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October 13, 2025

VIA EMAIL: Heidi.Lehrman@doj.ca.gov

Heidi Lehrman, Deputy Attorney General
Healthcare Rights and Access Section
California Department of Justice
1300 I Street,
Sacramento, California 95814

Re: **Providence Health System – Southern California: Response to Notice of Deficiency and Supplemental Letter dated September 8, 2025, regarding the sale of St. Elizabeth Care Center**

Dear Ms. Lehrman:

This letter and all attachments hereto shall serve as a supplemental submission and response to the notice of deficiency dated September 8, 2025 and the Letter dated September 8, 2025 (together, the "Notice of Deficiency") from the Office of the California Attorney General (the "Attorney General") in connection with the written notice ("Notice") for the proposed transaction ("Transaction") involving the sale of the assets and concurrent transfer of the operations of St. Elizabeth Care Center ("St. Elizabeth") by Providence Health System – Southern California, a California nonprofit corporation ("Providence"), to Toluca Way Health Holdings LLC, a Nevada limited liability company ("Toluca"), West Star Healthcare LLC, a Nevada limited liability company ("West Star"), and certain affiliates of The Ensign Group, Inc., a Delaware corporation (with its affiliates and subsidiaries, including West Star and Toluca, referred to collectively herein as "Ensign"), submitted to the Attorney General on July 7, 2025.

We respectfully submit the information outlined in and attached to this letter to address the Attorney General's supplemental requests and inquiries contained in the Notice of Deficiency. Specifically, we affirm that there has been no transfer in ownership, control, and governance of the assets and operations of St. Elizabeth, and any such transfer will not occur without the Attorney General's approval and consent to close the Transaction.

Please note for ease of reference we have included the specific requests from the Notice of Deficiency in italics within this letter, with responses immediately following.

I. NOTICE OF DEFICIENCIES

We provide the following responses to the questions and requests raised in the Notice of Deficiency, and have attached supporting documentation as applicable:

A. 999.5 (d)(3)(A).

1. *The notice states that employees receive a one-time stipend of $5,600 and a nominal amount attributable to retirement benefits to address the change in employee benefits. Please provide documents or writings relating or referring to this arrangement*.

Attached hereto as **Exhibit I.A.** are documents evidencing the arrangement to provide certain transferred Providence employees working at St. Elizabeth with a one-time stipend of $5,600 and a nominal amount attributable to retirement benefits.

B. 999.5(d)(4).

1. *Please provide the original articles of incorporation and all amendments thereto as the notice only contains Providence's current articles of incorporation*.

Attached hereto as **Exhibit I.B.** are copies of the original articles of incorporation of Providence and all amendments thereto.

2. *While the notice states that the proceeds from the transaction will be used to pay off operating debts and liabilities, it acknowledges that there may be remaining proceeds after the payment of such debts but does not provide a specific plan for the use of such proceeds. Please also provide a plan for use of the net proceeds after the close of the proposed transaction*.

The amount of the transaction proceeds allocated to St. Elizabeth is $4,966,000. The net proceeds after transaction costs, benefits mitigation, and PTO payments to providers is $4,103,000. Due to ongoing annual losses at the facility, St. Elizabeth is in a negative cash flow position of approximately -$3,400,000. As a result, any net proceeds will first be used to extinguish any outstanding debt. Any remaining amounts will be used by Providence towards continuing Providence's mission of providing compassionate and high-quality care for the communities served in California.

C. 999.5(d)(5)(C).

1. *Please specify the services provided at the facility, including transportation, pharmacy, radiology, laboratory, physical therapy, occupational therapy, speech therapy, and social services*.

The services available at St. Elizabeth include the following: skilled nursing; physical, occupational, speech therapy; dietary; housekeeping and facility management; social services; activities and recreational therapy; and pharmacy services.

2. *Please provide the demographic characteristics of and zip code data for the patients served by the health facility*.

Attached hereto as **Exhibit I.C.** is a summary of the demographic characteristics of and zip code data for the patients served by St. Elizabeth.

D. 999.5(d)(9).

1. *Please provide a list of the officers and directors, and the governance documents of the transferee, the transferee's parent company, and the parent company's affiliates and the most recent audited financial statements for the transferee (if such audited financial statements do not exist, please provide the most recent audited financial statements for the transferee's parent company and the parent company's affiliates).*

Attached hereto as **Exhibit I.D.** are copies of the following documents: (i) an organizational chart for The Ensign Group, Inc., which includes a list of its officers and directors; (ii) the governance documents of The Ensign Group, Inc.; (iii) the most recent audited financial statements for The Ensign Group, Inc.; (iv) an organizational chart for West Star Healthcare LLC; (v) an organizational chart for Toluca Way Health Holdings LLC; and (vi) the governance documents for Flagstone Healthcare South, LLC, which is the parent company of West Star, and serves as a guarantor of West Star pursuant to the Operations Transfer Agreement ("OTA"). We previously produced the governance documents for Toluca Way Health Holdings LLC at PHSSC 00787-00804 and for West Star Healthcare LLC at PHSSC 00805-00822.

As described in the Notice, The Ensign Group, Inc. is the ultimate parent and controlling entity of West Star and Toluca. The additional affiliates of The Ensign Group, Inc. that are referenced in the Purchase Agreement and the OTA will not be related or connected to the operations of St. Elizabeth following the closing of the proposed Transaction.

E. Additional Information

1. **Contracts and Other Information**

a. *Any agreements documenting the performance or participation of Ensign and any of its affiliates in collaboration(s) with Providence and any of its affiliates*

There are no agreements documenting the performance or participation of Ensign and any of its affiliates in collaboration(s) with Providence and any of its affiliates.

b. *A copy of the Management Services Agreement for the current manager of the Facility*

Prior to the IMA, as defined below, St. Elizabeth was operated and managed directly by Providence. As an operating division of Providence (and not a separate legal entity), a

management agreement for these services was not put into place, and there are no other management agreements, current or prior (other than the IMA), in place for the management of St. Elizabeth.

c. *All current payer or provider contracts, including the contracts disclosed at PHSSC 00054 (Contracts),*

Submitted under separate, confidential cover is **Exhibit I.E.1.c.** containing copies of all current payor contracts related to the operations of St. Elizabeth. The payor contracts each contain confidentiality provisions which restrict their disclosure to third parties except under certain limited circumstances. As such, and in accordance with Cal. Code Regs., Title 11, § 999.5(c)(3), we are requesting that Exhibit I.E.1.c be treated as confidential by the Attorney General and should not be treated as a public record because it contains trade secrets of the contracting parties.

There are no material provider contracts related to the operations of St. Elizabeth, and no provider contracts will be transferred in connection with the closing of the Transaction. With respect to the requests from the Notice of Deficiency listed in italics below, Providence intends to provide a response to these inquiries in subsequent correspondence with the Attorney General and is working to gather the information as quickly as possible.

d. *All requests to renegotiate Contracts and any responses to such requests*

e. *Correspondence regarding any negotiations on Contracts*

f. *Correspondence containing any threat to terminate and any terminations of those Contracts*

g. *Any subsequent correspondence following those terminations from 2015 to the present*

h. *The names, titles, contact information, and employer of all individuals who have and are negotiating Contracts for services at the Facility during fiscal year 2024-2025.*

2. **Information Regarding Change of Control**

We are confirming that there has been no transfer of assets or of ownership, control, or governance of the assets and operations of St. Elizabeth. The parties acknowledge and agree that the closing of the Transaction, including any transfer of control, governance, and operations under the Purchase Agreement and OTA, is conditioned upon the Attorney General's consent and approval, which is identified in these agreements. Currently, the only agreement between Providence and Ensign that is in effect is the Interim Management Agreement ("IMA"), which became effective on June 1, 2025 upon the California Department of Public Health's approval of the IMA and change of manager.

To confirm, the OTA is not in effect and will not take effect until the closing of the Transaction. We understand that the Side Letter between Providence and Ensign dated June 1, 2025 (PHSSC 00144) ("Side Letter") creates some confusion in this regard. Originally, the IMA and OTA were both intended to both take effect upon the Transaction's closing, and accordingly, were drafted in a way such that these agreements could function in tandem. However, earlier this year, Providence began to experience certain operational challenges. At that time, it became apparent that St. Elizabeth required additional support services, which Providence was not able to continue to provide directly. Thus, the parties agreed to utilize the IMA and arrange for Ensign to provide such support, which Providence deemed necessary in order to continue its operation of St. Elizabeth until the closing of the Transaction, and subject to Providence's ultimate authority and oversight. If the Transaction was not pending, or if Ensign was unable to perform these services during the pre-closing period, Providence would have contracted with a third-party management organization to provide these functions.

The intent of the Side Letter was to ensure that, to the extent that certain terms in the IMA referenced defined terms from the OTA, those definitions and meanings would be incorporated if the parties had any disagreement or dispute over the meaning of the IMA terms. In other words, because the initial arrangement was such that the IMA and OTA would take effect at the same time, the parties were attempting to address any potential gap in defined terms that might occur when the IMA was implemented on its own prior to closing. We recognize that the Side Letter should have more clearly set forth that, as of June 1, 2025, only the terms and conditions of the IMA were in effect and the OTA had not closed with respect to St. Elizabeth, which reflects the actual situation of the parties and operations. If helpful for the Attorney General's review and decision, the parties are willing and able to prepare an amendment to the Side Letter to evidence this intent and agreement.

As to the on-the-ground operations, St. Elizabeth has not transferred control to Ensign from a governance or financial standpoint, and Providence still maintains the ultimate authority and control over St. Elizabeth's operations and assets. St. Elizabeth remains under the Providence legal umbrella for financial and accounting purposes, and is the provider of record for all patient care – as part of this, including from a licensure and payor standpoint, Providence is required to retain control over all of these operations and does so. Pursuant to the IMA, Ensign performs certain services to manage and support the St. Elizabeth facility during the pendency of the Transaction. With respect to the change in management, the IMA represents an arms'-length relationship between Providence, as the licensee and owner and operator of St. Elizabeth, and Ensign, as a third-party contractor. The IMA terms include restrictions on the manager's rights and authority, as well as recourse and remedies for Providence. Specifically, in the event of the manager's breach, Providence may terminate the IMA as well as the Purchase Agreement, meaning that if it determines that the manager is not performing or managing the facility in accordance with Providence's standards, Providence may elect not to proceed with closing of the Transaction. In connection with this, Providence meets with Ensign on an ongoing basis to ensure there are no issues or considerations for Providence to address as the facility's licensee.

In addition, our specific responses to the questions raised in the Notice of Deficiency are included immediately below:

a. *Which of the provisions of the Operations Transfer Agreement ("OTA") have become effective as of June 1, 2025. (PHSSC 00144)*

None of the provisions of the OTA became effective as of June 1, 2025; the OTA will not take effect until closing, which the parties understand and agree is subject to the Attorney General's approval.

b. *Which of the provisions of the interim transfer agreement were interpreted as if the parties had closed under the OTA on June 1, 2025. (PHSSC 00144)*

None of the IMA provisions are interpreted as if the OTA closed on June 1, 2025. When Providence and Ensign entered into the Transaction, the parties originally contemplated and intended for the IMA and the OTA to become effective simultaneously upon the closing of the Transaction. However, leading up to and during the pendency of the Transaction, Providence faced challenges in managing the facility. As a result, there was a need for Providence to obtain additional support; at that time, the parties agreed that the IMA would be utilized to support Providence once CDPH provided approval for the management change, all subject to Providence's ultimate decision-making authority as licensee and owner of St. Elizabeth.

c. *That Providence has informed patients at St. Elizabeth Center that the transferee Ensign has assumed ownership, management and operation as of June 1, 2025. (PHSSC 00828)*

Providence confirms that it provided the information to residents cited in PHSSC 00828. However, the intent of this notice was to identify that St. Elizabeth had only undergone a change of management and keep residents apprised of the ongoing transition, which did not close on the date originally contemplated. We understand that this creates ambiguity, and the parties are willing and able to address this topic with residents if requested by the Attorney General.

d. *That the transferee is providing all patient care services at St. Elizabeth Center. (PHSSC 00148)*

We confirm that this means that during the pendency of the Transaction, Providence holds sole ownership and retains control over the operations of St. Elizabeth, including the ultimate control and decision making authority over patient care practices, policies, and procedures. Under the IMA, as the manager of the facility, Ensign has agreed to arrange for the provision of certain patient care services at St. Elizabeth; however, Providence retains sole ownership and control over the assets and operations of St. Elizabeth, including with respect to patient care. Providence, as the licensee and owner of St. Elizabeth, continues to be responsible for the operation of St. Elizabeth (see Section VIII of the IMA (Limitations on Authority of Manager)). Providence does not delegate any powers, duties, or responsibilities to Ensign which are prohibited by law from

being delegated, and Ensign is subject to Providence's ultimate statutory and regulatory authority as the current licensee of St. Elizabeth.

e. *That the transferee is in possession of all records, files, proceedings, and related information with respect to patients and the evaluation and improvement of the quality of patient care at St. Elizabeth Center. (PHSSC 00155)*

Providence has provided Ensign with access to all records, files, proceedings, and related information with respect to patients and evaluation and improvement of quality of patient care at St. Elizabeth. Providence has not assigned or transferred possession to Ensign its right, title, or interest in any records, files, proceedings, or related information with respect to patients and the evaluation and improvement of the quality of patient care at St. Elizabeth.

f. *That the transferee has provided "schedules of recommended charges, including any and all special charges, for services rendered to the residents" in connection with St. Elizabeth Center. (PHSSC 00148)*

Ensign has not provided any schedules of recommended charges for services rendered to patients of St. Elizabeth, and does not plan to do so until the closing of the Transaction. Pursuant to Section I(D) of the IMA (Regulatory Compliance), Providence, as the licensed owner of St. Elizabeth, currently retains discretion in determining and setting the charges and special charges for services rendered to St. Elizabeth's residents.

g. *That the transferee has billed and collected rent from the residents of St. Elizabeth Center. (PHSSC 00148)*

Providence has delegated authority to Ensign to serve as Providence's agent with respect to the billing and collection of rent payments from St. Elizabeth's residents. All payments collected by Ensign for such services are deposited into Providence's single consolidated bank account.

h. *That the transferee is administering all resident trust funds and accounts. (PHSSC 00149)*

Providence has delegated authority to Ensign to serve as Providence's agent with respect to the administration of all resident trust funds and accounts. Notwithstanding this delegation of authority, Providence retains control and governance over the practices, policies, and procedures with respect to the administration of all resident trust funds and accounts in accordance with applicable law. Providence has not assigned or transferred to Ensign its right, title, or interest in any trust funds or accounts related to patients at St. Elizabeth.

i. *That the transferee has billed and collected payments from third party payors, including government payors, including presenting claims under provider agreements. (PHSSC 00148)*

Providence has delegated authority to Ensign to serve as Providence's agent with respect to billing and collection of payments from third party payors, including government programs such as Medicare and Medi-Cal. All billed and collected claims for services provided at St. Elizabeth are billed under Providence's Tax Identification Number (TIN) and Providence's provider number, as applicable. All payments collected by Ensign for such services are deposited into Providence's single consolidated bank account. Providence continues to be the provider of record for all agreements with third party payors, and Providence has not assigned or transferred to Ensign its right, title, or interest in any third party payor agreements related to the operations of St. Elizabeth.

j. *That the transferee has issued bills and collected accounts and monies owed for goods and services furnished by St. Elizabeth Center, including Medicare, Medicaid, and any other government for services. (PHSSC 00149)*

We believe the response to Section I.E.2.i. (immediately above) addresses this question, but please confirm if you need any further information.

k. *The transferee has paid the expenses of St. Elizabeth Center including payroll, employee benefits, supplies, equipment, utilities, manager's fees, and any other capital and operating expenses. (PHSSC 00149)*

Providence has delegated authority to Ensign to serve as Providence's agent with respect to the payment of expenses of St. Elizabeth, including payroll, employee benefits, supplies, equipment, utilities, manager's fees, and any other capital and operating expenses. This remains subject to Providence's oversight and ultimate authority.

l. *That the transferee is currently able to pay itself one hundred percent (100%) of the profits and is solely responsible for one hundred percent (100%) of the losses, if any (including without limitation any tax benefits from losses), of St. Elizabeth Center. (PHSSC 00152)*

The management fee for Ensign's management services is based on one hundred percent (100%) of the profits and losses of St. Elizabeth. The parties structured the management fee this way because, in light of the financial and operational challenges that St. Elizabeth was experiencing and facing, this was determined to be commercially reasonable and fair market value for Ensign's services.

m. *The transferee has the ability to "hire and fire the personnel at the Facility as employees" of the transferee, including the ability to "recruit, train, promote, direct and discipline personnel of the Facility; establish salary levels, personnel policies and employee benefits; and establish employee performance standards." (PHSSC 00149)*

Subject to Providence's policies and procedures governing the operations of St. Elizabeth, and pursuant to Section I(K) and Section I(H) of the IMA, Ensign arranges for the contracting with and managing personnel to provide such patient care.

n. *That as of June 3, 2025, personnel at St. Elizabeth Center have received their last paycheck from Providence (PHSSC 00829)*

As of June 3, 2025, Providence issued the last paycheck to personnel at St. Elizabeth.

II. CHANGE IN CONTROL

To the extent to which the Attorney General's concerns are not addressed in responses to Section I.E.2. or through the additional information provided in this letter, we can provide further information.

III. ETHICAL RELIGIOUS DIRECTIVES

The Asset Purchase and Sale Agreement references the Ethical and Religious Directives for Catholic Health Care Services issued by the United States Conference of Catholic Bishops and contains a covenant that the transferee "will operate its business in a manner consistent with the shared values" of Providence and the transferee, and specifically that the transferee shall not provide for assistance in dying at the facilities. (PHSSC 00022-23.) The Asset Purchase and Sale Agreement further states that "future partners will be expected to work with [Providence] to comply with The Ethical and Religious Directives for Catholic Health Care Services ("ERDs")." (PHSSC 00224.)

As outlined in Section 999.5(d)(11)(C) of the Notice, during the competitive bid process, Providence sought a partner that aligned with Providence's mission to provide high-quality, affordable, and mission-driven healthcare services to the community. The document referenced at PHSSC 00224 of the confidential materials submitted as part of the Notice includes the Confidential Offering Memorandum prepared by Providence's broker, Ziegler, for use in the solicitation of prospective buyers of St. Elizabeth. The Memorandum notes that Providence considered and intended to require a buyer to operate St. Elizabeth in compliance with the ERDs. As further noted in the Memorandum, Providence also requested bidders to complete a questionnaire to evaluate each bidder's ability to meet such requirement and to better understand whether it was viable to require the future operator of St. Elizabeth to comply with the ERDs.

Although Providence approached its bid process and subsequent negotiations with an expectation that bidders would consider compliance with the ERDs in the post-sale operation of St. Elizabeth, Ensign did not ultimately agree to operate the facility in compliance with the ERDs, as reflected in the definitive terms of the Transaction agreements. Ensign, as a non-religious and non-denominational organization, acknowledged Providence's application of the ERDs to its operation of St. Elizabeth (included at PHSSC 00022-23); however, the Purchase Agreement only requires Ensign to operate St. Elizabeth consistent with the parties' shared commitment to

providing accessible, compassionate, and high-quality care to all, regardless of coverage or ability to pay, in the pursuit of improving the health and well-being of the communities served.

A. *Any and all services that would implicate this covenant*

Ensign, consistent with its current practices and policies at its other facilities, will not provide assistance in dying (i.e., assisted suicide) at St. Elizabeth.

B. *How determinations are and will be expected to be made regarding which services implicate the covenant*

The parties do not have any plan to make ongoing determinations with respect to Ensign's provision of services post-closing.

C. The name(s) and title(s) of the person(s) who review and/or will be expected to review the application of this covenant to services

No person will be conducting such review.

D. The scope and expected implementation of this covenant in the context of care and services provided at St. Elizabeth Care Center

Post-closing, Ensign will operate St. Elizabeth consistent with its current practices and policies at its other facilities, which includes not providing assistance in dying.

E. The expected post-closing duration of this covenant

There is no expected post-closing duration for this covenant.

F. The parties' expectations for monitoring compliance with and enforcement of this covenant

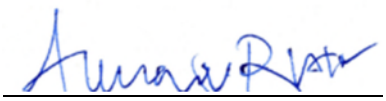
There are no expectations for monitoring compliance or enforcement of the covenant.

G. Any expectations of Providence's continued involvement with the operations and assets of the facilities.

Following the closing of the Transaction, there is no expectation of Providence's continued involvement with the operations and assets of St. Elizabeth. As described in Section 999.5(d)(1)(A) of the Notice and in Purchase Agreement and Operations Transfer Agreement, Ensign agrees to make efforts to participate in Providence's collaboratives and initiatives that were available to residents of St. Elizabeth to promote the improvement of patient outcomes and quality assurance. As such, Ensign may engage in future collaboration on patient care issues, but Providence will have no direct involvement in the ongoing operations or assets of St. Elizabeth.

Please let us know if we can provide further information regarding the Transaction. We appreciate your consideration of the Notice and the information and attachments contained herein.

Sincerely,



Alexandra Busto, Partner
of Nixon Peabody LLP

AB:vd

Attachments:
Exhibit I.A.
Exhibit I.B.
Exhibit I.C.
Exhibit I.D.

SUPPLEMENTAL MATERIALS
RESPONSE TO NOTICE OF DEFICIENCY

IN CONNECTION WITH

NOTICE OF PROPOSED SUBMISSION
AND REQUEST FOR CONSENT BY

PROVIDENCE HEALTH SYSTEM – SOUTHERN CALIFORNIA,
A CALIFORNIA NONPROFIT CORPORATION,

IN CONNECTION WITH ITS ASSET PURCHASE AND SALE AGREEMENT AND OPERATIONS TRANSFER AGREEMENT OF ITS HEALTH FACILITY,
ST. ELIZABETH CARE CENTER

TO

TOLUCA WAY HEALTH HOLDINGS LLC,
A NEVADA LIMITED LIABILITY COMPANY
(AS BUYER)

AND

WEST STAR HEALTHCARE LLC,
A NEVADA LIMITED LIABILITY COMPANY
(AS NEW OPERATOR)

PREPARED FOR THE OFFICE OF THE ATTORNEY GENERAL

CALIFORNIA DEPARTMENT OF JUSTICE
HEALTHCARE RIGHTS AND ACCESS SECTION

October 13, 2025

EXHIBIT I.A.

STIPEND TO PROVIDENCE EMPLOYEES AT ST. ELIZABETH

BENEFITS TRANSITION FAQ

BENEFITS MITIGATION

Will I receive any financial assistance to help with the transition from Providence to Ensign?

To assist you with adjusting to your new benefits, you may be eligible for up to two different types of supplemental pay. This supplemental pay will be paid to you by Providence. Any supplemental pay amount(s) will NOT be included in your offer letter and will be paid to you after your last day.

Health and Welfare Benefits Payment

Each Providence benefit eligible caregivers (.5 FTE and above, regardless of enrollment) who transition to Ensign will be eligible for the Health Care stipend. This $5,600 payment will be paid in the **next** normally scheduled payroll and noted as discretionary bonus on the pay stub.

Retirement plan lump sum

- To accommodate for differences in 401(k) retirement plan design, Providence will provide eligible transitioning caregivers with a one-time lump-sum payment on their next normally scheduled payroll after their final Providence paycheck.
- The payments are personalized and represent the estimated difference between what you would have received from Providence for May-Dec. 2025 and what you can earn in the new 401(k) plan for that same period.
- The estimate of what you would have received is based on how much you work, your pay, how much you were saving in the 401(k) as of Dec. 2024, and your years of service. Your years of service are important because they determine the amount of employer match and employer discretionary contributions you can earn in the Providence 401(k) Plan.
- The lump-sum payment will be shown on your pay slip as "Other Discretionary Comp."

COBRA

Will I receive a Consolidated Omnibus Budget Reconciliation Act (**COBRA**) notice if I am accepting a position with Ensign?

- When your medical, dental, vision and/or health care flexible spending account (FSA) coverage ends, information will be mailed to your home from Benefit Connect | COBRA, the COBRA administrator. This packet will explain your rights to continue coverage through the Providence plans. It will also have your **coverage termination date should you need documentation of loss of coverage to obtain other coverage due to a Qualifying Life Event.** For additional information, please visit the Caregiver Service Portal and search for "If You Lose Benefits Eligibility."
- Coverage under COBRA may be continued for up to 18 months beginning on the first of the month immediately following the loss of active coverage because of a reduction in hours or termination from Providence. Coverage for your health care flexible spending account may also be continued through the remainder of the calendar year in which you enrolled in this benefit. Your COBRA packet will contain additional details on your coverage continuation options.

Voluntary Benefits

What will happen to my Voluntary Benefits?

- Voluntary benefits include individual policies and programs offered at affordable group rates. These programs and policies include Auto and Home Insurance, Commuter benefits, Group Legal Insurance, Voluntary Short-Term disability, Pet Insurance, Accident and Critical Illness Insurance, Individual Theft and Credit Protection.
- If your policy is not already on direct bill through your voluntary benefit vendor, after termination of employment with Providence, your policy would go to direct bill.

Who can we call if we have questions about **Voluntary Benefits**?

