CID") from the U.S. Department of Justice ("DOJ") requesting information and documents relating to an investigation of Paradise Valley and Providence to determine whether Paradise Valley and Providence violated the False Claims Act by submitting false claims to Medicare. The investigation relates to whether Providence and Paradise Valley improperly induced patient referrals through remuneration in violation of the Anti-Kickback Statute. The CID includes requests for information relating to referral source relationships, including relationships with medical directors and other individuals. Since the receipt of the CID, the DOJ has made additional requests for information from Providence, including marketing materials and certain expense data across all Providence facilities. We are cooperating with the investigation, which is ongoing.

On September 11, 2024, we received a CID from the DOJ requesting information and documents relating to an investigation of our California-based skilled nursing facilities to determine whether PACS violated the False Claims Act by submitting false claims to Medicare for reimbursement under the patient-driven payment model for skilled nursing and rehabilitation services. The CID includes requests for information relating to PACS' practices and incentives pertaining to the completion and submission of Minimum Data Set Assessments and the resulting PDPM rates. We are cooperating with the investigation, which is ongoing.

On September 30, 2024, Providence Group, Inc. ("Providence Group") received a CID from the DOJ requesting information and documents relating to an investigation of its skilled nursing facilities, specifically including Bishop Care Center ("Bishop") to determine whether Providence Group violated the False Claims Act by submitting false claims to Medicare for reimbursement under the COVID-19 related Hospital Stay Waiver (otherwise known as the 1135 waiver).

The CID includes requests for information relating to 1135 COVID Waiver practices at Bishop. We are cooperating with the investigation, which is ongoing.

On February 26, 2025, we received a subpoena from the DOJ per the HIPAA relating to an investigation into possible violations of various sections of 18 U.S.C. that prohibit the making of fraudulent or false statements to any branch of the government of the United States. The subpoena includes requests for information relating to PACS' 1135 COVID Waiver practices, billing of Medicare Part B for respiratory and sensory integration therapy services, change of insurance enrollment, cost waivers for co-pays, deductibles, and co-insurance, and claim reimbursement from Medicare for bad debt. We are cooperating with the investigation, which is ongoing.

SEC Investigation

The SEC's Division of Enforcement is conducting an investigation into matters that relate to our accounting and financial reporting and disclosure, and our internal controls over financial reporting and disclosure controls.

We are cooperating with each of the regulatory investigations identified above and the SEC investigation to produce the requested information and documentation. At this time, we cannot predict the outcome of any of these investigations and there can be no assurance that one or more of these investigations will not result in suits or actions alleging, or findings of, violations of federal or state laws that could lead to the imposition of damages, fines, penalties, restitution, other monetary liabilities, sanctions, settlements or changes to our business practices or operations that could have a material adverse effect on our business, financial condition or results of operations. The legal costs associated with responding to the regulatory investigations and SEC investigations can be substantial, regardless of the outcome.

We are unable at this time to estimate a loss or range of loss that may arise in the event that a claim is asserted against us in connection with any of these investigations for reasons including that these matters are in early stages, no factual issues have been resolved in these matters, and there is uncertainty as to the outcome of these matters, which can result in large settlement amounts or damage awards.

Litigation

The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents served by our independent operating subsidiaries. We, and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. In addition, we, our independent operating subsidiaries, and others in the industry are subject to claims and lawsuits in connection with COVID-19 and a facility's preparation for and/or response to COVID-19.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories. We and other companies in its industry are routinely subjected to varying types of claims and suits, including class-actions. Class-action suits have the potential to result in large jury verdicts and settlements, and may result in significant legal costs. We expect the plaintiffs' bar to continue to be aggressive in their pursuit of claims.

We have been, and continue to be, subject to other claims and legal actions that arise in the normal course of business, including potential claims filed by patients or others on their behalf related to patient care and treatment (professional negligence claims), as well as employment related claims filed by current or former employees. While there can be no assurance, based on our evaluation of information currently available, we do not believe the results of such litigation would have a material adverse effect on our results of operations, financial position or cash flows, taken as a whole. However, our assessment may evolve based upon further developments in the proceedings at issue. The results of legal proceedings are inherently uncertain, and material adverse outcomes are possible.

For example, we have been subjected to, and are currently involved in, litigation alleging violations of state and federal wage and hour laws resulting from the alleged failure to pay wages, to timely provide and authorize meal and rest breaks, and related causes of action.

In addition to the litigation described above, we are also subject to the following litigation:

Litigation – Securities Class Action and Shareholder Derivative Actions

On November 13, 2024, a putative securities class action captioned *Manchin v. PACS Group, Inc., et al.*, Case No. 1:24-cv-08636-LJL (S.D.N.Y.) ("*Manchin* Action") was filed against us, individual defendants Jason Murray, Derick Apt, Mark Hancock, Jacqueline Millard, and Taylor Leavitt; and underwriter defendants Citigroup Global Markets Inc., J.P. Morgan Securities LLC, Truist Securities, Inc., RBC Capital Markets, LLC, Goldman Sachs & Co. LLC, Stephens Inc., KeyBanc Capital Markets Inc., Oppenheimer & Co. Inc., and Regions Securities LLC. The complaint brings claims under Sections 11 and 15 of the Securities Act, and Section 10(b), and 20(a) of the Exchange Act, and alleges we and our leadership engaged in a multi-year scheme to inflate revenue and profitability by (i) exploiting a COVID-era Medicare waiver to "flip" long-term Medicaid patients to higher-paying Medicare coverage, (ii) billing unnecessary Medicare Part B respiratory and sensory integration therapies, and (iii) falsifying licensure and staffing documentation. On January 7, 2025, the court consolidated the *Manchin* action with a similar action brought by plaintiff New Orleans Employees' Retirement System, and on February 11, 2025 the court appointed 1199SEIU Health Care Employees Pension Fund as lead plaintiff, and its counsel, Labaton Keller Sucharow LLP, as lead counsel. On December 19, 2025, after we filed our Quarterly Report on Form 10-Q for the period ended September 30, 2024 and our Annual Report on Form 10-K for the year ended December 31, 2024, the lead plaintiff filed a consolidated complaint. The new complaint added Joshua Jergensen and P.J. Sanford as named defendants, and also brought additional claims pursuant to Section 12(a)(2) of the Securities Act and Section 20A of the Exchange Act. Defendants moved to dismiss the consolidated complaint on February 17, 2026. According to the current operative schedule, Plaintiffs' opposition is due April 20, 2026, and Defendants' reply will be due June 4, 2026.

On February 14, 2025, a derivative action originally filed by plaintiff Theresa Howard-Hines ("*Howard-Hines* Action") captioned *IN RE PACS GROUP, INC. DERIVATIVE LITIGATION* Lead Case No. 1:25-cv-01343-LJL (S.D.N.Y.) was filed against defendants Jason Murray, Derick Apt, Mark Hancock, Michelle Lewis, Jacqueline Millard, Taylor Leavitt, and Evelyn Dilsaver, with the Company named as nominal defendant. The complaint brings claims of breach of fiduciary duties, unjust enrichment, waste of corporate assets, and contribution, based on substantially similar allegations as in the *Manchin* Action. On April 8, 2025, the court consolidated the *Howard-Hines* action with a similar derivative action filed by plaintiff Adam Beckman, under the name *In re PACS Group, Inc. Derivative Litigation*. On June 9, 2025, the parties filed a joint stipulation staying the action until the earlier of the dismissal of the *Manchin* Action, the denial of any motion to dismiss in the *Manchin* Action, or the termination of the stay.

On August 19, 2025, a derivative action captioned *Boers v. Murray, et. al.*, Case No. 1:25-cv-00119-DAK-DBP (D. Utah) was filed against the same defendants and alleging substantially the same claims and theories as *IN RE PACS GROUP, INC. DERIVATIVE LITIGATION*. The plaintiff voluntarily dismissed this case on December 8, 2025, without prejudice to her ability to refile.

Legal proceedings can be complex and take many months, or even years, to reach resolution, with the final outcome depending on a number of variables, some of which are not within our control. Therefore, although we will vigorously defend ourself in each of the actions described above and any other legal proceedings, their ultimate resolution and potential financial and other impacts on us are uncertain but could be material. Regardless of final outcomes, however, any such proceedings, claims, and investigations may nonetheless impose a significant burden on management and employees and be costly to defend, with unfavorable preliminary, interim or final rulings.

Item 4. MINE SAFETY DISCLOSURES

Not applicable.

PART II

Item 5. MARKET FOR REGISTRANT'S COMMON EQUITY, RELATED STOCKHOLDER MATTERS AND ISSUER PURCHASES OF EQUITY SECURITIES

Market Information for Common Stock

Our common stock is listed under the ticker symbol “PACS” on The New York Stock Exchange.

Holders of Record

As of January 30, 2026, there were 129 holders of record of our common stock. Because many of our shares of common stock are held by brokers and other institutions on behalf of stockholders, we are unable to estimate the total number of stockholders represented by these record holders.

Dividend Policy

We paid no dividends during the year ended December 31, 2025. For the years ended December 31, 2024 and 2023, we paid $33.7 million and $80.4 million, respectively, in cash dividends to holders of our common stock. We have no current plans to pay dividends or other distributions on our common stock in the foreseeable future. Any decision to declare and pay dividends in the future will be made at the sole discretion of our board of directors and will depend on, among other things, our results of operations, cash requirements, financial condition, contractual restrictions and other factors that our board of directors may deem relevant, and subject to the restrictions contained in any future financing instruments and applicable law.

Unregistered Sales of Equity Securities

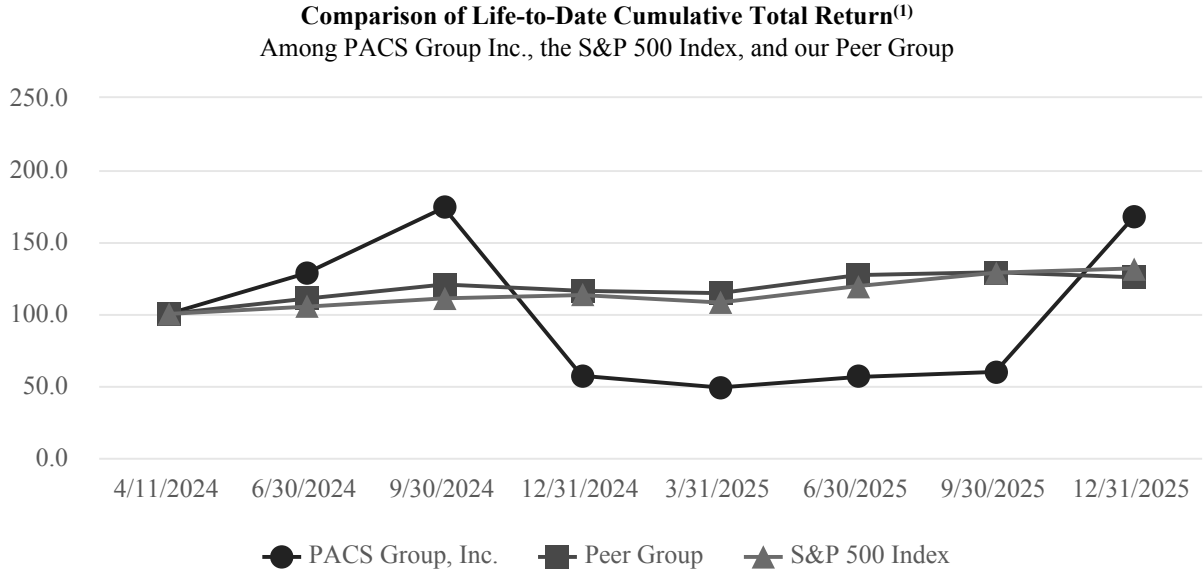
None.

Issuer Purchases of Equity Securities

None.

Stock Performance Graph

The graph below shows a cumulative total stockholder return of investment of $100 (and reinvestment of any dividend thereafter) on the date of our IPO, April 11, 2024 in (i) PACS Group, Inc. common stock, (ii) our Peer Group[(2)], and (iii) the S&P 500 Index.



(1) Assumes $100 invested on April 11, 2024 in stock in index, including reinvestment of dividends.

	April 11, 2024	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025
PACS Group, Inc.	$ 100.00	$ 128.26	$ 173.78	$ 57.00	$ 48.87	$ 56.17	$ 59.70	$ 167.00
Peer Group[(2)]	100.00	110.62	120.48	116.06	114.46	127.00	129.00	125.49
S&P 500 Index	100.00	105.03	110.84	113.13	107.94	119.35	128.65	131.67

(2) "Peer Group" includes the following companies: The Ensign Group, Inc., Encompass Healthcare Corp., and Select Medical Holdings Corp.

Item 6. [RESERVED]

Item 7. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

You should read the following discussion and analysis of our financial condition and results of operations together with our audited combined/consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K. Some of the information contained in this discussion and analysis or set forth elsewhere in this report, including information with respect to our plans and strategy for our business, includes forward-looking statements that involve risks and uncertainties. You should read the sections titled "Risk Factors" and "Special Note Regarding Forward-Looking Statements" for a discussion of important factors that could cause actual results to differ materially from the results described in or implied by the forward-looking statements contained in the following discussion and analysis. Our historical results are not necessarily indicative of the results to be expected in the future.

For a discussion of the year ended December 31, 2023 compared to the year ended December 31, 2024, refer to "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" found in our Annual Report on Form 10-K for the year ended December 31, 2024, that was filed with the Securities and Exchange Commission on November 19, 2025.

Overview

We are a leading post-acute healthcare company primarily focused on delivering high-quality skilled nursing care through a portfolio of independently operated facilities. Founded in 2013, we are one of the largest skilled nursing providers in the United States based on number of facilities. We also provide senior care, assisted living, and independent living options in some of our communities. As of December 31, 2025, our portfolio consisted of 321 post-acute care, assisted living, and independent living facilities across 17 states serving over 31,700 patients daily. We believe our significant historical growth has been primarily driven by our expertise in acquiring underperforming long-term custodial care skilled nursing facilities and transforming them into higher acuity, high value-add short-term transitional care skilled nursing facilities. We believe our success is driven in significant part by our locally led, centrally supported operating model, through which we empower local leaders at each facility to operate their facility autonomously and deliver excellence in clinical quality and a superior experience for our patients. We provide our independently operated facilities with a comprehensive suite of technology, support, and back-office services that enable local leadership teams to focus more of their time and effort on providing quality care to patients. We believe our operating model delivers value to all of our healthcare stakeholders, including patients and families, referring providers, payors, and administrators and clinicians.

We aim to create value by identifying and acquiring underperforming custodial care facilities and converting them into higher-value short-term transitional care facilities by investing in clinical teams and processes and upgrading technology, equipment, training, staffing, aesthetics, and other aspects of the business. We believe the resources and guidance offered by PACS Services are key to rapid integration of new facilities and provides our local leadership teams with an effective technology infrastructure, support tools, and regional support teams that enable local leadership to focus on operational improvements. Our facilities generally undergo an up to three-year post-acquisition transition period. During this period, we seek to implement best practices designed to realize and sustain the facility's full potential. These practices often result in significant improvements to clinical quality and other operational metrics, including skilled mix, occupancy rates and payor contracting. We believe the results of our acquisition strategy are demonstrated by our high average QM Star rating and occupancy rate for Mature facilities of 4.4 and 95%, respectively, as of December 31, 2025. As of December 31, 2025, the average QM Star rating and occupancy rate for New facilities was 3.5 and 81%, respectively.

Material Weakness

As previously disclosed on our Annual Report on Form 10-K for the year ended December 31, 2024 as filed with the SEC on November 19, 2025, we identified material weaknesses in our internal control over financial reporting where we did not design and maintain sufficient processes to identify, assess, and communicate relevant risks to appropriate levels of the organization, including potential compliance issues received through the hotline process and we did not design and maintain adequate controls within the revenue process to appropriately recognize revenue for new services in accordance with Financial Accounting Standards Board Accounting Standards Codification Topic 606, Revenue from Contracts With Customers.

In addition, in connection with the preparation of our combined/consolidated financial statements for the year ended December 31, 2025, our management identified control deficiencies that, individually or in the aggregate, constitute material weaknesses in our internal control over financial reporting. The material weaknesses identified by management were that we did not design and maintain effective controls within the revenue process to address the completeness and accuracy of underlying data used to determine routine revenue. We also did not design controls to timely assess operational trends that could materially impact variable consideration estimates related to revenue recognition.

In addition, our Chief Executive Officer and our Interim Chief Financial Officer have concluded that, due to the material weaknesses, our disclosure controls and procedures were not effective, as such term is defined under Rules 13a-15(e) and 15(d)-15(e) under the Exchange Act, as of December 31, 2025. Management is committed to maintaining a strong internal control environment. In response to the identified material weaknesses above, management, with the oversight of the Audit Committee, is taking comprehensive actions to remediate the above material weaknesses. For additional information regarding the material weaknesses and our steps for remediation, please see "Part II, Item 9A, Controls and Procedures."

Considering the material weaknesses described above, management performed additional analysis and other procedures to ensure that our combined/consolidated financial statements were prepared in accordance with U.S. generally accepted accounting principles (U.S. GAAP). Accordingly, management believes that the combined/consolidated financial statements included in this Annual Report on Form 10-K fairly present, in all material respects, our financial position, results of operations, and cash flows as of and for the periods presented, in accordance with U.S. GAAP.

Key Skilled Services Metrics and Non-GAAP Financial Measures

We use the following key skilled services metrics and non-GAAP financial measures to help us evaluate our business, identify trends that affect our financial performance, and make strategic decisions.

Key Skilled Services Metrics

We monitor the below key skilled services metrics across all of our facilities and by Mature facilities, Ramping facilities, and New facilities. Mature facilities are defined as facilities purchased more than 36 months prior to a respective measurement date. Ramping facilities are defined as facilities purchased within 18 to 36 months prior to a respective measurement date. New facilities are defined as facilities purchased, or built, less than 18 months prior to a respective measurement date.

- Skilled nursing services revenue — Skilled nursing services revenue reflects the portion of patient and resident service revenue generated from all patients in skilled nursing facilities, excluding revenue generated from our assisted and independent living services.

- Skilled mix — We measure both revenue and nursing patient days by payor. Medicare and managed care patients, whom we refer to as high acuity patients, typically require a higher level of skilled nursing care. As a result, Medicare and managed care reimbursement rates are typically higher than those 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. To monitor this performance, we evaluate two different measures of skilled mix:

    - Skilled mix by revenue — Skilled mix by revenue represents the portion of routine revenue generated from treating high acuity Medicare and managed care patients. Routine revenue refers to skilled nursing services revenue generated by contracted daily rates charged for skilled nursing services. Services provided outside of routine contractual agreements are recorded separately as ancillary revenue, including Medicare Part B therapy services, and are not routine revenue. The inclusion of therapy and other ancillary treatments in the contracted daily rate varies by payor source and by contract. Revenue associated with calculating skilled mix is 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, *Revenue from Contracts with Customers* (ASC 606).

    - Skilled mix by nursing patient days — Skilled mix by nursing patient days represents the number of days our high acuity Medicare and managed care patients receive skilled nursing services at skilled nursing facilities as a percentage of the total number of days that patients from all payor sources receive skilled nursing services at skilled nursing facilities for any given period.

- Occupancy — The total number of patients occupying a bed in a skilled nursing facility as a percentage of the beds in such facility that are available for occupancy during the period.

- Number of facilities — The total number of skilled nursing facilities that we operate. Excludes 30 and 27 assisted living and independent living facilities for the years ended December 31, 2025 and 2024, respectively.

- Number of operational beds — The total number of operational beds associated with the skilled nursing facilities that we own.

The following tables present the above key skilled services metrics by category for all skilled nursing facilities, and for the skilled nursing facilities in each of the three facility cohorts, as of and for the years ended December 31, 2025 and 2024:

	Year ended December 31,			
	2025	2024	Change	% Change
Total Facility Results	(Dollars in thousands)			
Skilled nursing services revenue	$ 5,178,456	$ 4,014,412	$ 1,164,044	29.0 %
Skilled mix by revenue	48.8 %	50.3 %	(1.5)%	(3.0)%
Skilled mix by nursing patient days	28.7 %	29.2 %	(0.5)%	(1.7)%
Occupancy for skilled nursing services:				
Available patient days	11,836,845	9,493,639	2,343,206	24.7 %
Actual patient days	10,541,457	8,585,654	1,955,803	22.8 %
Occupancy rate (operational beds)	89.1 %	90.4 %	(1.3)%	(1.4)%
Number of facilities at period end	291	287	4	1.4 %
Number of operational beds at period end	32,854	32,016	838	2.6 %

	Year ended December 31,			
	2025	2024	Change	% Change
Mature Facility Results	(Dollars in thousands)			
Skilled nursing services revenue	$ 2,914,727	$ 1,443,958	$ 1,470,769	101.9 %
Skilled mix by revenue	56.0 %	54.4 %	1.6 %	2.9 %
Skilled mix by nursing patient days	33.4 %	32.1 %	1.3 %	4.0 %
Occupancy for skilled nursing services:				
Available patient days	5,748,879	3,139,441	2,609,438	83.1 %
Actual patient days	5,457,745	2,964,909	2,492,836	84.1 %
Occupancy rate (operational beds)	94.9 %	94.4 %	0.5 %	0.5 %
Number of facilities at period end	149	137	12	8.8 %
Number of operational beds at period end	16,415	14,893	1,522	10.2 %

	Year ended December 31,			
	2025	2024	Change	% Change
Ramping Facility Results	(Dollars in thousands)			
Skilled nursing services revenue	$ 1,108,849	$ 1,521,162	$ (412,313)	(27.1)%
Skilled mix by revenue	41.8 %	54.2 %	(12.4)%	(22.9)%
Skilled mix by nursing patient days	22.8 %	31.6 %	(8.8)%	(27.8)%
Occupancy for skilled nursing services:				
Available patient days	2,806,713	3,254,715	(448,002)	(13.8)%
Actual patient days	2,422,237	3,054,690	(632,453)	(20.7)%
Occupancy rate (operational beds)	86.3 %	93.9 %	(7.6)%	(8.1)%
Number of facilities at period end	64	48	16	33.3 %
Number of operational beds at period end	8,286	5,737	2,549	44.4 %

	Year ended December 31,			
	2025	2024	Change	% Change
New Facility Results	(Dollars in thousands)			
Skilled nursing services revenue	$ 1,154,880	$ 1,049,292	$ 105,588	10.1 %
Skilled mix by revenue	37.7 %	39.2 %	(1.5)%	(3.8)%
Skilled mix by nursing patient days	24.6 %	22.8 %	1.8 %	7.9 %
Occupancy for skilled nursing services:				
Available patient days	3,281,253	3,099,483	181,770	5.9 %
Actual patient days	2,661,475	2,566,055	95,420	3.7 %
Occupancy rate (operational beds)	81.1 %	82.8 %	(1.7)%	(2.1)%
Number of facilities at period end	78	102	(24)	(23.5)%
Number of operational beds at period end	8,153	11,386	(3,233)	(28.4)%

The following tables present additional detail regarding our skilled mix, including our percentage of nursing patient days and revenue by payor source for all facilities, and for each of the three facility cohorts, for the years ended December 31, 2025 and 2024:

	Year ended December 31,							
	Mature		Ramping		New		Total	
Skilled mix by revenue	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**
Medicare	40.4 %	37.3 %	29.6 %	36.9 %	20.2 %	22.5 %	33.5 %	33.2 %
Managed care	15.6	17.1	12.2	17.3	17.5	16.7	15.3	17.1
Skilled mix	*56.0*	*54.4*	*41.8*	*54.2*	*37.7*	*39.2*	*48.8*	*50.3*
Medicaid	35.2	38.1	48.5	37.8	52.1	51.6	41.9	41.6
Private and other	8.8	7.5	9.7	8.0	10.2	9.2	9.3	8.1
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

	Year ended December 31,							
	Mature		Ramping		New		Total	
Skilled mix by nursing patient days	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**
Medicare	21.5 %	18.8 %	13.7 %	18.8 %	11.5 %	10.6 %	17.2 %	16.4 %
Managed care	11.9	13.3	9.1	12.8	13.1	12.2	11.5	12.8
Skilled mix	*33.4*	*32.1*	*22.8*	*31.6*	*24.6*	*22.8*	*28.7*	*29.2*
Medicaid	57.4	59.3	66.9	59.3	63.8	66.6	61.2	61.4
Private and other	9.2	8.6	10.3	9.1	11.6	10.6	10.1	9.4
Total	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

- 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. Revenue associated with calculating average daily rates is based on contractually agreed-upon amounts or rates, excluding the estimates of variable consideration under ASC 606. These rates also exclude additional state relief funding, which includes payments we recognized as part of The Families First Coronavirus Response Act (FFCRA).