- Providence does not sponsor, endorse, or contribute toward these voluntary benefits. These programs are sponsored by independent vendors and made available to you with your employer's permission. For questions about the voluntary benefits, including eligibility, enrollment, and available benefits and what will happen to the policy after your employment with Providence ends, please contact the vendor directly.

When will my Providence benefits **terminate**?

- Coverage ends on the last day of the month in which you terminate employment or through the end of the month in which you lose benefits eligibility, except LTD coverage which ends on the last day of active work.
    - Providence benefits coverage will terminate **effective 5/31/25 for caregivers going to Ensign.**

Will I owe **premiums** after my employment ends with Providence?

- You will be responsible for insurance premiums through the end of the month in which your employment with Providence ends. After your employment ends with Providence, you will not be expected to pay any additional premiums. However, if you elect to enroll in COBRA, the cost of COBRA depends on your current plan coverage. You are responsible for covering the cost of COBRA benefits and payments are submitted directly to BenefitConnect | COBRA.
- How does my Health Savings Account (HSA), Health Reimbursement Account (HRA) and Flexible Spending Account (FSA) work after I leave employment with Providence?
- The coverage period for the Providence benefit elections is the period between January 1, 2025, through May 31, 2025.

EXHIBIT I.B.

PROVIDENCE ARTICLES OF INCORPORATION, AS AMENDED

California Secretary of State

Business Programs Division
1500 11th Street, Sacramento, CA 95814

Request Type: Certified Copies
Entity Name: PROVIDENCE HEALTH SYSTEM-SOUTHERN CALIFORNIA
Formed In: CALIFORNIA
Entity No.: 0038992
Entity Type: Nonprofit Corporation - CA - Religious

Issuance Date: 09/12/2025
Copies Requested: 1
Receipt No.: 011383269
Certificate No.: 367622527

Document Listing

Reference #	Date Filed	Filing Description	Number of Pages
14542310-1	12/05/1903	Initial Filing	8
14542311-1	03/28/1941	Amendment	9
14542312-1	02/26/1946	Amendment	5
14542313-1	04/04/1950	Amendment	1
14542314-1	03/08/1951	Amendment	1
14542316-1	10/20/1972	Amendment	6
14542317-1	02/06/1973	Amendment	3
14542319-1	02/06/1973	Amendment	3
14542321-1	02/06/1973	Amendment	3
14542323-1	10/17/1974	Amendment	1
14542324-1	12/03/1976	Amendment	4
14542329-1	02/04/2002	Amendment	3
14542339-1	07/07/2020	Amendment	4

** **** ****** ******** End of list ******** ****** **** **

I, SHIRLEY N. WEBER, PH.D., California Secretary of State, do hereby certify on the Issuance Date, the attached document(s) referenced above are true and correct copies and were filed in this office on the date(s) indicated above.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California on September 12, 2025.

SHIRLEY N. WEBER, PH.D.
Secretary of State

To verify the issuance of this Certificate, use the Certifcate No. above with the Secretary of State Certification Verification Search available at **biz**fileOnline.sos.ca.gov.

38992

38992

ARTICLES OF INCORPORATION

of the

PROVIDENCE HOSPITAL OF OAKLAND.

DATED, December 4th, 1903.

FILED in the Office of the
SECRETARY OF STATE.
the 5th day of
Dec. A. D. 1903
T. F. Tennant
SECRETARY OF STATE.
By [illegible] DEPUTY.
Record Book, 151 Page, 280

Certificate Verification No.: 367622527 Date: 09/12/2025

ARTICLES OF INCORPORATION

of the

PROVIDENCE HOSPITAL OF OAKLAND.

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KNOW ALL MEN BY THESE PRESENTS:

That at a meeting regularly and duly held on the Fourth day of December, 1903, of the persons heretofore associated together, and now and heretofore known as and called the "PROVIDENCE HOSPITAL OF OAKLAND", (which Association had not and has not for its purpose pecuniary profit to said Association, or to the members thereof, which meeting was held at the principal place of business of said Association, at No. 495 26th Street, in the City of Oakland, County of Alameda, State of California, at which meeting there were actually and personally present the following members of said Association:

Rosalia Miller, Mary Brown, Margaret Maurer, Margaret Lemmick, Anna L. Haas and Wilhelmina Hartman, which said above-named five persons constituted all of the members of said Association, the following proceedings were had and the following resolutions were unanimously adopted, Rosalia Miller, President of said Association presiding:

"RESOLVED: That this Association and the persons constituting the same hereby determine to and do incorporate under the laws of the State of California, without a capital stock and with a Board of Directors consisting of five persons, and that in compliance with said laws and the rules, regulations and discipline of said Association, we now proceed to elect five members of said Association who shall act as incorporators of said proposed incorporation, and be the Directors thereof

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for the first year".

Thereupon the persons present at said meeting proceeded to elect said Directors, Rosalia Miller, the President, and Anna L. Haas, the Secretary of said Association being the officers who conducted said election, and by the unanimous vote of all present the following named persons were elected as such Directors, viz: Rosalia Miller, Mary Brown, ~~Margaret~~ Marguerite Meumer, Anna L. Haas and Wilhelmina Hartman.

C.K.M. N.P.

It was further unanimously

"RESOLVED, That the objects of said corporation be the same as those of this Association, namely: to erect, maintain and conduct in the City of Oakland, State of California, and elsewhere within said State, one or more hospitals for sick, injured and disabled persons, and to afford medical and surgical care and treatment to sick, injured and disabled persons either within or without such hospitals; to acquire by gift, devise, bequest or purchase all such real and personal property as may at any time be required for the successful accomplishment of the purposes aforesaid, and from time to time to sell, convey, mortgage and otherwise dispose of any and all property acquired and owned by this corporation, and any and all property of which it shall have the power to dispose. This corporation shall not have any capital stock, and the members and officers thereof shall derive no pecuniary profit therefrom. Pecuniary profit is not and never shall be the object of this corporation."

It was further unanimously

"RESOLVED: That said five elected directors execute and acknowledge the Articles of Incorporation as required by the provisions of Part IV of the Civil Code of the State of California applicable thereto."

It was further unanimously

"RESOLVED: That Rosalia Miller, the President of this

Certificate Verification No.: 367622527 Date: 09/12/2025

Association, and Anna L. Haas, the Secretary thereof be, and they hereby are authorized for the purposes of said incorporation, to authenticate and verify the proceedings had at this meeting."

STATE OF CALIFORNIA,)
) ss.
County of Alameda.)

Rosalia Miller, the President of the Association known as and called "PROVIDENCE HOSPITAL OF OAKLAND", and Anna L. Haas, the Secretary of said Association, being first duly sworn, each for herself, says: That they are the officers who conducted the election for Directors of the "PROVIDENCE HOSPITAL OF OAKLAND", a corporation, and that the foregoing statement of the proceedings had at the meeting of said Association held on the Fourth day of December, 1903, as therein set forth is true and correct, and that the various resolutions above set forth were passed and adopted at said meeting by the unanimous vote of the members present thereat, and that the members present thereat constituted all of the members of said Association, and that the five persons elected as Directors as set forth in said statement were each and all members of said Association and residents of the City of Oakland, County of Alameda, State of California.

....Rosalia Miller....

....Anna L. Haas....

Subscribed and sworn to before me
this 4th day of December, A. D. 1903.

C. K. Maroldace

Seal

Notary Public
In and for the County of Alameda,
State of California.

Certificate Verification No.: 367622527 Date: 09/12/2025

In accordance with the laws of the State of California and of the foregoing action of the members of the Association known as and called the "PROVIDENCE HOSPITAL OF OAKLAND", we the undersigned, do hereby certify that said Association and the persons associated together therein do hereby incorporate,

And we do further certify and set forth,

FIRST. That the name of said corporation is and shall be "PROVIDENCE HOSPITAL OF OAKLAND";

SECOND. That the purposes for which said corporation is formed are: To erect, maintain and conduct in the City of Oakland, State of California, and elsewhere within said State, one or more hospitals for sick, injured and disabled persons, and to afford medical and surgical care and treatment to sick, injured and disabled persons either within or without such hospitals; to acquire by gift, devise, bequest or purchase all such real and personal property as may at any time be required for the successful accomplishment of the purposes aforesaid, and from time to time to sell, convey, mortgage and otherwise dispose of any and all property acquired and owned by this corporation, and any and all property of which it shall have the power to dispose.

THIRD. That the place where the principal business of said corporation is to be transacted is, and shall be the City of Oakland, County of Alameda, State of California;

FOURTH. That the term for which said corporation is to exist, is Fifty years from and after the date of its incorporation;

FIFTH. That the number of the directors of said corporation is and shall be Five, and the names and residences of those who are elected and appointed for the first year are Rosalia Miller, Mary Brown, ~~Margaret Meumier~~ Marguerite Meumier, Anna L. Haas and

C.K.M.
N.P.

Certificate Verification No.: 367622527 Date: 09/12/2025

Wilhelmina Hartman, all of whom reside in the City of Oakland, County of Alameda, State of California.

SIXTH. That said corporation shall not have any capital stock, and the members and officers thereof shall derive no pecuniary profit therefrom. Pecuniary profit is not and never shall be the object of this corporation.

...Rosalia Miller (SEAL)

...Mary Brown... (SEAL)

...Marguerite Mercier (SEAL)

...Anna L. Haas. (SEAL)

Wilhelmina Hartman. (SEAL)

[Endorsed]
Filed Dec 4 1903
JOHN P. COOK, County Clerk,
By [illegible] Deputy Clerk

Certificate Verification No.: 367622527 Date: 07/10/2015

State of California, } ss.
COUNTY OF ALAMEDA.

I, ~~FRANK H. JORDAN~~ JOEL P. COOK, County Clerk of said County and ex-officio Clerk of the Superior Court in and for said County, hereby certify that I have compared the above and foregoing copy with the original Articles of Incorporation of the Board of Hospital of Oakland # 2101

and that the same is a full, ~~true and~~ correct copy of such original in the above entitled Articles and of the whole thereof, as the same now remains of record, and on file in the office of the Clerk of said Superior Court.

WITNESS my hand with the seal of said Superior Court affixed, at the City of Oakland, this 4th day of December A. D. 1903

Joel P. Cook County Clerk.

By J. A. Rogers Deputy Clerk.

59-7-11-2000

Certificate Verification No.: 367622527 Date: 09/12/2025

State of California } ss.
COUNTY OF ALAMEDA }

On this fourth day of December in the year of our Lord one thousand nine hundred and three

before me, C. K. MARSHALL, a Notary Public in and for the county of Alameda, State of California residing therein, duly commissioned and sworn, personally appeared Rosalia Muller Mary Brown Marguerite Meyner Anna L Haas and Wilhelmina Hartman

known to me to be the person s whose name s are subscribed to the within instrument, and I he y acknowledged to me that They executed the same

In Witness Whereof, I have hereunto set my hand and affixed my Official Seal, at my office in the City of Oakland, County and State aforesaid, the day and year in this certificate first above written.

C. K. Marshall

General

Notary Public in and for the County of Alameda, State of California.

Certificate Verification No.: 367622527 Date: 09/12/2025

Department of State
Corporation Number
38992

CERTIFICATE OF AMENDMENT OF ARTICLES OF INCORPORATION

OF PROVIDENCE HOSPITAL OF OAKLAND

The undersigned, Sister Louis Achille and Sister Francis Ignatius, do hereby certify that they are respectively and have been at all times herein mentioned the duly elected and acting Vice President and Secretary of Providence Hospital of Oakland, a California corporation, and further that,

One: At a special meeting of the Board of Directors of said corporation duly held at its principal office for the transaction of business at Oakland, California, at 4:00 o'clock P.M. on the 20th day of March, 1941, at which meeting there was at all times present and acting a quorum of the members of said Board, the following resolutions were duly adopted:

WHEREAS it is deemed by the Board of Directors of this corporation to be to its best interest and to the best interests of its members that its Articles of Incorporation be amended,

NOW, THEREFORE, BE IT RESOLVED that the Articles of Incorporation of this corporation be amended to read as follows:

FILED
In the office of the Secretary of State
of the State of California
MAR 28 1941
PAUL PEEK, Secretary of State
By _____ Assistant Secretary of State

"ARTICLES OF INCORPORATION

of the

PROVIDENCE HOSPITAL OF OAKLAND

-------oOo-------

KNOW ALL MEN BY THESE PRESENTS:

"That at a meeting regularly and duly held on the Fourth day of December, 1903, of the persons heretofore associated together, and now and heretofore known as and called the 'PROVIDENCE HOSPITAL OF OAKLAND', (which Association had not and has not for its purpose pecuniary profit to said Association, or to the members thereof,) which meeting was held at

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ATTORNEYS AT LAW
BANK OF AMERICA BLDG.
OAKLAND, CALIF.

MAR 28 1941

PHSSC 01035

the principal place of business of said Association, at No. 495 26th Street, in the City of Oakland, County of Alameda, State of California, at which meeting there were actually and personally present the following members of said Association:

"Rosalia Miller, Mary Brown, Marguerite Meunier, Anna L. Haas and Wilhelmina Hartman, which said above-named five persons constituted all of the members of said Association, the following proceedings were had and the following resolutions were unanimously adopted, Rosalia Miller, President of said Association presiding:

'RESOLVED: That this Association and the persons constituting the same hereby determine to and do incorporate under the laws of the State of California, without a capital stock and with a Board of Directors consisting of five persons, and that in compliance with said laws and the rules, regulations and discipline of said Association, we now proceed to elect five members of said Association who shall act as incorporators of said proposed incorporation, and be the Directors thereof for the first year.'

Thereupon the persons present at said meeting proceeded to elect said Directors, Rosalia Miller, the President, and Anna L. Haas, the Secretary of said Association being the officers who conducted said election, and by the unanimous vote of all present the following named persons were elected as such Directors, viz: Rosalia Miller, Mary Brown, Marguerite Meunier, Anna L. Haas and Wilhelmina Hartman.

It was further unanimously

'RESOLVED, That the objects of said corporation be the same as those of this Association, namely: to erect, maintain and conduct in the City of Oakland, State of California, and elsewhere within said State, one or more hospitals for sick, injured and disabled persons, and to afford medical

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Certificate Verification No.: 367622527 Date: 09/12/2025

PHSSC 01036

and surgical care and treatment to sick, injured and disabled persons either within or without such hospitals; to acquire by gift, devise, bequest or purchase all such real and personal property as may at any time be required for the successful accomplishment of the purposes aforesaid, and from time to time to sell, convey, mortgage and otherwise dispose of any and all property acquired and owned by this corporation, and any and all property of which it shall have the power to dispose. This corporation shall not have any capital stock, and the members and officers thereof shall derive no pecuniary profit therefrom. Pecuniary profit is not and never shall be the object of this corporation.'

It was further unanimously

'RESOLVED: That said five elected Directors execute and acknowledge the Articles of Incorporation as required by the provisions of Part IV of the Civil Code of the State of California applicable thereto.'

It was further unanimously

'RESOLVED: That Rosalia Miller, the President of this Association, and Anna L. Haas, the Secretary thereof be, and they hereby are authorized for the purpose of said incorporation, to authenticate and verify the proceedings had at this meeting.'

STATE OF CALIFORNIA)
) SS
County of Alameda)

"Rosalia Miller, the President of the Association known as and called 'PROVIDENCE HOSPITAL OF OAKLAND', and ANNA L. HAAS, the Secretary of said Association, being first duly sworn, each for herself, says: That they are the officers who conducted the election for Directors of the 'PROVIDENCE HOSPITAL OF OAKLAND', a corporation, and that the foregoing statement of the proceedings had at the meeting of said Association held on the Fourth day of

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BANK OF AMERICA BLDG.
OAKLAND, CALIF.

Certificate Verification No.: 367622527 Date: 09/12/2025

December, 1903, as therein set forth is true and correct and that the various resolutions above set forth were passed and adopted at said meeting by the unanimous vote of the members present thereat, and that the members present thereat constituted all of the members of said Association, and that the five persons elected as Directors as set forth in said statement were each and all members of said Association and residents of the City of Oakland, County of Alameda, State of California.

Rosalia Miller

Anna L. Haas

Subscribed and sworn to before me
this 4th day of December, A.D. 1903.

C. K. Marshall
(SEAL) Notary public in and for the
County of Alameda, State of California

"In accordance with the laws of the State of California and of the foregoing action of the members of the Association known as and called the 'PROVIDENCE HOSPITAL OF OAKLAND', we the undersigned, do hereby certify that said Association and the persons associated together therein do hereby incorporate,

And we do further certify and set forth,

"FIRST. That the name of said corporation is and shall be 'PROVIDENCE HOSPITAL OF OAKLAND';

SECOND. That said corporation is organized and operated exclusively for scientific, charitable, religious and educational purposes and the further purposes hereinafter enumerated, which said purposes are, however, purely incidental to and in furtherance of said purposes above enumerated; to erect, maintain and conduct in the City of Oakland, State of California, and elsewhere within said State, one or more hospitals for sick, injured and disabled persons, and to afford medical and surgical

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OAKLAND, CALIF.

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care and treatment to sick, injured and disabled persons either within or without such hospitals; to acquire by gift, devise, bequest or purchase all such real and personal property as may at any time be required for the successful accomplishment of the purposes aforesaid, and from time to time to sell, convey, mortgage and otherwise dispose of any and all property acquired and owned by this corporation, and any and all property of which it shall have the power to dispose, and to perform such other acts as said corporation may deem proper or convenient in connection with and in order to give effect to the foregoing purposes. That said corporation is a corporation which does not contemplate pecuniary gain or profit to the members thereof and said corporation shall never have as its purpose carrying on propaganda or otherwise attempting to influence legislation.

THIRD. That the place where the principal business of said corporation is to be transacted is, and shall be the City of Oakland, County of Alameda, State of California.

FOURTH. That said corporation shall have perpetual existence.

FIFTH. That the number of the directors of said corporation is and shall be five, and the name and residences of those who are elected and appointed for the first year are Rosalia Miller, Mary Brown, Marguerite Meunier, Anna L. Heas and Wilhelmina Hartman, all of whom reside in the City of Oakland, County of Alameda, State of California.

SIXTH. That said corporation shall not have any capital stock, and the members and officers thereof shall derive no pecuniary profit therefrom. Pecuniary profit is not and never shall be the object of this corporation, and no part of the net earnings of said corporation shall inure to the benefit of any member of the corporation or to any individual and in the event of the dissolution of said corporation the assets of

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BANK OF AMERICA BLDG.
OAKLAND, CALIF.

Certificate Verification No.: 367622527 Date: 09/12/2025

said corporation shall not inure to or be distributed to the benefit of any member or individual but shall be employed only for scientific, educational, charitable and religious purposes.

Rosalia Miller (SEAL)

Mary Brown (SEAL)

Marguerite Meunier (SEAL)

Anna L. Haas (SEAL)

Wilhelmina Hartman (SEAL)

State of California)
County of Alameda) ss

On this fourth day of December in the year of our Lord one thousand nine hundred and three before me, C. K. MARSHALL, a Notary Public in and for the county of Alameda, State of California, residing therein, duly commissioned and sworn, personally appeared Rosalia Miller, Mary Brown, Marguerite Meunier, Anna L. Haas and Wilhelmina Hartman known to me to be the persons whose names are subscribed to the within instrument, and they acknowledged to me that they executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my Official Seal, at my office in the City of Oakland, County and State aforesaid, the day and year in this certificate first above written.

C. K. MARSHALL
Notary Public in and for the County of Alameda, State of California

(SEAL)

AND RESOLVED FURTHER that the Board of Directors of this corporation hereby adopts and approves said amendment of said Articles of Incorporation and said Articles of Incorporation as amended.

RESOLVED FURTHER that the Vice President and the Secretary of this corporation be and they hereby are authorized and directed to procure the adoption and approval of the foregoing amendment by the written consent of the members of this corporation holding at least a majority of the voting power and thereafter to sign and verify by their oaths and to file a certificate in the form and manner required by Section 362(b) of the California Civil Code and in general to do any and all things necessary to effect said

Certificate Verification No.: 367622527 Date: 09/12/2025

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OAKLAND, CALIF.

PHSSC 01040

amendment in accordance with said Section 362(b).

Two: The number of members of said corporation consenting to such amendment of its Articles of Incorporation is four and the following is a copy of the written consent executed by said members:

"WRITTEN CONSENT OF MEMBERS TO AMENDMENT OF ARTICLES OF INCORPORATION OF PROVIDENCE HOSPITAL OF OAKLAND

"WHEREAS at a special meeting of the Board of Directors of Providence Hospital of Oakland, a California corporation, duly held at the principal office for the transaction of the business of said corporation at Oakland on the 20th day of March, 1941, at which meeting a quorum of the members of said Board was at all times present and acting, an amendment of the Articles of Incorporation of said corporation was adopted and approved by resolution of said Board amending said Articles of Incorporation in certain particulars known to and understood by each of the undersigned.

"NOW, THEREFORE, each of the undersigned members of said corporation does hereby adopt, approve and consent to said amendment of said Articles of Incorporation and does hereby consent that said Articles of Incorporation be amended in said particulars, as set forth in the copy attached hereto and made a part hereof.

"IN WITNESS WHEREOF each of the undersigned has hereunto signed her name and following her name the date of signing and the number of votes entitled to be voted by her on said date upon amendments of said Articles of Incorporation of the character of the foregoing amendment.

Name	Date	No. of Votes
Sister Louis Achille	March 27th,1941	1
Sister M. Napoleon	March 27th,1941	1
Sister Francesca	March 27th,1941	1
Sister Francis Ignatius	March 27th,1941	1

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BANK OF AMERICA BLDG.
OAKLAND, CALIF.

Certificate Verification No.: 367622527 Date: 09/12/2025

Three: The total number of members of said corporation entitled to vote on or consent to adoption of such amendment is six. That the copy attached to said written consent is an exact copy of the articles of incorporation of said corporation, as set forth in the resolution adopted by the board of directors thereof.

IN WITNESS WHEREOF, the undersigned have executed this certificate of amendment this 27th day of March, 1941.

Sister Louis Achille
Vice President of Providence Hospital of Oakland

(SEAL)

Sister Francis Ignatius
Secretary of Providence Hospital of Oakland

STATE OF CALIFORNIA)
) SS.
County of Alameda)

Sister Louis Achille and Sister Francis Ignatius, being first duly sworn, each for herself deposes and says:

That Sister Louis Achille is and was at all of the times mentioned in the foregoing Certificate of Amendment the Vice President of Providence Hospital of Oakland, the California corporation therein mentioned; that Sister Francis Ignatius is and was at all times mentioned in the foregoing Certificate of Amendment the Secretary of said corporation; that each has read said Certificate and each of the statements therein made and it is true of her own knowledge and the signatures purporting to be the signatures of the said Vice President and Secretary thereof are the genuine signatures of said Vice President and Secretary respectively.

Sister Louis Achille

Sister Francis Ignatius

Subscribed and sworn to before me this 27th day of March, 1941.

A. K. Rowell
Notary Public in and for the County of Alameda, State of California.

(SEAL)

8.

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OAKLAND, CALIF.

Certificate Verification No.: 367622527 Date: 09/12/2025

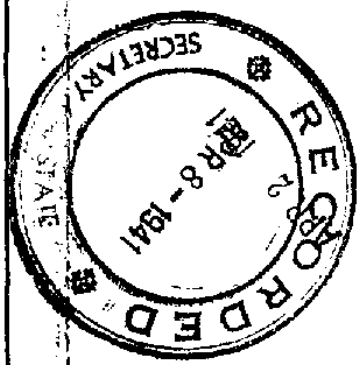
CERTIFICATE OF AMENDMENT

OF ARTICLES OF INCORPORA-

TION OF

PROVIDENCE HOSPITAL

OF OAKLAND



ENTERED

DONAHUE, RICHARDS & HAMLIN
ATTORNEYS AT LAW
BANK OF AMERICA BUILDING
Telephone GLencourt 0544
OAKLAND, CALIFORNIA

Certificate Verification No.: 367622527 Date: 09/12/2025

OFFICE OF
Secretary of State
Corporation Number
58992

FILED
In the office of the Secretary of State
of the State of California
FEB 26 1946
FRANK M. JORDAN, Secretary of State
By [signature] Deputy

CERTIFICATE OF AMENDMENT
OF
ARTICLES OF INCORPORATION
OF
PROVIDENCE HOSPITAL OF OAKLAND

The undersigned, Sister Louis Achille and Sister Francis Ignatius, do hereby certify that they are respectively and have been at all times herein mentioned the duly elected and acting Vice President and Secretary of Providence Hospital of Oakland, a California corporation, and further that,

ONE: At a special meeting of the Board of Directors of said corporation duly held at its principal office for the transaction of business at Oakland, California, at 4:30 o'clock p.m. on the 21st day of February, 1946, at which meeting there was at all times present and acting a quorum of the members of said Board, the following resolution was duly adopted:

"WHEREAS, it is deemed by the Board of Directors of this corporation to be to its best interest and to the best interests of its members that its Articles of Incorporation be amended;

NOW, THEREFORE, BE IT RESOLVED that paragraph numbered SECOND of the Articles of Incorporation of this Corporation be amended to read as follows:

'SECOND. That the purposes for which said corporation is formed are: To erect, maintain and conduct in the City of Oakland, State of California, and elsewhere within said State, one or more hospitals for sick, injured and disabled persons, and to afford medical and surgical care and treatment to sick, injured, and disabled persons either within or without such hospitals; to acquire by gift, devise, bequest or purchase all such real and personal property as may at any time be required for the successful accomplishment of the purposes aforesaid, and from time to time to sell, convey, mortgage and otherwise dispose of any and all property acquired and owned by this corporation, and any and all property of which it shall have the power to dispose; provided, however, that the property of this corporation is irrevocably dedicated to religious, charitable or hospital purposes and upon the liquidation, dissolution or abandonment thereof, will not inure to the benefit of any private person, but shall be distributed to a fund, foundation or corporation organized and operated for religious, hospital or charitable purposes as selected and designated by the board of Directors.'