The following table presents average daily rates by payor source, excluding services that are not covered by the daily rate, for the years ended December 31, 2025 and 2024:

	Year ended December 31,							
	Mature		Ramping		New		Total	
	2025	**2024**	**2025**	**2024**	**2025**	**2024**	**2025**	**2024**
Medicare	$ 988.46	$ 953.72	$ 983.18	$ 979.20	$ 765.30	$ 887.75	$ 949.55	$ 951.35
Managed care	688.43	620.20	610.06	671.44	584.66	571.75	644.71	624.64
Total for skilled patient payors [1]	*881.22*	*815.46*	*833.83*	*854.30*	*669.45*	*718.53*	*826.82*	*807.76*
Medicaid	322.91	309.76	329.58	317.30	356.12	323.83	333.32	316.90
Private and other	497.45	419.41	421.35	438.41	383.87	363.94	446.41	407.30
Total [2]	*$ 525.57*	*$ 481.54*	*$ 453.97*	*$ 498.25*	*$ 436.31*	*$ 418.23*	*$ 486.56*	*$ 468.56*

(1) Represents weighted average of revenue generated by Medicare and managed care payor sources.
(2) Represents weighted average.

Non-GAAP Financial Measures

In addition to our results provided throughout that are determined in accordance with GAAP, we also present the following non-GAAP financial measures: EBITDA, Adjusted EBITDA and Adjusted EBITDAR (collectively, Non-GAAP Financial Measures). EBITDA and Adjusted EBITDA are performance measures. Adjusted EBITDAR is a valuation measure. These Non-GAAP Financial Measures have no standardized meaning defined by GAAP, and therefore 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. You should review the reconciliation of net income to the Non-GAAP Financial Measures in the table below, together with our audited combined/consolidated financial statements and the related notes in their entirety, and should not rely on any single financial measure. Additionally, other companies may define these or similar Non-GAAP Financial Measures with the same or similar names differently, and because these Non-GAAP

Financial Measures are not standardized, it may not be possible to compare these financial measures to those of other companies.

Performance Measures

We use EBITDA and Adjusted EBITDA to facilitate internal comparisons of our historical operating performance on a more consistent basis, as well as for business planning and forecasting purposes. In addition, we believe the presentation of EBITDA and Adjusted EBITDA is useful to investors, analysts and other interested parties in comparing our operating performance across reporting periods on a consistent basis by excluding items that we do not believe are indicative of our ongoing operating performance.

EBITDA – We calculate EBITDA as net income, adjusted for net losses attributable to noncontrolling interest, before: interest expense; provision for income taxes; and depreciation and amortization.

Adjusted EBITDA – We calculate Adjusted EBITDA as EBITDA further adjusted for non-core business items, which for the reported periods includes, to the extent applicable, costs incurred to acquire operations that are not capitalizable, losses incurred from debt restructuring, gains on lease termination, stock-based compensation expense, loss from equity method investment, forfeiture of a seller's note, recognition of a bargain purchase gain, legal and other costs, recognition of Employee Retention Tax Credit (ERTC), disaster relief payment, and certain one-time expenses that are not representative of our underlying operating performance. Costs related to acquisitions include costs related to our acquisition of SNF facilities and providers, including related costs such as legal fees, financial and tax due diligence, consulting and escrow fees. The loss related to our equity method investment is a loss allocated to us from a discrete disposal recognized by one of our equity method investments. The bargain purchase gain was recognized as part of our acquisition from the former operator Prestige. Legal and other costs include legal and professional fees incurred associated with the Audit Committee's independent investigation and with other ongoing investigations. The adjustment related to the ERTC represents the recognition of the tax credit against labor as the statute of limitations surrounding the uncertainty of the qualifications, for a portion of the funds received, expired. The disaster relief payment was made to support facilities impacted by Hurricane Helene.

Valuation Measure

We use Adjusted EBITDAR as a measure to determine the value of prospective acquisitions and to assess the enterprise value of our business without regard to differences in capital structures and leasing arrangements. In addition, we believe that Adjusted EBITDAR is also a commonly used measure by investors, analysts and other interested parties to compare the enterprise value of different companies in the healthcare industry without regard to differences in capital structures and leasing arrangements, particularly for companies with operating and finance leases. For example, finance lease expenditures are recorded in depreciation and interest and are therefore removed from Adjusted EBITDA, whereas operating lease expenditures are recorded in rent expense and are therefore retained in Adjusted EBITDA. Adjusted EBITDAR is a financial valuation measure that is not specified in GAAP, and is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring cash operating expense, and is therefore presented only for the current period. While we believe that Adjusted EBITDAR provides useful insight regarding our underlying operations, excluding the impact of our operating leases, we must still incur cash operating expenses related to our operating leases and rent and such expenses are necessary to operate our leased operations. As a result, Adjusted EBITDAR may understate the extent of our cash operating expenses for the respective period relative to our actual cash needs to operate our leased operations and business.

Adjusted EBITDAR – We calculate Adjusted EBITDAR as Adjusted EBITDA plus rent-cost of services.

The table below presents a reconciliation of EBITDA, Adjusted EBITDA and Adjusted EBITDAR to net income, the most directly comparable financial measure calculated in accordance with GAAP, on a combined/consolidated basis for the periods presented:

	Year ended December 31,		
	2025	2024	2023
	(in thousands)		
Net income	$ 191,461	$ 55,344	$ 112,882
Less: Net (loss) income attributable to noncontrolling interest	(82)	(416)	8
Add: Interest expense	28,363	44,341	49,919
Provision for income taxes	92,989	46,210	44,435
Depreciation and amortization	55,663	40,809	25,632
EBITDA	$ 368,558	$ 187,120	$ 232,860
Adjustments to EBITDA:			
Acquisition related costs	310	2,506	998
Loss resulting from debt restructuring	—	—	3,628
Gain on lease termination	—	(8,046)	—
Stock-based compensation	54,069	115,544	—
Loss from equity method investment	—	2,736	—
Forfeiture of seller's note	—	500	—
Bargain purchase gain	—	(17,185)	—
Legal and other costs	97,032	9,727	—
Employee Retention Tax Credit	(14,946)	(14,599)	—
Disaster relief payment	—	1,154	—
Adjusted EBITDA	$ 505,023	$ 279,457	$ 237,486
Rent - cost of services	378,908	284,953	216,711
Adjusted EBITDAR	$ 883,931		

Components of Results of Operations

Revenue

Patient and Resident Service Revenue

Patient and resident service revenue typically represents over 99% of our total revenue. Patient and resident service revenue comprises skilled nursing services revenue, revenue generated from our senior assisted living services and revenue generated from certain ancillary services provided outside of routine contractual agreements.

We derive patient and resident service revenue from services rendered, under short-term contracts, to patients for skilled and intermediate nursing, rehabilitation therapy, and assisted living services. This revenue is reported at the amount that reflects the consideration to which we expect to be entitled in exchange for providing patient services. These amounts are due from patients, governmental programs, and other third-party payors, and include variable consideration for retroactive revenue adjustments due to settlement of audits and reviews. Within our skilled nursing operations, we generate revenue from payor sources including Medicaid, Medicare and other payors such as commercial insurance companies, health maintenance organizations, and preferred provider organizations.

We expect patient and resident service revenue to continue to represent the vast majority of our total revenue and that such revenue will continue to increase to the extent we successfully execute on our acquisition strategy.

Other Revenue

Other revenue relates to ancillary revenue generating activities and primarily consists of revenue associated with arrangements in which we are a lessor of certain facilities. Other revenue typically represents an immaterial portion of our total revenue and we expect this to continue for the foreseeable future.

Cost of Services (exclusive of rent and depreciation and amortization shown separately)

Our cost of services represents the costs of operating our operating subsidiaries, which primarily consist of payroll and related benefits, supplies, purchased services, and ancillary expenses such as the cost of pharmacy and therapy services provided to patients. Cost of services also includes the cost of general and professional liability insurance, rent expenses related to leasing our operational facilities (such as taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements), dietary services, contracted services and other administrative and general cost of services with respect to our operations. As we continue to execute on our acquisitions strategy and grow our business, we expect that our cost of services will continue to increase.

Rent - Cost of Services

Rent - cost of services consists solely of base rent amounts payable under lease agreements to third-party real estate owners. Our operating subsidiaries lease and operate, but do not own the underlying real estate of, 268 facilities and these amounts do not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements. As we continue to execute on our acquisitions strategy and expand our network of facilities, we expect that our rent - cost of services will continue to increase.

General and Administrative Expense

General and administrative expense consists primarily of payroll and related benefits and travel expenses for our PACS Services personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees) and costs relating to our information systems. Historically, our general and administrative expense has not included any stock-based compensation. In connection with our IPO in April 2024, we adopted the 2024 Plan and 2024 ESPP. From this point forward, our general and administrative expense includes stock-based compensation.

We expect general and administrative expense to increase on an absolute dollar basis for the foreseeable future as we continue to increase investments to support our growth. Our costs related to legal, audit, accounting, regulatory and tax-related services associated with maintaining compliance with exchange listing and SEC requirements, director and officer insurance costs, investor and public relations costs, and other expenses that we did not incur as a private company are higher as a public company. Legal and professional fees incurred associated with the Audit Committee's independent investigation and with ongoing investigations are included in general and administrative expense. We anticipate that general and administrative expense as a percentage of revenue will vary from period to period, but we expect to leverage these expenses over time as we grow our revenue.

Depreciation and Amortization

Property and equipment are recorded at their original historical cost. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets. The following is a summary of the estimated useful lives of our depreciable assets:

- Buildings and improvements - minimum of 5 years to a maximum of 40 years, but generally 30 years
- Leasehold improvements - shorter of the lease term or the estimated useful life, generally 5 years to 15 years
- Furniture and equipment - minimum of 3 years to a maximum of 15 years

Other Expense, net

Other expense, net consists primarily of interest expense related to our debt, as well as income from gains and losses from investments in partnerships, including joint ventures.

Provision for Income Taxes

Provision for income taxes consists primarily of income taxes in certain jurisdictions in which we conduct business.

Results of Operations

Year Ended December 31, 2025 Compared to the Year Ended December 31, 2024

	Year ended December 31,		Change	
	2025	2024	$	%
	(in thousands)			
Revenue				
Patient and resident service revenue	$ 5,287,885	$ 4,086,655	$ 1,201,230	29.4 %
Other revenues	1,047	3,079	(2,032)	(66.0)%
Total Revenue	$ 5,288,932	$ 4,089,734	$ 1,199,198	29.3 %
Operating Expenses				
Cost of services	4,129,696	3,297,091	832,605	25.3 %
Rent - cost of services	378,908	284,953	93,955	33.0 %
General and administrative expense	415,070	343,808	71,262	20.7 %
Depreciation and amortization	55,663	40,809	14,854	36.4 %
Total Operating Expenses	$ 4,979,337	$ 3,966,661	$ 1,012,676	25.5 %
Operating income	309,595	123,073	186,522	151.6 %
Other (Expense) Income				
Interest expense	(28,363)	(44,341)	15,978	(36.0)%
Gain on lease termination	—	8,046	(8,046)	(100.0)%
Other income, net	3,218	14,776	(11,558)	(78.2)%
Total Other Expense, net	$ (25,145)	$ (21,519)	$ (3,626)	16.9 %
Income before provision for income taxes	284,450	101,554	182,896	180.1 %
Provision for income taxes	92,989	46,210	46,779	101.2 %
Net Income	$ 191,461	$ 55,344	$ 136,117	245.9 %

Revenue

Patient and resident service revenue - Patient and resident service revenue increased by $1,201.2 million or 29.4% to $5.3 billion, for the year ended December 31, 2025, compared to the year ended December 31, 2024. For each of the years ended December 31, 2025 and 2024, skilled nursing services revenue represented more than 97.0% of patient and resident service revenue.

Skilled nursing services revenue increased by $1,164.0 million, or 29.0%, to $5.2 billion for the year ended December 31, 2025, compared to the year ended December 31, 2024. This change was driven by an increase in patient days of 1,955,803, or 22.8%. The increase in patient days for the year ended December 31, 2025 compared to the year ended December 31, 2024 was primarily due to large acquisitions in the second half of the year ended December 31, 2024, primarily driven by the Prestige acquisition, plus an additional increase during the year ended December 31, 2025, leading to a combined increase of 8,371 or 34%. Additionally we experienced a higher occupancy rate within the Mature facility cohorts of 94.9% for the year ended December 31, 2025, compared to 94.4% occupancy for Mature facilities for the year ended December 31, 2024, due to increased demand as a result of continued execution on our business model. Total facility occupancy decreased slightly year-over-year from 90.4% for the year ended December 31, 2024 compared to 89.1% for the year ended December 31, 2025 due to a decrease in the New and Ramping facility cohort occupancy as a result of the significant number of acquisitions during the last quarter of the year ended December 31, 2024 and into the year ended December 31, 2025.

Our skilled nursing services revenue was impacted by developments in our average daily rates and fluctuations in our payor sources. Our Medicare daily rates at Mature and Ramping facilities increased by 3.6% and 0.4%, respectively, for the year ended December 31, 2025.

Our average Medicaid rates increased 5.2% due to state reimbursement increases and our participation in supplemental Medicaid payment programs and quality improvement programs in various states. Medicaid rates exclude the amount of state relief revenue we recorded.

Other revenue - Other revenue decreased to $1.0 million for the year ended December 31, 2025, compared to $3.1 million for the year ended December 31, 2024 due to a decrease in lease income compared to the prior year in which we had the extended execution of our acquisition from the former operator Prestige. See Note 16, “Operation Expansions”, to our audited combined/consolidated financial statements for more information related to the 2024 acquisition.

Cost of services

Cost of services increased by $832.6 million, or 25.3% to $4.1 billion, for the year ended December 31, 2025, compared to the year ended December 31, 2024. The increase was primarily driven by an increase of $536.0 million in salaries and wages. Of the salaries and wages increase, facilities classified within the New facilities cohort accounted for $204.8 million or 38.2% of the increase. Our total number of post-acute care facilities, inclusive of skilled nursing facilities and assisted living facilities, increased throughout the second half of 2024 and through 2025, from 220 as of June 30, 2024, to 314 as of December 31, 2024, to 321 as of December 31, 2025, an increase of 45.9% and 2.2%, respectively. This increase in operations and employees led to the increase in labor cost for new facilities as they were acquired throughout the year ended December 31, 2024 and into the year ended December 31, 2025. The increase in salaries and wages was primarily driven by an increase in nursing salaries and wages driven by market needs, increases in administration wages and payroll taxes. Aside from labor costs, the increase in cost of services was primarily due to increases of $167.6 million in administrative and ancillary expenses for facility increases, driven by a $111.0 million increase in contracted services, a $56.3 million increase in quality assurance fees, a $5.2 million increase in software support and upgrades, and a $4.8 million increase in professional fees, offset by a decrease in liability insurance of $38.4 million. The remaining $28.6 million change in administrative and ancillary expenses were spread out across various expense types. Of the increase in non-labor administrative and ancillary costs, $82.2 million, or 49.1%, is attributable to the New facilities cohort, the remaining costs were spread across Mature and Ramping cohorts. Nursing and dietary expenses drove an additional $59.1 million of the increase, of which $23.5 million or 39.8% was due to facilities acquired within the past 18 months. The remaining $69.9 million increase is spread over various expense categories.

Rent - cost of services

Rent - cost of services increased by $94.0 million, or 33.0% to $378.9 million, for the year ended December 31, 2025, compared to the year ended December 31, 2024. The increase was primarily attributable to the addition of new facilities with operating leases throughout the year, as well as to annual escalators on existing facilities’ rent.

General and administrative expense

General and administrative expense increased by $71.3 million, or 20.7% to $415.1 million, for the year ended December 31, 2025, compared to the year ended December 31, 2024. This increase was primarily due to an increase in legal and professional fees incurred associated with the Audit Committee’s independent investigation and with ongoing government investigations of $87.3 million, over the previous year. The change was also impacted by an increase in salaries and wages of $28.7 million, or 18.3%, attributable to an increase in personnel to help integrate and facilitate the operational growth. These increases were offset by a decrease in stock compensation expense recognized during the year of $61.5 million, as the prior year had significant stock compensation expense associated with restricted stock units that were granted at the time of our IPO. The remaining change was spread over various expense categories.

Depreciation and amortization

Depreciation and amortization increased by $14.9 million, or 36.4% to $55.7 million, for the year ended December 31, 2025, compared to $40.8 million for the year ended December 31, 2024. This increase is directly attributable to new real estate obtained through acquisitions as well as growth of our finance lease portfolio.

Other expense, net

Other expense, net increased by $3.6 million, or 16.9% to $25.1 million, for the year ended December 31, 2025, compared to the year ended December 31, 2024. Other expense, net primarily consists of interest expense which decreased by $16.0 million, to $28.4 million for the year ended December 31, 2025, compared to the year ended December 31, 2024, due to a decrease in amounts drawn on lines of credit and long-term debt of $58.6 million during the year. During the year ended December 31, 2024, other expense, net also included a gain of $8.0 million recognized upon the termination of a lease. Additionally, during the year ended December 31, 2025, other expense, net included other income of $3.2 million, a decrease of $11.6 million from the year ended December 31, 2024. This decrease was driven by the recognition of a $17.2

million bargain purchase gain following our acquisition from the former operator Prestige during the year ended December 31, 2024 offset by a $2.7 million loss allocated to us from a discrete disposal recognized by one of our equity method investments and a $0.5 million forfeiture of a seller's note during the same period compared to the activity during the year ended December 31, 2025 which primarily consisted of gains from our investments.

Provision for income taxes

Provision for income taxes totaled $93.0 million for the year ended December 31, 2025, representing an effective tax rate of 32.6%, compared to a provision for income taxes of $46.2 million and an effective tax rate of 45.5% for the year ended December 31, 2024. The difference in the effective tax rate from the statutory rate is mainly due to state taxes, permanent book-tax differences, and other adjustments. The change in effective tax rate for the year ended December 31, 2025 compared to the year ended December 31, 2024 was primarily due to an increase in pre-tax book income, which reduced the overall impact on non-deductible expenses, including non-deductible compensation. See Note 12, "Income Taxes", to our audited combined/consolidated financial statements for more information.

Holding Company Status

We are a holding company with no significant direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, through a separate wholly-owned subsidiary, we provide centralized accounting, payroll, human resources, information technology, legal, risk management and other consulting and centralized services to the other operating subsidiaries through contractual relationships with those subsidiaries. We also have a wholly-owned captive insurance subsidiary that provides some claims-made coverage to our operating subsidiaries for professional liability and general liability insurance.

Liquidity & Capital Resources

Prior to our IPO, our liquidity was generally derived from our cash flows from operations, mortgage loans (including both Housing and Urban Development (HUD)-insured and non-HUD mortgage loans), and credit facilities maintained with commercial banks.

On April 15, 2024, we completed an IPO receiving initial net proceeds of $423.0 million. We used $370.0 million of the net proceeds from the IPO to repay amounts outstanding under our Amended and Restated Credit Facility (as defined below) and used the remaining amount for general corporate purposes to support the growth of the business. On September 9, 2024, we completed an underwritten follow-on offering receiving initial net proceeds of $96.4 million, of which we used $95.3 million to repay amounts outstanding under our Amended and Restated Credit Facility.

As of December 31, 2025, we had cash and cash equivalents (which include short-term investments with original maturities of three months or less at the time of purchase) of $197.0 million. The total principal amount outstanding under our Amended and Restated Credit Facility as of December 31, 2025 was $100.0 million. In addition, we had outstanding letters of credit of $7.9 million as of December 31, 2025.

The terms of our Amended and Restated Credit Facility permit optional prepayments from time to time without premium or penalty. We expect to continue to use the Amended and Restated Credit Facility as our single line of credit and to fund the potential acquisition of additional property and operations, as well as for working capital and for general corporate purposes. Cash paid to fund acquisitions was $143.8 million and $283.3 million for the years ended December 31, 2025 and 2024, respectively. Total capital expenditures for property and equipment were $105.4 million and $66.5 million for the years ended December 31, 2025 and 2024, respectively.

We believe our current cash balances and our cash flow from operations will be sufficient to cover our operating needs for at least the next 12 months. 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.

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

	Year ended December 31,	
	2025	2024
	(in thousands)	
Net cash provided by/(used in)		
Operating activities	$ 404,224	$ 367,341
Investing activities	(264,025)	(442,679)
Financing activities	(68,990)	117,476
Net change in cash	$ 71,209	$ 42,138
Cash, cash equivalents, and restricted cash - beginning of period	160,842	118,704
Cash, cash equivalents, and restricted cash - end of period	$ 232,051	$ 160,842

Operating activities

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

Net cash provided by operating activities for the year ended December 31, 2025 of $404.2 million increased by $36.9 million as compared with the same period in 2024. The increase was primarily driven by improved operational performance across our existing portfolio as well as the incremental operational performance across our 101 facilities acquired in the latter half of 2024 and throughout 2025. This increase was offset by a decrease in cash flows from the change in operating assets and liabilities of $85.5 million due to the timing of payables and other accrued liabilities.

Investing activities

Investing cash flows consist primarily of capital expenditures, investment activities, proceeds from sale of property and equipment and cash used for acquisitions.

Net cash used in investing activities for the year ended December 31, 2025 of $264.0 million decreased by $178.7 million as compared with the same period in 2024. The decrease in cash used was primarily attributable to a decrease of $139.6 million in cash used to acquire real estate facilities offset by an increase of $38.9 million in cash used to purchase property and equipment, in excess of cash used for these purposes in 2024. Further, in 2025 investments purchased through our captive insurance subsidiary, consisting of holdings in investment grade bond mutual funds, decreased by $69.7 million, and cash used to purchase investments in partnerships decreased by $32.9 million, as compared to the same period in 2024. These changes were offset by a decrease in sales of investments of $25.9 million as compared to 2024.

Financing activities

Financing cash flows consist primarily of payments and draws on lines of credit, distributions and repayment of short-term and long-term debt, borrowings on lines of credit, contributions from noncontrolling interest, and proceeds from equity offerings.