Certificate Verification No.: 367622527 Date: 09/12/2025

"IT IS FURTHER RESOLVED that the Board of Directors of this corporation hereby adopts and approved said amendment of said Articles of Incorporation; and

"IT IS RESOLVED FURTHER that the Vice-President and Secretary of this corporation be and they are hereby authorized and directed to procure the adoption and approval of the foregoing amendment by written consent of the members of this corporation holding at least two-thirds (2/3) of the voting power, and thereafter to sign and verify by their oaths and file a certificate in the form and manner required by Section 362b of the California Civil Code and in general to do any and all things necessary to effect said amendment in accordance with said Section 362b.

SISTER LOUIS ACHILLE /s/
Vice-President

Attest:

SISTER FRANCIS IGNATIUS /s/
Secretary "

TWO: The number of members of said corporation consenting to such amendment of its Articles of Incorporation is 5 and the following is a copy of the written consent executed by said members:

"WHEREAS, at a special meeting of the Board of Directors of Providence Hospital of Oakland, a California corporation, duly held at the principal office for the transaction of business of said corporation at Oakland on the 21st day of February, 1946, at which meeting a quorum of the members of said Board was at all times present and acting, an amendment of the Articles of Incorporation of said corporation was adopted and approved by resolution of said Board amending said Articles of Incorporation in certain particulars known to and understood by each of the undersigned.

NOW, THEREFORE, each of the undersigned members of said corporation does hereby adopt, approve and consent to said amendment of said Articles of Incorporation and does hereby consent that said Articles of Incorporation be amended in said particulars, as set forth in the copy attached hereto and made a part hereof.

IN WITNESS WHEREOF, each of the undersigned has hereunto signed her name and following her name the date of signing and the number of votes entitled to be voted by her on said date upon amendments of said Articles of Incorporation of the character of the foregoing amendment.

Certificate Verification No.: 367622527 Date: 09/12/2025

"

NAME	DATE	NO. OF VOTES
Sister Peter Francis	Feb. 21, 1946	1
Sister Louis Achille	Feb. 21, 1946	1
Sister Francis Ignatius	Feb. 21, 1946	1
Sister Francesca	Feb. 21, 1946	1
Sister Mary of the Cross	Feb 21, 1946	1

"

THREE: The total number of members of said corporation entitled to vote on or consent to adoption of such amendment is six. That the copy attached to said written consent is an exact copy of the Amendment to the Articles of Incorporation of said corporation, as set forth in the resolution adopted by the Board of Directors thereof.

IN WITNESS WHEREOF, the undersigned have executed this certificate of amendment this 21st day of February, 1946.

Sister Louis Achille.
Vice-President of Providence Hospital of Oakland

Sister Francis Ignatius
Secretary of Providence Hospital of Oakland

Certificate Verification No.: 367622527 Date: 09/12/2025

STATE OF CALIFORNIA)
) ss.
COUNTY OF ALAMEDA)

SISTER LOUIS ACHILLE and SISTER FRANCIS IGNATIUS, being first duly sworn, each for herself deposes and says:

That Sister Louis Achille is and was at all times mentioned in the foregoing Certificate of Amendment the Vice-President of Providence Hospital of Oakland, the California corporation therein mentioned; that Sister Francis Ignatius is and was at all times mentioned in the foregoing Certificate of Amendment the Secretary of said corporation; that each has read said Certificate and each of the statements therein made and it is true of her own knowledge, and the signatures purporting to be the signatures of the said Vice President and Secretary thereof are the genuine signatures of said Vice-President and Secretary, respectively.

Sister Louis Achille

Sister Francis Ignatius

SEAL

Subscribed and sworn to before me this 25th day of February, 1946.

Notary Public in and for the County of Alameda, State of California.

Certificate Verification No.: 367622527 Date: 09/12/2025

RECEIVED
MAR 7 - 1946
SECRETARY OF STATE

Certificate Verification No.: 367622527 Date: 09/12/2025

38782

Statement by Corporation of Address of Principal Office, Names of Officers and Designation of Agent for the Service of Process

(For filing with the Secretary of State of the State of California pursuant to Section 3301 or Section 9003, Corporations Code)

Providence Hospital of Oakland,

a corporation, makes the following statements:

1. That it is a corporation organized under the laws of the State of California.
2. The address and location of its principal office (California) are as follows:

(a) 378-30th.St. Oakland, 9, California
(Post Office or mail address)

(b) Same
(Street address or location)

FILED
In the office of the Secretary of State of the State of California
APR 4 - 1950
FRANK M. JORDAN, Secretary of State
By [signature] Deputy

3. The names of the following officers are:
(a) President, Sister Bonosa
(b) Secretary, Sister Francis Ignatius
(c) Treasurer, Sister Mary of the Cross
(d) Other officers desired to be named are, Sister Louis Achille, Vice President

(No officers other than the president or other head, the secretary, the treasurer, if any, need be named)

4. [redacted], whose address is
(Name of individual)

(Give address in California at which agent can be personally contacted)

is designated as Agent for the purpose of service of process.

Providence Hospital of Oakland

By [signature]
Secretary

NOTES: (A) Items 1 (identity), 2 (address and location of principal office) and 3 (names of officers) must be filled in in all cases. Item 4 (designation of agent) is optional and should not be filled in unless it is desired to designate a person to act as agent for the purpose of receiving process against the corporation. Item 4 should not be filled in at all by a foreign corporation.

(B) All domestic (California) corporations, profit and nonprofit, are required to file this statement with the Secretary of State (Section 3301, Corporations Code). After the original filing, unless required by Section 9003, Corporations Code, new statements need be filed only in the case of a change of address or location of principal office. New statements may be filed at any time desired for the purpose of designating an agent, or new agent, for purpose of service of process.

(C) Every domestic and qualified foreign nonprofit corporation expressly exempted from taxation by the provisions of the Bank and Corporation Franchise Tax Act of the State of California must file this statement (items 1, 2, and 3) with the Secretary of State sometime during each and every calendar year beginning with the year 1950. Failure to file creates a presumption of abandonment making the corporation name available for use by another corporation. Such presumption of abandonment may be removed at any time by the filing of this statement, subject to the adoption of a new name if the corporation's name has been appropriated by another corporation during the period of presumed abandonment (Section 9003, Corporations Code). The statement may also be filed at any time for the purpose of changing address or location of principal office of a domestic corporation or for the purpose of designating an agent or new agent, except that it may not be filed by a foreign corporation for either purpose.

(D) There is no fee for filing this statement if only items 1, 2, and 3 be filled in. If item 4 is filled in, however, for the purpose of designating an agent for the service of process, a filing fee of $5 will be charged.

Certificate Verification No.: 367622527 Date: 09/12/2025

38992

Statement by Nonprofit Corporation of Address of Principal Office and Names of Officers

(For filing with the Secretary of State of the State of California pursuant to Section 9003, Corporations Code)

Providence Hospital of Oakland

a corporation, makes the following statements:

1. That it is a nonprofit corporation organized under the laws of the State of California
2. The address and location of its principal office (California) are as follows:

(a) 3705-30th St.
(Post Office or mail address)

(b) Oakland, 9, California
(Street address or location)

3. The names of the following officers are:

(a) President, Sister Bonnea

(b) Secretary, Sister Francis Ignatius

(c) Other officers desired to be named are, Sister Louis Achilla, Vice President

Sister Mary of the Cross, Treasurer
(No officers other than the president or other head, and the Secretary, need be named)

FILED
In the office of the Secretary of State
of the State of California
MAR 8 - 1951
FRANK M. JORDAN, Secretary of State
By [signature]
Assistant Secretary of State

Providence Hospital of Oakland
Name of Corporation
By [signature]
(Title) Secretary

NOTES: (A) Every domestic and qualified foreign nonprofit corporation expressly exempted from taxation by the provisions of the Bank and Corporation Franchise Tax Act of the State of California must file this statement with the Secretary of State sometime during each and every calendar year beginning with the year 1950. Failure to file creates a presumption of abandonment making the corporation name available for use by another corporation. Such presumption of abandonment may be removed at any time by the filing of this statement, subject to the adoption of a new name if the corporation's name has been appropriated by another corporation during the period of presumed abandonment. (Section 9003, Corporations Code).

(B) There is no fee for filing this statement.

Certificate Verification No.: 367622527 Date: 09/12/2025

NA CHG TO: SISTERS OF PROVIDENCE IN CALIFORNIA

A126736
38992

FILED
In the office of the Secretary of State
of the State of California

OCT 20 1972

EDMUND G. BROWN Jr., Secretary of State
By Bell Hoesn
Deputy

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCOPORATION

OF PROVIDENCE HOSPITAL OF OAKLAND

SISTER FRANCIS IGNATIUS and SISTER VERONICA OF PROVIDENCE certify:

1. That they are the president and the secretary, respectively, of PROVIDENCE HOSPITAL OF OAKLAND, a California corporation.

2. That at a meeting of the board of directors of said corporation, duly held at Oakland, California on October 2, 1972, the following resolution was adopted:

RESOLVED that the Articles of Incorporation of this corporation be amended to read as follows:

ARTICLE I

The name of this corporation is SISTERS OF PROVIDENCE IN CALIFORNIA.

6

ARTICLE II

This corporation shall have perpetual existence.

ARTICLE III

The specific and primary purposes for which this corporation is formed and for which it shall be exclusively

Certificate Verification No.: 367622527 Date: 09/12/2025

administered and operated are charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large) purposes including, without limiting the generality of the foregoing:

(1) To maintain, establish, own and operate health care facilities and institutions of any and all kinds, including hospitals and nurses training schools in conjunction therewith, and to carry on health related services whether in the fields of education, or medical research for the benefit of the public at large, or otherwise, and to participate in and sponsor activities relating to health care in the community;

(2) To maintain, establish, own and operate schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code;

(3) To undertake, promote, develop, sponsor or carry on charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large), work or pursuits, or any one or more of the foregoing;

and for no other purpose. This corporation shall not directly or indirectly engage in carrying on propaganda, or otherwise attempt to influence legislation or participate in or intervene in (including the publishing or distribution of statements) in any political campaign on behalf of any candidate for public office. In order to accomplish the foregoing charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large) purposes and for no other purpose or purposes, this corporation shall also have the following powers:

(1) Sue and be sued;

(2) Make contracts;

(3) Receive property by devise or bequest, subject to the laws regulating the transfer of property by will, and otherwise acquire and hold all

Certificate Verification No.: 367622527 Date: 09/12/2025

property, real or personal, including shares of stock, bonds and securities of other corporations;

(4) Act as trustee under any trust whose objects are related to the principal objects of the corporation, and to receive, hold, administer, and expend funds and property subject to such trust;

(5) Convey, donate, exchange, lease, mortgage, encumber, pledge, transfer upon trust, or otherwise dispose of all property, real or personal, and the income, increase or benefits therefrom;

(6) Borrow money, contract debts, and issue bonds, notes and debentures, and secure the payment of and performance of its obligations; and

(7) Do all other acts necessary or expedient for the administration of the affairs and attainment of the purposes of the corporation; provided, however, that this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the primary purposes of this corporation.

ARTICLE IV

This corporation is organized pursuant to the General Nonprofit Corporation Law of the State of California and does not contemplate pecuniary gain or profit to the members thereof and is organized for nonprofit purposes.

ARTICLE V

The county in the State of California where the principal office for the transaction of the business of the corporation is located is the County of Alameda.

ARTICLE VI

The number of directors of this corporation shall be not less than 6 nor more than 9, and the first members and directors were: WILHELMINA HARTMAN, ROSALIA MILLER, MARY BROWN, MARGUERITE MEUNIER, ANNA L. HAAS, all of whom resided in the City of Oakland, County of Alameda, State of California.

Certificate Verification No.: 367622527 Date: 09/12/2025

ARTICLE VII

The persons who are the directors of this corporation from time to time shall be its only members and on ceasing to be a director of this corporation, any such person shall cease to be a member.

ARTICLE VIII

The property, assets, profits and net income of this corporation are irrevocably dedicated to religious, charitable, scientific (medical research for the benefit of the community at large), or educational (operating schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code) purposes and no part of the net income or assets of this organization shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person. Upon the dissolution or winding up of the corporation, its assets remaining after payment of, or provision of payment of, all debts and liabilities of this corporation, shall be distributed to a nonprofit fund, foundation or corporation that is organized and operated exclusively for religious, charitable scientific (medical research for the benefit of the community at large) or educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code) purposes and that has established its tax exempt status under section 501(c)(3) of the Internal Revenue Code and whose property is dedicated to exempt purposes as specified in section 214 of the California Revenue and Taxation Code.

3. That the members have adopted said amendment by resolution at a meeting held at Oakland, California on October 2, 1972. That the wording of the amended article, as set forth in the members' resolution, is the same as that set forth in the directors' resolution in Paragraph 2 above.

4. That the number of members who voted affirmatively for the adoption of said resolution is five and that the

Certificate Verification No.: 367622527 Date: 09/12/2025

number of members constituting a quorum is four.

Sister Francis Ignatius
Sister Francis Ignatius,
President

Sister Veronica of Providence
Sister Veronica of Providence,
Secretary

The undersigned declares under penalty of perjury that the matters set forth in the foregoing certificate are true and correct. Executed at Oakland, California on October 4, 1972.

Sister Veronica of Providence
Sister Veronica of Providence

Certificate Verification No.: 367622527 Date: 09/12/2025

VERIFICATION

STATE OF OREGON)
) ss.
County of JACKSON)

SISTER FRANCIS IGNATIUS, being first duly sworn, deposes and says:

That the matters set forth in the foregoing certificate are true and correct.

Sister Francis Ignatius
Sister Francis Ignatius

Subscribed and sworn to before me on this 10th day of October, 1972.

NOTARY PUBLIC STATE OF OREGON

Jack L. Cox

My commission Expires 10-16-75
Notary Public

Certificate Verification No.: 367622527 Date: 09/12/2025

A130093

SCRV
38992

FILED
In the office of the Secretary of State
of the State of California
FEB 6 1973
EDMUND G. BROWN Jr., Secretary of State
By Ralph Hoden
Deputy

CERTIFICATE OF MERGER

OF OFFICERS OF

SISTERS OF PROVIDENCE IN CALIFORNIA

SISTER BARBARA ELLEN and SISTER MARY GLEASON hereby certify that they are the president and secretary, respectively, of SISTERS OF PROVIDENCE IN CALIFORNIA, a California non-profit corporation; and they further certify:

A. That the Board of Directors of the corporation by unanimous written consent without a meeting, pursuant to authority in Article III of the corporation by-laws to so act, adopted the following resolutions which became effective on January 15, 1973, approving the terms and conditions of an agreement for merger of Providence College of Nursing, a California non-profit corporation, into Sisters of Providence in California.

3

B. "RESOLVED that the terms and conditions of the Agreement of Merger dated December 11, 1972, between this corporation and Providence College of Nursing be, and the same hereby are, approved; and be it further

"RESOLVED that the President and Secretary of this corporation be, and the same hereby are, authorized and directed to execute and acknowledge the said Agreement in the name of and on behalf of the corporation; and be it further

"RESOLVED that the proper officers of this corporation be, and the same hereby are, authorized and directed to do all further acts and execute such instruments as are necessary or proper to effectuate said merger and to accomplish the purposes of these resolutions."

C. The authorized number of Directors of this corporation is seven (7), of which seven (7), a quorum, voted in favor of the said resolutions.

Certificate Verification No.: 367622527 Date: 09/12/2025

D. That the written consents of all of the members of the corporation approving the terms and conditions of the said agreement have been filed with the corporation's secretary.

E. That the corporation has seven (7) members.

F. That the agreement of merger was approved by written consent of the members of said corporation.

G. That the name of the surviving corporation is "SISTERS OF PROVIDENCE IN CALIFORNIA."

H. That the agreement of merger of Providence College of Nursing into Sisters of Providence in California, filed with the Secretary of State concurrently with this certificate, pursuant to section 4113 of the California Corporations Code, is the agreement hereinabove referred to and sets forth the terms and conditions approved by said resolutions of the directors and written consent of the members of Sisters of Providence in California.

Dated: January 15, 1973

Sister Barbara Ellen
Sister Barbara Ellen,
President

Sister Mary Gleason
Sister Mary Gleason,
Secretary

Certificate Verification No.: 367622527 Date: 09/12/2025

VERIFICATION

STATE OF WASHINGTON)
) ss.
County of King)

SISTER BARBARA ELLEN and SISTER MARY GLEASON, being first duly sworn, depose and say: That they are the President and Secretary, respectively, of Sisters of Providence in California, a California corporation; that they have read the foregoing Certificate and know the contents thereof and that the matters set forth in such Certificate are true of their own knowledge.

DAISY THERESA KISSEL NOTARY PUBLIC COM. EXPIRES SEPT 22 1975 STATE OF WASHINGTON

Sister Barbara Ellen
Sister Barbara Ellen

Sister Mary Gleason
Sister Mary Gleason

Subscribed and sworn to before me this 15th day of January 1973.

Daisy Theresa Kissel
NOTARY PUBLIC
State of Washington

My Commission expires:

9-22-75

Certificate Verification No.: 367622527 Date: 09/12/2025

A130095

SCRV
38992

FILED
In the office of the Secretary of State
of the State of California
FEB 6 1973
EDMUND G. BROWN, Jr., Secretary of State
By Bill Hoeden
Deputy

CERTIFICATE OF MERGER

OF OFFICERS OF

SISTERS OF PROVIDENCE IN CALIFORNIA

SISTER BARBARA ELLEN and SISTER MARY GLEASON hereby certify that they are the president and secretary, respectively, of SISTERS OF PROVIDENCE IN CALIFORNIA, a California non-profit corporation; and they further certify:

A. That the Board of Directors of the corporation by unanimous written consent without a meeting, pursuant to authority in Article III of the corporation by-laws to so act, adopted the following resolutions which became effective on January 15, 1973, approving the terms and conditions of an agreement for merger of Sisters of Charity of the House of Providence, St. Joseph Hospital of Burbank, a California non-profit corporation, into Sisters of Providence in California.

B. "RESOLVED that the terms and conditions of the Agreement of Merger dated December 15, 1972, between this corporation and Sisters of the House of Providence, St. Joseph Hospital of Burbank be, and the same hereby are, approved; and be it further

"RESOLVED that the President and Secretary of this corporation be, and the same hereby are, authorized and directed to execute and acknowledge the said Agreement in the name of and on behalf of the corporation; and be it further

"RESOLVED that the proper officers of this corporation be, and the same hereby are, authorized and directed to do all further acts and execute such instruments as are necessary or proper to effectuate said merger and to accomplish the purposes of these resolutions."

C. The authorized number of Directors of this corporation is seven (7), of which seven (7), a quorum, voted in favor of the said resolutions.

Certificate Verification No.: 367622527 Date: 09/12/2025

D. That the written consents of all of the members of the corporation approving the terms and conditions of the said agreement have been filed with the corporation's secretary.

E. That the corporation has seven (7) members.

F. That the agreement of merger was approved by written consent of the members of said corporation.

G. That the name of the surviving corporation is "SISTERS OF PROVIDENCE IN CALIFORNIA."

H. That the agreement of merger of Sisters of Charity of the House of Providence, St. Joseph Hospital of Burbank into Sisters of Providence in California, filed with the Secretary of State concurrently with this certificate, pursuant to section 4113 of the California Corporations Code, is the agreement hereinabove referred to and sets forth the terms and conditions approved by said resolutions of the directors and written consent of the members of Sisters of Providence in California.

Dated: January 15, 1973

Sister Barbara Ellen
Sister Barbara Ellen,
President

Sister Mary Gleason
Sister Mary Gleason,
Secretary

Certificate Verification No.: 367622527 Date: 09/12/2025

VERIFICATION

STATE OF WASHINGTON)
) ss.
County of King)

SISTER BARBARA ELLEN and SISTER MARY GLEASON, being first duly sworn, depose and say: That they are the President and Secretary, respectively, of Sisters of Providence in California, a California corporation; that they have read the foregoing Certificate and know the contents thereof and that the matters set forth in such Certificate are true of their own knowledge.

DAISY THERESA KISSEL NOTARY PUBLIC COM. EXPIRES SEPT. 22, 75 STATE OF WASHINGTON

Sister Barbara Ellen
Sister Barbara Ellen

Sister Mary Gleason
Sister Mary Gleason

Subscribed and sworn to before me this 15th day of January 1973.

Daisy Theresa Kissel
NOTARY PUBLIC
State of Washington

My Commission expires:

9-22-75

Certificate Verification No.: 367622527 Date: 09/12/2025

A130097

FILED
In the office of the Secretary of State
of the State of California
FEB 6 1973
EDMUND G. BROWN JR., Secretary of State
By [signature] Deputy

SURV
38992

CERTIFICATE OF MERGER

OF OFFICERS OF

SISTERS OF PROVIDENCE IN CALIFORNIA

SISTER BARBARA ELLEN and SISTER MARY GLEASON hereby certify that they are the president and secretary, respectively, of SISTERS OF PROVIDENCE IN CALIFORNIA, a California non-profit corporation; and they further certify:

A. That the Board of Directors of the corporation by unanimous written consent without a meeting, pursuant to authority in Article III of the corporation by-laws to so act, adopted the following resolutions which became effective on January 15, 1973, approving the terms and conditions of an agreement for merger of Providence High School, a California non-profit corporation, into Sisters of Providence in California.

3

B. "RESOLVED that the terms and conditions of the Agreement of Merger dated December 15, 1972, between this corporation and Providence High School be, and the same hereby are, approved; and be it further

"RESOLVED that the President and Secretary of this corporation be, and the same hereby are, authorized and directed to execute and acknowledge the said Agreement in the name of and on behalf of the corporation; and be it further

"RESOLVED that the proper officers of this corporation be, and the same hereby are, authorized and directed to do all further acts and execute such instruments as are necessary or proper to effectuate said merger and to accomplish the purposes of these resolutions."

C. The authorized number of Directors of this corporation is seven (7), of which seven (7), a quorum, voted in favor of the said resolutions.

Certificate Verification No.: 367622527 Date: 09/12/2025

D. That the written consents of all of the members of the corporation approving the terms and conditions of the said agreement have been filed with the corporation's secretary.

E. That the corporation has seven (7) members.

F. That the agreement of merger was approved by written consent of the members of said corporation.

G. That the name of the surviving corporation is "SISTERS OF PROVIDENCE IN CALIFORNIA."

H. That the agreement of merger of Providence High School into Sisters of Providence in California, filed with the Secretary of State concurrently with this certificate, pursuant to section 4113 of the California Corporations Code, is the agreement hereinabove referred to and sets forth the terms and conditions approved by said resolutions of the directors and written consent of the members of Sisters of Providence in California.

Dated: January 15, 1973

Sister Barbara Ellen
Sister Barbara Ellen,
President

Sister Mary Gleason
Sister Mary Gleason,
Secretary

Certificate Verification No.: 367622527 Date: 09/12/2025

VERIFICATION

STATE OF WASHINGTON)
) ss.
County of King)

SISTER BARBARA ELLEN and SISTER MARY GLEASON, being first duly sworn, depose and say: That they are the President and Secretary, respectively, of Sisters of Providence in California, a California corporation; that they have read the foregoing Certificate and know the contents thereof and that the matters set forth in such Certificate are true of their own knowledge.

DAISY THERESA KISSEL NOTARY PUBLIC COM. EXPIRES SEPT. 22, 1975 STATE OF WASHINGTON

Sister Barbara Ellen
Sister Barbara Ellen

Sister Mary Gleason
Sister Mary Gleason

Subscribed and sworn to before me this 15th day of January 1973.

Daisy Theresa Kissel
NOTARY PUBLIC
State of Washington

My Commission expires:

9-22-75

Certificate Verification No.: 367622527 Date: 09/12/2025

A149202

DO NOT WRITE IN THIS SPACE
38992

FILED
In the office of the Secretary of State
of the State of California

OCT 17 1974

EDMUND G. BROWN Jr., Secretary of State
By Myrtle P. Reintomo
Deputy

DESIGNATION BY CALIFORNIA CORPORATION OF AGENT FOR THE SERVICE OF PROCESS

(For filing with the Secretary of State of the State of California pursuant to Section 3301, Corporations Code)

SISTERS OF PROVIDENCE IN CALIFORNIA, a corporation organized under the laws of the State of California, designates an agent for service of process as follows:

(Use the following paragraph 1 if the process agent is a natural person. See NOTES on the reverse of this form.)

1. not applicable,

a natural person residing in the State of California, whose complete ☐ business ☐ residence address is ,

is designated as its agent for the purpose of service of process.

(Use the following paragraph 2 if the process agent is a corporation. See NOTES on the reverse of this form.)

2. C T CORPORATION SYSTEM, a corporation organized and existing under the laws of DELAWARE,

is designated as its agent for the purpose of service of process. The name of the city, town or village wherein said corporate agent has an office, as set forth in the certificate filed by said corporate agent pursuant to Section 3301.5 or 3301.6 (if a domestic corporation) or pursuant to Section 6403.5 or 6403.6 (if a foreign corporation), California Corporations Code, at which the undersigned corporation may be served is

LOS ANGELES, CALIFORNIA
(State only name of city, town or village—no street address)

SISTERS OF PROVIDENCE IN CALIFORNIA
(Name of Corporation)

By Sister Lorraine Hofmeister
(Title)
Vice President

(CAL. - 364 - 6/27/72)

SEC/STATE FORM LL-18 (REV. 12-70)

Certificate Verification No.: 367622527 Date: 09/12/2025

38992

A172339

FILED
In the office of the Secretary of State
of the State of California
DEC 3 1976
MARCH FONG EU, Secretary of State
By [signature]
Deputy

CERTIFICATE OF AMENDMENT

OF

ARTICLES OF INCORPORATION

OF SISTERS OF PROVIDENCE IN CALIFORNIA

SISTER PHILIAS DENIS and SISTER MARY GLEASON certify:

1. That they are the president and the secretary, respectively, of SISTERS OF PROVIDENCE IN CALIFORNIA, a California corporation.

2. That at a meeting of the board of directors of said corporation, duly held at Seattle, Washington, on November 18, 1976, the following resolution was adopted:

RESOLVED that Article III of the Articles of Incorporation of this corporation be amended to read as follows:

"

ARTICLE III

The specific and primary purposes for which this corporation is formed and for which it shall be exclusively administered and operated are charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large) purposes including, without limiting the generality of the foregoing:

(1) To maintain, establish, own and operate health care facilities and institutions of any and all kinds, including hospitals and nurses training schools in conjunction therewith, and to

Certificate Verification No.: 367622527 Date: 09/12/2025

carry on health related services whether in the fields of education, or medical research for the benefit of the public at large, or otherwise, and to participate in and sponsor activities relating to health care in the community;

(2) To maintain, establish, own and operate schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code;

(3) To undertake, promote, develop, sponsor or carry on charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large), work or pursuits, or any one or more of the foregoing;

and for no other purpose. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and this corporation shall not participate in or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

In order to accomplish the foregoing charitable, educational (operation of schools of less than collegiate grade within the meaning of section 214 of the California Revenue and Taxation Code), religious and scientific (medical research for the benefit of the community at large) purposes and for no other purpose or purposes, this corporation shall also have the following powers:

(1) Sue and be sued;

(2) Make contracts;

(3) Receive property by devise or bequest, subject to the laws regulating the transfer of property by will, and otherwise acquire and hold all property,

Certificate Verification No.: 367622527 Date: 09/12/2025

real or personal, including shares of stock, bonds and securities of other corporations;

(4) Act as trustee under any trust whose objects are related to the principal objects of the corporation, and to receive, hold, administer, and expend funds and property subject to such trust;

(5) Convey, donate, exchange, lease, mortgage, encumber, pledge, transfer upon trust, or otherwise dispose of all property, real or personal, and the income, increase or benefits therefrom;

(6) Borrow money, contract debts, and issue bonds, notes and debentures, and secure the payment of and performance of its obligations; and

(7) Do all other acts necessary or expedient for the administration of the affairs and attainment of the purposes of the corporation;

provided, however, that this corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of the primary purposes of this corporation."

3. That the members have adopted said amendment by resolution at a meeting held at Seattle, Washington, on November 18, 1976, and that the wording of the amended article, as set forth in the members' resolution, is the same as that set forth in the directors' resolution in Paragraph 2 above.

4. That the number of members who voted affirmatively for the adoption of said resolution is 6 and that the

Certificate Verification No.: 367622527 Date: 09/12/2025

number of members constituting a quorum is 4.

Philias Denis, SP.
Sister Philias Denis
President

Mary Gleason, SP.
Sister Mary Gleason
Secretary

VERIFICATION

STATE OF WASHINGTON)
) ss.
County of King)

SISTER PHILIAS DENIS and SISTER MARY GLEASON, each being first duly sworn, deposes and says:

That the matters set forth in the foregoing certificate are true and correct.

Philias Denis, SP.
Sister Philias Denis

Mary Gleason, SP.
Sister Mary Gleason

SUBSCRIBED AND SWORN to before me on this 18th day of November, 1976.

Daisy Theresa Kissel
Notary Public in and for the State of Washington, residing at Seattle

Certificate Verification No.: 367622527 Date: 09/12/2025

A0576356

FILED
In the Office of the Secretary of State
of the State of California

FEB - 4 2002

BILL JONES, Secretary of State

0038992

CERTIFICATE OF AMENDMENT OF ARTICLES OF INCORPORATION

The undersigned certify that:

1. They are the president and the secretary, respectively, of PROVIDENCE HEALTH SYSTEM-SOUTHERN CALIFORNIA, a California nonprofit religious corporation.

2. The Restated Articles of Incorporation of this corporation are amended as follows:

   Article IV is amended in its entirety as follows:

ARTICLE IV
TAX EXEMPT STATUS

The corporation is organized and is to be operated exclusively for charitable, religious, educational and scientific purposes. The property of the corporation is irrevocably dedicated to charitable, religious, scientific and educational purposes meeting the requirements for exemption provided by Section 214 of the California Revenue and Taxation Code and no part of the net earnings of the corporation shall inure to the benefit of, or be distributed to, the Directors, Officers or other private persons, except that the corporation is authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its exempt purposes. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal income tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") (or the corresponding provision of any future United States Internal Revenue Law), (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code (or the corresponding provision of any future United States Internal Revenue Law), or (c) by a corporation to which the welfare exemption found in Section 214 of the California Revenue and Taxation Code is applicable.

Certificate Verification No.: 367622527 Date: 09/12/2025

Article VIII is amended in its entirety as follows:

ARTICLE VIII
DISSOLUTION

Upon dissolution of the corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the corporation, dispose of the assets of the corporation to an organization or organizations organized and operated exclusively for charitable, religious, scientific or educational purposes meeting the requirements for exemption provided by Section 214 of the Revenue and Taxation Code and shall at the time qualify as an exempt organization or organizations under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (or the corresponding provision of any future United States Internal Revenue Law), as the Members shall determine.

3. The foregoing amendment of the Articles of Incorporation has been duly approved by the required vote of the members.

4. The foregoing amendment of Articles of Incorporation has been duly approved by the required vote of the board of directors.

[Signature Page to Follow.]

Certificate Verification No.: 367622527 Date: 09/12/2025

We further declare under penalty of perjury under the laws of the State of California that the matters set forth in this certificate are true and correct of our own knowledge.

Date: 1/29/02

Name: Henry M. Walter
Title: President

Name: Jeffrey W. Rogers
Title: Secretary

Certificate Verification No.: 367622527 Date: 09/12/2025

A0843592

C0038992

FILED
Secretary of State
State of California
JUL 07 2020

AMENDED AND RESTATED ARTICLES OF INCORPORATION OF PROVIDENCE HEALTH SYSTEM - SOUTHERN CALIFORNIA

Mike Butler and Cynthia Strauss hereby certify that:

1. They are respectively the President and Secretary of Providence Health System - Southern California, a California nonprofit religious corporation.

2. The Articles of Incorporation of this corporation are amended and restated pursuant to Resolution of the Board of Directors of this corporation approved and dated May 14, 2020, as follows:

ARTICLE I
NAME

The name of the corporation shall be PROVIDENCE HEALTH SYSTEM - SOUTHERN CALIFORNIA.

ARTICLE II
DURATION

The corporation shall have perpetual existence.

ARTICLE III
PURPOSES

The purposes for which the corporation has been formed are as follows:

A. To establish, operate, manage and maintain for charitable purposes, hospitals, long-term care, housing, medical clinics, health plans, managed care, and other health care facilities, and educational facilities, and programs designed to meet the health, education and social needs of all people;

B. To provide scientific research, charitable education, charitable and such other activities, services and programs related to its health care facilities, educational facilities and other services;

C. To engage in other charitable works which are consistent with the objectives of the corporation and the mission and values of Providence Health & Services and guided by the tradition and charism of the Sisters of Providence and the Little Company of Mary Sisters as appropriate, or the successor entities to such provinces;

D. To do any and all other things in furtherance of these purposes which are consistent with the laws of the State of California, the Articles and Bylaws of

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Providence Health & Services, as well as the Roman Catholic Church moral traditions and the *Ethical and Religious Directives for Catholic Health Care Services.*

ARTICLE IV
TAX EXEMPT STATUS

The Corporation is organized and is to be operated exclusively for religious, charitable, hospital, scientific, and charitable and educational purposes. The property of the corporation is irrevocably dedicated to religious, charitable, hospital, scientific, and charitable and educational purposes meeting the requirements for exemption provided by Section 214 of the California Revenue and Taxation Code and no part of the net earnings of the corporation shall inure to the benefit of, or be distributed to, the Directors, Officers or other private persons, except that the corporation is authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its exempt purposes. No substantial part of the activities of the corporation shall be the carrying on of propaganda, or otherwise attempting to influence legislation and the corporation shall not participate in, or intervene in (including the publication or distribution of statements) any political campaign on behalf of or in opposition to any candidate for public office. Notwithstanding any other provision of these articles, the corporation shall not carry on any other activities not permitted to be carried on (a) by a corporation exempt from Federal Income Tax under Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code") (or the corresponding provision of any future United States Internal Revenue Law), (b) by a corporation, contributions to which are deductible under Section 170(c)(2) of the Code (or the corresponding provision of any future United States Internal Revenue Law), or (c) by a corporation to which the welfare exemption found in Section 214 of the California Revenue and Taxation Code is applicable.

ARTICLE V
RELIGIOUS CORPORATION

The corporation is a religious corporation and is not organized for the private gain of any person. It is organized under the Nonprofit Religious Corporation Law primarily for religious purposes.

ARTICLE VI
MEMBER

The sole Member of the Corporation is Providence Health & Services ("Providence"), a Washington nonprofit corporation.

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ARTICLE VII
AMENDMENTS

Any action to alter, amend or repeal the Articles of Incorporation of the Corporation must be approved by the Board of Directors and the Member of the Corporation.

ARTICLE VIII
DISSOLUTION

Upon dissolution of the Corporation, the Board of Directors shall, after paying or making provision for the payment of all of the liabilities of the Corporation, dispose of all of the assets of the Corporation to Providence, its sole corporate Member, or to its designee, provided that such recipient entity is organized and operated exclusively for charitable, religious, hospital, educational and scientific purposes meeting the requirements for exemption provided by Section 214 of the California Revenue and Taxation Code and qualifies as an exempt organization under Section 501(c)(3) of the Internal Revenue Code ("Code")(or the corresponding provision of any future United States Internal Revenue Code) and California Revenue and Taxation Code Section 214. If, at the time of dissolution, Providence is not in existence, is not an exempt organization under the Code, or makes no such designation, the Board of Directors shall dispose of all the corporate assets to Providence Ministries or its designee, provided that such recipient entity is still in existence and organized and operated exclusively for charitable, religious, hospital, educational and scientific purposes meeting the requirements for exemption provided by section 214 of the California Revenue and Taxation Code, and qualifies as an exempt organization under the Code and California Revenue and Taxation Code Section 214. If, at the time of dissolution, Providence Ministries is not in existence, is not an exempt organization under the Code, or makes no such designation, the Board of Directors shall dispose of all the corporate assets to any other organization(s) selected by the Sisters of Providence, General Administration, Montreal, and American Province of Little Company of Mary Sisters, provided that each such recipient entity is organized and operated exclusively for charitable, religious, hospital, educational and scientific purposes meeting the requirements for exemption provided by Section 214 of the California Revenue and Taxation Code and qualifies as an exempt organization under the Code and California Revenue and Taxation Code Section 214.

ARTICLE IX
PRINCIPAL OFFICE

The county of the State of California where the principal office for the transaction of business of this corporation is to be located is Los Angeles County.

ARTICLE X
DIRECTORS

The number of directors of this corporation shall be fixed in accordance with the Bylaws

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of the corporation.

3. The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the Board of Directors.

4. The foregoing amendment and restatement of the Articles of Incorporation has been duly approved by the required vote of the Member.

The undersigned declare, under penalty of perjury under the laws of the State of California, that the matters set forth in the foregoing amendment and restatement are true and correct of their own knowledge. Executed this 30th day of June, 2020 at Renton, Washington.

Mike Butler, President

Cindy Strauss

Cindy Strauss, Secretary

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EXHIBIT I.C.

ST. ELIZABETH
PATIENT DEMOGRAPHIC DATA

I. Demographic Data

Patient	Sex	Age	Race; Ethnicity
Patient 1	M	68	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 2	F	93	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 3	F	68	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 4	F	82	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 5	M	79	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 6	M	65	Black; Non-Hispanic, Latino/a, or Spanish Origin
Patient 7	M	87	American Indian or Alaska Native
Patient 8	M	60	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 9	F	84	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 10	F	94	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 11	F	83	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 12	M	79	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 13	F	88	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 14	M	95	White; Non-Hispanic, Latino/a, or Spanish Origin

Patient 15	F	94	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 16	F	95	Black; Non-Hispanic, Latino/a, or Spanish Origin
Patient 17	M	86	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 18	F	89	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 19	F	94	White; Mexican, Mexican American, Chicano/a
Patient 20	M	88	Korean
Patient 21	F	61	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 22	F	84	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 23	M	74	Race Not Identified; Hispanic, Latino/a, or Spanish Origin
Patient 24	M	82	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 25	F	95	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 26	M	87	Race Not Identified; Hispanic, Latino/a, or Spanish Origin
Patient 27	F	84	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 28	F	96	Korean
Patient 29	F	96	White; Non-Hispanic, Latino/a, or Spanish Origin
Patient 30	M	95	White; Non-Hispanic, Latino/a, or Spanish Origin

Patient 31	F	78	White; Non-Hispanic, Latino/a, or Spanish Origin

II. Zip Code Data

The following is a list of zip codes for patients served by St. Elizabeth:

90068
90806
91324
91331
91344
91352
91423
91501
91502
91504
91505
91506
91601
91604
91606
91607
92325
95032

EXHIBIT I.D.

ENSIGN AND AFFILIATES GOVERNANCE DOCUMENTS AND FINANCIAL STATEMENTS

The Ensign Group, Inc.

33-0861263

29222 Rancho Viejo Rd., Suite 127, San Juan Capistrano, CA 92675-1049

Spencer Burton, President – 0% Ownership, Christopher Christensen, Executive Chairman & Chairman of the Board – 0% Ownership; Barry Port, Chief Executive Officer, Director and Board Member – 0% Ownership; Ann Blouin, Board Member -0% Ownership; Barry Smith, Board Member – 0% Ownership, Daren Shaw, Board Member – 0% Ownership; John Agwunobi Board Member – 0% Ownership; Swati Abbott, Board Member – 0% Ownership; Suzanne Snapper, CFO, Executive V.P. Board Member – 0% Ownership; Mark V. Parkinson, Board Member – 0% Ownership, Chad A. Keetch, Executive VP and Secretary – 0% Ownership; Beverly Wittekind, Executive VP and General Counsel - 0% ownership

(The Ensign Group, Inc. does not own, manage, operate, or control any facilities on the attached Schedule)

Exhibit 3.2

AMENDED AND RESTATED BYLAWS

OF

THE ENSIGN GROUP, INC.

(Effective as of November 15, 2007)

ARTICLE I
OFFICES

Section 1.01 *Registered Office.* The registered office of The Ensign Group, Inc. (the "corporation") in the State of Delaware shall be at 160 Greentree Drive, Suite 101, Dover, Delaware 19904. The name of the corporation's registered agent at that address shall be National Registered Agents, Inc.

Section 1.02 *Other Offices.* The corporation also may have an office or offices at such other place or places either within or without the State of Delaware as the board of directors of the corporation (the "board" or the "board of directors") may from time to time determine or the business of the corporation may from time to time require.

Section 1.03 *Books and Records.* The books and records of the corporation may be kept at the corporation's headquarters in Mission Viejo, California or at such other locations within or without the State of Delaware as may from time to time be designated by the board of directors.

ARTICLE II
MEETINGS OF STOCKHOLDERS

Section 2.01 *Place of Meetings.* Each meeting of the stockholders of the corporation shall be held at such place either within or without the State of Delaware as shall be fixed by resolution of the board of directors and specified in the notice of said meeting. If no designation is made by the board of directors, the place of meeting shall be the principal office of the corporation.

Section 2.02 *Annual Meetings.* The annual meeting of the stockholders for the transaction of such business as may properly come before the meeting shall be held at such place, date and time as shall be determined by the board of directors.

Section 2.03 *Special Meetings.* A special meeting of the stockholders for any purpose or purposes may be called at any time only by the chairman of the board, the chief executive officer or by a majority of the board of directors. This Section 2.03 may not be altered, amended or repealed except by the board of directors or by the affirmative vote of holders of at least a majority of the outstanding voting stock of the corporation.

Section 2.04 *Notice of Annual and Special Meetings.* Except as otherwise required by law, written, printed or electronic notice stating the place, date and hour of each meeting of stockholders, whether annual or special, and the purposes for which the meeting is called shall be given not less than ten (10) days nor more than sixty (60) days before the date of the meeting, either personally, by mail or, to the extent permitted by law, by a form of electronic transmission (as such term is defined in the Delaware General Corporation Law), to each stockholder of record entitled to vote at such meeting. If mailed, such notice shall be deemed to be delivered when deposited in the U.S. mail with postage thereon prepaid, addressed to the stockholder at his address as it appears on the stock transfer books of the corporation. Notice given by a form of electronic transmission that satisfies the requirements of the Delaware General Corporation Law and has been consented to by the stockholder to whom notice is given shall be deemed given at the times specified with respect to the giving of notice by electronic transmission in the Delaware General Corporation Law. An affidavit of the corporation's secretary, an assistant secretary or an agent of the corporation that notice has been given shall, in the absence of fraud, be prima facie evidence of the facts stated in the affidavit.

Section 2.05 *Business at Annual and Special Meetings.* The business to be transacted at any annual or special meeting of stockholders shall be limited to business that is properly brought before the meeting. For the purposes of these bylaws, "properly brought before the meeting" shall mean the business that is (i) specified in the notice of the meeting (or any supplement thereto) given

by or at the direction of the board of directors, (ii) otherwise brought before an annual meeting by or at the direction of the board of directors, or (iii) a proper matter for stockholder action under the Delaware General Corporation Law that has been otherwise properly brought before an annual meeting by a stockholder who is a stockholder of record on the date of the giving of the notice provided for in this Section 2.05 and on the record date for the determination of stockholders entitled to vote at such annual meeting and who complies with the notice procedures set forth in this Section 2.05. In order for business to be properly brought before an annual meeting by a stockholder, the stockholder must, in addition to any other applicable requirements, give written notice in proper form of such stockholder's intent to bring a matter before the annual meeting, which notice must be received by the secretary of the corporation at the corporation's principal executive offices no later than the close of business on the sixtieth (60th) day, nor earlier than the close of business on the ninetieth (90th) day, prior to the anniversary date of the immediately preceding annual meeting; provided, however, that in the event that no annual meeting was held in the previous year or the annual meeting is called for a date that is not within thirty (30) days before or after such anniversary date, notice by the stockholder to be timely must be so received not earlier than the close of business on the ninetieth (90th) day prior to such annual meeting and not later than the close of business on the later of the sixtieth (60th) day prior to such annual meeting, or not later than the close of business on the 10th day following the day on which public disclosure of the date of the meeting was made by the corporation, whichever occurs first. In no event shall the public announcement of a postponement or adjournment of an annual meeting to a later date or time commence a new time period for the giving of a stockholder's notice as described above. Except with respect to nominations for the election of directors, which shall be governed by Section 3.02 hereof, to be in proper form, each such notice shall set forth: (a) the name and address of the stockholder who intends to bring such matter before a meeting; (b) the class or series and number of shares of capital stock of the corporation entitled to vote at such meeting which are owned beneficially or of record by such stockholder; (c) a representation that the stockholder is a holder of record of stock of the corporation entitled to vote at such meeting and intends to appear in person or by proxy at the meeting to bring such matter before the meeting; (d) a description of the business desired to be brought before the meeting and the reasons therefor; (e) such other information regarding the stockholder and the business proposed by such stockholder as would be required to be included in the proxy statement pursuant to the rules and regulations of the Securities and Exchange Commission; and (f) a representation as to the stockholder's material interest in the business being proposed. In addition, the stockholder making such proposal shall promptly provide any other information reasonably requested by the corporation. Notwithstanding the foregoing, in order to include information with respect to a stockholder proposal in the proxy statement and form of proxy for a stockholder's meeting, stockholders must provide notice as required by, and otherwise comply with the requirements of, the Securities and Exchange Act of 1934, as amended, and the regulations promulgated thereunder. The presiding officer of the meeting shall refuse to acknowledge any business proposed to be brought before an annual or special meeting not made in compliance with the foregoing procedures. This Section 2.05 may not be altered, amended or repealed except by the board or by the affirmative vote of holders of at least a majority of the outstanding voting stock of the corporation.

Section 2.06 *Quorum and Adjourned Meetings.* The holders of a majority of the voting power of the stock entitled to vote at a meeting of the stockholders, present in person or represented by proxy, shall constitute a quorum at all meetings of the stockholders for the transaction of business, except as otherwise provided by statute or by the certificate of incorporation. Where a separate vote by a class or series or classes or series of stock is required at a meeting, the presence, in person or by proxy, of the holders of a majority of the voting power of each such class or series shall also be required to constitute a quorum. If, however, such quorum shall not be present or represented at any meeting of the stockholders, either the chairperson of the meeting or the holders of a majority of the voting power of the stock entitled to vote thereat, present in person or represented by proxy, shall have the power to adjourn the meeting from time to time, without notice other than announcement at the meeting, until a quorum shall be present or represented. At such adjourned meeting, at which the quorum shall be present or represented, any business may be transacted which might have been transacted at the meeting as originally noticed. Notice of an adjourned meeting need not be given if the time and place, if any, are announced at the meeting so adjourned, except that if the adjournment is for more than thirty (30) days, or if after the adjournment a new record date is fixed for the adjourned meeting, a notice of the adjourned meeting shall be given to each stockholder of record entitled to vote at the meeting. A quorum, once established at a meeting, shall not be broken by the withdrawal of the holders of enough voting power to leave less than a quorum. If a quorum is present at an original meeting, a quorum need not be present at an adjourned session of that meeting.

Section 2.07 *Required Vote.* When a quorum is present at any meeting, the vote of the holders of a majority of the voting power of the stock entitled to vote thereat, present in person or represented by proxy, shall decide any question brought before such meeting, unless the question is one upon which, by express provision of statute or by the certificate of incorporation or these bylaws, a different level of vote is required, in which case such express provisions shall govern and control the decision of such question. Notwithstanding the preceding sentence, elections of directors at all meetings of the stockholders at which directors are to be elected shall be by written ballot, and, except with respect to the right, if any, of the holders of any series of preferred stock or any other series or class of stock to elect additional directors under specified circumstances, a plurality of the voting power of the stock, present in person or represented by proxy, at the meeting and entitled to vote on the matter shall elect directors.

Section 2.08 *Conduct of Meetings of Stockholders.* The chairman of the board of directors, or if there shall be none or in his or her absence, the chief executive officer or if there shall be none or in his or her absence, the president, who is present at the meeting, or in all of their absences an individual designated by the board of directors, shall call to order and act as the chair of any meeting of the stockholders of the corporation. The secretary of the corporation shall serve as the secretary of the meeting or, if there shall be none or in his or her absence, the secretary of the meeting shall be such person as the chair of the meeting appoints. The board of directors may, to the extent not prohibited by law, adopt by resolution such rules, regulations and procedures for the conduct of the meeting of stockholders as it shall deem appropriate. Except to the extent inconsistent with such rules, regulations and procedures as adopted by the board of directors, the chair of the meeting shall have the right and authority to prescribe such rules, regulations and procedures and to take or refrain from taking such actions as, in the judgment of the chair of the meeting, are appropriate for the conduct of the meeting. To the extent not prohibited by applicable law or these bylaws, such rules, regulations and procedures, whether adopted by the board of directors or prescribed by the chair of the meeting, may include, without limitation, establishment of (i) an agenda or order of business for the meeting, (ii) the method by which business may be proposed and procedures for determining whether business has been properly (or not properly) introduced before the meeting, (iii) procedures for casting and the form of ballots to be used by stockholders in attendance at the meeting and the procedures to be followed for counting stockholder votes, (iv) rules, regulations and procedures for maintaining order at the meeting and the safety of those present, (v) limitations on attendance at or participation in the meeting to stockholders of record of the corporation, their duly authorized proxies or such other persons as the chair of the meeting shall determine, (vi) restrictions on entry to the meeting after the time fixed for commencement thereof and (vii) limitations on the time allotted to questions or comments by participants. Unless and to the extent otherwise determined by the board of directors or the chair of the meeting, it shall not be necessary to follow Roberts' Rules of Order or any other rules of parliamentary procedure at the meeting of stockholders. Following completion of the business of the meeting as determined by the chair of the meeting, the chair of the meeting shall have the exclusive authority to adjourn the meeting.