Net cash used in financing activities for the year ended December 31, 2025 of $69.0 million consisted of $42.0 million of payments on lines of credit and $18.2 million of payments on long-term debt. Additionally, the Company paid $8.4 million in taxes related to net share settlement of equity awards. This is a decrease of $186.5 million as compared with the same period in 2024 in which we had $117.5 million of cash provided by financing activities. In the year-ended December 31, 2024, cash provided by financing activities consisted of $509.4 million in proceeds from equity offerings, and $52.9 million of net borrowings on long-term debt. This activity during the year-ended December 31, 2024, was offset by $378.0 million in net payments on lines of credit, dividends paid of $33.7 million, and taxes paid related to net share settlement of equity awards of $33.6 million.

Credit facility

We maintain a revolving credit facility between PACS Group, Inc., as holdings, PACS Holdings, LLC, as borrower, and certain of our subsidiaries with Truist Bank, as administrative agent (the “Administrative Agent”), and a syndicate of

lenders (the "Amended and Restated Credit Facility"). The Amended and Restated Credit Facility provides for a Revolving Commitment (as defined in the Amended and Restated Credit Facility) of up to $600.0 million (including a $50.0 million letter of credit sub-facility and a $20.0 million swingline sub-facility).

Outstanding borrowings under the Amended and Restated Credit Facility bear interest, at our option, at either (a) SOFR (subject to a 0.10% credit spread adjustment), plus a margin ranging from 2.25% to 3.25% per annum; or (b) the Base Rate (as defined in the Amended and Restated Credit Agreement), plus a margin ranging from 1.25% to 2.25% per annum, with such margins, in each case, determined by reference to our Total Leverage Ratio (as defined in the Amended and Restated Credit Agreement). We are required to pay a commitment fee ranging from 0.25% to 0.45% per annum on the unused portion of the Revolving Commitments, based upon our Total Leverage Ratio and other customary fees.

The Amended and Restated Credit Facility includes customary affirmative and negative covenants and two financial covenants: a requirement that our Total Leverage Ratio not exceed 3.00:1.00 as of the end of each fiscal quarter, and a requirement that our Fixed Charge Coverage Ratio (as defined in the Amended and Restated Credit Agreement) not fall below 1.10:1.00, in each case, tested quarterly for the trailing four fiscal quarters. The Amended and Restated Credit Agreement matures on December 7, 2028. Additionally, the Amended and Restated Credit Facility, as amended by the Sixth Amendment and Waiver, contains a Liquidity Requirement, as described in further detail below, which will apply until the Liquidity Requirement Termination Date.

On May 16, 2024, we entered into an amendment to the Amended and Restated Credit Facility that, among other things, waived an event of default that had occurred and was then continuing under the Amended and Restated Credit Facility and modified the affirmative covenants thereunder requiring the joinder of certain subsidiaries of PACS Group, Inc. to the Amended and Restated Credit Facility, as further set forth therein. On November 14, 2024, we entered into another amendment to the Amended and Restated Credit Facility that, among other things, extended the deadline for our delivery of unaudited quarterly financial statements for the fiscal quarter ended September 30, 2024. On March 27, 2025, and May 29, 2025, we entered into further amendments to the Amended and Restated Credit Facility that, among other things, extended the deadline for delivery of audited annual financial statements for the fiscal year ended December 31, 2024. The May 29, 2025 amendment also supplemented the Amended and Restated Credit Agreement's financial covenants requiring us to maintain unrestricted cash and certain permitted investments of at least $100 million until delivery of audited financial statements for the fiscal year ended December 31, 2024 (the "Liquidity Requirement").

On July 24, 2025 and August 13, 2025 we entered into two separate forbearance agreements with the Administrative Agent and the lenders, pursuant to which the lenders agreed to temporarily forbear from exercising remedies under the Amended and Restated Credit Facility with respect to certain technical events of default, including without limitation matters relating to inaccuracies in certain representations and warranties made, which inaccuracies also triggered an event of default under the Third Consolidated Master Lease, dated June 30, 2023 (as amended, restated, amended and restated, supplemented or otherwise modified from time to time, the "Omega Master Lease"), which in turn triggered an additional event of default under the Amended and Restated Credit Facility. In addition, a separate representation and warranty event of default occurred under the Omega Master Lease, which triggered an event of default under the Amended and Restated Credit Agreement (all such technical events of default under the Amended and Restated Credit Facility, the "Initial Technical Events of Default"). The August 13, 2025 Forbearance Agreement and Fifth Amendment Credit Agreement required that the Liquidity Requirement remain in place for the entirety of the forbearance period and further extended the delivery period with respect to the fiscal year 2024 financial statements.

On October 21, 2025, we entered into a third forbearance agreement (the "October Forbearance Agreement"). Under the October Forbearance Agreement, the lenders again agreed to temporarily forbear from exercising rights and remedies under the Amended and Restated Credit Agreement with respect to the Initial Technical Events of Default, as well as certain additional technical events of default including without limitation matters relating to the designation of certain immaterial conflicted subsidiaries; failure to join certain subsidiaries to the loan documents; noncompliance with cash management requirements; and inaccuracies in certain representations and warranties made as a result of the foregoing (collectively, with the Initial Technical Events of Default, the "Technical Events of Default"). The Technical Events of Default also triggered an event of default under the Omega Master Lease, which in turn triggered an additional event of default under the Amended and Restated Credit Agreement.

On November 26, 2025, we entered into another amendment to and waiver (the "Sixth Amendment and Waiver") under the Amended and Restated Credit Facility that, among other things, waived all Technical Events of Default. The Sixth Amendment and Waiver also amended the Amended and Restated Credit Agreement to, among other things, require that the Liquidity Requirement remain in place until we deliver to the Administrative Agent financial statements and a

corresponding compliance certificate for the fiscal quarter ended June 30, 2026 (the "Liquidity Requirement Termination Date").

Long-term debt

During the year ended December 31, 2025, none of our subsidiaries entered into Department of Housing and Urban Development (HUD)-insured mortgage loans, whereas in the year ended December 31, 2024, certain of our subsidiaries entered into HUD-insured mortgage loans in the aggregate amount of $68.3 million. Additionally, we converted a $22.5 million construction loan to a HUD-insured mortgage loan during the year ended December 31, 2024. As of December 31, 2025, 13 of our subsidiaries had mortgage loans insured with HUD in the aggregate amount of $248.9 million as of December 31, 2025, of which $4.2 million was classified as current and the remaining $244.7 million was classified as non-current. As of December 31, 2024, 13 of our subsidiaries had HUD-insured mortgage loans in the aggregate amount of $252.9 million of which $4.0 million was classified as current and the remaining $248.9 million was classified as non-current. These subsidiaries are subject to HUD-mortgage oversight and periodic inspections. As of December 31, 2025, our HUD-insured mortgage loans bear fixed interest rates ranging from 2.4% to 6.3% per annum and have various maturity dates through October 1, 2061. 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 based on the principal balance on the date of prepayment. The original terms for all the HUD-insured mortgage loans are 24 to 37 years.

In addition to the HUD-insured mortgage loans above, our subsidiaries have four other mortgage loans or promissory notes. The non-HUD insured mortgage loans and notes bear interest rates in the range of 2.0% and 7.5% per annum with various maturity dates through June 1, 2027. The notes are secured by equipment and guarantees by PACS Group, Inc. and its stockholders. As of December 31, 2025 and 2024, we had $4.3 million and $17.0 million, respectively, of debt outstanding under the non-HUD mortgage loans and promissory notes, of which $0.3 million is classified as current and the remaining $4.0 million is classified as non-current as of December 31, 2025, and $10.8 million is classified as current and the remaining $6.2 million is classified as non-current as of December 31, 2024.

Operating and finance leases

We lease most of our skilled nursing and assisted living facilities, as well as office space and certain vehicles and equipment, under various non-cancelable operating lease agreements. These operating leases expire at various dates through 2050.

Substantially all operating leases for skilled nursing and assisted living facilities are on a "triple-net" basis, which require lessees to pay for all insurance, repairs, utilities, and real property taxes assessed on the leased property, and most of the leases are guaranteed by us and/or our stockholders.

For 36 of the facility operating leases, we hold an option to purchase the real estate which can be exercised at varying times until March 31, 2038. At lease inception it was determined that the exercise of these purchase options was not reasonably assured. Options on three leases have become subject to disagreement with the landlord regarding whether the option exercise window has closed, and the Company will be working with the landlord to resolve the disagreement.

At our option, the facility leases are generally renewable for additional terms ranging from 5 to 20 years. All facility leases provide for an additional percentage rent based upon specified rates per the terms of the agreements.

We also lease certain skilled nursing and assisted living facilities under finance lease agreements. The lease terms of one of the facility finance leases allow for a purchase option during a specified window. We have determined that we are reasonably certain to exercise the purchase option at the end of the purchase option window. Therefore, we have calculated the lease term through the end of the purchase option window for such lease. In addition, for one of the facility finance leases, the lessor holds an option which could require us to purchase the associated real estate. The total obligation to purchase such real estate is approximately $32,000 and can be exercised by the lessor through June 30, 2026. For other finance leases, the duration of the lease term represented the major part of the remaining economic life of the facility at inception.

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 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.

Off-Balance Sheet Arrangements

We may enter into off-balance sheet arrangements and transactions that can give rise to material off-balance sheet obligations. As of December 31, 2025, we had $7.9 million of borrowing capacity under the Amended and Restated Credit Facility pledged as collateral to secure outstanding letters of credit. We may enter into further contractual arrangements in the future in order to support our business plans. There are no other transactions, arrangements or other relationships with unconsolidated entities or other persons that are reasonably likely to materially affect our liquidity or availability of our capital resources.

Critical Accounting Estimates

Our discussion and analysis of our financial condition and results of operations are based on our combined/consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these combined/consolidated financial statements and related disclosures requires us to make judgments, estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined/consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. We believe that the application of the following accounting policies, which are important to our financial condition and results of operations, require significant judgments and estimates on the part of management. See Note 2, "Summary of Significant Accounting Policies", to our audited combined/consolidated financial statements for a summary of our significant accounting policies, including the accounting policies discussed below.

Revenue Recognition- Revenue recognized from healthcare services is adjusted for estimates of variable consideration to arrive at the transaction price. We determine the transaction price based on contractually agreed-upon amounts or rates, adjusted for estimates of variable consideration. Variable consideration includes estimates of implicit price concessions so that the estimated transaction price is reflective of the amount to which we expect to be entitled in exchange for providing the healthcare services to customers. If actual amounts of consideration ultimately received differ from the estimates, we adjust these estimates, which would affect net service revenue in the period such variances become known.

Professional Liability and General Liability Self-Insurance Liabilities- We are principally self-insured for risks related to professional and general liability. Accrued risk reserves include the accrual for risks associated with professional liability claims and include a liability for unpaid reported claims and estimates for incurred but unreported claims.

We utilize a wholly-owned captive insurance subsidiary to provide coverage to our various consolidated operating subsidiaries related to professional and general liability insurance. The related assets and liabilities of this consolidated subsidiary are included in the accompanying combined/consolidated financial statements.

Our policy is to accrue amounts using the information obtained from the actuarially determined 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. We develop information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluate the estimates for claim loss exposure on a quarterly basis. We use actuarial valuations to estimate the liability based on historical experience and industry information.

Recent Accounting Pronouncements

See Note 2, "Summary of Significant Accounting Policies", to our combined/consolidated financial statements for a description of recently adopted accounting pronouncements and recently issued accounting pronouncements not yet adopted as of the date of this Annual Report on Form 10-K.

Item 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

We are exposed to risks associated with market changes in interest rates through our borrowing arrangements. As of December 31, 2025, we had approximately $100.0 million of variable rate debt, none of which was subject to an interest rate hedge. In particular, our credit facility exposes us to variability in interest payments due to changes in SOFR interest rates. Accordingly, as of December 31, 2025, based on the amount of variable rate debt outstanding and the then-current SOFR rate, a hypothetical 10% increase in interest rates would have increased annual interest expense by approximately $0.7 million and a hypothetical 10% decrease in interest rates would have decreased annual interest expense by approximately $0.7 million. We manage our exposure to this market risk by monitoring available financing alternatives. Our mortgages and promissory notes 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.

Our cash and cash equivalents as of December 31, 2025 consisted of cash and short-term investments with original maturities of three months or less at the time of purchase. Risks due to changing interest rates impact the return we realize related to our cash and short-term investment balances.

As of December 31, 2025, we had outstanding indebtedness under mortgage loans insured with HUD of $248.9 million, all of which were at fixed interest rates.

The above only incorporates those exposures that exist as of December 31, 2025 and does not consider those exposures or positions which could arise after that date.

Item 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

PACS GROUP, INC. AND SUBSIDIARIES
INDEX TO COMBINED/CONSOLIDATED FINANCIAL STATEMENTS

Report of Independent Registered Public Accounting Firm PCAOB ID No. 42	90
Combined/Consolidated Financial Statements	
Combined/Consolidated Balance Sheets as of December 31, 2025 and 2024	92
Combined/Consolidated Statements of Income for the Years Ended December 31, 2025, 2024, and 2023	94
Combined/Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2025, 2024, and 2023	95
Combined/Consolidated Statements of Cash Flows for the Years Ended December 31, 2025, 2024, and 2023	96
Notes to Combined/Consolidated Financial Statements	98

Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of PACS Group, Inc.

Opinion on the Financial Statements

We have audited the accompanying combined/consolidated balance sheets of PACS Group, Inc. and subsidiaries (the Company) as of December 31, 2025 and 2024, the related combined/consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2025, and the related notes (collectively referred to as the "combined/consolidated financial statements"). In our opinion, the combined/consolidated financial statements present fairly, in all material respects, the financial position of the Company at December 31, 2025 and 2024, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2025, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of December 31, 2025, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated February 26, 2026 expressed an adverse opinion thereon.

Basis for Opinion

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

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

Critical Audit Matter

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

Professional liability and general liability claims reserve

Description of the Matter	At December 31, 2025, the Company's professional liability and general liability self-insurance liabilities were $296 million. As further described in Note 18 to the combined/consolidated financial statements, the professional liability and general liability self-insurance liabilities include an estimate of the Company's liability for professional claims that have been reported as well as claims that have been incurred but not reported. The Company utilizes an external actuary to assist management in estimating the exposure for claims obligations, both asserted and unasserted. Auditing the professional liability and general liability self-insurance liabilities involved significant judgment in estimating the projected settlement value of reported and unreported claims. This assessment required a high degree of auditor judgment and an increased audit effort, including the involvement of our actuarial specialists, to evaluate whether the reserves were appropriately recorded.
How We Addressed the Matter in Our Audit	To test the professional liability and general liability self-insurance liabilities, our audit procedures included, among others, obtaining an understanding of the factors considered and assumptions made by management and its external actuary in developing the estimate of the professional liability and general liability self-insurance liabilities, including the sources of data relevant to these factors and assumptions. We tested underlying claims data, including the completeness and accuracy of open and settled cases. We reviewed the Company's insurance contracts to understand the policy terms and verified that the policy terms were factored into the actuarial computations. We also involved our actuaries to assist in evaluating the methodologies and key assumptions used in the actuarial report. We compared the Company's professional liability and general liability self-insurance liabilities to an independent range calculated by our actuaries.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2022.

Salt Lake City, Utah

February 26, 2026

PACS GROUP, INC. AND SUBSIDIARIES
COMBINED/CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except for share and per share values)

	December 31,	
	2025	**2024**
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 197,016	$ 157,674
Accounts receivable, net	628,128	641,775
Other receivables	73,965	74,746
Prepaid expenses and other current assets	170,630	64,066
Total Current Assets	1,069,739	938,261
Property and equipment, net	1,201,096	990,580
Operating lease right-of-use assets	2,968,176	2,994,519
Insurance subsidiary deposits and investments	87,192	66,258
Escrow funds	18,404	25,122
Goodwill and other indefinite-lived assets	68,061	67,061
Other assets	171,366	161,108
Total Assets	$ 5,584,034	$ 5,242,909

PACS GROUP, INC. AND SUBSIDIARIES
COMBINED/CONSOLIDATED BALANCE SHEETS
(dollars in thousands, except for share and per share values)

	December 31, 2025	December 31, 2024
LIABILITIES AND EQUITY		
Current Liabilities:		
Accounts payable	$ 192,232	$ 175,062
Accrued payroll and benefits	187,516	146,177
Current operating lease liabilities	153,066	136,232
Current maturities of long-term debt	4,463	14,852
Current portion of accrued self-insurance liabilities	128,994	75,966
Current line of credit	—	142,000
Refund liability	181,129	145,795
Other accrued expenses	154,030	142,348
Total Current Liabilities	1,001,430	978,432
Long-term operating lease liabilities	2,939,854	2,935,773
Line of credit	100,000	—
Long-term debt, less current maturities, net of deferred financing fees	244,803	250,984
Accrued self-insurance liabilities, less current portion	192,561	164,979
Other liabilities	152,937	197,050
Total Liabilities	$ 4,631,585	$ 4,527,218
Commitments and contingencies (Note 17)		
Equity:		
PACS Group, Inc. stockholders' equity:		
Common stock: $0.001 par value; 1,250,000,000 shares authorized; 156,615,144 shares issued and outstanding as of December 31, 2025, and 155,177,511 shares issued and outstanding as of December 31, 2024	157	155
Additional paid-in capital	637,035	591,363
Retained earnings	309,579	118,036
Total PACS Group, Inc. stockholders' equity	946,771	709,554
Noncontrolling interest in subsidiary	5,678	6,137
Total Equity	$ 952,449	$ 715,691
Total Liabilities and Equity	$ 5,584,034	$ 5,242,909

See accompanying notes to combined/consolidated financial statements.

PACS GROUP, INC. AND SUBSIDIARIES
COMBINED/CONSOLIDATED STATEMENTS OF INCOME
(dollars in thousands, except for share and per share values)

	Year Ended December 31,		
	2025	**2024**	**2023**
Revenue			
Patient and resident service revenue	$ 5,287,885	$ 4,086,655	$ 3,110,114
Additional funding	—	—	375
Other revenues	1,047	3,079	1,003
Total Revenue	$ 5,288,932	$ 4,089,734	$ 3,111,492
Operating Expenses			
Cost of services	4,129,696	3,297,091	2,447,713
Rent - cost of services	378,908	284,953	216,711
General and administrative expense	415,070	343,808	213,664
Depreciation and amortization	55,663	40,809	25,632
Total Operating Expenses	$ 4,979,337	$ 3,966,661	$ 2,903,720
Operating income	309,595	123,073	207,772
Other (Expense) Income			
Interest expense	(28,363)	(44,341)	(49,919)
Gain on lease termination	—	8,046	—
Other income (expense), net	3,218	14,776	(536)
Total Other Expense, Net	$ (25,145)	$ (21,519)	$ (50,455)
Income before provision for income taxes	284,450	101,554	157,317
Provision for income taxes	92,989	46,210	44,435
Net Income	$ 191,461	$ 55,344	$ 112,882
Less:			
Net (loss) income attributable to noncontrolling interest	(82)	(416)	8
Net Income Attributable To PACS Group, Inc.	$ 191,543	$ 55,760	$ 112,874
Net Income Per Share Attributable To PACS Group, Inc.			
Basic	$ 1.23	$ 0.38	$ 0.88
Diluted	$ 1.22	$ 0.38	$ 0.88
Weighted-Average Common Shares Outstanding			
Basic	156,180,786	146,663,371	128,723,386
Diluted	156,700,339	148,574,606	128,723,386

See accompanying notes to combined/consolidated financial statements.

PACS GROUP, INC. AND SUBSIDIARIES

COMBINED/CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(dollars in thousands, except for share values)

	Common Stock		Additional	Retained	Noncontrolling	
	Shares	Amount	Paid-in Capital	Earnings	Interest	Total
Balance January 1, 2023	128,723,386	$ 129	$ —	$ 63,517	$ 5,005	$ 68,651
Contributions	—	—	—	—	587	587
Dividends on common stock ($0.6246 per share)	—	—	—	(80,394)	—	(80,394)
Net income attributable to noncontrolling interest	—	—	—	—	8	8
Net income attributable to PACS Group, Inc.	—	—	—	112,874	—	112,874
Balance December 31, 2023	128,723,386	$ 129	$ —	$ 95,997	$ 5,600	$ 101,726
Contributions	—	—	—	—	953	953
Issuance of common stock	24,206,350	24	509,418	—	—	509,442
Employee stock-based compensation	3,847,652	4	115,540	—	—	115,544
Tax withholdings related to net share settlement of equity awards	(1,599,877)	(2)	(33,595)	—	—	(33,597)
Dividends on common stock ($0.2173 per share)	—	—	—	(33,721)	—	(33,721)
Net loss attributable to noncontrolling interest	—	—	—	—	(416)	(416)
Net income attributable to PACS Group, Inc.	—	—	—	55,760	—	55,760
Balance December 31, 2024	155,177,511	$ 155	$ 591,363	$ 118,036	$ 6,137	$ 715,691
Employee stock-based compensation	—	—	54,069	—	—	54,069
Issuance of common stock to employees and directors resulting from the vesting of restricted stock unit awards	2,325,126	3	(3)	—	—	—
Tax withholdings related to net share settlement of equity awards	(887,493)	(1)	(8,394)	—	—	(8,395)
Noncontrolling interest distribution	—	—	—	—	(377)	(377)
Net loss attributable to noncontrolling interest	—	—	—	—	(82)	(82)
Net income attributable to PACS Group, Inc.	—	—	—	191,543	—	191,543
Balance December 31, 2025	156,615,144	$ 157	$ 637,035	$ 309,579	$ 5,678	$ 952,449

See accompanying notes to combined/consolidated financial statements.