Section 2.09 *Conduct of Business.* No business shall be conducted at an annual meeting of stockholders of the corporation except business brought before the meeting in accordance with the procedures set forth in these bylaws. If the introduction of any business at an annual meeting of stockholders does not comply with the procedures specified in this Article, the chair of the meeting shall declare that such business is not properly before the meeting and shall not be considered at the meeting.

Section 2.10 *Stockholder List.* The secretary of the corporation shall prepare and make available, at least ten (10) days before every meeting of stockholders, a complete list of the stockholders entitled to vote at the meeting, arranged in alphabetical order, and showing the address of each stockholder and the number of shares registered in the name of each stockholder. Such list shall be open to the examination of any stockholder, for any purpose germane to the meeting, during ordinary business hours, for a period of at least ten (10) days prior to the meeting, at the corporation's principal place of business. The list shall also be produced and kept at the time and place of the meeting during the whole time thereof, and may be inspected by any stockholder who is present.

Section 2.11 *Inspectors of Elections.* The board of directors by resolution shall appoint one or more inspectors of election, which inspector or inspectors may include individuals who serve the corporation in other capacities, including, without limitation, as officers, employees, agents or representatives of the corporation, to act at the meeting (or any adjournment thereof) and make a written report thereof. Such inspector shall decide upon the qualification of the voters and shall certify and report the number of shares represented at the meeting and entitled to vote on any question, determine the number of votes entitled to be cast by each share, shall conduct the vote and, when the voting is completed, accept the votes and ascertain and report the number of shares voted respectively for and against each question, and determine, and retain for a reasonable period a record of the disposition of, any challenge made to any determination made by such inspector. One or more persons may be designated as alternate inspectors to replace any inspector who fails to act. If no inspector or alternate has been appointed to act, or if all inspectors or alternates who have been appointed are unable to act, at a meeting of stockholders, the chairman of the meeting shall appoint one or more inspectors to act at the meeting. Each inspector, before discharging his or her duties, shall take and sign an oath faithfully to execute the duties of inspector with strict impartiality and according to the best of his or her ability. The inspectors shall have the duties prescribed by the General Corporation Law of the State of Delaware.

Section 2.12 *Fixing Record Date.* If the corporation proposes to take any action for which the Delaware General Corporation Law would permit it to fix a record date, the board of directors may fix such a record date as provided under the Delaware General Corporation Law.

Section 2.13 *Action Without a Meeting.* To the extent permitted by law, any action required to be taken at any annual or special meeting of stockholders of the corporation, or any action which may be taken at any annual or special meeting of such stockholders, may be taken only with regards to an action that has been earlier approved by the board, without a meeting, without prior notice and without a vote, if a consent in writing, setting forth the action so taken and earlier approved by the board, shall be signed by the holders of outstanding stock having not less than the minimum number of votes that would be necessary to authorize or take such

action at a meeting at which all shares entitled to vote thereon were present and voted. Prompt notice of the taking of the corporate action without a meeting by less than unanimous written consent shall be given to those stockholders who have not consented in writing.

ARTICLE III
BOARD OF DIRECTORS

Section 3.01 *General Powers.* The business, property and affairs of the corporation shall be managed under the direction of the board of directors.

Section 3.02 *Nomination of Directors.* Only persons who are nominated in accordance with the following procedures shall be eligible for election as directors, except as may be otherwise provided in the certificate of incorporation with respect to the right, if any, of holders of a class of preferred stock of the corporation to nominate and elect a specified number of directors. To be properly brought before an annual meeting of the stockholders, or any special meeting of the stockholders called for the purpose of electing directors, nominations for the election of a director must be (i) made by or at the direction of the board of directors (or any duly authorized committee thereof) and specified in the notice of meeting (or any supplement thereto) given by or at the direction of the board of directors, (ii) made by or at the direction of the board of directors (or any duly authorized committee thereof) to be brought before an annual meeting, or (iii) made by any stockholder of the corporation who is a stockholder of record on the date of the giving of the notice provided for in this Section 3.02 and on the record date for the determination of stockholders entitled to vote at such meeting and who complies with the notice procedures set forth in this Section 3.02. In addition to any other applicable requirements, for a nomination to be made by a stockholder, such stockholder must have given timely notice thereof in proper written form to the secretary of the corporation. To be timely, such stockholder's notice must be received by the secretary of the corporation at the corporation's principal executive offices, (i) in the case of an annual meeting, in accordance with the time provisions set forth in Section 2.05, and, (ii) in the case of a special meeting of the stockholders called for the purpose of electing directors, not later than the close of business on the tenth (10th) day following the day on which notice of the date of the special meeting was mailed or public disclosure of the date of the special meeting was made by the corporation, whichever first occurs. To be in proper written form, each such stockholder's notice shall set forth: (a) the name, age, business address, residence address and principal occupation or employment of each nominee, and the name and address of the stockholder making the nomination, (b) the class or series and number of shares of capital stock of the corporation entitled to vote at such meeting which are owned beneficially or of record by each nominee and by the stockholder making the nomination, (c) a representation that the nominating stockholder is a stockholder of record of the corporation's stock entitled to vote at the meeting and intends to appear in person or by proxy at such meeting to nominate the person specified in the notice, (d) each nominee's qualifications for membership on the board of directors, (e) all of the information relating to each nominee and the stockholder making the nomination that would be required in a proxy statement soliciting proxies for the election of the nominee as a director, or would otherwise be required, in each case pursuant to the rules and regulations of the Securities and Exchange Commission, (f) a description of all direct or indirect arrangements or understandings between the nominating stockholder and each nominee and any other person or persons (naming such person or persons) pursuant to whose request the nomination is being made by the stockholder, (g) all other companies to which each nominee is being recommended as a nominee for director, (h) a signed written consent of the nominee to cooperate with reasonable background checks and personal interviews, to be named in the proxy statement and to serve as a director of the corporation, if elected, and (i) such additional information as the board of directors or a nomination or similar committee appointed by the board of directors may require pursuant to resolutions of the board of directors or such committee's charter. In addition, the stockholder making such nomination shall promptly provide any other information reasonably requested by the corporation. Notwithstanding the foregoing, in order to include information with respect to a stockholder nomination in the proxy statement and form of proxy for a stockholder's meeting, stockholders must provide notice as required by, and otherwise comply with the requirements of, the Securities and Exchange Act of 1934, as amended, and the regulations promulgated thereunder. The presiding officer of the meeting shall refuse to acknowledge the nomination of any person not made in compliance with the foregoing procedure. This Section 3.02 may not be altered, amended or repealed except by the board or by the affirmative vote of holders of at least a majority of the outstanding voting stock of the corporation.

Section 3.03 *Number of Directors.* The number of directors to constitute the whole board of directors shall be such number (not less than four nor more than seven) as shall be fixed from time to time by resolution adopted by a majority of the entire board of directors. Directors need not be stockholders. This Section 3.03 may not be altered, amended or repealed except by the board or by the affirmative vote of holders of at least a majority of the outstanding voting stock of the corporation.

Section 3.04 *Quorum and Manner of Acting.* A majority of the number of the directors in office at the time shall constitute a quorum for the transaction of business at any meeting. Thereafter, a quorum shall be deemed present for purposes of conducting business and determining the vote required to take action for so long as at least a third of the total number of directors is present. Except as otherwise required by the certificate of incorporation or these bylaws, the affirmative vote of a majority of the directors

present at any meeting at which a quorum is present shall be required for the taking of any action by the board of directors. In the absence of a quorum at any meeting of the board, such meeting need not be held, or a majority of the directors present thereat or, if no director is present, the secretary, may adjourn such meeting from time to time until a quorum shall be present. Notice of any adjourned meeting need not be given.

Section 3.05 *Offices; Place of Meetings.* The board of directors may hold meetings and have an office or offices at such place or places within or without the State of Delaware, as the board of directors may from time to time determine.

Section 3.06 *Annual Meeting.* A regular meeting of the board of directors shall be held without notice immediately after and at the same place as the annual meeting of the stockholders.

Section 3.07 *Regular Meeting.* Regular meetings of the board of directors shall be held at such places and at such times as the board of directors shall from time to time determine. Notice of regular meetings of the board of directors need not be given.

Section 3.08 *Special Meetings and Notice.* Special meetings of the board of directors shall be held whenever called by the chairman of the board, the chief executive officer or any two of the directors. Except as otherwise provided by law or by these Bylaws, notice of each such special meeting shall be given by the secretary (i) in person or by telephone to the director at least 24 hours in advance of the meeting, (ii) by personally delivering written notice to the director's last known business or home address at least 48 hours in advance of the meeting, (iii) by delivering an electronic transmission (including, without limitation, via telefacsimile or electronic mail) to the director's last known number or address for receiving electronic transmissions of that type at least 48 hours in advance of the meeting, (iv) by depositing written notice with a reputable delivery service or overnight carrier addressed to the director's last known business or home address for delivery to that address no later than the business day preceding the date of the meeting or (v) by depositing written notice in the U.S. mail, postage prepaid, addressed to the director's last known business or home address no later than the third business day preceding the date of the meeting. Each such notice shall state the time and place of the meeting but need not state the purposes thereof except as otherwise herein expressly provided. Notice of any such meeting need not be given to any director, however, if waived by him or her in writing or by facsimile, electronic transmission or similar means, or by mail, whether before or after such meeting shall be held, or if he or she shall be present at such meeting; and any meeting of the board shall be a legal meeting without any notice thereof having been given if all of the directors shall be present thereat.

Section 3.09 *Organization.* At each meeting of the board of directors, the chairman of the board, or in the absence of the chairman of the board, if they be directors, the chief executive officer, or in the absence of the chief executive officer, the president, or in the absence of the president, any director chosen by a majority of the directors present thereat, shall preside. The secretary, or in his or her absence an assistant secretary of the corporation, or in the absence of the secretary and all assistant secretaries, a person whom the chairman of such meeting shall appoint, shall act as secretary of such meeting and keep the minutes thereof.

Section 3.10 *Order of Business.* At all meetings of the board of directors, business shall be transacted in the order determined by the board of directors.

Section 3.11 *Action by Unanimous Consent.* Any action required or permitted to be taken at any meeting of the board of directors or of any committee thereof may be taken without a meeting if all members of the board or of such committee, as the case may be, consent to the action in writing or by electronic transmission. The writing or writings or electronic transmission or transmissions shall be filed with the minutes of the proceedings of the board of directors or of the relevant committee.

Section 3.12 *Telephone, etc. Meetings.* Members of the board of directors, or any committee designated by the board of directors, may participate in a meeting of the board of directors, or committee, by means of conference telephone or similar communications equipment by means of which all persons participating in the meeting can hear each other, and such participation shall constitute the presence of such person at such meeting.

Section 3.13 *Resignation.* Any director of the corporation may resign, as a director or as a committee member or both, at any time by giving notice in writing or by electronic transmission of his or her resignation to the chairman of the board, the chief executive officer or the secretary of the corporation. Such resignation shall take effect at the time specified therein (if the remaining directors agree to such time), or, if the time when it shall become effective shall not be specified therein, then it shall take effect when received. Except as aforesaid, the acceptance of such resignation shall not be necessary to make it effective.

Section 3.14 *Compensation.* Each director, in consideration of his or her serving as such, shall be entitled to receive from the corporation such amount per annum, or such fees for attendance at board and committee meetings, or both, or such other compensation, including options to acquire capital stock of the corporation, as the board of directors shall from time to time determine by resolution.

The board of directors likewise may provide by resolution that the corporation shall reimburse each director or member of a committee for any expenses incurred by him or her on account of his or her attendance at any such meeting. Nothing herein contained shall be construed to preclude any director from serving the corporation in any other capacity and receiving proper compensation therefor.

Section 3.15 *Removal.* Unless otherwise specified by law or the certificate of incorporation, any director or the entire board of directors may be removed at any time by the affirmative vote of the holders of at least a majority of the shares then entitled to vote at an election of directors, but only for cause.

Section 3.16 *Vacancies.* Except as otherwise provided in the certificate of incorporation and subject to the rights, if any, of the holders of any preferred stock then outstanding, any vacancy in the board, whether because of death, resignation, disqualification, an increase in the authorized number of directors, removal, or any other cause, may be filled by a vote of the majority of the remaining directors, although less than a quorum, or by a sole remaining director. When the board fills a vacancy, the director chosen to fill that vacancy shall complete the term of the director he or she succeeds (or shall complete the term of the class of directors in which the new directorship was created) and shall hold office until such director's successor shall have been elected and qualified or until such director's earlier death, resignation or removal. No reduction of the authorized number of directors shall have the effect of removing any director prior to the expiration of such director's term of office.

Section 3.17 *Chairman and Vice-Chairman of the Board.* The board of directors may elect from its members a chairman of the board and a vice chairman. If a chairman has been elected and is present, the chairman shall preside at all meetings of the board of directors and the stockholders. The chairman shall have such other powers and perform such other duties as the board of directors may designate. If the board of directors elects a vice chairman, the vice chairman shall, in the absence or disability of the chairman, perform the duties and exercise the powers of the chairman and have such other powers and perform such other duties as the board of directors may designate.

ARTICLE IV
COMMITTEES

The board of directors may, by resolution or resolutions passed by a majority of the full board of directors, designate one or more committees, each such committee to consist of one or more directors of the corporation, which, to the extent provided in said resolution or resolutions and the committee's charter and subject to the limitations contained in the Delaware General Corporation Law, shall have and may exercise all the powers of the board of directors in the management of the business and affairs of the corporation. Such committee or committees shall have such name or names as may be determined from time to time by resolution adopted by the board of directors. The board of directors may make, alter and repeal a committee's charter or other rules for the conduct of such committee's business. Any such committee shall keep written minutes of its meetings and report the same to the board at the next regular meeting of the board. Unless the board or these bylaws shall otherwise prescribe the manner of proceedings of any such committee, meetings of such committee may be regularly scheduled in advance and may be called at any time by the chairman of the committee or by any two (2) members thereof; otherwise, the provisions of these bylaws with respect to notice and conduct of meetings of the board shall govern. The board of directors shall have power to change the members of any such committee at any time, to fill vacancies and to discharge any such committee, either with or without cause, at any time, unless otherwise provided in such committee's charter, or other rules for the conduct of its business, adopted by the board of directors.

ARTICLE V
OFFICERS

Section 5.01 *Number.* The principal officers of the corporation shall be chosen by the board of directors and shall be a chief executive officer, a chief financial officer, a president, one or more vice presidents as the board of directors from time to time may appoint (the number thereof and their respective titles to be determined by the board of directors and one or more of whom may be designated as executive or senior vice presidents), a secretary and a treasurer. In addition, there may be such subordinate officers, agents and employees as may be appointed in accordance with the provisions of Section 5.03. Any two or more offices may be held by the same person. Any officer may be, but need not be, a director or stockholder. The offices of the corporation for which officers may be elected shall be set forth from time to time by resolution of the board of directors.

Section 5.02 *Election, Qualification and Term of Office.* Each officer of the corporation shall be elected by the board of directors from time to time and shall hold office until his or her successor shall have been duly elected and qualified, unless a different term is specified in the resolution electing the officer, or until his or her death, or until he or she shall have resigned or shall have been removed in the manner herein provided.

Section 5.03 *Other Officers.* The corporation may have such other subordinate officers, agents and employees as the board of directors may deem necessary, including one or more assistant secretaries, one or more assistant treasurers, a controller and one or more assistant controllers, each of whom shall have such authority and perform such duties as the board of directors may from time to time determine.

Section 5.04 *Removal.* Any officer may be removed, either with or without cause, by resolution of the board of directors. Such removal from office shall not affect any rights that such removed officer may have under any employment or stockholder agreement.

Section 5.05 *Resignation.* Any officer may resign at any time by giving notice in writing or by electronic transmission to the board of directors, the chairman of the board or the chief executive officer. Any such resignation shall take effect at the time specified therein (if the board agrees to such time) or, if the time when it shall become effective shall not be specified therein, then it shall take effect when accepted by action of the board of directors. Except as aforesaid, the acceptance of such resignation shall not be necessary to make it effective.

Section 5.06 *Vacancies.* A vacancy in any office because of death, resignation, removal, disqualification or any other cause shall be filled for the unexpired portion of the term in the manner prescribed in these bylaws for regular election or appointment to such office.

Section 5.07 *Powers.* Unless otherwise specified by the board of directors, each officer shall have those powers and shall perform those duties that are (i) set forth in these bylaws (if any are so set forth), (ii) set forth in the resolution of the board of directors electing that officer or any subsequent resolution of the board of directors with respect to that officer's duties or (iii) commonly incident to the office held.

Section 5.08 *Chief Executive Officer.* The chief executive officer shall have general supervisory management over the business, affairs and policies of the corporation and over its officers, shall report to the board of directors and shall see that all orders and resolutions of the board of directors are carried into effect, all subject to the general direction and control of the board of directors. The chief executive officer shall have the authority to sign all certificates, contracts and other instruments on behalf of the corporation and take such actions required in connection therewith. In the absence of the chairman of the board for any reason, including the failure of the board of directors to elect the chairman of the board, or in the event of the chairman's inability or refusal to act, the chief executive officer shall have all the powers of, and be subject to all the restrictions upon, the chairman of the board.

Section 5.09 *President.* The president shall be subject to the direction and control of the chief executive officer and the board of directors and shall be responsible for the general active management of the business, affairs and policies of the corporation, shall perform such other duties as may be prescribed by the board of directors or the chief executive officer and shall have authority to sign all certificates, contracts and other instruments on behalf of the corporation and take such actions required in connection therewith. In the absence of the chief executive officer for any reason, including the failure of the board of directors to elect a chief executive officer, or in the event of the chief executive officer's inability or refusal to act, the president shall have all the powers of, and be subject to all the restrictions upon, the chief executive officer.

Section 5.10 *Chief Financial Officer.* The chief financial officer shall be subject to the direction and control of the board of directors and the chief executive officer, shall have primary responsibility for the financial affairs of the corporation and shall (i) keep accurate financial records for the corporation; (ii) deposit all moneys, drafts and checks in the name of, and to the credit of, the corporation in such banks and depositories as the board of directors shall, from time to time, designate or otherwise authorize; (iii) have the power to endorse, for deposit, all notes, checks and drafts received by the corporation; (iv) disburse the funds of the corporation in accordance with the corporation's policies and procedures as adopted by resolution of the board of directors, making or causing to be made proper vouchers therefor; (v) render to the chief executive officer and

the board of directors, whenever requested, an account of all of his or her transactions as chief financial officer and of the financial condition of the corporation, and (vi) perform such other duties as may, from time to time, be prescribed by the board of directors or by the chief executive officer. The powers and duties specified herein may be modified or limited at any time by the board of directors.

Section 5.11 *Vice President.* The vice president or, if there be more than one, the vice presidents, in the order determined by the board of directors (or if there is no such determination, then in the order of their election), shall be subject to the direction and control of the board of directors and the chief executive officer, shall have such powers and duties as the board of directors or the chief executive officer may assign to them, and shall, in the absence of the president for any reason, including the failure of the board of directors to elect a president or in the event of the president's inability or refusal to act, perform the duties of the president, and, when

so acting, have all the powers of, and be subject to all of the restrictions upon, the president. If the board of directors elects more than one vice president, then it shall determine their respective titles, seniority and duties. The vice president or vice presidents shall perform such other duties and have such other powers as the board of directors or the chief executive officer may from time to time prescribe.

Section 5.12 *Secretary.* The secretary shall, to the extent practicable, attend all meetings of the stockholders and the board of directors. The secretary shall record or cause to be recorded in books kept for such purpose the minutes of the meetings (and the actions by written consent) of the stockholders, the board of directors and all committees of which a secretary shall not have been appointed; shall see that all notices are duly given in accordance with the provisions of these bylaws and as required by law; shall be custodian of all corporate records (other than financial); shall see that the books, reports, statements, certificates and all other documents and records required by law are properly kept and filed; and, in general, shall perform all duties as may from time to time be assigned to him or her by the board of directors or the chief executive officer.

Section 5.13 *Assistant Secretary.* The assistant secretary, or if there be more than one, the assistant secretaries, in the order determined by the board of directors (or if there be no such determination, then in the order of their election), shall have such powers and duties as the board of directors or the chief executive officer may assign to them and shall, in the absence of the secretary for any reason, including the failure of the board of directors to elect a secretary or in the event of the secretary's inability or refusal to act, perform the duties and exercise the powers of the secretary and perform such other duties and have such other powers as the board of directors or chief executive officer may from time to time prescribe. Any assistant secretary shall have authority to attest by his or her signature to the same extent as the secretary.

Section 5.14 *Treasurer.* The treasurer shall have charge and custody of, and be responsible for, all funds and securities of the corporation, and shall deposit all such funds to the credit of the corporation in such banks, trust companies or other depositories as shall be selected by the board of directors or any officer or officers authorized by board of directors to make such determinations; shall disburse the funds of the corporation as may be ordered by the board of directors or any officer or officers authorized by the board of directors to make such determinations, making proper vouchers for such disbursements; shall keep full and accurate accounts of all funds received and paid on account of the corporation and shall render to the board of directors or the chief executive officer, whenever the board or the chief executive officer may require him or her so to do, a statement of all his or her transactions as treasurer; and, in general, shall perform all the duties incident to the office of treasurer and such other duties as from time to time may be assigned to him or her by the board of directors or the chief executive officer. In the absence of the chief financial officer for any reason, including the failure of the board of directors to elect a chief financial officer or in the event of the chief financial officer's inability or refusal to act, the treasurer shall perform the duties of the chief financial officer, and, when so acting, have all the powers of, and be subject to all of the restrictions upon, the chief financial officer.

Section 5.15 *Assistant Treasurer.* The assistant treasurer, or if there be more than one, the assistant treasurers, in the order determined by the board of directors (or if there be no such determination, then in the order of their election), shall, in the absence of the treasurer, for any reason, including the failure of the board of directors to elect a treasurer, or the treasurer's inability or refusal to act, perform the duties and exercise the powers of the treasurer, and perform such other duties and have such other powers as the board of directors and chief executive officer may from time to time prescribe.

Section 5.16 *Compensation.* The compensation of the officers shall be fixed from time to time by or in the manner prescribed by the board of directors, and none of such officers shall be prevented from receiving compensation by reason of the fact that he or she is also a director of the corporation. The application of this Section 5.16 shall not affect the right any officer may have regarding compensation under an employment agreement.

ARTICLE VI
STOCK CERTIFICATES AND TRANSFERS

Section 6.01 *Stock Certificates.* The corporation's shares of stock shall be represented by certificates, provided that the board of directors may, subject to the limits imposed by law, provide by resolution or resolutions that some or all of any or all classes or series shall be uncertificated shares. Shares of stock represented by certificates shall be in such form as shall be approved by the board of directors, to the extent consistent with applicable law. Stock certificates shall be numbered in the order of their issue and shall be signed by or in the name of the corporation by (i) the chairperson or vice chairperson, if any, of the board of directors, the president or a vice president and (ii) the treasurer, an assistant treasurer, the secretary or an assistant secretary. Any or all of the signatures on a certificate may be a facsimile. In case any officer, transfer agent or registrar who signed or whose facsimile signature has been placed upon a certificate shall have ceased to be an officer, transfer agent or registrar before such certificate is issued, it may be issued by the corporation with the same effect as if such person were such officer, transfer agent or registrar at the date of issue. Each certificate that is subject to any restriction on transfer shall have conspicuously noted on its face or back either the full text of the restriction or a

statement of the existence of the restriction. Each certificate shall have on its face or back a statement that the corporation will furnish without charge to each stockholder who so requests the powers, designations, preferences and relative, participating, optional or other special rights of each class of stock or series thereof and the qualifications, limitations or restrictions of such preferences or rights.

Section 6.02 *Lost Certificates.* The board of directors may direct a new certificate or certificates or uncertificated shares to be issued in place of any certificate or certificates theretofore issued by the corporation alleged to have been lost, stolen or destroyed, upon the making of an affidavit of that fact by the person claiming the certificate of stock to be lost, stolen or destroyed. When authorizing such issue of a new certificate or certificates or uncertificated shares, the board of directors may, in its discretion and as a condition precedent to the issuance thereof, require the owner of such lost, stolen or destroyed certificate or certificates, or his /her legal representative, to advertise the same in such manner as it shall require and/or to give the corporation a bond in such sum as it may direct as indemnity against any claim that may be made against the corporation with respect to the certificate alleged to have been lost, stolen or destroyed or the issuance of such new certificate or certificates or uncertificated shares.

Section 6.03 *Stock Transfers.* The shares of the stock of the corporation shall be transferred on the books of the corporation by the holder thereof in person or by his attorney, (i) with regard to certificated shares, upon surrender for cancellation of certificates for the same number of shares, with an assignment and power of transfer endorsed thereon or attached thereto, duly executed, and with such proof of the authenticity of the signature as the corporation or its agents may reasonably require, and (ii) with regard to uncertificated shares, upon delivery of an instruction duly executed, and with such proof of the authenticity of the signature as the corporation or its agents may reasonably require. Whenever any transfer of shares shall be made for collateral security, and not absolutely, it shall be so expressed in the entry of transfer if, when the certificates are presented to the corporation for transfer or uncertificated shares are requested to be transferred, both the transferor and transferee request the corporation to do so.

ARTICLE VII
GENERAL PROVISIONS

Section 7.01 *Dividends.* Dividends upon the capital stock of the corporation, subject to the provisions of the certificate of incorporation, if any, may be declared by the board of directors at any regular or special meeting, pursuant to law. Dividends may be paid in cash, in property, or in shares of the capital stock, subject to the provisions of the certificate of incorporation. Before payment of any dividend, there may be set aside out of any funds of the corporation available for dividends such sum or sums as the directors from time to time, in their absolute discretion, think proper as a reserve or reserves to meet contingencies, or for equalizing dividends, or for repairing or maintaining any property of the corporation, or for such other purposes as the directors shall think conducive to the interest of the corporation, and the directors may modify or abolish any such reserve in the manner in which it was created.

Section 7.02 *Contracts and Checks.* Except as otherwise required by law or the certificate of incorporation, any bonds, contracts, deeds, leases, checks, drafts or other orders for payment of money, demands for money, notes or other evidence of indebtedness, or other instruments may be executed and delivered in the name and on the behalf of the corporation by such officer or officers of the corporation as provided in these bylaws or as the board of directors may from time to time direct. Such authority may be general or confined to specific instances as the board of directors may determine, and unless so authorized by the board or by these bylaws, no officer, agent, or employee shall have any power or authority to bind the corporation by any contract or engagement or to pledge its credit or to render it liable for any purpose or in any amount. The chairman of the board, the chief executive officer, the chief financial officer, the president or any vice president may execute bonds, contracts, deeds, leases, checks, drafts or other orders for payment of money, demands for money, notes or other

evidence of indebtedness, and other instruments to be made or executed for or on behalf of the corporation. Subject to any restrictions imposed by the board of directors or the chairman of the board, the chief executive officer, the chief financial officer or the president of the corporation may delegate contractual powers to others under his jurisdiction, it being understood, however, that any such delegation of power shall not relieve such officer of responsibility with respect to the exercise of such delegated power.

Section 7.03 *Fiscal Year and Audits.* The fiscal year of the corporation shall begin on the first day of January and end on the thirty-first day of December of each year, unless otherwise fixed by resolution of the board of directors. The accounts, books and records of the corporation shall be audited upon the conclusion of each fiscal year by an independent certified public accountant selected by the board of directors, and it shall be the duty of the board of directors to cause such audit to be made annually.

Section 7.04 *Seal.* The Board of Directors may adopt a corporate seal having inscribed thereon the name of the corporation, the year of its organization and the words “Corporate Seal, Delaware.” The seal may be used by causing it or a facsimile thereof to be impressed or affixed or reproduced or otherwise.

Section 7.05 *Waiver of Notices.* Whenever notice is required to be given by these bylaws or the certificate of incorporation or by law, the person entitled to said notice may waive such notice in writing, either before or after the time stated therein, and such waiver shall be deemed equivalent to notice.

Section 7.06 *Electronic Transmission.* For purposes of these bylaws, "electronic transmission" shall mean a form of communication not directly involving the physical transmission of paper that satisfies the requirements with respect to such communications contained in the Delaware General Corporation Law.

Section 7.07 *Voting Stock of Other Organizations.* Except as the board of directors may otherwise designate, each of the chief executive officer and the chief financial officer may waive notice of, and act as, or appoint any person or persons to act as, proxy or attorney-in-fact for the corporation (with power of substitution) at any meeting of the stockholders, members or other owners of any other corporation or organization the securities or ownership interests of which are owned by the corporation.

ARTICLE VIII
INDEMNIFICATION

Section 8.01 *Indemnification.* The corporation shall, to the fullest extent permitted by law, indemnify every person who is or was a party or is or was threatened to be made a party to any action, suit or proceeding, whether civil, criminal, administrative or investigative (an "Action"), by reason of the fact that such person is or was a director or officer of the corporation or is or was serving at the request of the corporation as a director, officer, trustee, plan administrator or plan fiduciary of another corporation, partnership, limited liability company, trust, employee benefit plan or other enterprise (an "Indemnified Person"), against all expenses (including attorneys' fees), judgments, fines and amounts paid in settlement or other disposition that the Indemnified Person actually and reasonably incurs in connection with the Action and shall reimburse each such person for all legal fees and expenses reasonably incurred by such person in seeking to enforce its rights to indemnification under this Article (by means of legal action or otherwise).

Section 8.02 *Advancement of Expenses.* Upon written request from an Indemnified Person, the corporation shall pay the expenses (including attorneys' fees) incurred by such Indemnified Person in connection with any Action in advance of the final disposition of such Action. The corporation's obligation to pay expenses pursuant to this Section shall be contingent upon the Indemnified Person providing the undertaking required by the Delaware General Corporation Law.

Section 8.03 *Non-Exclusivity.* The rights of indemnification and advancement of expenses contained in this Article shall not be exclusive of any other rights to indemnification or similar protection to which any Indemnified Person may be entitled under any agreement, vote of stockholders or disinterested directors, insurance policy or otherwise.

Section 8.04 *Heirs and Beneficiaries.* The rights created by this Article shall inure to the benefit of each Indemnified Person and each heir, executor and administrator of such Indemnified Person.

Section 8.05 *Effect of Amendment.* Neither the amendment, modification or repeal of this Article nor the adoption of any provision in these bylaws inconsistent with this Article shall adversely affect any right or protection of an Indemnified Person with respect to any act or omission that occurred prior to the time of such amendment, modification, repeal or adoption.

ARTICLE IX
AMENDMENTS

Except as otherwise set forth in these bylaws, the certificate of incorporation or the Delaware General Corporation Law, these bylaws may be altered, amended or repealed, or new bylaws may be adopted, by the board of directors or a majority of the voting power of all of the shares of common stock outstanding and entitled to vote thereon. If the power to adopt, amend or repeal bylaws is conferred upon the board of directors by the certificate of incorporation, it shall not divest or limit the power of the stockholders to adopt, amend or repeal bylaws.

CERTIFICATE OF SECRETARY
OF THE ENSIGN GROUP, INC.

The undersigned, Gregory K. Stapley, hereby certifies that he is the duly elected and acting Secretary of The Ensign Group, Inc., a Delaware corporation, and that the Bylaws attached hereto constitute the Bylaws of said corporation as duly adopted by the board of directors on October 4, 2007 to be effective as of November 15, 2007.

IN WITNESS WHEREOF, the undersigned has hereunto subscribed his name this 15th day of November, 2007.

/s/ Gregory K. Stapley

Gregory K. Stapley,
Secretary

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

FORM 10-K

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

For the fiscal year ended December 31, 2024.
OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**
For the transition period from _____ to_____ .

Commission file number: 001-33757

THE ENSIGN GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	**33-0861263**
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

29222 Rancho Viejo Road, Suite 127
San Juan Capistrano, CA 92675
(Address of Principal Executive Offices and Zip Code)
(949) 487-9500
(Registrant's Telephone Number, Including Area Code)

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

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

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
if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act.	☐	Yes	☑	**No**
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
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
whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act:				
Large accelerated filer ☑ | Accelerated filer ☐ | Non-accelerated filer ☐ | Smaller reporting company ☐ | Emerging growth company ☐				
If an emerging growth company, indicate if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.	☐	Yes	☐	No
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.	☑	**Yes**	☐	No
If securities are registered pursuant to Section 12(b) of the Act, whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements.	☐	Yes	☑	**No**
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).	☐	Yes	☑	**No**
whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act).	☐	Yes	☑	**No**

As of June 30, 2024, the aggregate market value of the Registrant's Common Stock held by non-affiliates was:

Common Stock	$4,196,977,000

The aggregate market value of Common Stock was computed by reference to the closing price as of the last business day of the registrant's most recently

completed second fiscal quarter. Shares of Common Stock held by each executive officer, director and each person owning more than 10% of the outstanding Common Stock of the registrant have been excluded (in the amount of $2,620,517,000) in that such persons may be deemed to be affiliates of the registrant. This determination of affiliate status is not necessarily a conclusive determination for other purposes.

As of January 31, 2025, 57,455,374 shares of the registrant’s common stock, $0.001 par value, were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE:

Part III of this Form 10-K incorporates information by reference from the Registrant's definitive proxy statement for the Registrant's 2025 Annual Meeting of Stockholders to be filed within 120 days after the close of the fiscal year covered by this annual report.

THE ENSIGN GROUP, INC.
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FOR THE FISCAL YEAR ENDED DECEMBER 31, 2024
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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

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

As used in this Annual Report on Form 10-K, the words, "Ensign," "Company," “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our independent subsidiaries, the Service Center (defined below) and our wholly-owned captive insurance subsidiary (the Captive Insurance) and captive real estate investment trust called Standard Bearer Healthcare REIT, Inc. (Standard Bearer) are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar terms in this Annual Report on Form 10-K are not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. In addition, certain of our wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other independent subsidiaries through contractual relationships with such subsidiaries. The Captive Insurance provides some claims-made coverage to our independent subsidiaries for general and professional liability, as well as for certain workers' compensation insurance liabilities. Standard Bearer owns and manages our real estate business.

The Service Center address is 29222 Rancho Viejo Rd Suite 127, San Juan Capistrano, CA 92675, and our telephone number is (949) 487-9500. Our corporate website is located at *www.ensigngroup.net.* The information contained in, or that can be accessed through, our website does not constitute a part of this Annual Report on Form 10-K.

Ensign™ is our United States trademark. All other trademarks and trade names appearing in this annual report are the property of their respective owners.

PART I.

ITEM 1. BUSINESS

Founded in 1999, The Ensign Group, Inc. (Ensign) is a holding company with independent subsidiaries that provide skilled nursing, senior living and rehabilitative services, as well as other ancillary businesses (including mobile diagnostics and medical transportation), in 15 states. As part of our investment strategy, we also acquire, lease and own healthcare real estate to service the post-acute care continuum through acquisition and investment opportunities in healthcare properties. For the year ended December 31, 2024, we generated approximately 95.7% of our revenue from our skilled nursing facilities. The remainder of our revenue is primarily generated from our real estate properties, senior living services and other ancillary services.

OPERATIONS

Overview

As of December 31, 2024, we offered skilled nursing, senior living and rehabilitative care services through 327 skilled nursing and senior living facilities. Of the 327 facilities, we operated 231 facilities under long-term lease arrangements and have options to purchase 12 of those 231 facilities. Our real estate portfolio consists of 129 owned real estate properties, which included 96 facilities operated and managed by us, 33 operations leased to and operated by third-party operators, and the Service Center's California location. Of the 33 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that we own and operate.

Our Unique Approach and Structure

The name "Ensign" is synonymous with a "flag" or a "standard" and refers to our goal of setting the standard by which all others in our industry are measured. We believe that through our efforts and leadership, we can foster a new level of patient care and professional competence at our independent subsidiaries and set a new industry standard for each patient we service. We view healthcare services primarily as a local business. We believe our success is largely driven by our proven ability to build strong relationships with key stakeholders in local healthcare communities, in part, by leveraging our reputation for providing superior care. Accordingly, our brand strategy and organizational structure promotes the empowerment of local leadership and staff to make their facility the “operation of choice” in their community. This is accomplished by allowing local leadership to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then work to create a superior service offering for, and reputation in, their particular community. This local empowerment is unique within the healthcare services industry.

We believe that our localized approach encourages prospective patients and referral sources to choose or recommend our local operations. In addition, our leaders share real-time operating data, clinical benchmark and operational performance metrics with their peers in order to improve clinical care, enhance patient satisfaction and augment operational efficiencies, promoting the sharing of best practices.

We organize our independent subsidiaries into portfolio companies, which we believe has enabled us to maintain a local, field-driven organizational structure, attract additional qualified leadership talent, and to identify, acquire, and improve operations at a generally faster rate. Each of our portfolio companies has its own leader. These leaders, who are generally taken from the ranks of operational CEOs, serve as leadership resources within their own portfolio companies, and have the primary responsibility for recruiting qualified talent, finding potential acquisition targets, and identifying other internal and external growth opportunities. We believe this organizational structure has improved the quality of our recruiting and will continue to facilitate successful acquisitions.

Real estate investments are part of our strategies to further our mission of dignifying post-acute care in the eyes of the world through thoughtful acquisitions of property and leases that promote healthy long-term operations. In the past, we have spun-off our owned real estate properties into a public real estate investment trust (REIT). Currently, we plan to continue to expand our real estate portfolio. We own 129 real estate properties, including 33 real estate properties that are leased to third parties under triple-net long-term leases. We manage and operate the remaining real estate properties, including the Service Center's California location. We are committed to growing our real estate portfolio, which we believe will further enhance our earnings and maximize long-term shareholder value.

To continue with our growth strategy on our real estate portfolio, in January 2022, we formed Standard Bearer. Standard Bearer owns and manages our real estate business. The REIT structure allows us to better demonstrate the growing value of our owned real estate and provides us with an efficient vehicle for future acquisitions of properties that could be operated by our independent subsidiaries or other third parties. We believe this structure gives us new pathways to growth with transactions we would not have considered in the past. Standard Bearer elected to be taxed as a REIT, for U.S. federal income tax purposes, commencing with its taxable year ended December 31, 2022. The real estate portfolio in Standard Bearer consists of 124 of our 129 owned real estate properties. During the year ended December 31, 2024, Standard Bearer acquired the real estate of 11 stand-alone skilled nursing facilities, three stand-alone senior living facilities, and three campus operations. Of these additions, the 11 skilled nursing facilities and three campus operations acquired are operated by the Company's independent subsidiaries. The senior living operations are leased to a third-party operator. For further details on the Standard Bearer REIT, refer to Note 6, *Standard Bearer*, in Notes to the Consolidated Financial Statements of this Annual Report on Form 10-K.

SEGMENTS

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

We also report an “all other” category that includes operating results from our senior living operations, mobile diagnostics, transportation, other real estate and other ancillary operations. These businesses are neither significant individually, nor in aggregate, and therefore do not constitute a reportable segment. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level. We have presented our segment results in this Annual Report on Form 10-K on a comparative basis to conform to the segment structure. For more information about our operating segments, as well as financial information, see Part II, Item 7. *Management’s Discussion and Analysis of Financial Condition and Results of Operations* and Note 8, *Business Segments* of the Notes to the Consolidated Financial Statements.

Skilled Services

As of December 31, 2024, our skilled nursing companies provided skilled nursing care at 316 operations, with 33,547 operational beds, in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. We provide short and long-term nursing care services for patients with chronic conditions, prolonged illness, and the elderly. Our residents are often high-acuity patients that come to our facilities to recover from strokes, cardiovascular and respiratory conditions, neurological conditions, joint replacements, and other muscular or skeletal disorders. We use interdisciplinary teams of experienced medical professionals to provide services prescribed by physicians. These medical professionals provide individualized comprehensive nursing care to our short-stay and long-stay patients. Many of our skilled nursing facilities are equipped to provide specialty care, such as on-site dialysis, ventilator care, cardiac and pulmonary management. We also provide standard services such as room and board, special nutritional programs, social services, recreational activities, entertainment, and other services. We are dedicated to ensuring our residents are happy, comfortable, and motivated to achieve their health goals through the provision of quality care. We generate our skilled services revenue from Medicaid, Medicare, managed care, commercial insurance, and private pay. During the year ended December 31, 2024, approximately 46.9% and 25.9% of our skilled services revenue was derived from Medicaid and Medicare programs, respectively.

Standard Bearer

We engage in the acquisition and leasing of skilled nursing and senior living properties. We generate rental revenue primarily by leasing post-acute care properties we acquired to healthcare operators under triple-net lease arrangements, whereby the tenant is solely responsible for the costs related to the property, including property taxes, insurance and maintenance and repair costs, subject to certain exceptions. As of December 31, 2024, our real estate portfolio within Standard Bearer is comprised of 124 real estate properties located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. Of these properties, 92 are leased to our independent subsidiaries and 33 are leased to operations wholly-owned and managed by third-party operators. Of the 33 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that we own and operate. During the year ended December 31, 2024, we generated rental revenues of $95.1 million, of which $78.1 million was derived from our independent subsidiaries, and therefore eliminated in consolidation.

Other

Revenue from our senior living operations, mobile diagnostics, transportation, other real estate and other ancillary operations comprise approximately 4.5% of our annual revenue.

Senior Living — As of December 31, 2024, we had an aggregate of 3,088 senior living units across 41 operations, of which 30 were located on the same site location as our skilled nursing care operations. Our senior living communities located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Texas, Utah and Washington, provide residential accommodations, activities, meals, housekeeping and assistance in the activities of daily living to seniors who are independent or who require some support, but not the level of nursing care provided in a skilled nursing operation. Our independent living units are non-licensed independent living apartments in which residents are independent and require no support with the activities of daily living.

Our senior living operations comprise approximately 2.1% of our annual revenue. We generate revenue at these operations primarily from private pay sources, Medicaid and other state-specific programs. Specifically, during the year ended December 31, 2024, approximately 60% of our senior living revenue was derived from private pay sources.

Ancillary — As of December 31, 2024, our independent subsidiaries operate ancillary services located in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. We have invested in and are exploring new business lines that are complementary to our existing skilled services and senior living services. These new business lines consist of mobile ancillary services, including digital x-ray, ultrasound, electrocardiograms, sub-acute services, dialysis, respiratory, long-term care pharmacy and patient transportation to people in their homes or at long-term care facilities. To date, these businesses were not meaningful contributors to our operating results.

GROWTH

We have an established track record of successful acquisitions. Much of our historical growth can be attributed to implementing our expertise in acquiring real estate or leasing both under-performing and performing post-acute care operations and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. With each acquisition, we apply our core operating expertise to improve these operations, both clinically and financially. In years where pricing has been high, we have focused on the integration and improvement of our existing independent subsidiaries while limiting our acquisitions to strategically situated properties.

From January 1, 2020 through December 31, 2024, we acquired 99 facilities, which added 10,375 operational skilled nursing beds and 834 senior living units to our independent subsidiaries. The following table summarizes cumulative skilled nursing and senior living operations, operational skilled nursing beds and senior living unit counts for each of the last five years to reflect our growth over a five-year period as a result of the acquisition of these facilities:

	December 31,				
	2020[1]	**2021[1]**	**2022[1]**	**2023[1]**	**2024**
Cumulative number of skilled nursing and senior living operations	228	245	271	297	327
Cumulative number of operational skilled nursing beds	23,172	25,032	28,130	30,602	33,547
Cumulative number of senior living units	2,254	2,237	3,021	3,121	3,088

(1) Number of operational beds and number of operations for 2020-2023 include operational beds and operations that we no longer operate. The number of operations and operational beds do not include the closed facilities beginning in the year of their closures.

We have also invested in new business lines that are complementary to our existing businesses, such as ancillary services. We plan to continue to grow our revenue and earnings by:

- continuing to grow our talent base and develop future leaders;
- increasing the overall percentage or “mix” of higher acuity patients;
- focusing on organic growth and internal operating efficiencies;
- continuing to acquire additional operations in existing and new markets;
- expanding and renovating our existing operations, and
- strategically investing in and integrating other post-acute care healthcare businesses.

New Market CEO and New Ventures Programs — In order to broaden our reach into new markets, and in an effort to provide existing leaders in our company with the entrepreneurial opportunity and challenge of entering a new market and starting a new business, we established our New Market CEO program in 2006. Supported by our Service Center and other resources, a New Market CEO evaluates a target market, develops a comprehensive business plan, and relocates to the target market to find talent and connect with other providers, regulators and the healthcare community in that market, with the goal of ultimately acquiring businesses and establishing an operating platform for future growth. In addition, this program includes other lines of business that are closely related to the skilled nursing industry. The New Ventures program encourages our local leaders to evaluate service offerings with the goal of establishing an operating platform in new markets and new businesses. We believe that this program will not only continue to drive growth, but will also provide a valuable training ground for our next generation of leaders, who will have experienced the challenges of growing and operating a new business.

OPERATION EXPANSIONS

During the year ended December 31, 2024, we expanded through a combination of long-term leases and real estate purchases, with the addition of 28 stand-alone skilled nursing operations and three campus operations. Of these additions, Standard Bearer acquired the real estate of 11 of the stand-alone skilled nursing operations and three campus operations, which were leased back to Ensign's independent subsidiaries. These new operations added a total of 3,030 operational skilled nursing beds and 218 operational senior living units to be operated by our independent subsidiaries. Additionally, we invested in new ancillary services that are complementary to our existing businesses.

Subsequent to December 31, 2024, we expanded through a combination of a long-term lease and a real estate purchase, with the addition of seven stand-alone skilled nursing operations totaling 682 operational skilled nursing beds to be operated by our independent subsidiaries, including one in a new state, Alabama.

For further discussion of our acquisitions, see Note 7, *Operation Expansions* in the Notes to the Consolidated Financial Statements.

QUALITY OF CARE MEASURES

Improvement in Acquired Facilities — The Five-Star Quality Rating System introduced by the Centers for Medicare and Medicaid Services (CMS) intends to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each skilled nursing operation a rating between one and five stars in various categories including health inspections, staffing and quality measures (QM). We have a strong history of quickly improving the quality of care in the facilities we acquire. Thus, as new assessments are conducted post-acquisition, the star ratings see consistent improvement. At the time of acquisition, the majority of our facilities have 1 and 2-Star ratings.

Over the last few years, CMS has modified the star rating requirements. These changes have been significant and made it more difficult to achieve a 4 or 5-Star rating, resulting in certain skilled nursing operations losing stars in their "Quality" and "Staffing" ratings, which negatively impacted the "Overall" ratings. Nevertheless, we continue to demonstrate strong performance in the Five-Star Quality Rating System. We believe compliance and quality outcomes are precursors to outstanding financial performance. Thus, we strive to aggressively increase quality and compliance in every facility we acquire, and to adjust our overall policies to adapt to CMS’s changing criteria for the Five-Star Quality Rating System.

On October 1, 2023, a significant change impacting the QM category was a shift in focus from a resident's functional status to their functional abilities and goals, commonly referred to as the Minimum Data Set (MDS) Section G to Section GG. The transition resulted in numerous QM modifications and changes which impacted the Five-Star rating. As part of this change, in April 2024, CMS froze the associated new and modified quality measures as part of the transition on the Nursing Home Compare website. Starting in October 2024, CMS replaced the short-stay functionality QM with the new cross-setting functionality QM, which is used in the SNF Quality Reporting Program (QRP). The remaining three measures will continue to be frozen until January 2025 while the data for the equivalent measures are collected. Additionally, beginning in April of 2024, CMS revised the staffing rating methodology to give the lowest possible score for staffing turnover measures to providers who fail to submit staffing data or submit erroneous data. Therefore, the predictability and movement in the QM ratings will not necessarily be consistent with our current quality performance. In addition, what and how we are measuring the QM will not be consistent with the historical practice and accordingly will not be comparable. Therefore, depending on the changes, we may experience periods of time where the number of facilities with 4 or 5-Star ratings decline.

The table below summarizes the number of our facilities with 4 and 5-Star ratings since 2020:

	As of December 31,				
	2020	**2021**	**2022**	**2023**	**2024**
4 and 5-Star Quality Rated skilled nursing facilities	116	114	113	130	129

Above-Average Ratings — As of October 2024, despite the fact that Ensign's acquisition of facilities with 1 or 2-Star ratings skews our company-wide ratings, our mean score on the Five-Star Quality Rating System is 62.5%, which exceeds the national average score of 56.9%. Our average cycle 1 health inspections for all of our facilities, which is based on the latest inspections, is 8.1% better than the national average.

INDUSTRY TRENDS

The post-acute care industry has evolved to meet the growing demand for post-acute and custodial healthcare services generated by an aging population, increasing life expectancies and the trend toward shifting patient care to lower cost settings. The industry has evolved in recent years, which we believe has led to a number of favorable improvements in the industry, as described below:

- ***Shift of Patient Care to Lower Cost Alternatives*** — The growth of the senior population in the U.S. continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher acuity patients than in the past.
- ***Significant Acquisition and Consolidation Opportunities*** — The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. Due to the increasing demands from hospitals and insurance carriers to implement sophisticated and expensive reporting systems, we believe this fragmentation provides us with significant acquisition and consolidation opportunities.
- ***Improving Supply and Demand Balance*** — The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- ***Increased Demand Driven by Aging Populations*** — As seniors account for an increasing percentage of the total U.S. population, we believe the demand for skilled nursing and senior living services will continue to increase. According to the census projection released by the U.S. Census Bureau in early 2020, between 2016 and 2030, the number of individuals over 65 years old is projected to be one of the fastest growing segments of the United States population, growing from 15% to 21%. The Bureau expects this segment to increase nearly 50% to 73 million, as compared to the total U.S. population which is projected to increase by 10% over that time period. Furthermore, the generation currently retiring has accumulated less savings than prior generations, creating demand for more affordable senior housing and skilled nursing services. As a high-quality provider in lower cost settings, we believe we are well-positioned to benefit from this trend.
- ***Value-based Care and Reimbursement Reform*** — In response to rising healthcare spending in the United States, commercial, government and other payors are generally shifting away from fee-for-service (FFS) payment models towards value-based models, including risk-based payment models that tie financial incentives to quality, efficiency and coordination of care. We believe that patient-centered outcomes driven reimbursement models will continue to grow in prominence. Many of our operations already receive value-based payments, and as valued-based payment systems continue to increase in prominence, it is our view that our strong clinical outcomes will be increasingly rewarded.