PACS GROUP, INC. AND SUBSIDIARIES
COMBINED/CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year Ended December 31,		
	2025	**2024**	**2023**
Cash flows from operating activities			
Net income	$ 191,461	$ 55,344	$ 112,882
Adjustments to reconcile net income to net cash provided by operating activities			
Depreciation and amortization	55,663	40,809	25,632
Amortization and write-off of deferred financing fees	3,148	3,115	6,068
Stock-based compensation	54,069	115,544	—
Loss on investment in partnership	773	4,565	391
Gain on insurance subsidiary deposits and investments	(4,896)	(1,258)	—
Deferred taxes	(17,733)	(44,484)	(9,923)
Noncash lease expense	48,454	34,647	22,727
Other noncash operating activities	573	843	581
Change in operating assets and liabilities			
Accounts receivable, net	13,647	(93,968)	(176,883)
Other receivables	781	(22,487)	(3,059)
Prepaid expenses and other current assets	(69,523)	(17,210)	(18,765)
Other assets	(2,660)	(13,338)	(3,338)
Escrow funds	6,718	(9,473)	568
Operating lease liabilities	(1,196)	(20,784)	(2,011)
Accounts payable	14,856	33,398	33,371
Accrued payroll and benefits	40,992	52,041	6,325
Accrued self-insurance liabilities	80,610	67,242	35,576
Refund liability	35,334	145,795	—
Other accrued expenses	13,227	73,210	(55,501)
Other liabilities	(60,074)	(36,210)	89,056
NET CASH PROVIDED BY OPERATING ACTIVITIES	$ 404,224	$ 367,341	$ 63,697
Cash flows from investing activities			
Investment in partnerships	$ —	$ (32,891)	$ (2,597)
Non-operating distributions from investment in partnership	5,593	3,521	1,862
Purchase of available-for-sale securities	(21,212)	(90,874)	—
Sale of available-for-sale securities	—	25,874	—
Acquisition of facilities	(143,751)	(283,344)	(127,024)
Purchase of property and equipment	(105,405)	(66,465)	(45,782)
Proceeds from the sale of assets	750	1,500	750
NET CASH USED IN INVESTING ACTIVITIES	$ (264,025)	$ (442,679)	$ (172,791)

PACS GROUP, INC. AND SUBSIDIARIES
COMBINED/CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year Ended December 31,		
	2025	**2024**	**2023**
Cash flows from financing activities			
Borrowing on lines of credit, net of deferred financing fees	$ —	$ 676,000	$ 855,704
Payments on lines of credit	(42,000)	(1,054,000)	(497,986)
Borrowings of long-term debt, net of deferred financing fees	—	72,305	411,313
Payments on long-term debt	(18,218)	(19,455)	(559,632)
Noncontrolling interest distribution	(377)	—	—
Contributions from noncontrolling interest	—	502	587
Dividends on common stock	—	(33,721)	(80,394)
Proceeds from initial public offering, net of issuance costs	—	414,157	—
Proceeds from common stock offering, net of issuance costs	—	95,285	—
Taxes paid related to net share settlement of equity awards	(8,395)	(33,597)	—
NET CASH (USED IN)/PROVIDED BY FINANCING ACTIVITIES	$ (68,990)	$ 117,476	$ 129,592
Net change in cash	71,209	42,138	20,498
Cash, cash equivalents, and restricted cash - beginning of period	160,842	118,704	98,206
Cash, cash equivalents, and restricted cash - end of period	$ 232,051	$ 160,842	$ 118,704
Cash and cash equivalents	$ 197,016	$ 157,674	$ 73,416
Restricted cash (included in prepaid expenses and other current assets)	35,035	3,168	4,977
Restricted cash (included in other assets)	—	—	40,311
Cash, cash equivalents, and restricted cash	$ 232,051	$ 160,842	$ 118,704
Supplemental disclosures of cash flow information			
Cash paid during the period for:			
Interest	$ 40,509	$ 48,248	$ 50,558
Income taxes	$ 84,047	$ 107,831	$ 60,009
Non-cash financing and investing activity			
Accrued capital expenditures	$ 6,031	$ 3,716	$ 3,000
Assets acquired in operation expansions in exchange for notes payable	$ —	$ —	$ 2,150
Assets acquired in operation expansions through settlement of notes receivable	$ —	$ 500	$ —
Contributions from noncontrolling interest through relief of notes payable	$ —	$ 451	$ —

See accompanying notes to combined/consolidated financial statements.

NOTE 1. ORGANIZATION AND NATURE OF BUSINESS

PACS Group, Inc. (PACS Group or the Company), a Delaware corporation, was incorporated on March 24, 2023. PACS Group is a holding company which consolidates various operating and other subsidiaries. PACS Group's applicable operating subsidiaries operate various skilled nursing facilities (SNF) and assisted living facilities (ALF). PACS Group also owns other subsidiaries that are engaged in the acquisition, ownership, and leasing of health care-related properties. As of December 31, 2025 PACS Group subsidiaries operated 321 health care facilities in the states of Alaska, Arizona, California, Colorado, Idaho, Kansas, Kentucky, Missouri, Montana, Nevada, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, and Washington. PACS Group subsidiaries operated 32,854 skilled nursing beds and 2,525 assisted living beds as of that date. As of December 31, 2025, PACS Group subsidiaries operated 268 facilities under long-term lease arrangements and had options to purchase 37 of those facilities.

PACS Group owns subsidiaries that own real estate and related improvements that are leased to applicable affiliated SNF operating entities. PACS Group's real estate portfolio includes 53 properties which are operated and managed by applicable PACS Group subsidiaries. PACS Group subsidiaries also have equity method investments in partnerships that own the underlying real estate and related improvements of 49 post-acute care facilities that are operated by other PACS Group subsidiaries.

Providence Administrative Consulting Services, Inc. (PACS), a California corporation, is a subsidiary of PACS Group and provides administrative support services, on a consulting basis, to other subsidiaries of PACS Group.

PACS Group also has a wholly-owned captive insurance subsidiary, Welsch Insurance Ltd. (Welsch). Welsch provides coverage to various consolidated operating subsidiaries related to Professional Liability and General Liability (PLGL) insurance.

Reorganization

Prior to June 30, 2023, Providence Group, Inc. (PGI) owned the operating subsidiaries of PACS Group. On June 30, 2023, PGI and its consolidated subsidiaries reorganized (the Reorganization) to facilitate their entrance into a new credit agreement, dated June 30, 2023 (2023 Credit Agreement), between certain lenders party thereto, Truist Bank, as administrative agent, PACS Group, and PACS Holdings, LLC (PACS Holdings) as borrower thereunder. PACS Group and its wholly owned subsidiary PACS Holdings were created on March 24, 2023, and April 10, 2023, respectively, in anticipation of the Reorganization. The equity interests of certain other direct or indirect wholly-owned subsidiaries of PGI at the time of the Reorganization were also contributed to other new direct or indirect wholly-owned subsidiaries of PACS Group to facilitate the new credit agreement. PACS Group and its consolidated subsidiaries subsequent to the Reorganization are collectively referred to herein as the Company. The credit agreement, as amended and restated over time, is described in Note 10, "Credit Facilities".

The Reorganization was effected by the two then-existing stockholders of PGI (which at the time was the direct or indirect parent company of all consolidated entities comprising the Company), contributing their respective shares in PGI to newly-formed PACS Holdings, in exchange for a proportionate interest of shares in newly-formed PACS Group (via issuance of shares of PACS Group), and thus became the sole stockholders of PACS Group.

As a result of the Reorganization, (i) for most practical purposes PACS Group in effect became the successor to the historical consolidated business of PGI, and (ii) both of the two stockholders of PGI immediately prior to the Reorganization became the sole stockholders of PACS Group, and maintained their respective pro rata ownership percentage in PACS Group that they held in PGI immediately prior to the Reorganization (which was and remained 50/50).

The Reorganization was accounted for as an equity reorganization between entities under common control. The Reorganization combined entities that historically have not been presented together resulting in financial statements that are effectively considered to be those of a different reporting entity. Accordingly, the historical financial statements for periods prior to the Reorganization are presented as combined financial statements and the financial statements after the Reorganization are presented as consolidated financial statements. The contribution of shares of PGI and receipt of shares of PACS Group are accounted for on a retrospective basis. Accordingly, all share and per share amounts in these

combined/consolidated financial statements and related notes have been retrospectively restated, where applicable, for all periods herein, to give effect to the current shares outstanding of PACS Group.

NOTE 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The accompanying combined/consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States (U.S. GAAP). The combined/consolidated financial statements include the accounts of PACS Group, and its consolidated subsidiaries, or the Company as defined above. All intercompany transactions and balances have been eliminated in combination and consolidation. The Company presents noncontrolling interests within the equity section of its combined/consolidated balance sheets and the amount of combined/consolidated income that is attributable to the Company and the noncontrolling interest in its combined/consolidated statements of income.

Use of Estimates

The preparation of the combined/consolidated financial statements in accordance with U.S. 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 combined/consolidated financial statements and the reported amounts of revenue and expenses during the reporting period. Estimates in the Company's combined/consolidated financial statements include those related to revenue, acquired property, business combinations, right-of-use assets, lease liabilities, impairment of long-lived assets, and general and professional liabilities included in accrued self-insurance liabilities. Actual results could materially differ from estimated amounts.

Restricted Cash, Cash and Cash Equivalents

Cash and cash equivalents consist of cash and short-term investments with original maturities of three months or less at the time of purchase and therefore approximate fair value. The Company considers highly liquid debt instruments purchased with a maturity of three months or less to be cash equivalents. The Company maintains its cash and short-term investment balances in several high-credit quality financial institutions.

Included in restricted cash are funds held for PLGL. Funds held in restricted cash are contractually obligated to be segregated from the Company's other cash accounts and are legally restricted for the use of funding PLGL claims. See Note 8, "Fair Value Measurement", for information on the use of restricted cash in other assets to purchase investments in the period.

At any point in time the Company has funds in operating accounts and restricted cash accounts that are with third-party financial institutions. While management monitors the cash balances in operating accounts, these cash and restricted cash balances could be impacted if the underlying financial institutions fail or could be subject to other adverse conditions in the financial markets.

Cash in Excess of FDIC Limits

The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250,000. The Company has not experienced any losses in such accounts.

Insurance Subsidiary Deposits and Investments

The Company's captive insurance subsidiary cash and cash equivalents, deposits and investments are designated to support long-term insurance subsidiary liabilities and have been classified as current and non-current assets based on the timing of expected future payments of the Company's captive insurance liabilities.

Patient and Resident Service Revenue

The Company's patient and resident service revenue is derived primarily from the Company's applicable subsidiaries providing healthcare services to their respective patients and residents. Revenue is recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled. These amounts are due from residents, third-party payors (including health insurers and government payors), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits and other reviews by the payor. Generally, the licensed healthcare provider entity providing the applicable services bills the applicable payors monthly.

The healthcare services in skilled patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Revenue is recognized as the performance obligations are satisfied. Routine services are treated as a single performance obligation satisfied over time as services are rendered. These routine services represent a bundle of services that are not capable of being distinct. Performance obligations are determined based on the nature of the services provided by the applicable licensed healthcare provider entity.

Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Company believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to residents receiving services in the facility. The Company measures the performance obligation from admission into the facility, or the commencement of the service, to the point when the applicable licensed healthcare provider entity is no longer required to provide services to that resident, which is generally at the time that the resident discharges from the applicable facility or passes away. Additionally, there may be ancillary services which are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time when those services are rendered.

Revenue recognized from healthcare services is adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rates, adjusted for estimates of variable consideration. Variable consideration includes estimates of implicit price concessions so that the estimated transaction price is reflective of the amount to which the Company expects to be entitled in exchange for providing the healthcare services to customers. Variable consideration is estimated using the expected value method based on the Company's historical reimbursement experience. The amount of variable consideration constrains the transaction price, such that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company's estimates, it adjusts these estimates, which would affect net service revenue in the period such variances become known.

The Company maintains a refund liability for consideration collected related to revenue that is not probable that a significant revenue reversal will not occur. The Company expects to refund some or all of that consideration back to the payor.

Agreements with third-party payors typically provide for payments at amounts less than established charges. A summary of the payment arrangements with major third-party payors is as follows:

Medicare: Payments for skilled nursing facility services rendered to Medicare program beneficiaries are based on prospectively determined daily rates which vary according to a patient diagnostic classification system.

Medicaid: Payments for skilled nursing facility services rendered to Medicaid program beneficiaries are based on an established daily reimbursement rate for eligible stays. The rate is adjusted periodically. The final settlement is determined after submission of an annual cost report and audits thereof by Medicaid.

Managed Care, Private and Other: Payments for services rendered to private payors and other primary payors included in the table below are based on established rates or on agreements with certain commercial insurance companies, health maintenance organizations, and preferred provider organizations, which provide for various discounts from the established rates.

The Company's contracts are short term in nature with a duration of one year or less. The Company has minimal unsatisfied performance obligations at the end of the reporting period as patients are typically under no obligation to remain admitted in the Company's facilities or under the Company's care. As the period between the time of service and time of payment is typically one year or less, the Company does not adjust for the effects of a significant financing component.

Included in the Company's combined/consolidated balance sheets are contract balances, comprised of billed accounts receivable and unbilled receivables, which are the result of differences between the timing of revenue recognition and billings and cash collections, as well as contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company has no material contract liabilities and contract assets as of December 31, 2025 and 2024.

Laws and regulations concerning government programs, including Medicare and Medicaid, are complex and subject to varying interpretation. As a result of audits and other reviews by governmental agencies or payor sources, health care providers from time to time receive requests for information and notices regarding billing audits and potential noncompliance with applicable laws and regulations, which, in some instances, can ultimately result in substantial monetary recoupments or other remedies being imposed on the healthcare provider. Compliance with such laws and regulations may also be subject to future government review and interpretation, as well as significant regulatory action, including fines, penalties, and potential exclusion from the related programs. The Company believes that it is in compliance with all applicable laws and regulations.

The contracts the Company has with commercial payors also provide for retrospective audit and review of claims.

Settlements with third-party payors for retroactive adjustments due to audits or other reviews are considered variable consideration and are included in the determination of the estimated transaction price for providing resident services. 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, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as information becomes available. Historically, differences between estimated settlements and actual settlements have been immaterial.

Accounts Receivable and Allowance for Credit Losses

Accounts receivable consist primarily of amounts due from Medicare and Medicaid, managed care health plans and private payor sources, net of estimates for variable consideration. At December 31, 2025 and 2024, the allowance for credit losses was immaterial to the combined/consolidated financial statements.

Government Grants

In the absence of specific guidance to account for government grants under U.S. GAAP, the Company accounts for government grants in accordance with International Accounting Standard (IAS) 20, Accounting for Government Grants and Disclosure of Government Assistance, and as such, the Company recognizes grant income on a systematic basis in line with the recognition of specific expenses and lost revenues for which the grants are intended to compensate. Additional funding presented on the combined/consolidated statements of income is associated with government grants received through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). See Note 4, "Revenue and Accounts Receivable", for more details.

Property and Equipment, Net

Property and equipment are stated at historical cost less accumulated depreciation and amortization. Repair and maintenance charges which do not increase the useful lives of the assets are charged to expense as incurred. Depreciation is

computed using the straight-line method over the estimated useful life of the property and equipment. The following is a summary of the estimated useful lives of the Company's depreciable assets:

- Buildings and improvements - minimum of 5 years to a maximum of 40 years, but generally 30 years
- Leasehold improvements - shorter of the lease term or the estimated useful life, generally 5 years to 15 years
- Furniture and equipment - minimum of 3 years to a maximum of 15 years

Upon sale or retirement, the cost and the related accumulated depreciation and amortization are eliminated from the respective accounts and the resulting gain or loss is included in other income (expense), net.

Leases

The Company leases skilled nursing facilities, assisted living facilities, and commercial office space. The Company determines if an arrangement is a lease upon execution of each respective agreement.

Real estate leases are generally classified as operating leases and therefore the Company records rent expense on a straight-line basis over the term of the lease. The lease term is calculated from the date the Company is given control of the leased premises through the end of the lease term. Renewals are not assumed in the determination of the lease term unless they are deemed to be reasonably certain at the commencement of the lease. The Company has made an accounting policy election to keep leases with an initial term of 12 months or less off of the balance sheets and recognize those lease payments in the combined/consolidated statements of income on a straight-line basis over the lease term. The Company has also elected the practical expedient to not separate lease and non-lease components for all of its leases.

In determining the discount rate used to measure the right-of-use asset and lease liability, the Company uses rates implicit in the lease, or if not readily available, the Company will use its incremental borrowing rate. The Company's incremental borrowing rate is based on an estimated secured rate comprised of a risk-free rate plus a credit spread as secured by its assets. Determining a credit spread as secured by the Company's assets may require significant judgment.

The Company's real estate leases generally have initial lease terms of ten years or more and typically include one or more options to renew, with renewal terms that generally extend the lease term for an additional five to twenty years. Exercise of renewal options is generally subject to the satisfaction of certain conditions which vary by contract and generally follow payment terms that are consistent with those in place during the initial term, including contractual rent escalators.

Business Combinations

The Company accounts for acquisitions using the acquisition method of accounting in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 805, *Business Combinations* (ASC 805). Acquisitions are included in the combined/consolidated financial statements from their respective acquisition dates. Assets acquired and liabilities assumed, if any, are measured at fair value on the acquisition date. In determining the fair value of identifiable assets, the Company uses various valuation techniques. These valuation methods require management to make estimates and assumptions surrounding projected revenues and costs, future growth, and discount rates.

ASC 805 defines the definition of a business to assist entities with evaluating when a set of transferred assets and activities is deemed to be a business. Determining whether a transferred set constitutes a business is important because the accounting for a business combination differs from that of an asset acquisition. The definition of a business also affects the accounting for dispositions. When substantially all of the fair value of assets acquired is concentrated in a single asset, or a group of similar assets, the assets acquired would not represent a business and business combination accounting would not be required.

Goodwill and Other Indefinite-Lived Intangible Assets

Goodwill represents the excess of the purchase price of acquired businesses over the estimated fair value assigned to the individual assets acquired and liabilities assumed. The Company assesses goodwill for impairment at least annually on

October 1st. The Company will perform an impairment assessment at other times if facts and circumstances indicate that it is more likely than not that the fair value of a reporting unit that has goodwill is less than its carrying value.

When assessing goodwill for impairment the Company may elect to first perform a qualitative assessment to determine if the quantitative impairment test is necessary. If the Company does not perform a qualitative assessment, or if the qualitative assessment indicates it is more likely than not that the fair value of a reporting unit is less than its carrying amount, the Company performs a quantitative test. The Company recognizes an impairment charge for the amount by which the carrying amount exceeds the reporting unit's fair value; however, the loss recognized would not exceed the total amount of goodwill allocated to the reporting unit.

The Company's indefinite-lived intangible assets primarily consist of costs to obtain licenses. The Company reviews indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable.

The Company may elect to first perform a qualitative assessment to determine whether it is more likely than not that the fair value of an indefinite-lived intangible asset is less than its carrying value. If the Company does not perform the qualitative assessment, or if the qualitative assessment indicates it is more likely than not that the fair value of the indefinite-lived intangible asset is less than its carrying amount, the Company calculates the estimated fair value of the indefinite-lived intangible asset. If the estimated fair value of the indefinite-lived intangible asset is lower than its carrying amount, an impairment loss is recognized for the difference.

Fair Value Measurements

The Company's financial instruments consist principally of cash and cash equivalents, accounts receivable, insurance subsidiary deposits and investments, accounts payable and borrowings.

Fair value measurements are based on a three-tier hierarchy that prioritizes the inputs used to measure fair value. The three-tiers include: Level 1: observable inputs such as quoted market prices in active markets; Level 2: inputs other than quoted market prices included in Level 1 that are directly or indirectly observable for the asset or liability and Level 3: unobservable inputs for which little or no market data exists, thereby requiring management to develop their own estimates and assumptions.

Impairment of Long-Lived Assets

The Company's non-financial assets, which include goodwill, intangible assets, property and equipment and right-of-use assets, are not required to be measured at fair value on a recurring basis. In accordance with FASB ASC Topic 360, *Property, Plant, and Equipment* (ASC 360), long-lived assets are reviewed for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiaries to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the expected future cash flow from the use of the asset and its eventual disposition is less than the carrying amount of the asset, an impairment loss is recognized and measured using the fair value of the related assets. The Company did not identify any indicators of impairment of its long-lived assets during the years ended December 31, 2025, 2024, and 2023.

Accrued Risk Reserves

The Company is principally self-insured for risks related to PLGL claims. Additionally, the Company is partially self-insured for risks related to workers' compensation (WC) policies. Accrued risk reserves primarily represent the accrual for risks associated with WC and PLGL claims. The accrued risk reserves include a liability for unpaid reported claims and estimates for incurred but unreported claims. The Company's policy with respect to its PLGL claims, is to use an external actuary to assist management in estimating the Company's exposure for claims obligation (for both asserted and unasserted claims). The Company's retrospective-rated premium WC policy is subject to an annual assessment of the policy premium in relation to the payroll and losses incurred for the policy period. The Company recognizes the WC retrospective policy adjustment as the amount of settlement is determined.

Investments in Partnerships

Investments in various partnerships, in which the Company exercises significant influence over operating and financial policies, are accounted for using the equity method of accounting. Under this method, the investment is carried at cost and is adjusted to recognize the investor's share of earnings or losses of the investee, after the date of acquisition, including amortization of certain basis differences, in the other (expense) income, net line in the Company's combined/consolidated statements of income. Any difference between the carrying amount of the equity method investment on the Company's combined/consolidated balance sheet and the underlying equity in net assets on the investee's balance sheet results in a basis difference which is adjusted as the related underlying assets are depreciated, amortized, or sold and the liabilities are settled. The investment is adjusted for impairment whenever it is determined that a decline in the fair value below the cost basis is other than temporary. The fair value of the investment then becomes the new cost basis of the investment, and it is not adjusted for subsequent recoveries in fair value. The Company's maximum exposure to loss on these equity method investments is the total invested capital. These investments are included in other assets in the Company's combined/ consolidated balance sheets. The Company evaluates its investments, including cost in excess of book value (equity method goodwill) for impairment whenever indicators of impairment exist. No indicators of impairment existed as of December 31, 2025 and 2024.

U.S. GAAP requires the Company to identify entities for which control is achieved through voting rights or other means and to determine which business enterprise is the primary beneficiary of variable interest entities (VIE). If the Company is determined to be the primary beneficiary of the VIE, the Company consolidates the VIE. The Company may change its original assessment of a VIE due to events such as modifications of contractual arrangements that affect the characteristics or adequacy of the entity's equity investments at risk and the disposal of all or a portion of an interest held by the primary beneficiary.

The Company identifies the primary beneficiary of a VIE as the enterprise that has both: (i) the power to direct the activities of the VIE that most significantly impact the entity's economic performance; and (ii) the obligation to absorb losses or the right to receive benefits of the VIE that could be significant to the entity. The Company performs this analysis on an ongoing basis.

As it relates to investments in partnerships, the Company assesses any partners' rights and their impact on the presumption of control of the partnership by any single partner. The Company reassesses its determination of which investing entity controls the investee if: there is a change to the terms or in the exercisability of the rights of any partners or members, the managing member increases or decreases its ownership interests, or there is an increase or decrease in the number of outstanding ownership interests. As of December 31, 2025, the Company's determination of which entity controls its investments in partnerships has not changed as a result of any reassessment.

Noncontrolling Interest

The Company is the majority-owner in a subsidiary which was formed to develop land, a building, and other assets to be leased to an entity operated by the Company upon completion which occurred during the year ended December 31, 2024. The noncontrolling interest in a subsidiary is initially recognized at estimated fair value on the contribution date and is presented within total equity in the Company's combined/consolidated balance sheets since these interests are not redeemable. The Company presents net (loss) income attributable to noncontrolling interest and net income attributable to PACS Group, Inc. in its combined/consolidated statements of income. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

Advertising

Advertising costs are expensed as incurred. For the years ended December 31, 2025, 2024, and 2023, advertising expenses included in the Company's combined/consolidated statements of income were $11,231, $7,633, and $7,127, respectively.

Income Taxes

The Company utilizes FASB ASC Topic 740, *Income Taxes* (ASC 740), which requires an asset and liability approach for financial accounting and reporting for income taxes. Under this guidance, deferred tax assets and liabilities are determined based upon differences between financial reporting and tax basis of assets and liabilities and are measured using the enacted tax laws that will be in effect when the differences are expected to reverse. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. See Note 12, "Income Taxes", for further discussion of the Company's accounting for income taxes.

Under ASC 740, tax positions are evaluated for recognition using a more–likely–than–not threshold, and those tax positions requiring recognition are measured at the largest amount of tax benefit that is greater than 50 percent likely of being realized upon ultimate settlement with a taxing authority that has full knowledge of all relevant information. Liabilities for income tax matters include amounts for income taxes, applicable penalties, and interest thereon and are the result of the potential alternative interpretations of tax laws and the judgmental nature of the timing of recognition of taxable income.

The Company recognizes deferred tax assets (DTAs) to the extent that it believes that the assets are more likely than not to be realized. In making such a determination, the Company considers all available positive and negative evidence, including future reversals of existing taxable temporary differences, projected future taxable income, tax-planning strategies, carryback potential if permitted under the tax law, and results of recent operations. The Company generally expects to fully utilize its DTAs; however, when necessary, the Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized.

Concentration of Credit Risks

The Company's credit risks primarily relate to cash and cash equivalents, restricted cash, and accounts receivable. Cash and cash equivalents are primarily held in bank accounts and overnight investments. Restricted cash is primarily invested in commercial paper and certificates of deposit with financial institutions and other interest-bearing accounts. Accounts receivable consist primarily of amounts due from patients (funded through Medicare, Medicaid, other contractual programs and through private payors) and from other health care companies for management, accounting and other services. The collectability of account receivable balances is dependent on the availability of funds from certain programs that rely on governmental funding, primarily Medicare and Medicaid. The Company's receivables from Medicare and Medicaid programs accounted for 23% and 30% of total accounts receivable, respectively, at December 31, 2025 and 18% and 39% of total accounts receivable, respectively, at December 31, 2024. 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's operating subsidiaries, excluding the subsidiaries that exclusively operate assisted living and independent living facilities, have all of their skilled nursing beds designated for care of patients under federal Medicare and/or state Medicaid programs. Approximately 48% of skilled nursing beds are located in California.

Stock-based Compensation

The Company measures and recognizes compensation expense for all stock-based payment awards made to employees and directors based on estimated fair values, ratably over the requisite service period of the award. Stock-based compensation expense within net income reflects the recognition of the fair value of all restricted stock unit awards issued, the amount of which is based upon the number of grants and other variables. The Company accounts for award forfeitures as they occur.

Comprehensive Income

Comprehensive income consists of gains and losses affecting stockholders' equity that, under U.S. GAAP, are excluded from net income. There were no components of comprehensive income for the years ended December 31, 2025 and 2023. For the year ended December 31, 2024, comprehensive income includes unrealized gains and losses on the Company's available-for-sale debt securities, offsetting to $0 in the period. The Company does not have any components

of other comprehensive income recorded within its combined/consolidated financial statements to present and, therefore, does not separately present a statement of comprehensive income in its combined/consolidated financial statements.

Commitments and Contingencies

The Company has been, is currently, and expects in the future to be involved in claims, lawsuits, and regulatory and other government audits, investigations and proceedings arising in the ordinary course of business, some of which may involve material amounts. The defense and resolution of these claims, lawsuits, and regulatory and other government audits, investigations and proceedings may require the Company to incur significant expense. Loss contingency provisions are recorded for probable and estimable losses at the Company's best estimate of a loss or, when a best estimate cannot be made, at the Company's estimate of the minimum loss, which could be zero. These estimates are often developed prior to knowing the amount of the ultimate loss, require the application of considerable judgment, and are refined as necessary when additional information becomes known and expectations change.

Recent Accounting Standards Adopted by the Company

In December 2023, the FASB issued ASU 2023-09, *Income Taxes (Topic 740): Improvements to Income Tax Disclosures*. The standard requires the Company to disclose disaggregated jurisdictional and categorical information for the tax rate reconciliation, income taxes paid and other income tax related amounts. This guidance was effective for annual periods beginning after December 15, 2024. The Company adopted the standard on a retrospective basis in Note 12, "Income Taxes", of this annual report on Form 10-K.

Recent Accounting Standards Issued But Not Yet Adopted by the Company

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. This guidance is effective for annual periods beginning after December 15, 2026, which will be the Company's fiscal year 2027, and interim reporting periods beginning after December 15, 2027, which will be the Company's fiscal year 2028. Early adoption is permitted. The Company is currently evaluating the impact this guidance will have on the disclosures included in the notes to the combined/consolidated financial statements.

In December 2025, the FASB issued ASU 2025-11, *Interim Reporting (Topic 270): Narrow-Scope Improvements*, which clarifies interim disclosure requirements and the applicability of Topic 270. The guidance will be effective for interim periods beginning January 1, 2028. Early adoption is permitted. Upon adoption, the guidance can be applied prospectively or retrospectively. The Company is currently evaluating the impact this guidance will have and does not expect the adoption of this guidance to have a material impact on the interim condensed consolidated financial statements.

NOTE 3. BUSINESS SEGMENTS

The Company has one reportable segment. The Company's chief operating decision maker (CODM), the Chief Operating Officer, reviews the consolidated results of operations when making decisions about allocating resources and assessing the performance of the Company as a whole. The Company does not distinguish between markets or regions for the purpose of allocating resources. This structure reflects its current operational and financial management and provides the best structure to maximize the quality of care and investment strategy provided, while maintaining financial discipline. The segment's measure of profit or loss is net income which is also reported on the combined/consolidated statements of income. Net income is also used to monitor budget versus actual results.

As the Company's single reportable segment is at the consolidated level, the accounting policies of the reportable segment are the same as those disclosed in Note 2, "Summary of Significant Accounting Policies". The Company's CODM does not review segment assets at a different asset level or category than that disclosed in its combined/consolidated balance sheets and therefore assets by segment are not disclosed below.

The following table sets forth financial information for the segment:

	Year ended December 31,		
	2025	2024	2023
Revenue	$ 5,288,932	$ 4,089,734	$ 3,111,492
Less:			
Labor expense[1]	2,772,006	2,207,875	1,664,163
Depreciation and amortization	55,663	40,809	25,632
Interest expense, net	28,363	44,341	49,919
Equity in the net loss of investees accounted for under the equity method	773	4,565	391
Provision for income taxes	92,989	46,210	44,435
Other segment items[2]	2,147,677	1,690,590	1,214,070
Segment net income	$ 191,461	$ 55,344	$ 112,882

(1) Labor expense includes nursing and departmental salaries and wages, payroll taxes and benefits, and agency staffing expenses.
(2) Other segment items included in segment net income include cost of services except for labor cost of services, rent - cost of services, general and administrative expense except for labor general and administrative expense, gain on lease termination, and other (expense) income except for interest expense, net, and equity in the net income of investees accounted for under the equity method.

NOTE 4. REVENUE AND ACCOUNTS RECEIVABLE

Patient and resident service revenue is derived from services rendered, under short-term contracts, to patients for skilled nursing, rehabilitation therapy, and assisted living services. Patient and resident service revenue is reported at the amount that reflects the consideration to which the Company expects to be entitled in exchange for providing patient services. These amounts are due from patients, governmental programs, and other third-party payors, and include variable consideration for retroactive revenue adjustments due to settlement of audits, reviews, and investigations.

Disaggregation of Revenue

The Company disaggregates revenue from contracts with its patients by payors. The Company determines 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. The composition of patient and resident service revenue by primary payors for the years ended December 31, 2025, 2024, and 2023 are as follows:

	2025	% of Revenue	2024	% of Revenue	2023	% of Revenue
Medicare	$ 1,783,686	33.7 %	$ 1,381,236	33.8 %	$ 1,200,801	38.6 %
Medicaid	2,139,613	40.5 %	1,651,401	40.4 %	1,168,455	37.6 %
Managed care	989,072	18.7 %	813,865	19.9 %	586,850	18.9 %
Private and other	375,514	7.1 %	240,153	5.9 %	154,008	4.9 %
Total patient and resident service revenue	$ 5,287,885	100.0 %	$ 4,086,655	100.0 %	$ 3,110,114	100.0 %

Refund Liability

The balance of the refund liability was $181,129 and $145,795 as of December 31, 2025 and 2024, respectively, and is presented within current liabilities on the Company's combined/consolidated balance sheets.

Additional Funding and CARES Act

Through the CARES Act of 2020, the Company received $14,962 in funding from the U.S. Department of Health and Human Services (HHS) through the Provider Relief Fund (PRF) during the year ended December 31, 2022. These funds were provided to healthcare providers who diagnosed, tested, or cared for individuals with cases of COVID-19 and had

health-care-related expenses and lost revenues attributable to COVID-19. The Company recorded these funds as deferred revenue upon receipt and revenue was recognized only to the extent that health-care-related expenses or lost revenues had been incurred and were not reimbursed from other funding sources. The Company recognized an immaterial amount of revenue within additional funding on its combined/consolidated statements of income for the ended December 31, 2023 for funds received prior to 2023. The Company did not receive any funds related to this program during the years ended December 31, 2025, 2024 or 2023.

The CARES Act also provided for refundable payroll tax credits known as the Employee Retention Tax Credit (ERTC), which allowed qualified employers to receive a credit of 70% of the employee qualified wages and related payroll costs paid after December 31, 2020 through September 30, 2021, up to a maximum credit of $7 per employee, per quarter, for a maximum of $21 per employee in 2021. Due to uncertainty related to meeting the necessary qualifications, the Company recorded a reserve against the entire amount claimed. In the years ended December 31, 2025 and 2024, the Company recognized $14,946 and $14,599, respectively, of the ERTC as an offset to labor in cost of services, as the statute of limitations surrounding the uncertainty of the qualifications, for certain of the funds received, expired. As of December 31, 2025 and 2024, the Company has recorded $9,674 and $21,917, respectively, in other liabilities to reflect the cash already received related to these credits which may need to be returned and potential penalties.

NOTE 5. ESCROW FUNDS

Certain subsidiaries of the Company have obtained Department of Housing and Urban Development (HUD)-insured mortgages on properties that they lease to affiliated operating subsidiaries of the Company, while various other subsidiaries of the Company lease properties from unrelated third-party landlords that have obtained HUD-insured mortgages on the applicable properties. Under the terms of the HUD-insured mortgages, borrowers and/or their tenants are required to make certain deposits into escrow funds to be used for payment of property insurance, mortgage insurance premiums, and taxes.

Additionally, some HUD-insured mortgages require a reserve for replacement account and a non-critical repair reserve. Under the terms of the HUD-insured mortgages and the related regulatory agreements required by HUD, the tenants are required to make regular monthly deposits into a reserve for replacement account to assure the availability of funds to replace building components, furniture and equipment over time. All disbursements from this account require prior written approval by HUD and the mortgage lender. The non-critical repair reserve is used to cover estimated repairs on the properties typically within 12 months of closing on the HUD loans.

During 2021, the Company obtained a construction loan from an unaffiliated third-party lender. During the year ended December 31, 2024, the Company converted this construction loan to a HUD-insured mortgage. As of December 31, 2025 and 2024, this subsidiary had escrows related to debt service reserves, working capital escrows, and various other construction related escrows, in accordance with the terms of the loan agreement.

These reserve and escrow accounts are maintained under the control of the mortgage lender for the benefit of the applicable tenant and are generally held in an interest-bearing account with a federally insured financial institution.

NOTE 6. PROPERTY AND EQUIPMENT, NET

Property and equipment consists of the following:

	December 31,	
	2025	2024
Buildings and improvements	$ 823,490	$ 654,975
Leasehold improvements	125,832	79,440
Furniture, fixtures, and other	131,812	107,896
Construction in process	24,565	23,952
Land	94,024	84,774
Finance lease right-of-use assets	155,539	145,262
	$ 1,355,262	$ 1,096,299
Less: accumulated depreciation and amortization	154,166	105,719
Property and equipment, net	$ 1,201,096	$ 990,580

The Company evaluated its long-lived assets and did not record any impairment charges for the years ended December 31, 2025, 2024, and 2023.

During the year ended December 31, 2025, the Company acquired a building used as its primary office space in Salt Lake City, Utah for a purchase price of $31,344. See Note 16, “Operation Expansions”, for additional information on expansions during the years ended December 31, 2025, 2024, and 2023 impacting property and equipment, net.

NOTE 7. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

Goodwill consisted of the following:

	Goodwill
Balance as of January 1, 2024	$ 59,021
Acquisitions	1,770
Balance as of December 31, 2024	$ 60,791
Acquisitions	1,000
Balance as of December 31, 2025	$ 61,791

There are no prior period accumulated goodwill impairment losses nor any goodwill impairment losses for the years ended December 31, 2025, 2024, and 2023.

As of the years ended December 31, 2025 and 2024, the Company's indefinite-lived intangible assets consisted of the following:

	December 31,	
	2025	2024
Licenses	$ 6,270	$ 6,270
Total other indefinite-lived intangible assets	$ 6,270	$ 6,270

There are no prior period accumulated indefinite-lived intangible asset impairment losses nor any indefinite-lived intangible asset impairment losses for the years ended December 31, 2025, 2024, and 2023.

NOTE 8. FAIR VALUE MEASUREMENT

The Company's financial assets include insurance subsidiary deposits and highly liquid investments which are held by the consolidated captive insurance entity and are designated to support long-term insurance subsidiary liabilities and are recorded at fair value of $87,192 and $66,258 as of December 31, 2025 and 2024, respectively. The insurance subsidiary deposits and investments include net unrealized gains of $5,280 and $384 as of December 31, 2025 and 2024, respectively. Gains and losses on investments are recorded within other income (expense), net. Insurance subsidiary deposits and investments consist of holdings in investment grade bond mutual funds and are derived using Level 2 inputs. These assets are recorded in insurance subsidiary deposits and investments in our combined/consolidated balance sheets and are classified as available-for-sale equity securities. These mutual funds are primarily valued utilizing calculations which incorporate observable inputs such as yield, maturity and credit quality.

NOTE 9. INVESTMENT IN PARTNERSHIPS

As of December 31, 2025 and 2024, the Company held $30,801 and $37,167, respectively, in multiple equity investments, referred to as partnerships. These entities were formed to develop, own, and lease health care facilities. Some of the partnerships hold options to purchase the related real estate property holdings. Each of the entities is governed by a managing member who makes the significant decisions that impact the economic performance of the entity. The Company is not the managing member of any of the entities in which it is invested.

The Company holds a 50.0% ownership interest in the entity BRFS SNF Ventures V, LLC (BRFS). This investment holds three post-acute care facilities which it leases to the Company. BRFS is a VIE, however the Company does not consolidate the entity as it does not have the power to direct the activities that most significantly impact its economic performance. Therefore, the Company only accounts for its specific interest in the investment. The investment was $14,948 and $15,528 on the Company’s combined/consolidated balance sheets as of December 31, 2025 and 2024, respectively.

The Company holds a 25.8% ownership interest in the entity Next Saddle Investors, LLC (Saddle). Saddle acquired the operations for all 53 facilities included in the 2024 Prestige acquisition and subsequently assigned them to the Company. Saddle also acquired the underlying real estate for 37 of the facilities from the Prestige acquisition, which it leases to the Company. The Company determined the Saddle manager held a de facto agency relationship with the Company under FASB ASC Topic 810, *Consolidation* (ASC 810). Saddle is a VIE; however, because the Company is not the primary beneficiary, it does not consolidate the entity. The investment was $4,986 and $8,536 on the Company’s balance sheets as of December 31, 2025 and 2024, respectively.

All of the Company’s other equity investments are individually immaterial with the largest investment of $7,727 in an entity representing an ownership of 49.0%. Loss from the investment in all partnerships was $773, $4,565, and $391, for the years ended December 31, 2025, 2024, and 2023, respectively.

NOTE 10. CREDIT FACILITIES

The Company maintains a revolving credit facility between the Company and certain of its subsidiaries, and Truist Bank (Truist) as administrative agent (Administrative Agent) and a syndicate of lenders (the Amended and Restated Credit Facility). The Amended and Restated Credit Facility provides for a Revolving Commitment (as defined in the Amended and Restated Credit Facility) of up to $600,000 which revolving commitments may also be utilized for (x) the issuance of letters of credit in an aggregate face amount not to exceed $50,000 and/or (y) the borrowing of swingline loans in aggregate principal amount not to exceed $20,000 at any time outstanding.

Outstanding borrowings under the Amended and Restated Credit Facility bear interest at the option of the Company equal to either (a) SOFR (plus a 0.10% credit spread adjustment) plus a margin ranging from 2.25% to 3.25% per annum; or (b) the Base Rate (which is defined in a customary manner for credit facilities of this type) plus the applicable margin ranging from 1.25% to 2.25% per annum. The applicable margin is based on the Company’s debt to income ratio as calculated consistent with the terms of the credit agreement. In addition, the Company will pay a commitment fee ranging from 0.25% to 0.45% per annum on the unused portion of the Revolving Commitment, depending on the same debt to income ratio.

The credit agreement contains certain financial and non-financial covenants and restrictions. Default by the applicable credit party on any covenant or restriction could affect the lender's commitment to lend, and, if not waived or corrected, could make the outstanding balances due on demand. Under the Amended and Restated Credit Facility, the Company must maintain a debt-to-income ratio of not greater than 3.00:1.00. The Amended and Restated Credit Facility also requires that the Company maintain a minimum interest/rent coverage ratio of not less than 1.10:1.00. Additionally, the Amended and Restated Credit Facility, as amended by the Sixth Amendment and Waiver, contains a Liquidity Requirement, as described in further detail below, which will apply until the Liquidity Requirement Termination Date.

On May 16, 2024, the Company entered into an amendment to the Amended and Restated Credit Facility that, among other things, waived an event of default that had occurred and was then continuing under the Amended and Restated Credit Facility and modified the affirmative covenants thereunder requiring the joinder of certain subsidiaries of the Company to the Amended and Restated Credit Facility, as further set forth therein. On November 14, 2024, the Company entered into another amendment to the Amended and Restated Credit Facility that, among other things, extended the deadline for the delivery of unaudited quarterly financial statements for the fiscal quarter ended September 30, 2024. On March 27, 2025, and May 29, 2025, the Company entered into further amendments to the Amended and Restated Credit Facility that, among other things, extended the deadline for delivery of audited annual financial statements for the fiscal year ended December 31, 2024. The May 29, 2025 amendment supplemented the Amended and Restated Credit Agreement's the financial covenants requiring the Company to maintain unrestricted cash and certain permitted investments of at least $100,000 until the Company delivers audited financial statements for the fiscal year ended December 31, 2024 (the "Liquidity Requirement").

On July 24, 2025 and August 13, 2025 the Company entered into two separate forbearance agreements with the Administrative Agent and the lenders, pursuant to which the lenders agreed to temporarily forbear from exercising remedies under the Amended and Restated Credit Facility with respect to certain technical events of default, including without limitation matters relating to inaccuracies in certain representations and warranties made, which inaccuracies also triggered an event of default under the Third Consolidated Master Lease, dated June 30, 2023 (as amended, restated, amended and restated, supplemented or otherwise modified from time to time, the "Omega Master Lease"), which in turn triggered an additional event of default under the Amended and Restated Credit Facility. In addition, a separate representation and warranty event of default occurred under the Omega Master Lease, which triggered an event of default under the Amended and Restated Credit Agreement (all such technical events of default under the Amended and Restated Credit Facility, the "Initial Technical Events of Default"). The August 13, 2025 Forbearance Agreement and Fifth Amendment to the Credit Agreement required that the Liquidity Requirement remain in place for the entirety of the forbearance period and further extended the delivery period with respect to the fiscal year 2024 financial statements.

On October 21, 2025, the Company entered into a third forbearance agreement (the "October Forbearance Agreement"). Under the October Forbearance Agreement, the lenders again agreed to temporarily forbear from exercising rights and remedies under the Amended and Restated Credit Agreement with respect to the Initial Technical Events of Default, as well as certain additional technical events of default including without limitation matters relating to the designation of certain immaterial conflicted subsidiaries; failure to join certain subsidiaries to the loan documents; noncompliance with cash management requirements; and inaccuracies in certain representations and warranties made as a result of the foregoing (collectively, with the Initial Technical Events of Default, the "Technical Events of Default"). The Technical Events of Default also triggered an event of default under the Omega Master Lease, which in turn triggered an additional event of default under the Amended and Restated Credit Agreement.

On November 26, 2025, the Company entered into another amendment to and waiver (Sixth Amendment and Waiver) under the Amended and Restated Credit Facility that, among other things, waived all Technical Events of Default. The Sixth Amendment and Waiver also amended the Amended and Restated Credit Agreement to, among other things, require that the Liquidity Requirement remain in place until the Company delivers to the Administrative Agent financial statements and a corresponding compliance certificate for the fiscal quarter ended June 30, 2026 (the "Liquidity Requirement Termination Date").

The Company was in compliance with all such covenants and restrictions as of December 31, 2025.

The Company maintains the Amended and Restated Credit Facility as its single line of credit. At December 31, 2025, the total commitment limit continues to be $600,000 and was secured by Company assets. The agreement matures on

December 7, 2028. Due to the covenants and restrictions outlined above, the Amended and Restated Credit Facility was classified as current on the Company's balance sheet as of December 31, 2024. The balance outstanding on the credit facility was $100,000 and $142,000 at December 31, 2025 and 2024, respectively. The Company had $7,850 and $13,923 in letters of credit outstanding as of December 31, 2025 and 2024, respectively.

Net deferred financing fees on lines of credit were $8,867 and $11,886 as of December 31, 2025 and 2024, respectively, and are recorded in other assets on the Company's balance sheets. Expense recognized relating to deferred financing fees on lines of credit is included in interest expense and amounted to $3,019, $3,020, and $889 for the years ended December 31, 2025, 2024, and 2023, respectively.

NOTE 11. LONG-TERM DEBT

During the year ended December 31, 2025 the Company and its subsidiaries did not enter into any HUD-insured mortgage loans, whereas in the year ended December 31, 2024, certain of the Company's subsidiaries entered into HUD-insured mortgage loans in the aggregate amount of $68,345. Additionally, the Company converted a $22,463 construction loan to a HUD-insured mortgage loan as disclosed in Note 5, "Escrow Funds" during the year ended December 31, 2024. As of December 31, 2025, 13 of the Company's subsidiaries had mortgage loans insured with HUD in the aggregate amount of $248,906, of which $4,169 was classified as current and the remaining $244,737 was classified as non-current. As of December 31, 2024, 13 of the Company's subsidiaries had mortgage loans insured with HUD in the aggregate amount of $252,913 of which $4,007 was classified as current and the remaining $248,906 was classified as non-current. These subsidiaries are subject to HUD-mortgage oversight and periodic inspections. As of December 31, 2025, the Company's HUD-insured mortgage loans bear fixed interest rates ranging from 2.4% to 6.3% per annum and have various maturity dates through October 1, 2061. 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. The original terms for all the HUD-insured mortgage loans are 24 to 37 years.

In addition to the HUD-insured mortgage loans above, the Company's subsidiaries had four other mortgage loans or promissory notes. The non-HUD-insured mortgage loans and notes bear interest rates that range from 2.0% to 7.5% per annum with various maturity dates through June 1, 2027. As of December 31, 2025, the Company had $4,305 of debt principal outstanding under the non-HUD-insured mortgage loans and promissory notes, of which $294 is classified as current and the remaining $4,011 is classified as non-current. As of December 31, 2024, the Company had $16,997 of debt principal outstanding under the non-HUD-insured mortgage loans and promissory notes, of which $10,845 is classified as current and the remaining $6,152 is classified as non-current.

The Company was in compliance with all applicable loan covenants with respect to the foregoing as of December 31, 2025 and 2024. The notes and loans above are secured through guarantees by the Company and certain stockholders. Additionally, various loans are secured by facility assets and real property with a carrying value amounting to $254,540, and $263,219 at December 31, 2025 and 2024, respectively.