A significant goal of U.S. federal health care reform is to transform the delivery of health care by changing reimbursement to reflect and support a focus on equity, payment for value and efficacious delivery of person-centered care. Reimbursement models and demonstrations that increase accountability and provide financial incentives to encourage efficiency, affordability and high-quality care, have been developed and implemented by government and commercial third-party payers. Special focus is placed on increasing the number of beneficiaries in care relationships with accountability for quality and total cost of care, improvements in care coordination, reducing inequities at the population level and supporting care innovation to close care gaps and increase access. The most prominent value-based models designed to accomplish these aims include Accountable Care Models (e.g., MSSP ACOs, ACO REACH) and Disease-Specific & Episode-Based Models (e.g., BPCI Advanced, GUIDE Model, CJR). These models, alongside State & Community, Statutory and Health Plan Models, are aimed at alignment across payers and care settings, leveraging effective clinical tools, outcomes-focused payment approaches and stakeholder-led policy development. Reimbursement methodology reform includes Value-Based Purchasing (VBP), in which a portion of provider reimbursement is redistributed based on relative performance, or improvement on designated economic, clinical quality and patient satisfaction metrics. These reimbursement methodologies and similar programs are likely to continue and expand, both in government and commercial health plans. Many of our operations already participate in value-based initiatives and models. With our focus on quality care and strong clinical outcomes, we are well-positioned to benefit from these outcome-based payment models.

We believe the post-acute industry has been and will continue to be impacted by several other trends. The use of long-term care insurance is increasing among seniors as a means of planning for the costs of skilled nursing services. In addition, as a result of increased mobility in society, reduction of average family size and the increased number of two-wage earner couples, more residents are looking for alternatives outside the family for their care.

REVENUE SOURCES

We derive revenue primarily from the Medicaid and Medicare programs, managed care and commercial insurance payors and private pay patients. The majority of our revenue is derived from skilled nursing, which is highly dependent upon the Medicaid and Medicare programs. Thus, any changes to payment models, reimbursements and budgets impact our revenue, some positively and some negatively. A detailed discussion of the regulatory framework impacting our business is found in the *Government Regulation* section below. See also, Item 1A., *Risk Factors*.

A brief overview of each of our revenue sources is as follows:

Medicaid — Medicaid is a program financed by state funds and matching federal funds administered by the states and their political subdivisions, and often go by state-specific names, such as Medi-Cal in California and the Arizona Healthcare Cost Containment System in Arizona. Medicaid programs generally provide health benefits for qualifying individuals and may supplement Medicare benefits for the disabled and for persons aged 65 and older meeting financial eligibility requirements. Medicaid reimbursement formulas are established by each state with the approval of the federal government in accordance with federal guidelines. Seniors who enter skilled nursing facilities as private pay clients can become eligible for Medicaid once they have substantially depleted their assets. Medicaid is generally the largest source of funding for most skilled nursing facilities.

Medicaid reimbursement varies from state to state and is based upon a number of different systems, including cost-based, prospective payment; case mixed adjusted payments and negotiated rate systems. Rates are subject to a state's annual budgetary requirements and funding, statutory and regulatory changes and interpretations and rulings by individual state agencies and State Plan Amendments approved by CMS. However, given that most states are required to have balanced budgets and Medicaid is frequently their largest program, many states have implemented or might consider implementing various strategies to manage Medicaid expenses.

Medicaid typically covers patients that require standard room and board services and provides reimbursement rates that are generally lower than rates earned from other sources. We monitor our payor mix to measure the level received from each payor across each of our business units. We intend to continue to focus on enhancing our care offerings to accommodate more high acuity patients.

We received revenues from Medicaid in all the states in which we operate, with approximately 90% coming from Arizona, California, Colorado, Idaho, Texas, Utah and Washington. As a result, we are sensitive to potential changes in state-based revenue programs, such as Medicaid, as well as regulatory, economic, environmental, and competitive changes in those states. While the Medicaid spending of each state reflects its own population size, trends and public health challenges, the broad trend across our largest states in 2024 was either stable or increasing rate growth. With some states even electing to make the temporary Covid funding part of their long term budgets. Over the long term, Medicaid spending is expected to increase across all states as a result of the increases in costs of care and the increase in population eligible for Medicaid benefits. For example, California projected its Medicaid spending to increase from current levels through the state's 2028-2029 budget period. However, the increased Medicaid spending may not directly translate into rate increases for care. Additionally, we have seen that some state budgets continue to be pressured by budget shortfalls. For example, in Colorado, recent budget shortfalls have caused the state to propose provider compensation that is stagnant despite increases in costs for the 2025-2026 budget period. This is an area we monitor closely and will continue to follow as it affects the success of our independent facilities and overall business.

Medicare — Medicare is a federal program that provides healthcare benefits to individuals who are 65 years of age or older or are disabled. To achieve and maintain Medicare certification, a skilled nursing facility must sign a Medicare provider agreement and meet the CMS "Conditions of Participation" on an ongoing basis, as determined in periodic facility inspections or "surveys" conducted primarily by the state licensing agency in the state where the facility is located. Medicare pays for inpatient skilled nursing facility services under the prospective payment system (PPS). Under PPS, facilities are paid a predetermined amount per patient, per day, for certain services. Medicare Part A skilled nursing facility coverage is limited to 100 days per episode of illness for those beneficiaries who require daily care following discharge from an acute care hospital.

For Medicare beneficiaries who qualify for the Medicare Part A coverage, rehabilitation services are included in the per diem payment. For beneficiaries who do not meet the coverage criteria for Part A services, rehabilitation services may qualify for the services to be provided under Medicare Part B.

Managed Care and Private Insurance — Managed care patients consist of individuals who are insured by certain third-party entities, or who are Medicare beneficiaries who have assigned their Medicare benefits to a managed care organization plan. Another type of insurance, long-term care insurance, is also becoming more available to consumers, but is not expected to contribute significantly to industry revenues in the near term.

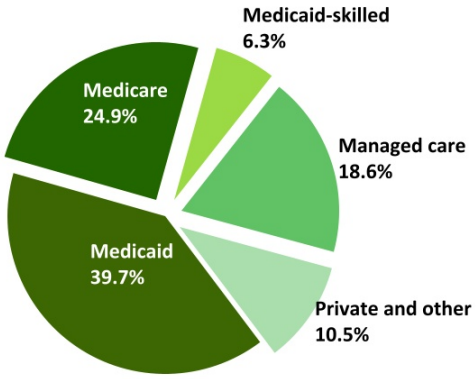
Private and Other Payors — Private and other payors consist primarily of individuals, family members or other third parties who directly pay for the services we provide.

Rental Revenue — Real estate rental revenue is generated by leasing post-acute care properties that we acquired to healthcare operators under triple-net lease arrangements, whereby the tenant is solely responsible for the costs related to the property, including property taxes, insurance and maintenance and repair costs, subject to certain exceptions.

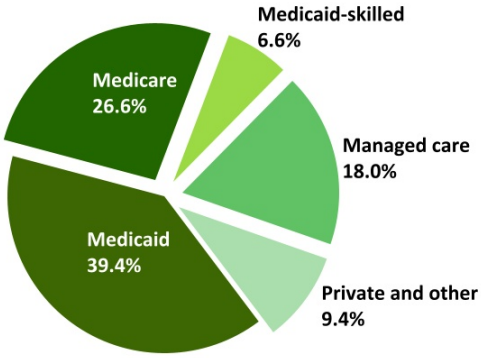
The following charts sets forth our total service revenue by payor source generated by our consolidated operations and skilled services segment as a percentage of total revenue for the years ended December 31, 2024 and 2023, respectively:

CONSOLIDATED SERVICE REVENUE BY PAYOR

December 31, 2024

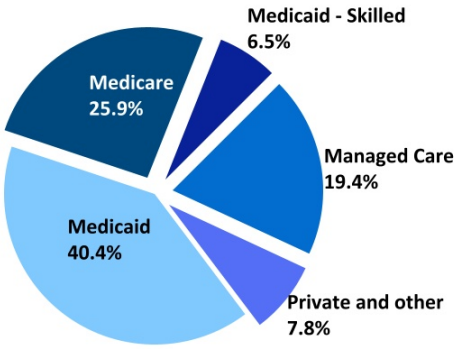


December 31, 2023

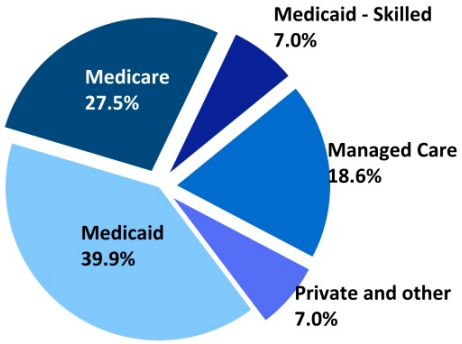


SKILLED SERVICES REVENUE BY PAYOR

December 31, 2024



December 31, 2023



Payor Sources as a Percentage of Skilled Services — The following table sets forth our percentage of skilled nursing patient days by payor source:

	Year Ended December 31,	
	2024	**2023**
Percentage of Skilled Nursing Days:		
Medicare	11.4 %	12.3 %
Managed care	13.4	13.0
Other skilled	5.1	5.1
SKILLED MIX	**29.9**	**30.4**
Private and other payors	10.7	11.0
Medicaid	59.4	58.6
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**

REIMBURSEMENT FOR SPECIFIC SERVICES

Reimbursement for Skilled Services — Skilled nursing facility revenue is primarily derived from Medicaid, Medicare, managed care and private payors. Our skilled nursing operations provide Medicaid-covered services to eligible individuals consisting of nursing care, room and board and social services. In addition, states may, at their option, cover other services such as physical, occupational and speech therapies.

Historically, adjustments to reimbursement under Medicare and Medicaid have had a significant effect on our revenue and results of operations. Recently enacted, pending and proposed legislation and administrative rulemaking at the federal and state levels could have similar effects on our business. Efforts to impose reduced reimbursement rates, greater discounts and more stringent cost controls by government and other payors are expected to continue for the foreseeable future and could adversely affect our business, financial condition and results of operations. Additionally, any delay or default by the federal or state governments in making Medicare and/or Medicaid reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

Reimbursement for Rehabilitation Therapy Services — Rehabilitation therapy revenue is primarily received from private pay, managed care and Medicare for services provided at skilled nursing operations and senior living operations. The payments are based on negotiated patient per diem rates or a negotiated fee schedule based on the type of service rendered.

Reimbursement for Senior Living — Senior living facility revenue is primarily derived from private pay patients at rates we established, with the secondary source of revenue derived from state-specific programs such as Medicaid.

Reimbursement for Other Ancillary Services — Other ancillary revenue, such as mobile diagnostics and medical transportation, is primarily derived from Medicare Part B, Medicaid, managed care and private payors at rates we establish based upon the services we provide and market conditions in the area of operation.

RENTAL REVENUE

Rental revenue from third-party rental property tenants — Standard Bearer's owned properties are leased pursuant to non-cancelable operating leases, generally with an initial term of 10 to 20 years. All of the leases for post-acute care healthcare properties contain renewal options. The leases provide for fixed minimum base rent during the initial and renewal periods. Standard Bearer's leases contain provisions for specified annual increases over the rents of the prior year and those increases are generally calculated based on the Consumer Price Index.

Each lease is a triple net lease which requires the lessee to pay all taxes, insurance, maintenance and repairs, capital and non-capital expenditures and other costs necessary in the operations of the facilities. In addition, Standard Bearer's leases with third-parties are typically structured as master leases. The master leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography.

If a lessee makes payments for taxes and insurance directly to a third-party on our behalf, we are required to exclude these payments from variable payments and from revenue recognition in our consolidated statements of income. Otherwise, tenant reimbursements paid to us for taxes and insurance are classified as additional rental revenue recognized by us on a gross basis.

Rental revenue from our independent subsidiaries — Rental revenue from our independent subsidiaries is based on mutually agreed-upon base rents that are subject to change from time to time. Intercompany revenue is eliminated in consolidation, along with the corresponding intercompany rent expenses of the related healthcare facilities.

COMPETITION

The post-acute care industry is highly competitive, and we expect that the industry will become increasingly competitive in the future. The industry is highly fragmented and characterized by numerous local and regional providers, in addition to large national providers that have achieved geographic diversity and economies of scale. Our independent subsidiaries 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 skilled nursing facility. 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 caregivers;
- reputation and achievements of quality healthcare outcomes;
- attractiveness and location of facilities;
- 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 the “operation of choice.” This means that the operation leaders are generally free to discern and address the unique needs and priorities of healthcare professionals, customers 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 customers and referral sources to choose or recommend the operation.

Increased competition could limit our ability to attract and retain patients, 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 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.

Our other services, such as senior living facilities and other ancillary services, also compete with local, regional, and national companies. The primary competitive factors in these businesses are similar to those for our skilled nursing facilities and include reputation, cost of services, quality of clinical services, responsiveness to patient/resident needs, location and the ability to provide support in other areas such as third-party reimbursement, information management and patient recordkeeping.

Our Standard Bearer segment competes for real property investments with healthcare providers, healthcare-related REITs, real estate partnerships, banks, private equity funds, venture capital funds and other investors. Some of these competitors are significantly larger and have greater financial resources and lower costs of capital than us. Our ability to compete successfully for real property investments will be determined by numerous factors, including our ability to identify suitable acquisition targets, our ability to negotiate acceptable terms for any such acquisition and our cost of capital in the event an acquisition requires debt or equity financing.

OUR COMPETITIVE STRENGTHS

We believe that we are well positioned to benefit from the ongoing changes within our industry. We believe that our ability to acquire, integrate and improve our facilities is a direct result of the following key competitive strengths:

Experienced and Dedicated Employees — We believe that our independent subsidiaries' employees are among the best in their respective industries. We believe each of our independent subsidiaries is led by an experienced and caring leadership team, including dedicated front-line care staff, who participates daily in the clinical and operational improvement of their individual operations. We have been successful in attracting, training, incentivizing and retaining a core group of outstanding business and clinical leaders to spearhead our independent subsidiaries. These leaders operate as separate local businesses. With broad local control, these talented leaders and their care staffs are able to quickly meet the needs of their patients and residents, employees and local communities, without waiting for permission to act or being bound to a “one-size-fits-all” corporate strategy.

Unique Incentive Programs — We believe that our employee compensation programs are unique within the industry. Employee stock options and performance bonuses, based on achieving target clinical quality, cultural, compliance and financial benchmarks, represent a significant component of total compensation for our operational leaders. We believe that these compensation programs assist us in encouraging our leaders and key employees to act with a shared ownership mentality. Furthermore, our leaders are motivated to help local operations within a defined “cluster” and "market," which is a group of geographically proximate operations that share clinical best practices, real-time financial data and other resources and information.

Staff and Leadership Development — We have a culture that believes ongoing education, training and professional development is essential. Accordingly, our operational leaders participate in regular training. Most participate in training sessions at Ensign University, our in-house educational system. Other training opportunities are generally offered via on-demand training tools, including podcasts. In addition, we offer weekly cultural and interactive educational topics including leadership development, our values, updates on Medicaid and Medicare billing requirements, updates on new regulations or legislation, infection control, emerging healthcare service alternatives and other relevant clinical, business and industry specific coursework. We also encourage and provide ongoing education classes for our clinical staff to maintain licensing and increase the breadth of their knowledge and expertise. We believe that our commitment to, and substantial investment in, ongoing education will further strengthen the quality of our operational leaders and staff, and the quality of the care they provide to our patients and residents.

Innovative Service Center Approach — We do not maintain a corporate headquarters; rather, we operate service centers to support the efforts of each operation. Our Service Center is a dedicated service organization that acts as a resource and provides centralized information technology, human resources, accounting, payroll, legal, risk management, educational and other back-office support services, so that local leaders can focus on delivering top-quality care and efficient business operations. Our Service Center approach allows individual operations to function with the strength, synergies and economies of scale found in larger organizations, but without what we believe are the disadvantages of a top-down management structure or corporate hierarchy. We believe our Service Center approach is unique within the industry, and allows us to preserve the "one-operation-at-a-time" focus and culture that has contributed to our success.

Proven Track Record of Successful Acquisitions — We have established a disciplined acquisition strategy that is focused on selectively acquiring operations within our target markets. Our acquisition strategy is driven by our operations team. Prospective leaders are included in the decision-making process and compensated as these acquired operations reach pre-established clinical quality and financial benchmarks, helping to ensure that we only undertake acquisitions that key leaders believe can become clinically sound and contribute to our financial performance.

As of December 31, 2024, we have expanded to 327 facilities with an aggregate of 33,547 operational skilled nursing beds and 3,088 senior living units, through both long-term leases and real estate purchases. We believe our experience in acquiring these operations and our demonstrated success in significantly improving their operations enables us to consider a broad range of acquisition targets. In addition, we believe we have developed expertise in transitioning newly acquired operations to our unique organizational culture and systems, which enables us to acquire operations with limited disruption to patients, residents and operating staff, while significantly improving quality of care. We have also constructed new facilities to target demand, which exists for high-end healthcare facilities when we determine that market conditions justify the cost of new construction in some of our markets.

Successful Real Estate Investment Strategy — As part of our Standard Bearer segment, we maintain a real estate portfolio of long-term healthcare facilities diversified by geographic location and operated by a diverse group of established healthcare providers. We are focused on selectively acquiring real estate properties based on our industry experience and opportunistic strategy, which we believe provides us with greater investment and purchasing opportunities. Due to our credit strength, we have the ability to acquire large portfolios of real estate properties; a portion of which can be managed and operated by our independent subsidiaries and their established healthcare leaders and a portion of which can be leased to third parties.

As of December 31, 2024, our real estate portfolio consists of 129 owned facilities, which include properties leased to and operated by third parties and properties we managed and operated. We believe our real estate investment strategy has allowed us to accumulate a portfolio that aids our healthcare operators in improving performance and generating additional returns through leases with third parties.

Reputation for Quality Care — We believe that we have achieved a reputation for high-quality and cost-effective care and services to our patients and residents within the communities we serve. We believe that our achievement of quality outcomes enhances our reputation for quality, that when coupled with the integrated services that we offer, allows us to attract patients that require more intensive and medically complex care and generally result in higher reimbursement rates than lower acuity patients.

Community Focused Approach — We view our services primarily as a local, community-based business. Our local leadership-centered management culture enables each operation's nursing support staff and leaders to meet the unique needs of their patients and local communities. We believe that our commitment to this "one-operation-at-a-time" philosophy helps to ensure that each operation, its patients, their family members and the community will receive the individualized attention they need. By serving our patients, their families, the community and our fellow healthcare professionals, we strive to make each individual business the operation of choice in its local community.

We further believe that when choosing a healthcare provider, consumers usually choose a person or people they know and trust, rather than a corporation or business. Therefore, rather than pursuing a traditional organization-wide branding strategy, we actively seek to develop the operations brand at the local level, serving and marketing one-on-one to caregivers, our patients, their families, the community and our fellow healthcare professionals in the local market.

Investment in Information Technology — We utilize information technology that enables our operational leaders to access, and to share with their peers, both clinical and financial performance data in real time. Armed with relevant and current information, our operation leaders and their management teams are able to share best practices and the latest information, adjust to challenges and opportunities on a timely basis, improve quality of care, mitigate risk and improve both clinical outcomes and financial performance. We have also invested in specialized healthcare technology systems to assist our nursing and support staff. We have installed software and touch-screen interface systems in each operation to enable our clinical staff to more efficiently monitor and deliver patient care and record patient information. We believe these systems have improved the quality of our medical and billing records, while improving the productivity of our staff.

OUR GROWTH STRATEGY

We believe that the following strategies are primarily responsible for our growth to date, and will continue to drive the growth of our business:

Grow Talent Base and Develop Future Leaders — Our primary growth strategy is to expand our talent base and develop future leaders. A key component of our organizational culture is our belief that strong local leadership is a primary key to the success of each operation. While we believe that significant acquisition opportunities exist, we have generally followed a disciplined approach to growth that permits us to acquire an operation only when we believe, among other things, that we will have qualified leadership for that operation. To develop these leaders, we have a rigorous "CEO-in-Training Program" that attracts proven business leaders from various industries and backgrounds, and provides them the knowledge and hands-on training they need to successfully lead one of our independent subsidiaries. We generally have between 55 and 65 prospective administrators progressing through the various stages of this training program, which is generally much more rigorous, hands-on and intensive than the minimum 1,000 hours of training mandated by the licensing requirements of most states where we do business. Once administrators are licensed and assigned to an operation, they continue to learn and develop in our operational Chief Executive Officer Program (CEO Program), which facilitates the continued development of these talented business leaders into outstanding operational chief executive officers, through regular peer review, our leadership development tools and on-the-job training.

In addition, our Chief Operating Officer Program (COO Program) recruits and trains highly qualified Directors of Nursing to lead the clinical programs in our operations. Working together with their operational CEO and/or administrator, other key operational leaders and front-line staff, these experienced nurses manage delivery of care and other clinical personnel and programs to optimize both clinical outcomes and employee and patient satisfaction.

Increase Mix of High Acuity Patients — Many skilled nursing facilities are serving an increasingly larger population of patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, as a result of government and other payors seeking lower-cost alternatives to traditional acute-care hospitals. We generally receive higher reimbursement rates for providing care for these medically complex patients. In addition, many of these patients require therapy and other rehabilitative services, which we are able to provide as part of our integrated service offerings. Where higher complex services are medically necessary and prescribed by a patient's physician or other appropriate healthcare professional, we generally receive additional revenue in connection with the provision of those services. By making these integrated services available to such patients and maintaining established clinical standards in the delivery of those services, we are able to increase our overall revenues. We believe that we can continue to attract high acuity patients to our operations by maintaining and enhancing our reputation for quality care and continuing our community focused approach.

Focus on Organic Growth and Internal Operating Efficiencies — We plan to continue to grow organically by focusing on increasing patient occupancy within our existing operations. Although some of the facilities we have acquired were in good physical and operating condition, the majority have been clinically and financially troubled, with some facilities having had occupancy rates as low as 30% at the time of acquisition. Additionally, we believe that incremental operating margins on the last 20% of our beds/units are significantly higher than on the first 80%, offering opportunities to improve financial performance within our existing facilities.

Our overall occupancy is impacted significantly by the number of facilities acquired and the operational occupancy on the acquisition date. We historically have acquired operations with lower occupancy and skilled mix. Therefore, consolidated occupancy will vary significantly based on these factors. Our average consolidated occupancy rates for our skilled nursing facilities were 80.5% and 78.5% for the years ended December 31, 2024 and 2023, respectively. Throughout most of our history, our business is affected by seasonal fluctuations in occupancy and acuity, which are most prominent when comparing the summer and winter months of the calendar year. For skilled nursing occupancy and skilled mix, our historic seasonal trend tends to show stronger occupancy and acuity during the first and fourth quarters and softening in the second and third quarters.

We also believe we can generate organic growth by improving operating efficiencies and the quality of care at the patient level. By focusing on staff development, clinical systems and the efficient delivery of quality patient care, we believe we are able to deliver higher quality care at lower costs than many of our competitors.

Historically, we have achieved incremental occupancy and revenue growth by creating or expanding clinical service offerings in existing operations. For example, by expanding clinical programs to provide outpatient therapy services in many markets, we are able to increase revenue while spreading the fixed costs of maintaining these programs over a larger patient base. Outpatient therapy has also proven to be an effective marketing tool, raising the visibility of our facilities in their local communities and enhancing the reputation of our facilities with short-stay rehabilitation patients.

Add New Facilities and Expand Existing Facilities — One of our growth strategies includes the acquisition of new and existing facilities from third parties and the expansion and upgrade of current facilities. In the near term, we plan to take advantage of the fragmented skilled nursing industry by acquiring operations within select geographic markets and may consider the construction of new facilities. In addition, we have targeted facilities that we believed were performing and operations that were underperforming, where we believed we could improve service delivery, occupancy rates and cash flow. With experienced leaders in place at the community level and demonstrated success in significantly improving operating conditions at acquired facilities, we believe that we are well positioned for continued growth. While the integration of underperforming facilities generally has a negative short-term effect on overall operating margins, these facilities are typically accretive to earnings within 12 to 18 months following their acquisition. For the facilities that we acquired from 2002 through 2024, the aggregate EBITDAR as a percentage of revenue improved from 13.3% during the first full three months of operations to 16.5% during the thirteenth through fifteenth months of operation and to 18.6% during the 45th quarter of operation.

Standard Bearer Portfolio Growth — An important part of our business strategy is to continue to expand and diversify our real estate portfolio through accretive acquisition and investment opportunities in healthcare properties. Our execution of this strategy hinges on our ability to successfully identify, secure and consummate beneficial transactions. We have a proven track record of acquiring properties that we have determined are investment opportunities and develop these into thriving properties that are well-suited for operational purposes. We then use these properties for our skilled nursing or senior living operations, or we lease the properties to other long-term care facility operators. We expect that our REIT structure will allow us to expand our real estate footprint while bringing the best operational practices to our own and other operators in the industry.