Long-term debt consists of the following:

	December 31,	
	2025	2024
HUD-insured mortgage loans	$ 248,906	$ 252,913
Other non-HUD mortgage loans and promissory notes	4,305	16,997
Less: current maturities	(4,463)	(14,852)
Less: deferred financing fees, net	(3,945)	(4,074)
Total	$ 244,803	$ 250,984

Long-term debt and line of credit maturities, excluding deferred financing fees, for the next five years and in the aggregate are as follows as of December 31, 2025:

	Long-Term Debt	Credit Facility	Total
2026	$ 4,463	$ —	$ 4,463
2027	8,350	—	8,350
2028	4,516	100,000	104,516
2029	4,702	—	4,702
2030	4,896	—	4,896
Thereafter	226,284	—	226,284
Total	$ 253,211	$ 100,000	$ 353,211

Deferred financing fees on long-term debt are being amortized over the life of the respective loans. Expense recognized related to deferred financing fees on long-term debt is included in interest expense and amounted to $129, $95, and $1,551 for the years ended December 31, 2025, 2024, and 2023, respectively.

NOTE 12. INCOME TAXES

The provision for income taxes for the years ended December 31, 2025, 2024, and 2023 is summarized as follows:

	Year Ended December 31,		
	2025	2024	2023
Current			
Federal	$ 79,031	$ 66,292	$ 38,242
State	31,691	30,729	16,116
Total current provision	$ 110,722	$ 97,021	$ 54,358
Deferred			
Federal	$ (12,461)	$ (34,582)	$ (6,641)
State	(5,272)	(16,229)	(3,282)
Total deferred provision	$ (17,733)	$ (50,811)	$ (9,923)
Total income tax provision	$ 92,989	$ 46,210	$ 44,435

A reconciliation of the income tax expense at the federal statutory rate to income tax expense for the years ended December 31, 2025, 2024 and 2023, respectively, is as follows:

	Year Ended December 31,					
	2025		2024		2023	
	Total	%	Total	%	Total	%
Income tax expense at federal statutory rate	$ 59,735	21.0 %	$ 21,326	21.0 %	$ 33,037	21.0 %
State income taxes – net of federal benefit[1]	20,045	7.0	7,106	7.0	10,283	6.5
Tax credits	(5,000)	(1.8)	(947)	(0.9)	(336)	(0.2)
Change in valuation allowance	272	0.1	(622)	(0.6)	2,107	1.3
Nontaxable or nondeductible items						
Nondeductible compensation	9,413	3.3	16,780	16.5	71	0.0
Other nontaxable or nondeductible items	2,262	0.8	2,053	2.0	1,368	0.9
Other						
Stock-based compensation	5,498	1.9	—	—	—	—
Change to deferred taxes	733	0.3	1,031	1.0	(2,486)	(1.6)
Other adjustments	31	—	(517)	(0.5)	391	0.2
Income tax expense	$ 92,989	32.6 %	$ 46,210	45.5 %	$ 44,435	28.1 %

(1) State taxes in California comprise the majority (greater than 50 percent) of the tax effect of this category for the years ended December 31, 2025, 2024, and 2023, respectively.

Income taxes paid are as follows:

	Year Ended December 31,		
	2025	2024	2023
Federal[1]	$ 50,415	$ 75,741	$ 42,447
California	26,104	25,396	17,387
Other	7,528	6,694	175
Total state and local	$ 33,632	$ 32,090	$ 17,562
Total income taxes paid	$ 84,047	$ 107,831	$ 60,009

(1) Excludes amounts paid to purchase transferable tax credits of $28,372 during the year ended December 31, 2025.

The Company's deferred tax assets and liabilities as of December 31, 2025 and 2024 are summarized as follows:

	December 31,	
	2025	2024
Deferred tax assets (liabilities)		
Accrued expenses	$ 30,474	$ 28,275
Allowance for doubtful accounts	27,298	21,737
Insurance	42,098	36,577
Intangible assets	6,892	4,931
Deferred compensation	3,006	2,097
Lease liability	823,131	826,397
Stock-based compensation	6,404	5,166
Total deferred tax assets	$ 939,303	$ 925,180
Valuation allowance	(1,263)	(991)
Total net deferred tax assets	$ 938,040	$ 924,189
Fixed assets	(65,661)	(53,106)
Prepaid expenses	(11,005)	(10,307)
Investment in partnership	(7,124)	(8,030)
Right of use asset	(789,932)	(805,552)
Other	(354)	(963)
Total deferred tax liabilities	$ (874,076)	$ (877,958)
Net deferred tax assets	$ 63,964	$ 46,231

As of December 31, 2025 and 2024, the Company recorded a valuation allowance of $1,263 and $991, respectively, against its captive insurance dual consolidated loss deferred tax asset. This valuation allowance was established because it was more likely than not that the deferred tax asset will not be realized.

The Company is subject to U.S. federal income tax, as well as income tax in certain states in which it operates. The Company's federal returns for tax years 2022 and forward are subject to examination, and state returns for tax years 2021 and forward are subject to examination. The Company is not, to its knowledge, under examination by any federal or state income tax authority. The Company's balance of net deferred tax assets is included within other assets on the combined/ consolidated balance sheets as of December 31, 2025 and 2024.

As of December 31, 2025 and 2024, the Company did not have any unrecognized tax benefits. The Company recognizes accrued interest and penalties related to unrecognized tax benefits in income tax expense. The Company does not anticipate the uncertain tax position to change materially within the next 12 months.

NOTE 13. LEASES

Operating Leases

The Company leases most of its skilled nursing and assisted living facilities, as well as its office space, under various non-cancelable operating lease agreements. These operating leases expire at various dates through 2050.

Substantially all operating leases for skilled nursing and assisted living facilities are on a "triple-net" basis, which require lessees to pay for all insurance, repairs, utilities, and real property taxes assessed on the leased property, and most of the leases are guaranteed by the Company and/or its stockholders.

For 36 of the facility operating leases, the Company holds an option to purchase the real estate which can be exercised at varying times until March 31, 2038. At lease inception it was determined that the exercise of each of the purchase options was not reasonably certain. Options on three of the Company's leases have become subject to disagreement with

the landlord regarding whether the option exercise window has closed, and the Company is working with the landlord to resolve the disagreement.

All facility leases provide for an additional percentage rent based upon specified rates per the terms of the agreements. This additional percentage rent is variable and is expensed as incurred.

Finance Leases

The Company leases certain skilled nursing and assisted living facilities under finance lease agreements. The lease terms of one of the facility finance leases allow for a purchase option to be exercised during a specified window closing May 22, 2027. The Company has determined that it is reasonably certain to exercise the purchase option at the end of the purchase option window. Therefore, the Company has calculated the lease term through the end of the purchase option window for each such lease.

In addition, for one of the facility finance leases, the lessor holds an option which could require the Company to purchase the associated real estate. The total obligation to purchase such real estate is approximately $32,000 and can be exercised by the lessor through June 30, 2026 (the "Lessor Option"). For other finance leases, the duration of the lease term represented the major part of the remaining economic life of the facility at inception.

Finance lease right-of-use assets are included in property and equipment and have a balance of $150,595 and $139,472 as of December 31, 2025 and 2024, respectively. The current portion of finance lease liabilities is included in other accrued expenses and has a balance of $28,935 and $21,177 as of December 31, 2025 and 2024, respectively. The non-current portion of finance lease liabilities is included in other liabilities and has a balance of $126,960 and $125,470 as of December 31, 2025 and 2024, respectively.

The components of lease expense were as follows:

	Year Ended December 31,		
	2025	2024	2023
Operating lease expense			
Rent - cost of services [1]	$ 378,908	$ 284,953	$ 216,711
General and administrative expense	2,599	2,435	941
Other variable lease costs [2]	38,620	31,480	26,399
Total operating lease expense	$ 420,127	$ 318,868	$ 244,051
Finance lease expense			
Amortization of right-of-use assets	$ 5,184	$ 3,327	$ 1,264
Interest on lease liabilities	11,142	7,370	1,113
Total financing lease expense	$ 16,326	$ 10,697	$ 2,377
Total lease expense	$ 436,453	$ 329,565	$ 246,428

(1) Rent - cost of services includes variable lease costs such as Consumer Price Index (CPI) increases and other rent adjustments of $1,958, $2,383, and $2,745 for the years ended December 31, 2025, 2024, and 2023, respectively.
(2) Other variable lease costs of facilities, including property taxes and insurance, are classified in cost of services in the Company's combined/ consolidated statements of income.

The following table summarizes supplemental cash flow information related to leases:

	Year Ended December 31,		
	2025	2024	2023
Operating cash paid for amounts included in the measurement of operating lease liabilities	$ 333,053	$ 252,742	$ 194,925
Operating cash paid for amounts included in the measurement of finance lease liabilities	11,142	7,370	1,113
Financing cash paid for amounts included in the measurement of finance lease liabilities	1,545	811	1,708
Operating lease right-of-use assets obtained in exchange for lease liabilities	173,355	1,326,598	805,866
Decrease in operating lease right-of-use assets and liabilities due to lease termination/modification	(15,463)	(141,382)	—
Finance lease right-of-use assets obtained in exchange for lease liabilities	118,947	18,298	5,521
Decrease in finance lease right-of-use assets and liabilities due to lease termination/modification	(102,640)	(2,272)	—

Information relating to the lease term and discount rate is as follows:

	Year Ended December 31,		
	2025	2024	2023
Weighted-average remaining lease term (years)			
Operating leases	13	14	13
Finance leases	22	6	3
Weighted-average discount rate			
Operating leases	6.5 %	6.4 %	5.7 %
Finance leases	6.5 %	6.1 %	7.2 %

Maturities of lease liabilities as of December 31, 2025 were as follows:

	Finance Leases	Operating Leases	Total
2026	$ 37,321	$ 343,651	$ 380,972
2027	24,885	345,250	370,135
2028	7,902	349,372	357,274
2029	7,746	352,039	359,785
2030	7,509	355,924	363,433
Thereafter	254,388	2,986,215	3,240,603
Total lease payments	$ 339,751	$ 4,732,451	$ 5,072,202
Less: present value discount	(183,856)	(1,639,531)	(1,823,387)
Present value of lease liabilities	$ 155,895	$ 3,092,920	$ 3,248,815

Maturities of finance leases include amounts the Company would pay in the earliest period in which the lessor can exercise the Lessor Option.

In addition to its lessee activity, the Company generates an immaterial amount of revenue from arrangements where it is a lessor of certain facilities. Revenue from those arrangements is included in other revenue on the combined/consolidated statements of income.

NOTE 14. RETIREMENT PLANS

The Company has two 401(k) defined contribution plans for the benefit of all eligible union and non-union employees. Employees over the age of 18 may begin elective deferrals and become eligible for matching contributions after two months of service. Employer discretionary matching contributions may be up to 50% of the employee's elective deferrals that do not exceed 4% of the employee's compensation. Employees vest in matching contributions over four years in accordance with the vesting schedule set out in the plan documents.

The Company has a non-qualified deferred compensation plan. The deferred compensation plan allows certain employees to receive supplemental retirement income payments through the deferral of base salary and bonus compensation. Eligible employees may elect to defer receipt of no less than $20 of base salary and bonus compensation for any plan year. Additionally, the Company may elect to make a discretionary matching contribution on behalf of the participant. Participants become fully vested in discretionary matching contributions after five years of continued employment from the date of the applicable matching contribution. Payment of vested balances will occur at future dates, as defined by the plan documents. Deferred compensation plan balances are recorded in other long-term liabilities on the combined/consolidated balance sheets and amounted to $11,295 and $7,794 at December 31, 2025 and 2024, respectively.

NOTE 15. RELATED PARTY TRANSACTIONS

On July 1, 2021, the Company entered into a Consulting and Strategic Advisory Services Agreement with Helios Consulting, LLC (Helios), a limited liability company owned by Jason Murray, the Company's Chief Executive Officer and Chairman of its board of directors, and Mark Hancock, Executive Vice Chairman of its board of directors, (Helios Consulting Agreement) which automatically renewed for successive one-year terms. The Helios Consulting Agreement provided for a cash consulting fee of $4,000 annually, paid in monthly installments, for consulting and strategic advisory services provided to the Company by Helios. As of December 31, 2024, the Company terminated the Helios Consulting Agreement. For both of the years ended December 31, 2025 and 2024, the Company paid $0, respectively, and for the year ended December 31, 2023, the Company paid $4,000 (inclusive of $150 paid to a subsidiary of Helios).

On March 24, 2023, the Company entered into subscription agreements with Mr. Murray and Mr. Hancock, pursuant to which Mr. Murray and Mr. Hancock each purchased 10,000 shares of the Company's common stock for a purchase price of $0.001 per share, in a private placement concurrent with the Company's incorporation in the State of Delaware and in anticipation of effecting the reorganization on June 30, 2023.

NOTE 16. OPERATION EXPANSIONS

2025 Expansions and Divestitures

During the year ended December 31, 2025, the Company's consolidated operations and real estate portfolio grew through a combination of long-term leases and real estate purchases. The Company acquired operations of eight skilled nursing, assisted living, and subacute facilities and executed seven real estate purchases. Of the seven real estate purchases, one of the properties was acquired in conjunction with the operations of the associated facility. For the other six real estate purchases, the Company previously operated the respective facilities and has now acquired the real estate associated with those operations. These new operations added 655 and 271 operational skilled nursing and assisted living beds, respectively.

The aggregate purchase price for these expansions during the year ended December 31, 2025 was $143,751. The fair value of assets for the entities where real estate was acquired were concentrated in property and equipment amounting to $142,751. As such, these transactions were classified as asset acquisitions. The remaining aggregate purchase price for transactions during the year ended December 31, 2025 was concentrated in goodwill in the amount of $1,000. Such transactions were classified as business combinations. The Company expects 100% of the goodwill to be deductible for income tax purposes.

During the year ended December 31, 2025, the Company also divested of one leased facility which included 120 skilled nursing beds.

2024 Expansions

On September 1, 2024, for nominal consideration, the Company finalized the acquisition of operations for 32 skilled nursing and 21 assisted living and independent living facilities inclusive of 2,511 and 1,334 skilled nursing and assisted living beds, respectively. This acquisition from the former operator Prestige (Prestige acquisition), expanded the Company's operations in eight states, five of which were new operating states. In connection with the Prestige acquisition, the Company invested $10,000 for a 25.8% interest in a newly formed entity, Saddle. This investment is recorded as an investment in partnership within other assets on the Company's combined/consolidated balance sheets. Saddle acquired the operations for all 53 facilities included in the Prestige acquisition, and subsequently assigned them to the Company. Saddle acquired 37 properties from the sellers of the skilled nursing and assisted living and independent living facilities. The Company then leased these 37 properties from Saddle. The Company also assumed eight leases from the prior operator and negotiated new leases for the remaining eight facilities with unaffiliated third-party landlords. The Company has recorded the associated right-of-use assets and right-of-use liabilities for all 53 leases. This transaction was classified as a business combination in accordance with ASC 805.

The table below represents the purchase price allocation to total identifiable assets acquired and net liabilities assumed using the acquisition method, based on their respective fair values as of September 1, 2024.

	Amount
Prepaid expenses and other current assets	$ 832
Operating lease right-of-use assets	76,351
Other assets	9,600
Current operating lease liabilities	(4,970)
Long-term operating lease liabilities	(58,301)
Deferred tax liability	(6,327)
Bargain purchase gain	(17,185)
Total purchase price	$ —

Prepaid expenses and other current assets acquired consist of on-hand supplies at the facilities. Other assets acquired consist of contracts assumed with local hospitals, wherein the Company agrees to hold a specified number of beds available for potential hospital discharge, for a set date range. The fair value of these hospital contracts was determined using the

income approach. This approach utilized significant assumptions including management's best estimates of the expected future cash flows and renewal rates of the contracts.

Right-of-use assets specified in the table above are related specifically to the eight leases assumed as part of the transaction excluding the new lease agreements for 37 properties leased from Saddle and eight properties leased from unaffiliated third-party landlords. The value of the right-of-use assets was determined under a market approach. The market approach utilized significant assumptions based on estimated market rent assessments for the acquired lease contracts.

The deferred tax liability recognized is due to the Company having no tax basis in the assets acquired and liabilities assumed. The Company did not assume any liabilities other than those associated with the post-assumption obligations under the assumed leases.

Total fair value of the net assets acquired exceeds consideration transferred, resulting in a bargain purchase gain. The Company reassessed whether it correctly identified all of the assets acquired and all of the liabilities assumed prior to recognition of the gain, in accordance with ASC 805. This bargain purchase gain was recorded within other income (expense), net on the Company's combined/consolidated statements of income.

In addition to the Prestige acquisition, during the year ended December 31, 2024, the Company's consolidated operations and real estate portfolio grew through a combination of long-term leases and real estate purchases. The Company acquired operations at 53 stand-alone skilled nursing, assisted living, and subacute facilities and 15 real estate purchases. Of the 15 real estate purchases, eight of the properties were acquired in conjunction with the operations of the associated facility. For the other seven acquired properties, the Company previously operated the respective facilities and has now acquired the real estate associated with those operations. These new operations added 6,414 and 174 operational skilled nursing beds and assisted living beds, respectively.

The aggregate purchase price for these expansions during the year ended December 31, 2024 was $283,844. The fair value of assets for the entities where real estate was acquired was concentrated in property and equipment amounting to $282,074. As such, these transactions were classified as asset acquisitions. The remaining aggregate purchase price for transactions during the year ended December 31, 2024 was concentrated in goodwill in the amount of $1,770. Such transactions were classified as business combinations. The Company expects 100% of the goodwill to be deductible for income tax purposes.

In connection with the new operations made through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenants' post-assumption rights and obligations under the long-term leases. The Company entered into separate agreements with the applicable prior operators as part of each transaction.

2023 Expansions

During the year ended December 31, 2023, the Company's consolidated operations and real estate portfolio grew through a combination of long-term leases and real estate purchases. The Company acquired operations at 58 stand-alone skilled nursing, assisted living, and subacute facilities and six real estate purchases. Of the six real estate purchases, two of the properties were acquired in conjunction with the operations of the associated facility. For the other four acquired properties, the Company previously operated the respective facilities and has now acquired the real estate associated with those operations. These new operations added 6,744 and 484 operational skilled nursing and assisted living beds, respectively.

The aggregate purchase price for these expansions during the year ended December 31, 2023 was $129,174. The fair value of assets for the entities where real estate was acquired were concentrated in property and equipment amounting to $124,874. As such, these transactions were classified as asset acquisitions. The remaining aggregate purchase price for transactions during the year ended December 31, 2023 was concentrated in goodwill and other assets in the amount of $3,800 and $500, respectively. Such transactions were classified as business combinations. The Company expects 100% of the goodwill to be deductible for income tax purposes.

In connection with the new operations made through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenants' post-assumption rights and obligations under the long-term leases. The Company entered into separate agreements with the applicable prior operators as part of each transaction.

The Company's expansion strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities to improve both clinical and financial performance of the acquired facility. The purpose of any such expansion, may include, without limitation, to expand the scope of the Company's operations, add team members with important skill sets, and/or realize synergies. The operations added by the Company are frequently underperforming financially and have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. The Company believes that prior operating results are not typically a meaningful representation of the Company's current operating results or indicative of the integration potential of its newly acquired operating subsidiaries. The assets added during the year ended December 31, 2025 and through the issuance of the combined/consolidated financial statements were not material operations to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. The additions have been included in the December 31, 2025 and 2024 combined/consolidated balance sheets of the Company, and the operating results have been included in the combined/consolidated statements of income of the Company since the date the Company gained effective control.

2026 Expansions and Divestitures

Subsequent to December 31, 2025, the Company's operations expanded in two existing states with the addition of three stand-alone facilities, two of which were acquired with the underlying real estate and one of which was acquired through a long-term lease. These new facilities added 207 assisted living beds operated by the Company's affiliated operating subsidiaries. The aggregate purchase price for these facilities was $50,500.

Additionally, during the same period the Company expanded its portfolio of owned properties by acquiring one property, for which it had previously operated the facility, for an aggregate purchase price of $35,750.

Subsequent to December 31, 2025, the Company also divested of one leased facility which included 110 skilled nursing beds.

NOTE 17. COMMITMENTS AND CONTINGENCIES

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 including fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations is monitoring performed by the Office of Civil Rights which covers the Health Insurance Portability and Accountability Act of 1996, the terms of which require healthcare providers (among other things) to safeguard the privacy and security of certain patient protected health information.

Regulatory Investigations

The Company is subject to various governmental inspections, audits, and investigations that arise in the ordinary course of its business. The following governmental investigations are ongoing, although the government entities conducting these investigations have not asserted claims against the Company in connection with these investigations.

On April 8, 2024, Providence Administrative Consulting Services ("Providence") and Paradise Valley Healthcare Center ("Paradise Valley") received a Civil Investigative Demand ("CID") from the U.S. Department of Justice ("DOJ") requesting information and documents relating to an investigation of Paradise Valley and Providence to determine whether Paradise Valley and Providence violated the False Claims Act by submitting false claims to Medicare. The investigation relates to whether Providence and Paradise Valley improperly induced patient referrals through remuneration in violation of the Anti-Kickback Statute. The CID includes requests for information relating to referral source relationships, including relationships with medical directors and other individuals. Since the receipt of the CID, the DOJ has made additional

requests for information from Providence, including marketing materials and certain expense data across all Providence facilities. The Company is cooperating with the investigation, which is ongoing.

On September 11, 2024, the Company received a CID from the DOJ requesting information and documents relating to an investigation of the Company's California-based skilled nursing facilities to determine whether the Company violated the False Claims Act by submitting false claims to Medicare for reimbursement under the patient-driven payment model (PDPM) for skilled nursing and rehabilitation services. The CID includes requests for information relating to the Company's practices and incentives pertaining to the completion and submission of Minimum Data Set Assessments and the resulting PDPM rates. The Company is cooperating with the investigation, which is ongoing.

On September 30, 2024, Providence Group, Inc. ("Providence Group") received a CID from the DOJ requesting information and documents relating to an investigation of its skilled nursing facilities, specifically including Bishop Care Center ("Bishop") to determine whether Providence Group violated the False Claims Act by submitting false claims to Medicare for reimbursement under the COVID-19 related Hospital Stay Waiver (otherwise known as the 1135 waiver). The CID includes requests for information relating to 1135 COVID Waiver practices at Bishop. The Company is cooperating with the investigation, which is ongoing.

On February 26, 2025, the Company received a subpoena from the DOJ per the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") relating to an investigation into possible violations of various sections of 18 U.S.C. that prohibit the making of fraudulent or false statements to any branch of the government of the United States. The subpoena includes requests for information relating to PACS' 1135 COVID Waiver practices, billing of Medicare Part B for respiratory and sensory integration therapy services, change of insurance enrollment, cost waivers for co-pays, deductibles, and co-insurance, and claim reimbursement from Medicare for bad debt. The Company is cooperating with the investigation, which is ongoing.

SEC Investigation

The SEC's Division of Enforcement is conducting an investigation into matters that relate to the Company's accounting and financial reporting and disclosure, and the Company's internal controls over financial reporting and disclosure controls.

The Company is cooperating with each of the regulatory investigations identified above and the SEC investigation to produce the requested information and documentation. At this time, the Company cannot predict the outcome of any of these investigations and there can be no assurance that one or more of these investigations will not result in suits or actions alleging, or findings of, violations of federal or state laws that could lead to the imposition of damages, fines, penalties, restitution, other monetary liabilities, sanctions, settlements or changes to our business practices or operations that could have a material adverse effect on our business, financial condition or results of operations. The legal costs associated with responding to the regulatory investigations and SEC investigations can be substantial, regardless of the outcome.

The Company is unable at this time to estimate a loss or range of loss that may arise in the event that a claim is asserted against it in connection with any of these investigations for reasons including that these matters are in early stages, no factual issues have been resolved in these matters, and there is uncertainty as to the outcome of these matters, which can result in large settlement amounts or damage awards.

Litigation

The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents served by the Company's independent operating subsidiaries. The Company, and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. In addition, the Company, its independent operating subsidiaries, and others in the industry are subject to claims and lawsuits in connection with COVID-19 and a facility's preparation for and/or response to COVID-19.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories. The Company and other companies in its industry are routinely subjected to varying types of claims and suits,

including class-actions. Class-action suits have the potential to result in large jury verdicts and settlements, and may result in significant legal costs. The Company expects the plaintiffs' bar to continue to be aggressive in their pursuit of claims.

The Company has been, and continues to be, subject to other claims and legal actions that arise in the normal course of business, including potential claims filed by patients or others on their behalf related to patient care and treatment (professional negligence claims), as well as employment related claims filed by current or former employees. For example, the Company has been subjected to, and is currently involved in, litigation alleging violations of state and federal wage and hour laws resulting from the alleged failure to pay wages, to timely provide and authorize meal and rest breaks, and related causes of action.

In addition to the litigations described above, the Company is also subject to the following litigation:

Litigation – Securities Class Action and Shareholder Derivative Actions

On November 13, 2024, a putative securities class action captioned *Manchin v. PACS Group, Inc., et al.*, Case No. 1:24-cv-08636-LJL (S.D.N.Y.) ("*Manchin* Action") was filed against the Company, individual defendants Jason Murray, Derick Apt, Mark Hancock, Jacqueline Millard, and Taylor Leavitt; and underwriter defendants Citigroup Global Markets Inc., J.P. Morgan Securities LLC, Truist Securities, Inc., RBC Capital Markets, LLC, Goldman Sachs & Co. LLC, Stephens Inc., KeyBanc Capital Markets Inc., Oppenheimer & Co. Inc., and Regions Securities LLC. The complaint brings claims under Sections 11 and 15 of the Securities Act, and Section 10(b), and 20(a) of the Exchange Act, and alleges the Company and its leadership engaged in a multi-year scheme to inflate revenue and profitability by (i) exploiting a COVID-era Medicare waiver to "flip" long-term Medicaid patients to higher-paying Medicare coverage, (ii) billing unnecessary Medicare Part B respiratory and sensory integration therapies, and (iii) falsifying licensure and staffing documentation. On January 7, 2025, the court consolidated the *Manchin* action with a similar action brought by plaintiff New Orleans Employees' Retirement System, and on February 11, 2025 the court appointed 1199SEIU Health Care Employees Pension Fund as lead plaintiff, and its counsel, Labaton Keller Sucharow LLP, as lead counsel. On December 19, 2025, after the Company filed its Quarterly Report on Form 10-Q for the period ended September 30, 2024 and its Annual Report on Form 10-K for the year ended December 31, 2024, the lead plaintiff filed a consolidated complaint. The new complaint added Joshua Jergensen and P.J. Sanford as named defendants, and also brought additional claims pursuant to Section 12(a)(2) of the Securities Act and Section 20A of the Exchange Act. Defendants moved to dismiss the consolidated complaint on February 17, 2026. According to the current operative schedule, Plaintiffs' opposition is due April 20, 2026, and Defendants' reply will be due June 4, 2026.

On February 14, 2025, a derivative action originally filed by plaintiff Theresa Howard-Hines ("*Howard-Hines* Action") captioned *IN RE PACS GROUP, INC. DERIVATIVE LITIGATION* Lead Case No. 1:25-cv-01343-LJL (S.D.N.Y.) was filed against defendants Jason Murray, Derick Apt, Mark Hancock, Michelle Lewis, Jacqueline Millard, Taylor Leavitt, and Evelyn Dilsaver, with the Company named as nominal defendant. The complaint brings claims of breach of fiduciary duties, unjust enrichment, waste of corporate assets, and contribution, based on substantially similar allegations as in the *Manchin* Action. On April 8, 2025, the court consolidated the *Howard-Hines* action with a similar derivative action filed by plaintiff Adam Beckman, under the name *In re PACS Group, Inc. Derivative Litigation*. On June 9, 2025, the parties filed a joint stipulation staying the action until the earlier of the dismissal of the *Manchin* Action, the denial of any motion to dismiss in the *Manchin* Action, or the termination of the stay.

On August 19, 2025, a derivative action captioned *Boers v. Murray, et. al.*, Case No. 1:25-cv-00119-DAK-DBP (D. Utah) was filed against the same defendants and alleging substantially the same claims and theories as *IN RE PACS GROUP, INC. DERIVATIVE LITIGATION*. The plaintiff voluntarily dismissed this case on December 8, 2025, without prejudice to her ability to refile.

Legal proceedings can be complex and take many months, or even years, to reach resolution, with the final outcome depending on a number of variables, some of which are not within our control. Therefore, although the Company will vigorously defend itself in each of the actions described above and any other legal proceedings, their ultimate resolution and potential financial and other impacts on the Company are uncertain but could be material. Regardless of final outcomes, however, any such proceedings, claims, and investigations may nonetheless impose a significant burden on management and employees and be costly to defend, with unfavorable preliminary, interim or final rulings.

The Company accrues a liability amount when it believes that it is both probable that a liability has been incurred, and the amount can be reasonably estimated. Significant judgment is required to determine both probability and the estimated amount. Such legal matters are inherently unpredictable and subject to significant uncertainties, some of which are beyond the Company's control. The Company is unable to estimate a loss or range of loss in connection with the Securities Class Action and Shareholder Derivative Actions at this time for reasons including that these matters are in early stages, no factual issues have been resolved in these matters, and there is uncertainty as to the outcome of these matters.

The defense of any of the litigations described above may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards. While there can be no assurance, based on the Company's evaluation of information currently available, management does not believe the results of such litigations would have a material adverse effect on the results of operations, financial position or cash flows of the Company, taken as a whole. However, the Company's assessment may evolve based upon further developments in the proceedings at issue. The results of legal proceedings are inherently uncertain, and material adverse outcomes are possible.

Insurance Claims

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 is $750 per claim, subject to an additional one-time deductible of $9,500 for the Company's independent subsidiaries in California. For a subset of the Company's independent subsidiaries acquired as part of the Plum acquisition in 2021 across California and Nevada, the combined self-insured retention is $500 per claim, subject to an additional one-time deductible of $6,000. For the independent subsidiaries not in California, the self-insured claim is $750 per claim, subject to an additional one-time deductible of $10,000. For all independent subsidiaries, except those located in Colorado, Kansas, and Pennsylvania the third-party coverage above these limits is $1,000 per claim, $3,000 per operation, with a $10,000 aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, Kansas, and Pennsylvania, the third-party coverage above these limits is $1,000 per claim and $3,000 per operation, which is independent of the aforementioned aggregate limits that apply outside of these states. Subsequent to December 31, 2025, the combined self-insured retention is $750 per claim ($650 if an enforceable arbitration agreement applies), subject to an additional one-time deductible of $9,500 for the Company's independent subsidiaries in California. 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 $10,200.

The majority of the self-insured retention and deductible limits for professional and general liabilities are self-insured through the captive insurance subsidiary, the related assets and liabilities of which are included in the accompanying combined/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.

As part of the Plum acquisition in 2021, the Company assumed Plum's workers' compensation plan. Plum purchased an occurrence-based high deductible self-insured workers' compensation policy whereby the Company is responsible for the first layer of coverage, generally ranging from $250 to $500 per claim. The estimated obligation recorded at December 31, 2025 and 2024 was $5,611, and $6,172, respectively. The Plum facilities were transferred onto the Company's retrospective-rated premium workers' compensation policy as of the acquisition date.

The Company believes that adequate provision has been made in the combined/consolidated financial statements for liabilities that may arise out of patient care, workers' compensation and related services provided to date. The amount of the Company's reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires the Company to continuously monitor and evaluate the life cycle of the claims. It is the Company's policy to use an external actuary to assist management in estimating the

expense and related self-insurance liabilities for PLGL claims, both asserted and unasserted, on an undiscounted basis. 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. 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 damage awards with respect to unpaid claims. The self-insured liabilities are based upon estimates, and while management believes that the estimates of loss are reasonable, the ultimate liability may be in excess of or less than the recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that the Company could experience changes in estimated losses that could be material to net income. If the Company's actual liabilities exceed its estimates of losses, its future earnings, cash flows and financial condition would be adversely affected.

The following table represents the Company's self-insurance liabilities, on an undiscounted basis, inclusive of anticipated insurance recoveries, as of December 31, 2025 and 2024:

	December 31,	
	2025	2024
PLGL self- insurance liabilities	$ 296,280	$ 216,534
Workers' compensation liabilities	25,275	24,411
Total self-insurance liabilities	$ 321,555	$ 240,945
Less: current self-insurance liabilities	128,994	75,966
Long-term self-insurance liabilities	$ 192,561	$ 164,979

The following table represents activity in the Company's PLGL self- insurance liabilities as of and for the years ended December 31, 2025 and 2024:

	Amount
Balance January 1, 2024	$ 162,976
Current year expense	147,061
Claims paid	(87,421)
Change in obligations covered by unrelated insurer	(6,082)
Balance December 31, 2024	$ 216,534
Current year expense	144,237
Claims paid	(79,530)
Change in obligations covered by unrelated insurer	15,039
Balance December 31, 2025	$ 296,280

PLGL self-insurance liabilities as of December 31, 2025 and 2024 include $102,882 and $76,650, respectively, that were related to unasserted claims. The anticipated insurance recoveries included in the self-insurance liabilities are presented gross rather than net with the corresponding asset of $17,453 and $26,179 as of December 31, 2025 and $4,861 and $23,732 as of December 31, 2024, included in Other Receivables and Other Assets, respectively, on the consolidated balance sheets.

Indemnities

From time to time, the Company enters into certain types of contracts that contingently require it to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from the Company use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of facilities against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer to the Company's independent operating subsidiary, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, and

(iv) certain agreements with the Company officers, directors and others, under which the Company may be required to indemnify such persons for liabilities arising out of the nature of their relationship to the Company. 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 combined/consolidated balance sheets for any of the periods presented.

NOTE 18. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is calculated by dividing net income attributable to the common stockholders by the weighted-average shares of common stock outstanding 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 shares of common stock that would have been outstanding if the dilutive potential shares of common stock had been issued, which are comprised of restricted stock units using the treasury stock method.

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

	Year Ended December 31,		
	2025	2024	2023
Numerator:			
Net income	$ 191,461	$ 55,344	$ 112,882
Less: net (loss) income attributable to noncontrolling interest	(82)	(416)	8
Net income attributable to PACS Group, Inc.	$ 191,543	$ 55,760	$ 112,874
Denominator:			
Weighted average common shares outstanding	156,180,786	146,663,371	128,723,386
Basic net income per common share	$ 1.23	$ 0.38	$ 0.88

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

	Year Ended December 31,		
	2025	2024	2023
Numerator:			
Net income	$ 191,461	$ 55,344	$ 112,882
Less: net (loss) income attributable to noncontrolling interest	(82)	(416)	8
Net income attributable to PACS Group, Inc.	$ 191,543	$ 55,760	$ 112,874
Denominator:			
Weighted average common shares outstanding	156,180,786	146,663,371	128,723,386
Plus: effect of diluted shares[(1)]	519,553	1,911,235	—
Adjusted weighted average common shares outstanding	156,700,339	148,574,606	128,723,386
Diluted net income per common share	$ 1.22	$ 0.38	$ 0.88

(1) The diluted per share amounts do not reflect 2,289,103 common share equivalents from restricted stock units for the year ended December 31, 2025 because of their anti-dilutive effect.

NOTE 19. STOCK AWARDS

Stock-based compensation expense consists of stock-based payment awards made to employees and directors, comprised of restricted stock units, based on their estimated fair values. Stock-based compensation expense recognized in

the Company's combined/consolidated statements of income for the years ended December 31, 2025, 2024, and 2023 was based on the vesting of awards granted to date.

2024 Incentive Award Plan (2024 Plan)

The 2024 Plan allows the Company to make equity-based and cash-based incentive awards to its officers, employees, directors and consultants. The number of shares initially available for issuance under awards granted pursuant to the 2024 Plan (which number includes 15,390,579 shares of common stock issuable upon the vesting of restricted stock unit (RSU) awards granted in connection with the IPO) was equal to 10.25% of the number of shares of common stock outstanding immediately following the completion of the IPO (disregarding the shares issuable under the 2024 Plan). The number of shares available for issuance under the 2024 Plan increases annually on the first day of the year by an amount equal to up to 2% of the aggregate number of shares outstanding on the final day of the immediately preceding calendar year. As of December 31, 2025, the total number of shares available for issuance under the 2024 Plan was 4,552,426.

2024 Employee Stock Purchase Plan (2024 ESPP)

The number of shares initially available for issuance pursuant to the 2024 ESPP (which number included 1,501,520 shares of common stock issuable pursuant to rights granted under the plan) was equal to 1% of the number of shares of common stock outstanding immediately following the completion of the IPO (disregarding the shares issuable under the 2024 Plan). The number of shares available for issuance under the 2024 ESPP increases annually on the first day of the year by an amount equal to up to 1% of the aggregate number of shares outstanding on the final day of the immediately preceding calendar year. As of December 31, 2025 the total number of shares available for issuance under the 2024 ESPP was 3,053,295.

Restricted Stock Unit Awards

Pursuant to the 2024 Plan, the Company granted 3,362,538 and 15,409,470 RSU awards during the years ended December 31, 2025 and 2024, respectively. Awards granted to key executives at the time of the IPO vested 25% upon issuance with the remaining shares scheduled to vest in equal increments on an annual basis over the next five years. All other awards generally vest in equal increments on an annual basis over three years as the grantees meet the requisite service condition. These awards granted used the market price on the date of the respective grant date to determine the award fair value. The fair value per share of RSU awards granted during the years ended December 31, 2025 and 2024 ranged from $13.72 to $36.37 and from $21.00 to $24.85, respectively.

A summary of the status of the Company's non-vested RSU awards for the years ended December 31, 2025 and 2024 is presented below (there was no such activity prior to the approval of the 2024 Plan, including in 2023):

	Non-Vested Restricted Stock Unit Awards	Weighted Average Grant Date Fair Value
Non-vested at January 1, 2024	—	$ —
Granted	15,409,470	21.00
Vested	(3,847,652)	21.00
Forfeited	—	—
Non-vested at December 31, 2024	11,561,818	$ 21.01
Granted	3,362,538	21.79
Vested	(2,325,126)	21.03
Forfeited	(2,342,935)	20.38
Non-vested at December 31, 2025	10,256,295	$ 21.40

During the year ended December 31, 2025, the Company granted 13,197 RSU awards to non-employee directors for their service on the Company's board of directors from the 2024 Plan. The fair value per share of these awards were $36.37 based on the market price on the grant date.

During the year ended December 31, 2025 and 2024, the aggregate fair value of RSU awards that vested was $21,642 and $92,882, respectively. The number of RSU awards vested includes shares of common stock that the Company withheld on behalf of employees to satisfy statutory tax withholding requirements.

Stock-based compensation expense

Stock-based compensation expense recognized during the years ended December 31, 2025 and 2024 for the Company's equity incentive plans was $54,069 and $115,544, respectively.

In future periods, the Company expects to recognize $176,719 in stock-based compensation expense for unvested RSU awards that were outstanding as of December 31, 2025. Future stock-based compensation expense will be recognized over 2.96 weighted average years for unvested RSU awards.

Item 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

Item 9A. CONTROLS AND PROCEDURES

(a) Inherent Limitations on Effectiveness of Controls

In designing and evaluating our disclosure controls and procedures, management recognizes that there are inherent limitations in the effectiveness of any control system, including the potential for human error and the possible circumvention or overriding of controls and procedures. No matter how well designed and operated, an effective control system can provide only reasonable, not absolute, assurance that the control objectives of the system are adequately met. Accordingly, the management of the Company, including its Chief Executive Officer and Interim Chief Financial Officer, does not expect that the control system can prevent or detect all error or fraud. In addition, the design of disclosure controls and procedures must reflect the fact that there are resource constraints, and that management is required to apply judgment in evaluating the benefits of possible controls and procedures relative to their costs.

(b) Evaluation of Disclosure Controls and Procedures

Our management, with the participation of our Chief Executive Officer and Interim Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures, as such term is defined under Rules 13a-15(e) and 15(d)-15(e) under the Exchange Act, as of December 31, 2025. Based on that evaluation, our Chief Executive Officer and Interim Chief Financial Officer concluded that our disclosure controls and procedures were not effective at the reasonable assurance level as of December 31, 2025, due to the material weaknesses described below.

(c) Material Weakness

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis.

As previously disclosed in our Annual Report on Form 10-K for the year ended December 31, 2024 as filed with the SEC on November 19, 2025, in connection with the preparation of our combined/consolidated financial statements for the year ended December 31, 2024, together with facts learned during the course of the Audit Committee's independent investigation, our management identified control deficiencies that, individually or in the aggregate, constitute a material weakness in our internal control over financial reporting. The material weaknesses identified by management were:

- We did not design and maintain an effective control environment commensurate with the financial reporting requirements of a public company. Specifically, we did not design and maintain sufficient processes to identify, assess, and communicate relevant risks to appropriate levels of the organization, including potential compliance issues received through the hotline process.

- In addition, we did not design and maintain adequate controls within the revenue process to appropriately recognize revenue for new services in accordance with ASC 606.

These material weaknesses led to errors in our previously-issued interim condensed combined/consolidated financial statements for the three months ended March 31, 2024 and the three and six months ended June 30, 2024 (the "Prior Financial Statements"). As a result, we restated the Prior Financial Statements and included the restated financial statements in Part II, Item 8, of the Annual Report on Form 10-K for the year ended December 31, 2024.

Although we have taken steps to remediate the material weaknesses by enhancing our internal controls and hiring additional personnel, the remediation actions have not yet been fully implemented and we have not yet been able to conclude that these controls were operating effectively for a sufficient period of time. Accordingly, the material weaknesses identified in the prior year have not yet been remediated.

In addition, in connection with the preparation of our combined/consolidated financial statements for the year ended December 31, 2025, our management identified control deficiencies that, individually or in the aggregate, constitute

material weaknesses in our internal control over financial reporting. The material weaknesses identified by management were:

- We did not design and maintain effective controls within the revenue process to address the completeness and accuracy of underlying data used to determine routine revenue.

- We also did not design controls to timely assess operational trends that could materially impact variable consideration estimates related to revenue recognition.

Notwithstanding these material weaknesses, management has concluded that the combined/consolidated financial statements for the year ended December 31, 2025 present fairly, in all material respects, our financial position, results of operations, and cash flows in accordance with U.S. GAAP.

(d) Remediation Plan

Our management is committed to maintaining a strong internal control environment. In response to the identified material weaknesses above, management with the oversight of the Audit Committee, is taking comprehensive actions to remediate the above material weaknesses. Specifically, we have made, and are continuing to advance, the following enhancements to our internal control over financial reporting:

- We have retained a Chief Compliance Officer ("CCO") who has extensive healthcare regulatory experience and experience advising public companies, and who reports directly to our CEO accompanied by regular reporting and access to the Audit Committee.

- We have recruited, and continue to recruit, additional compliance, legal and internal audit personnel to enhance our risk assessment capabilities.

- We have formed a Compliance Committee of senior management, chaired by the CCO, with a detailed charter and oversight from the Audit Committee and Board of Directors.

- We have developed and launched an enhanced compliance training program throughout the organization, and have upgraded our compliance hotline and process for investigating complaints, including elevating matters that may have a financial impact to the Chief Financial Officer, Chief Accounting Officer, and Board of Directors.

- We enhanced our Disclosure Committee process by adding sub-certifications and key personnel to specifically address the evaluation and communication of compliance and other business activities as they inform financial reporting. In addition, we are including a broader group of internal stakeholders in certain meetings to ensure information that could impact financial reporting is being shared timely.

- We are in the process of enhancing the controls related to revenue recognition for new services, in which the Company's compliance team will oversee a thorough review and approval process for new billing codes prior to billing. Once approved for use by the compliance team, these services will be reviewed in accordance with ASC 606, by the accounting function, prior to revenue recognition.

- We are in the process of expanding existing controls and designing other appropriate controls to address the design and operation of controls within our revenue process, including over variable consideration.

The material weaknesses will not be remediated until the necessary internal controls have been designed, implemented, tested and determined to be operating effectively for a sufficient period of time. In addition, we may need to take additional measures to address the material weaknesses or modify the planned remediation steps, and we cannot be certain that the measures we have taken, and expect to take, to improve our internal controls will be sufficient to address the issues identified, to ensure that our internal controls are effective or to ensure that the identified material weaknesses will not result in a material misstatement of our combined/consolidated financial statements. Moreover, we cannot provide assurance that we will not identify additional material weaknesses in our internal control over financial reporting in the future. Until we remediate the material weaknesses, our ability to record, process and report financial information accurately, could be adversely affected.

(e) Management's Annual Report on Internal Control Over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rules 13a-15(f) or 15d-15(f) under the Exchange Act.

Our management, including our principal executive officer and principal financial officer, conducted an assessment of the effectiveness of our internal control over financial reporting based on the criteria set forth in "Internal Control-Integrated Framework (2013)" issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on this assessment, and as a result of the material weaknesses described above, management concluded that, as of December 31, 2025, our internal control over financial reporting was not effective.

The effectiveness of our internal control over financial reporting as of December 31, 2025, has been audited by Ernst & Young LLP, an independent registered public accounting firm. Their report is set forth below.

(f) Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of PACS Group, Inc.

Opinion on Internal Control Over Financial Reporting

We have audited PACS Group, Inc's and subsidiaries internal control over financial reporting as of December 31, 2025, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, because of the effect of the material weaknesses described below on the achievement of the objectives of the control criteria, PACS Group, Inc. and subsidiaries (the Company) has not maintained effective internal control over financial reporting as of December 31, 2025, based on the COSO criteria.

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis. The following material weaknesses have been identified and included in management's assessment. Management did not design and maintain sufficient processes to identify, assess, and communicate relevant risks to appropriate levels of the organization, including potential compliance issues received through the hotline process and did not design and maintain adequate controls within the revenue process to appropriately recognize revenue for new services in accordance with ASC 606. Additionally, Management did not design and maintain effective controls within the revenue process to address the completeness and accuracy of underlying data used to determine routine revenue. They also did not design controls to timely assess operational trends that could materially impact variable consideration estimates related to revenue recognition.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the combined/consolidated balance sheets of the Company as of December 31, 2025 and 2024, the related combined/consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2025, and the related notes (collectively referred to as the combined/consolidated financial statements). These material weaknesses were considered in determining the nature, timing and extent of audit tests applied in our audit of the 2025 combined/consolidated financial statements, and this report does not affect our report dated February 26, 2026, which expressed an unqualified opinion thereon.

Basis for Opinion

The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Annual Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects.

Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

Definition and Limitations of Internal Control Over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Salt Lake City, Utah

February 26, 2026

(g) Changes in Internal Control Over Financial Reporting

Other than the ongoing remediation efforts described above, there were no changes in our internal control over financial reporting, as defined in Rules 13a-15(f) or 15d-15(f) promulgated under the Exchange Act, that occurred during the quarter ended December 31, 2025 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. OTHER INFORMATION

On December 8, 2025, John Mitchell, our Chief Legal Officer, adopted a Rule 10b5-1 trading arrangement that is intended to satisfy the affirmative defense of Rule 10b5-1(c) for the sale of up to 80,152 shares of the Company's common stock until October 16, 2026.

Other than as set forth above, during the three months ended December 31, 2025, none of our directors or officers (as defined in Rule 16a-1(f) under the Securities Exchange Act of 1934, as amended) adopted, modified or terminated a "Rule 10b5-1 trading arrangement" or a "non-Rule 10b5-1 trading arrangement", as each term is defined in Item 408(a) of Regulation S-K.

Item 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III

Item 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

Information about our Executive Officers.

The following table presents information concerning our executive officers as of the date hereof.

Name	Age	Position(s)
Jason Murray	46	Director, Chairman and Chief Executive Officer
Mark Hancock	50	Director, Executive Vice Chairman and Interim Chief Financial Officer
Joshua Jergensen	41	President and Chief Operating Officer
John Mitchell	50	Chief Legal Officer and Secretary
Michelle Lewis	49	Chief Accounting Officer
Kelly Priegnitz	62	Chief Compliance Officer
Trent Bingham	54	Chief Human Resources Officer

The following are brief biographies describing the backgrounds of our executive officers.

Jason Murray has served as our Chief Executive Officer and a member of our board of directors since January 2013 and has served as Chairman since January 2024. Mr. Murray co-founded our company and has worked in the post-acute sector for more than 20 years. Prior to our founding, Mr. Murray was an Operations Officer for Intermountain Healthcare, Inc. a non-profit healthcare system, from June 2011 to January 2013 where he was the interim Chief Executive Officer of Park City Medical Center from June 2012 to October 2012. From February 2009 to June 2011, Mr. Murray served as a nursing home administrator with Plum Healthcare Group, a skilled nursing facility operator. Mr. Murray received a B.A. in Healthcare Administration and a Master of Healthcare Administration from Weber State University. We believe Mr. Murray is qualified to serve on our board of directors because of his business acumen, executive leadership and extensive knowledge of our business.

Mark Hancock has served as our Interim Chief Financial Officer since September 2025, Executive Vice Chairman since January 2024 and a member of our board of directors since January 2013 and previously served as our Chief Financial Officer and Secretary from January 2013 to January 2024. Mr. Hancock is also a co-founder of our company. Prior to our founding, Mr. Hancock was Vice President of Finance and Treasurer of Farm Credit Mid-America, a financial services provider, from 2010 to 2013 and served as a nursing home administrator at a facility affiliated with Plum Healthcare Group, a skilled nursing facility operator, from 2009 to 2010. From 2007 to 2009, Mr. Hancock was the Director of Corporate Finance for Steel Technologies Inc., a publicly traded steel processor, and served as a Finance Manager for Ford Motor Company, a publicly traded multinational automobile manufacturer, from 2000 to 2007. Mr. Hancock received a B.S. in Civil Engineering and a Master of Business Administration with a focus in Finance from Brigham Young University. We believe Mr. Hancock is qualified to serve on our board of directors because of his extensive leadership experience, financial expertise and strong understanding of our business.

Joshua Jergensen has served as our President and Chief Operating Officer since January 2023. Prior to that, Mr. Jergensen served as our Executive Vice President of Operations from July 2014 to January 2023. From October 2009 to July 2014, Mr. Jergensen was a nursing home administrator at Balboa Nursing and Rehabilitation Center, one of our affiliated skilled nursing facilities. Mr. Jergensen received a B.S. in Business Management with an emphasis in Finance from Brigham Young University and a Master of Healthcare Administration from the University of Southern California.

John Mitchell has served as our Chief Legal Officer since January 2023. Prior to that, Mr. Mitchell served as our Executive Vice President and General Counsel since joining our company in January 2017. From April 2016 to November 2016, Mr. Mitchell served as Vice President, Legal at HCP, a publicly traded REIT. Prior to that, Mr. Mitchell was Senior Vice President of Legal Affairs and Chief Compliance Officer of Skilled Healthcare Group, Inc., a publicly traded provider of post-acute healthcare services, from January 2011 to May 2015. Mr. Mitchell received a B.A. in History and a J.D. from Brigham Young University.

Michelle Lewis has served as our Chief Accounting Officer since January 2023. Prior to that, Ms. Lewis served in various roles of increasing responsibility, including as our Controller, since joining our company in July 2018. Prior to that,

Ms. Lewis owned and operated Michelle Lewis Accounting Services, PLLC, a certified public accounting firm, and also provided controller functions at a privately held healthcare organization, from January 2008 to May 2015. Ms. Lewis received a B.S. in Business Administration from the California State University, East Bay.

Kelly Priegnitz has served as our Chief Compliance Officer since December 2025. Prior to that, she served as Executive Vice President and Chief Legal and Compliance Officer of Pinnacle Treatment Centers from October 2020 until November 2025. Prior to her service at Pinnacle Treatment Centers, Ms. Priegnitz held a variety of senior healthcare compliance leadership roles throughout her career, including Senior Vice President and Chief Compliance Officer at Trilogy Health Services from October 2019 until September 2020, Executive Vice President and Chief Compliance Officer at Healogics from September 2017 until September 2019, and Senior Vice President and Chief Compliance Officer at Kindred Healthcare from February 2011 until September 2017. Ms. Priegnitz received her law degree from the University of Oklahoma and her bachelor's degree from Troy University.

Trent Bingham has served as Chief Human Resources Officer since November 2025. Mr. Bingham has extensive experience in senior Human Resources leadership roles, most recently as Vice President of HR Business Partnerships at Swire Coca-Cola from September 2022 until June 2025. He previously served as Chief Human Resources Officer at Renalytix from October 2020 until June 2021 and held leadership positions at Edwards Lifesciences from July 2013 until October 2020, eBay from March 2012 until June 2013, and Eli Lilly & Co. from May 2003 until March 2012. Mr. Bingham is a CPA who began his professional career in public accounting with KPMG. He received his MBA from Brigham Young University, and his bachelor's degree from Utah State University.

Information about our Directors

The following table presents information concerning our board of directors as of the date hereof. The biographies of Jason Murray and Mark Hancock are set forth under the section above "-Information about our Executive Officers."

Name	Age	Position(s)
Evelyn Dilsaver	70	Director
Taylor Leavitt	48	Director
Jacqueline Millard	65	Director

The following are brief biographies describing the backgrounds of our directors.

Evelyn Dilsaver has served as a member of our board of directors since May 2024. Ms. Dilsaver has served on the board of directors of Tempur Sealy International, Inc., since 2014, QuidelOrtho Corporation, since 2022, and HealthEquity, Inc. since 2014. In the past five years, Ms. Dilsaver has also served as a director of Aéropostale Inc., HighMark Funds, Russell Exchange Traded Funds, Longs Drug Stores Corp. and Tamalpais Bancorp. She is also a member of the board of directors of a privately held corporation and real estate investment trust. Ms. Dilsaver was formerly a member of The Charles Schwab Corporation from 1991 until her retirement in 2007. During her tenure at The Charles Schwab Corporation, Ms. Dilsaver held various senior management positions within the organization, including Executive Vice President (The Charles Schwab Corporation) and President and Chief Executive Officer (Charles Schwab Investment Management). Prior to becoming President and Chief Executive Officer of Charles Schwab Investment Management, a position she held from 2003 to 2007, Ms. Dilsaver held the position of Senior Vice President, Asset Management Products and Services. Ms. Dilsaver holds a B.S. in Accounting from California State University, East Bay, and is a Certified Public Accountant. We believe that Ms. Dilsaver's extensive financial industry experience and public company board experience qualifies her to serve as a member of our board of directors.

Taylor Leavitt has served as a member of our board of directors since July 2023. Mr. Leavitt owns and has served as the Chief Executive Officer and Managing Partner of Leavitt Equity Partners, a healthcare-focused private equity firm, since August 2014. Mr. Leavitt currently serves on the board of directors of several private entities that provide healthcare services. Previously, Mr. Leavitt was a co-founder and Partner of Leavitt Partners, a healthcare strategy consulting firm, from June 2009 to December 2020. Mr. Leavitt received a B.S. in Finance and Economics from Utah State University and a Master of Business Administration from the UCLA Anderson School of Management. We believe Mr. Leavitt is qualified to serve on our board of directors because of his strong business acumen and extensive experience in finance and investing.

Jacqueline Millard has served as a member of our board of directors since July 2023. Since January 2021, Ms. Millard has owned and operated a private investment advisory firm. Previously, Ms. Millard was the Vice President and Chief Investment Officer of Intermountain Healthcare, Inc., a non-profit healthcare system, from June 1993 to January 2021. She also has over 20 years of experience serving on other non-profit company boards, as an advisory board member to private equity firms, and serving as an investment committee member for family offices. Ms. Millard received a B.S. in Finance from Weber State University and a Master of Business Administration from Westminster College. We believe Ms. Millard is qualified to serve on our board of directors because of her extensive financial and leadership experience.

Code of Business Conduct and Ethics

We have a written Code of Conduct and Business Ethics that applies to our directors, officers, and employees, including our principal executive officer, principal financial officer, principal accounting officer or controller, or persons performing similar functions. We have posted a current copy of the Code of Conduct and Business Ethics on our website, *https://ir.pacs.com/*, in the "Governance Documents" section under "Governance". In addition, we intend to post on our website all disclosures that are required by law or the rules of the NYSE concerning any amendments to, or waivers from, any provision of the Code of Conduct and Business Ethics.

The remainder of the information required by this Item will be included in the definitive proxy statement to be filed with the SEC with respect to the Company's 2026 Annual Meeting of Stockholders (the "2026 Annual Meeting") and is incorporated herein by reference.

Item 11. EXECUTIVE COMPENSATION

The information required by this Item will be included in the definitive proxy statement to be filed with the SEC with respect to the Company's 2026 Annual Meeting and is incorporated herein by reference.

Item 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this Item will be included in the definitive proxy statement to be filed with the SEC with respect to the Company's 2026 Annual Meeting and is incorporated herein by reference.

Item 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS, AND DIRECTOR INDEPENDENCE

The information required by this Item will be included in the definitive proxy statement to be filed with the SEC with respect to the Company's 2026 Annual Meeting and is incorporated herein by reference.

Item 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by this Item will be included in the definitive proxy statement to be filed with the SEC with respect to the Company's 2026 Annual Meeting and is incorporated herein by reference.

PART IV

Item 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

(a)(1) For a list of the financial statements included herein, see Index to the Combined/Consolidated Financial Statements on page 89 of this Annual Report on Form 10-K, incorporated into this Item by reference.

(a)(2) Financial statement schedules have been omitted because they are either not required or not applicable or the information is included in the combined/consolidated financial statements or the notes thereto.

(a)(3) Exhibits:

The exhibits listed below are filed as part of this Annual Report on Form 10-K or are incorporated herein by reference, in each case as indicated below.

		Incorporated by Reference				
Exhibit Number	Exhibit Description	Form	File No.	Exhibit	Filing Date	Filed/ Furnished Herewith
3.1	Amended and Restated Certificate of Incorporation of PACS Group, Inc.	8-K	001-42011	3.1	4/15/2024	
3.2	Amended and Restated Bylaws of PACS Group, Inc.	8-K	001-42011	3.2	4/15/2024	
4.1	Form of Certificate of Common Stock	S-1/A	333-277893	4.1	4/8/2024	
4.2	Registration Rights Agreement by and between PACS Group, Inc. and certain securityholders of PACS Group, Inc., dated as of April 10, 2024	8-K	001-42011	10.1	4/15/2024	
4.3	Stockholders Agreement by and between PACS Group, Inc. and certain securityholders of PACS Group, Inc., dated as of April 10, 2024	8-K	001-42011	10.2	4/15/2024	
4.4	Description of Capital Stock					*
10.1	Form of Indemnification Agreement between PACS Group, Inc. and its directors and officers	S-1	333-277893	10.2	3/13/2024	
10.2#	PACS Group, Inc. Non-Employee Director Compensation Program	S-1/A	333-277893	10.3	4/1/2024	
10.3#	PACS Group, Inc. 2024 Incentive Award Plan	S-8	333-277893	99.1	4/11/2024	
10.4#	Form of Stock Option Agreement under PACS Group, Inc. 2024 Incentive Award Plan	S-8	333-277893	99.2	4/11/2024	
10.5#	Form of Restricted Stock Unit Agreement under PACS Group, Inc. 2024 Incentive Award Plan	S-8	333-277893	99.3	4/11/2024	
10.6#	Form of Restricted Stock Unit Award Agreement (Executive IPO Awards) under PACS Group, Inc. 2024 Incentive Award Plan	S-8	333-277893	99.4	4/11/2024	
10.7#	PACS Group, Inc. 2024 Employee Stock Purchase Plan, as amended and restated					*
10.8#	Providence Administrative Consulting Services, Inc. Nonqualified Deferred Compensation Plan	10-Q	001-42011	10.10	5/13/2024	

Exhibit Number	Exhibit Description	Incorporated by Reference				Filed/ Furnished Herewith
		Form	File No.	Exhibit	Filing Date	
10.9#	Employment Offer Letter, dated as of December 19, 2023, by and between PACS Group, Inc. and Derick Apt	S-1	333-277893	10.10	3/13/2024	
10.10#	PACS Group, Inc. Executive Severance Plan	10-Q	001-42011	10.11	5/13/2024	
10.11#	Separation and Consulting Agreement with PACS Group, Inc. and Peter (PJ) Sanford, each dated August 15, 2025	10-K	001-42011	10.11	11/19/2025	
10.12^	Amended and Restated Credit Agreement, dated as of December 7, 2023, by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	S-1	333-277893	10.1	3/13/2024	
10.13	First Amendment to Amended and Restated Credit Agreement, dated as of May 16, 2024 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	10-K	001-42011	10.13	11/19/2025	
10.14	Second Amendment to Amended and Restated Credit Agreement, dated as of November 14, 2024 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	8-K	001-42011	10.1	11/15/2024	
10.15	Third Amendment to Amended and Restated Credit Agreement, dated as of March 27, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	10-K	001-42011	10.15	11/19/2025	
10.16	Fourth Amendment to Amended and Restated Credit Agreement, dated as of May 29, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	10-K	001-42011	10.16	11/19/2025	
10.17	Forbearance Agreement, dated as of July 24, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank, the lenders party thereto and the other loan parties thereto	10-K	001-42011	10.17	11/19/2025	
10.18	Forbearance Agreement and Fifth Amendment to Amended and Restated Credit Agreement, dated as of August 13, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank, the lenders party thereto and the other loan parties thereto	10-K	001-42011	10.18	11/19/2025	
10.19#	Separation Agreement with PACS Group, Inc. and Derick Apt, dated September 2, 2025	10-K	001-42011	10.19	11/19/2025	

Exhibit Number	Exhibit Description	Incorporated by Reference				Filed/ Furnished Herewith
		Form	File No.	Exhibit	Filing Date	
10.20	Forbearance Agreement, dated as of October 21, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank, the lenders party thereto and the other loan parties thereto	10-K	001-42011	10.20	11/19/2025	
10.21	Sixth Amendment to Amended and Restated Credit Agreement, dated as of November 26, 2025 by and among PACS Group, Inc., PACS Holdings, LLC, Truist Bank and the lenders party thereto	8-K	001-42011	10.1	12/01/2025	
19.1	PACS Group, Inc. Insider Trading Policy and Procedures	10-K	001-42011	19.1	11/19/2025	
21.1	List of subsidiaries of PACS Group, Inc.					*
23.1	Consent of Ernst & Young LLP, independent registered public accounting firm					*
31.1	Rule 13a-14(a)/15d-14(a) Certification of Principal Executive Officer					*
31.2	Rule 13a-14(a)/15d-14(a) Certification of Principal Financial Officer					*
32.1	Section 1350 Certification of Principal Executive Officer					**
32.2	Section 1350 Certification of Principal Financial Officer					**
97.1	PACS Group, Inc. Policy for Recovery of Erroneously Awarded Compensation	10-K	001-42011	97.1	11/19/2025	
101.INS	XBRL Instance Document.					*
101.SCH	XBRL Taxonomy Extension Schema Document.					*
101.CAL	XBRL Taxonomy Extension Calculation Linkbase Document.					*
101.DEF	XBRL Taxonomy Extension Definition Linkbase Document					*
101.LAB	XBRL Taxonomy Extension Label Linkbase Document					*
101.PRE	XBRL Taxonomy Extension Presentation Linkbase Document					*
104	Cover Page Interactive Data File (embedded within the Inline XBRL document)					*

* Filed herewith.

** The certifications attached as Exhibit 32.1 and 32.2 that accompany this Annual Report on Form 10-K are deemed furnished and not filed with the U.S. Securities and Exchange Commission and are not to be incorporated by reference into any filing of PACS Group, Inc. under the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended, whether made before or after the date of this Annual Report on Form 10-K, irrespective of any general incorporation language contained in such filing.

# Indicates management contract or compensatory plan.

^ Registrant has omitted schedules and exhibits pursuant to Item 601(a)(5) of Regulation S-K. The Registrant agrees to furnish supplementally a copy of the omitted schedules and exhibits to the SEC upon request.

Item 16. FORM 10-K SUMMARY

Not applicable.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

PACS GROUP, INC.

Date: February 26, 2026

By: /s/ Jason Murray
Jason Murray
Director, Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ Jason Murray Jason Murray	Director, Chairman and Chief Executive Officer (*Principal Executive Officer*)	February 26, 2026
/s/ Mark Hancock Mark Hancock	Director, Executive Vice Chairman, and Interim Chief Financial Officer (*Principal Financial Officer*)	February 26, 2026
/s/ Michelle Lewis Michelle Lewis	Chief Accounting Officer *(Principal Accounting Officer)*	February 26, 2026
/s/ Jacqueline Millard Jacqueline Millard	Director	February 26, 2026
/s/ Taylor Leavitt Taylor Leavitt	Director	February 26, 2026
/s/ Evelyn Dilsaver Evelyn Dilsaver	Director	February 26, 2026

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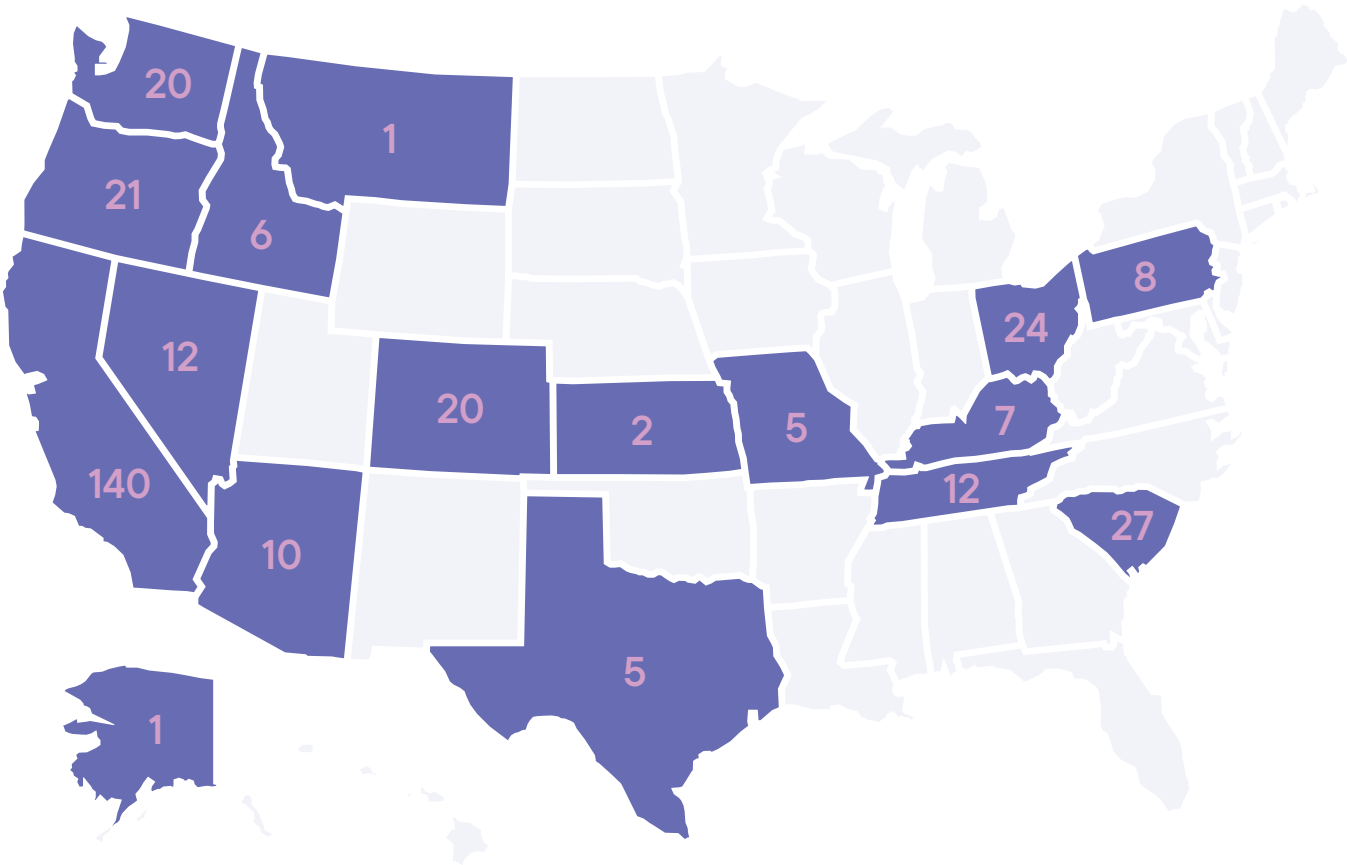
Our Facilities

Since our founding in 2013, PACS has developed a diverse set of data-driven strategies to create value, trust, and confidence for skilled nursing and post-acute care patients and facilities across the country. What started out as two facilities has expanded to 321* today, and our journey has only begun.



* as of 12/31/2025

BOARD OF DIRECTORS

Jason Murray
Co-Founder, CEO and Chairman

Jacqueline Millard
Director and Audit Committee Chair

Evelyn Dilasaver
Director and Nominating and Corporate Governance Committee Chair

Mark Hancock
Co-Founder, Executive Vice Chairman

Taylor Leavitt
Lead Independent Director and Compensation Committee Chair

Patrick Conway
Director

MANAGEMENT TEAM

Jason Murray
Co-Founder, CEO and Chairman

Joshua Jergensen
President and Chief Operating Officer

Michelle Lewis
Chief Accounting Officer

Trent Bingham
Chief Human Resources Officer

Mark Hancock
Co-Founder, Executive Vice Chairman

Carey Hendrickson
Chief Financial Officer

John Mitchell
Chief Legal Officer and Secretary

Kelly Priegnitz
Chief Compliance Officer

CORPORATE HEADQUARTERS

90 S 400 W, Suite 700
Salt Lake City, UT 84101

PACS INVESTOR RELATIONS

IR@pacs.com

TRANSFER AGENT

Broadridge Corporate Issuer Solutions, LLC
51 Mercedes Way
Edgewood, NY 11717
1-844-998-0339
shareholder@broadridge.com

Annual Meeting of Stockholders
Wednesday, June 10, 2026
11:00 a.m., Mountain Time
Via Live Webcast
www.virtualshareholdermeeting.com/PACS2026

PACS