HUMAN CAPITAL

At December 31, 2024, we had approximately 39,300 full-time equivalent employees who were employed by our Service Center and our independent subsidiaries. For the year ended December 31, 2024, approximately 60.0% of our total expenses were payroll related. Periodically, market forces, which vary by region, require that we increase wages in excess of general inflation or in excess of increases in reimbursement rates we receive. We believe that we staff appropriately, focusing primarily on the acuity level and day-to-day needs of our patients and residents. In most of the states where we operate, our skilled nursing facilities are subject to state mandated minimum staffing ratios, so our ability to reduce costs by decreasing staff, notwithstanding decreases in acuity or need, is limited and subject to government audits and penalties in some states. We seek to manage our labor costs by improving staff retention, improving operating efficiencies, maintaining competitive wage rates and benefits and reducing reliance on overtime compensation and temporary nursing agency services. The Service Center's Chief Human Capital Officer, together with the Unity Committee, oversee the following human capital initiatives:

Our Culture — The operation of our skilled nursing and senior living facilities requires a large number of highly skilled healthcare professionals and support staff. Our employees are at the heart of our Company and we are committed to their health, professional development and workplace satisfaction. Our core values, which focus on developing our employees, fostering an ownership mentality and allowing for intelligent risk taking, guide us in our decision making and inspire us to be better people, both professionally and personally.

Compensation and Benefits — The healthcare industry as a whole has been experiencing shortages of qualified professional clinical staff. We believe that our ability to attract and retain qualified professional clinical staff stems from our ability to offer attractive wage and benefits packages, a high level of employee training, an empowered culture that provides incentives for individual efforts and a quality work environment.

Unity — Our commitment to inclusion is deeply rooted in our core values, including *Love One Another*, where we foster a welcoming and supportive environment for residents and their families and ensure that every individual—whether resident, family member, or team member—feels valued, informed, and comfortable to work together. Our commitment is to provide equal opportunity and fair treatment to all individuals based on merit and without discrimination. Our teams enable us to be a more relevant, competitive, and resilient organization. These efforts are supported by our Unity Committee, a multidisciplinary group led by our Chief Executive Officer.

Training and Development — We provide training and development to all employees. We have many training programs at all levels such as our CEO in Training, Director of Nursing in Training, Director of Rehab in Training, nursing certified assistant schools, weekly culture trainings, boot camps and annual meetings, where we focus on both career and professional development.

Social Sustainability — We continuously work towards bridging the gap between what the healthcare system currently provides and the basic needs of individuals. We aim to have an enduring impact on the communities in which we live and work. We partner with Elevate Charities, a non-profit organization that is dedicated to elevating the condition and quality of life for members of the senior healthcare community, employees, caregivers, family members, patients and residents. Elevate Charities has three unique funds: Heritage Fund, Heritage Scholarship Fund and the Emergency Fund.

The Heritage Fund and the Heritage Scholarship Fund engage in a mission to enhance the quality of life for seniors in our communities through caring service, fulfilling essential needs and providing education to caregivers. The Heritage Fund helps the caregiver identify specific and practical ways to meet the needs of those under their care. This can help provide a better life, improved experience and greater satisfaction for our aging population. The financial support provided by the Heritage Fund benefits seniors directly. In addition, the Heritage Scholarship Fund helps qualified clinical professionals who may not be able to afford to advance in the field of long-term care. Through grants and scholarships, the fund helps these qualified professionals gain the education needed to advance in the field of senior-focused healthcare. Since 2018, we have partnered with public charities who have awarded 244 scholarships to employees in our workforce.

Lastly, the Emergency Fund is a way of passing the hat to help long term care staff whose lives are affected by tragedy. This program is funded for our team members by our team members. All team members are encouraged to contribute to the fund either through a one-time donation or by recurring payroll deduction. In 2024, approximately 90% of those employed by our independent subsidiaries contributed to Elevate Charities Emergency Fund. In 2024, the public charity distributed approximately $4.8 million in grants to members of our independent subsidiaries. To date, the Emergency Fund has distributed over 19,400 grants totaling almost $20.6 million to members of our independent subsidiaries in their time of need.

For additional information on human capital matters, please see our most recent proxy statement or ESG report, each of which is available on our website at www.ensigngroup.net. For additional information on Elevate Charities, please visit www.elevatecharities.org. The information contained in, or that can be accessed through, either of the foregoing websites does not constitute a part of this Annual Report on Form 10-K.

GOVERNMENT REGULATION

General

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

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

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

Proposed, Anticipated and Recently Issued Rulemaking and Administrative Actions

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

Biden-Harris Administration's Nursing Home Care Priorities — The Biden-Harris Administration sought reform around reimbursement, staffing levels, standards of care, increased transparency and public disclosure of ownership, and enhanced civil remedies as a means of enforcement against those facilities that do not satisfy CMS's standards. Through rules that were proposed and finalized beginning 2023, including those highlighted below, the Biden-Harris Administration directed the government to exercise greater oversight of SNFs and ALFs receiving federal reimbursement. For example, the SNF PPS FY 2025 Final Rule grants CMS greater sanctioning authority for ongoing or persistent deficiencies in Medicare-participating SNFs. These increased sanctioning authorities will take effect in the 2025 federal fiscal year, beginning October 1, 2024. With the new administration, it currently is unknown whether any of these rules will be reduced in their scope or application, or whether they will be increased in any respects. The individuals anticipated to be nominated to serve as the Secretary of HHS and Director of CMS, respectively, have not yet provided any indication what their priorities of anticipated future actions would be in this area.

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 any facility or part of a facility, or provides services to a facility that include its policies and procedures or cash management services; (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. This rule's disclosure requirements came into effect throughout 2024, with all SNFs required to comply by November of 2024.

Certain states have adopted laws reflecting their concerns regarding ownership transparency. For example, Iowa adopted laws requiring disclosure of ownership information not previously required for licensure to promote transparency in 2023. Additionally, in March 2024, the California Department of Health Care Access and Information of the California Health and Human Services Agency issued its notice of approval of regulatory action establishing policies and procedures that implement financial and ownership transparency requirements for California-licensed SNFs that are required by California law passed in 2021.

Federal Legislation — The Home and Community-Based Services (HCBS) Access Act (Access Act) was introduced in 2023 to expand access to and resources available for HCBS. The Access Act ensures that Medicaid funding is made available to individuals who provide direct home- and community-based care to adults over the age of 60 or people who have disabilities. This bill also provides financial resources for the training of these direct care providers, who are intended to provide services to the elderly or disabled that range from advocacy and community integration to transportation and daily assistance tasks ranging from bathing and laundry to meal preparation and housekeeping. As of the date of filing, no further action has been taken on the HCBS Access Act since its introduction and referral to the House of Representatives committees.

In addition, the HCBS Relief Act introduced in 2023, provides additional funds to states to stabilize their HCBS service delivery networks, recruit and retain HCBS direct care workers, and meet long-term service and support needs of people eligible for Medicaid home and community-based services. To qualify for the enhanced rate, a state must commit to initiatives aimed at improving the provision of services. As of the date of this filing, no action has been taken on the HCBS Relief Act since its introduction and referral to the Senate Committee on Finance.

State Legislation — Many states in which our independent subsidiaries operate have introduced or passed legislation that would create or change laws and regulations related to our business and industry.

In the past, California had discussed issuing proposed regulations on direct care spending requirements that may have affected our business and SNFs operating within that state. These proposals have included requirements for healthcare facilities certified by CMS, including SNFs, to report all annual revenues to the State of California and certify that a stated percentage of all revenues should be used for direct patient-related services, including staffing and operational costs.

California has also signed into law a bill that impacts the minimum wages of healthcare workers. Effective October 16, 2024, the law raised the minimum wage for California healthcare employees and set a new wage threshold for those who are considered exempt healthcare employees. The bill only becomes effective for SNFs if a direct care minimum spending requirement bill is also passed. While the existing requirement bill has not seen any traction, we anticipate a minimum spending bill could be proposed in the future, including the next California legislative session that begins in 2025.

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.

Final Rule Fiscal Year 2025 Skilled Nursing Facility Prospective Payment System (SNF PPS) — CMS released the final rule for the SNF PPS for FY 2025 (SNF PPS FY 2025 Final Rule) in July 2024 to update the Medicare payment rates within the SNF PPS and provide significant enhancements to CMS's enforcement capabilities within nursing homes.

This final rule results in a net 4.2% increase in SNF payments under Medicare Part A in fiscal year 2025, which started on October 1, 2024 and will run through September 30, 2025. The net increase is based on the SNF market basket of 3.0%, plus a 1.7% market basket forecast error adjustment, and a negative 0.5% productivity adjustment. This increase does not include the SNF VBP reductions for certain SNFs subject to the net reduction in payments under the SNF VBP. CMS also revised the SNF market basket base year from the 2018 base year to the current 2022 base year and updated the payment rates used under the SNF PPS based on the FY 2025 market basket increase factor, which is adjusted by both the productivity adjustment and forecast error correction. Within this rule, CMS also updated the SNF PPS wage index using core-based statistical areas (CBSAs) to reflect regional wage costs.

The SNF PPS FY 2025 Final Rule also includes significant enhancements to CMS's enforcement capabilities within nursing homes, aiming to reinforce the safety and quality of care. The rule broadens CMS's ability to use financial penalties to ensure sustained remediation of health and safety infractions, thereby motivating facilities to quickly comply with CMS regulations. The rule eliminates the restrictions of per instance (PI) for isolated violations or per day (PD) for ongoing non-compliance restrictions, allowing for more flexible imposition of both PD and PI penalties, which would not exceed statutory daily limits. This change is intended to provide CMS with enhanced tools to address violations more effectively and reflect the severity of the impact on residents' health and safety. Additionally, the SNF PPS FY 2025 includes updates to the QRP to better account for social determinants of health, adding items to be reported regarding these social determinants of health—living situation, food, and utilities—in the minimum data set each SNF is required to report to CMS. The SNF PPS FY 2025 also contains an update to the SNF Value-Based Purchasing (VBP) Program, including how its measurements are retained or removed from use in evaluating quality of care, updates to technical measures so that measures can be updated using a sub-regulatory process, and administrative policies for updating and correcting data CMS relies on in calculating its measurements.

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. 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.

Final Rule Fiscal Year 2024 SNF PPS — The SNF PPS FY 2024 Final Rule, which was effective October 1, 2023, updated the Medicare payment rates and modified the SNF QRP and the SNF VBP Program.

The SNF PPS FY 2024 Final Rule finalized the rates to be paid in fiscal year 2024, which started on October 1, 2023 and ran through September 30, 2024. The net effect of these changes was an overall 4.0% increase in payments to SNFs in FY 2024. The increase included a 6.4% net market basket update to the payment rates of 3.0%, plus a 3.6% market basket forecast error adjustment, less a 0.2% productivity adjustment, as well as a negative 2.3% in the FY 2024 SNF PPS rates due to the second phase of the Patient Driven Payment Model (PDPM) parity adjustment recalibration. In addition, this final rule also updates the SNF QRP for FY 2024 and future years, including the adoption of two new quality reporting measures, modification of one measure and removal of three measures resulting in public reporting of four QRP measures. Additionally, the SNF PPS FY 2024 Final Rule made changes to the SNF VBP Program, specifically adopting four new measures: the nursing staff turnover measure, the discharge function score measure, the long stay hospitalization measure per 1,000 resident days and the percent of residents experiencing one or more falls with a major injury (long stay); the existing SNF 30-day all-cause readmission measure (SNFRM) is replaced with the SNF within stay potentially preventable readmissions measure beginning in FY 2028.

SNF PPS FY 2024 Final Rule adopted the Nursing Staff Turnover (NST) measure for the SNF VBP program beginning with the FY 2026 program year. This is a structural measure that has been collected and publicly reported on Care Compare, and the measure assesses the stability of the staffing within a SNF using nursing staff turnover. The NST measure uses facility-reported, electronic data from CMS' Payroll-Based Journal (PBJ) system to calculate annual turnover rates for nursing staff, including RNs, LPNs, and nurse assistants. Facilities would begin reporting this measure in FY 2024, with payment effects beginning in FY 2026.

The NST measure looks at six consecutive quarters of data. It starts with a baseline quarter and the first two quarters of the performance period to identify eligible employees. Then, uses the next four quarters to find the number of employment cycles that ended in turnover. Finally, the data from the sixth quarter is validated to identify gaps in days worked that began in the last 60 days of the fifth quarter used for the measure. The measure score is then calculated by comparing the total number of eligible employees with 60-day gaps in working during the specified periods. After submission, CMS may audit the data and if discrepancies are found, the consequences may include penalties, decreased ratings and suppression of metrics for the trailing 6 quarters.

CMS Minimum Staffing Standards Final Rule — CMS issued its final rule establishing minimum staffing standards for skilled nursing facilities (Staffing Rule) in April 2024. The Staffing Rule contains three primary staffing requirements and provides for a staggered and phase implementation over the next several years following the Staffing Rule's publication.

The initial phase, effective 90 days from the Staffing Rule's publication, which is August 8, 2024, requires facility self-assessment, which enhances the current assessment that all SNFs must perform and document annually and on an as-needed basis. The Staffing Rule's requirement for enhanced self-assessments requires the following: 1) facilities must use evidence-based methods when planning for resident care, including accommodation of behavioral health needs; 2) facilities to use their self-assessment to assess the specific needs of each resident, with adjustments made for changes in the resident population; 3) facilities include the input of staff, including leadership, management, nurse staff and other direct care providers who render other services to residents; and 4) the facility's staffing plan maximizes recruitment and retention of staff in a manner consistent with the President Biden's April 2023 Executive Order on increasing access to high-quality care and supporting caregivers.

The second phase, effective within two years of the Staffing Rule's publication, which is May 2026 for non-rural facilities, requires that all SNFs have a registered nurse (RN) available to provide direct resident care onsite 24 hours per day, seven days per week (24/7). The rule states that administrative nurses may satisfy this requirement, provided that the nurse is available to provide direct resident care. In addition to the 24/7 RN, the Staffing Rule requires facilities to provide a minimum of 3.48 hours per resident per day (HPRD) of direct nursing care to residents.

The third phase, effective within three years of the Staffing Rule's publication, which is May 2027 for non-rural facilities, requires that the HPRD are satisfied through RNs providing 0.55 HPRD, nurse aides (NAs) providing 2.45 HPRD, and any combination of RNs, licensed practical nurses (LPNs), licensed vocational nurses (LVNs), or NAs to account for the final 0.48 HPRD.

The Staffing Rule finalized the hardship exemption for the HPRD requirements. A facility can qualify for a temporary hardship exemption from the new minimum staffing ratios and 24/7 RN onsite staffing requirement (the self-assessment standards must still be satisfied) if it is in an area where the supply of RN, NA, or total nursing staff is insufficient to meet the needs of that area. This exemption is based on the provider-to-population ratio for the nursing workforce, which must be at least 20% below the national average as calculated by CMS. Additionally, the Staffing Rule provides a one year extension of deadlines to rural facilities on Phases 2 and 3.

The Staffing Rule also enhances transparency for the use of Medicaid payments for facility services, referenced as Medicaid Institutional Payment Transparency Reporting provisions (MIPTR). The MIPTR provisions within the Staffing Rule require States to report to CMS the percentage of Medicaid payments for nursing facility services spent on direct care workers and support staff, regardless of whether such payments are made under a fee-for-service or managed care model.

Prior to the publication of the Staffing Rule, two bills, named the Protecting America's Seniors' Access to Care Act and Protecting Rural Seniors' Access to Care Act (one in the House and a companion bill in the Senate) were introduced to block the Staffing Rule from taking effect. Both bills have been referred to committee and are pending further action. These bills reason that the minimum staffing standard would endanger rural nursing facilities, subjecting them to potential fines and closures for failure to comply and might require them to discharge residents or limit the number of residents they accept in an effort to meet the requirements of the bill. It is uncertain if any of these bills or other legislative action will pass as well as their potential impact on the Staffing Rule.

The Staffing Rule has been met with further opposition and proposed legislation to halt its implementation. On May 23, 2024, the American Health Care Association (AHCA) filed a lawsuit in the Northern District of Texas against HHS and CMS, alleging that the Staffing Rule exceeds the scope of CMS's statutory authority and violates the Administrative Procedure Act. The State of Texas brought suit and was granted consolidation of its lawsuit with AHCA's in the same venue arguing the rule is "arbitrary and capricious" and in violation of the Administrative Procedure Act. Subsequently, over 20 additional states have filed similar suits in opposition to the rule, as well as industry groups including Leading Age and the South Dakota Association of Healthcare Organizations. On May 10, 2024, a joint resolution was introduced in the House of Representatives under the Congressional Review Act to overturn the Staffing Rule, which was referred to the House Ways and Means committee and its Subcommittee on Health on May 17, 2024, with no further action taken on the joint resolution since then. Related to the pending proposed legislation regarding the Staffing Rule, the Long-Term Care Workforce Support Act was introduced in both the Senate and House of Representatives in April of 2024 and both versions of the bill were subsequently referred to the Senate Committee on Finance and the House Ways and Means committee and its Subcommittee on Health, respectively, by April 19, 2024, with no action taken on either bill since then. These companion bills were introduced in order to increase the direct care workforce and improve pay, by increasing the federal match for Medicaid by up to 10% for each state across 10 years. The recent Supreme Court decision in *Loper Bright Enterprises v. Raimondo* ("Chevron" decision) gives courts greater authority to challenge federal agencies' statutory interpretations. As such, the Staffing Rule may see increased legal challenges under the new doctrine. (For further discussion of the Chevron case and its implications see "United States Supreme Court Decisions" section below.)

Medicare

Medicare presently accounts for approximately 25.9% of our skilled nursing services revenue year-to-date, being our second-largest revenue payor. The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins.

Patient-Driven Payment Model (PDPM) — The SNF PPS Rule included a case mix model called PDPM that focuses on the patient's condition (clinically relevant factors) and resulting care needs to determine Medicare reimbursement. PDPM utilizes clinically relevant factors for determining Medicare payment by using diagnosis codes and other patient characteristics as the basis for patient classification. PDPM makes effective use of five case-mix adjusted payment components: physician 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. PDPM is intended to achieve a more value-based, unified post-acute care payment system. For example, PDPM adjusts Medicare payments based on each aspect of a resident's care. Under the SNF PPS PDPM system, the payment to SNFs and nursing homes is based heavily on the patient's condition rather than the specific services provided by each SNF.

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

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

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

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

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

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

CMS's SNF PPS FY 2025 Final Rule adopts several updates to the SNF QRP aimed at enhancing the integration of social determinants of health (SDOH) into patient assessments and ensuring the accuracy of reported data. Starting in fiscal year 2027, CMS will introduce four new SDOH items related to living situation, food security, and utility access, and modify an existing item on transportation availability in the MDS. Additionally, CMS requires that SNFs participating in the SNF QRP undergo a data validation process similar to that already implemented in the SNF VBP Program. Also beginning in fiscal year 2027, SNFs participating in the SNF QRP program must participate in a validation program similar to that used for SNFs participating in the SNF VBP Program.

Medicare Annual Payment Rule — CMS is required to calculate an annual Medicare market-basket update to the payment rates. The SNF PPS FY 2025 Final Rule, issued on July 31, 2024 increased the Medicare payment rates to SNFs in fiscal year 2025 by 4.2%, which is based on a market basket of 3.0% plus a 1.7% market basket forecast error adjustment and a negative 0.5% productivity adjustment.

On July 31, 2023, CMS issued the SNF PPS FY 2024 Final Rule that increased Medicare payment rates by 4.0% to SNFs in fiscal year 2024. This increase results from the 6.4% net market basket update to the payment rates, which is based on a 3.0% SNF market basket increase plus a 3.6% market basket forecast error adjustment, less a 0.2% productivity adjustment and a negative 2.3% adjustment as a result of the recalibrated parity adjustment.

On July 29, 2022, CMS issued a final rule for fiscal year 2023 that increased the Medicare payment rates to aggregate net market basket by 2.7%. The increase results from the 5.1% update to the market basket, which is based on a 3.9% current year market basket increase plus a 1.5% market basket error adjustment, less a 0.3% productivity adjustment and a negative 2.3% adjustment as a result of the recalibrated parity adjustment. The recalibrated parity adjustment is being phased in at a rate of 2.3% per year on both the SNF PPS FY 2024 and FY 2023 Final Rules.

Sequestration of Medicare Rates —The Budget Control Act of 2011 requires a mandatory, across the board reduction in federal spending, called sequestration. Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013 incur a 2.0% reduction in Medicare payments through at least 2023, unless Congress takes further action. Under the CAA 2023, a further 4.0% cut to Medicare spending that would have been required under the Statutory Pay-As-You-Go Act of 2010 (PAYGO) was waived for fiscal years 2023 and 2024. Instead, the CAA 2023 deferred any further Medicare sequestration under PAYGO until fiscal year 2025. The CAA 2023 also offset planned Medicare sequestrations that would have been as high as 4.0% and instead maintained fee schedule cuts of approximately 2.0%. Absent a further act by Congress, such as a consolidated appropriations act for 2025 or other bill addressing spending in fiscal year 2025 (including retroactively), the sequestration of Medicare FFS claims is expected to take effect in fiscal year 2025. On October 29, 2024, the Medicare Patient Access and Stabilization Act of 2024 (MPASA) was introduced in the House of Representatives, seeking to increase the amount paid to physicians under Medicare by 4.73%. MPASA was referred to the House Ways and Means Committee and House Committee on Energy and Commerce on October 29, 2024, referred to the Subcommittee on Health on December 17, 2024 and no further action has been taken on this bill.

Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program — The SNF-VBP Program rewards SNFs with incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure. CMS annually adjusts its payment rules for SNFs using the SNF-VBP Program. The program also introduced quality measures to assess how health information is shared and adopted several standardized patient assessment data elements that assess factors such as cognitive function and mental status, special services and social determinants of health. CMS uses regulations to specify how it measures the performance for SNFs as well as the data that SNFs are to report to CMS. The deadlines for baseline period quality measure quarterly reporting and performance periods and standards began in the 2023 program year. The final rule for the fiscal year 2023 SNF PPS also provided for SNF-VBP program expansion beyond the use of its single, all-cause hospital readmission measure to determine payment, with the inclusion of measures in fiscal year 2026 for SNF healthcare associated infections requiring hospitalization (SNF HAI) and total nursing hours per resident day measures and in fiscal year 2027, the discharge to community post-acute care measure for SNFs, which assess the rate of successful discharges to the community from a SNF setting.

The SNF PPS FY 2024 Final Rule elected to replace the SNFRM measure with the SNF within-stay (WS) potentially preventable readmission (PPR) measure beginning in the FY 2028 program year. The PPR measure assesses the risk-standardized rate of unplanned and potentially avoidable readmissions during SNF stays for Medicare fee-for-service beneficiaries. The new SNF WS PPR measure refines the original Skilled Nursing Facility 30-Day Potentially Preventable Readmission (SNFPPR) measure, which followed the requirements of the Protecting Access to Medicare Act (PAMA) of 2014. The refinement in the SNF WS PPR measure shifts the observation window from a fixed 30-day post-hospital discharge to the duration of the SNF stay. Moreover, the time gap allowed between the prior inpatient discharge and the SNF admission has been extended from one day to 30 days. These changes, based on feedback from expert panels and a 2015 partnership, better align the measure with the IMPACT Act's provisions and enhance the reliability of tracking preventable readmissions. Additionally, the SNF WS PPR measure's calculations use two years of Medicare claims data to generate a provider-specific risk-standardized readmission rate.

The SNF PPS FY 2025 Final Rule adopted several operational and administrative updates to the SNF VBP Program. The SNF rule adopted 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. The rule allows CMS to update the case-mix methodology for the Total Nurse Staffing measure, and its policies to allow the review and revise measures, as well as review and correct data, allow SNFs to review and correct Payroll-Based Journal (PBJ) data from fiscal year 2026 and MDS data from fiscal year 2027, allowing CMS to fashion more accurate measures based on updated data.

Part B Rehabilitation Requirements — A portion of our revenue is paid by the Medicare Part B program under a fee schedule. Part B services are limited with a payment cap by combined speech-language pathology services (SLP), physical therapy (PT) services and a separate annual cap for occupational therapy (OT) services. Part B services are limited by a payment cap as there is one amount for physical therapy (PT) services and speech-language pathology (SLP) services combined and a separate amount for occupational therapy (OT) services. On November 1, 2024, CMS issued the Calendar Year (CY) 2025 Physician Fee Schedule (PFS) Final Rule (2025 PFS Final Rule).

The Bipartisan Budget Act of 2018 (BBA) establishes coding modifier requirements to obtain payments beyond certain payment thresholds, discussed below and reaffirms the specific $3,000 claim audit threshold requirements for Medicare Administrative Contractors. For PT and SLP combined the threshold for coding modifier requirements was $2,330 for CY 2024 with the same threshold for OT services. The KX modifier is added to medical claims to indicate the providing clinician attests that the services corresponding to that claim were medically necessary and that the justification for those services is contained within the patient’s medical records. This modifier is intended for use where the services will exceed the threshold for those services set by the BBA and updated by annual fee schedule rules, yet are still appropriate and medically necessary, and thus should be compensated by Medicare.

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

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

Through the end of CY 2024, certain of our Part B services provided through telehealth would qualify for Medicare reimbursement based on flexibility first provided under the Emergency Waivers, which added physical therapy, occupational therapy and speech-language pathology to the list of approved telehealth Providers for the Medicare Part B programs provided by a SNF. During the Public Health Emergency (PHE), CMS added certain PT and OT services to the list of Medicare-covered telehealth services on a temporary basis, some of which were made permanent for use and new codes were added for PT, OT, or SLP telehealth services—including some "sometimes therapy" codes that were not subject to MPPR. The CAA 2023 extended certain, but not all, telehealth flexibilities until December 31, 2024, allowing certain telehealth flexibilities to continue after the PHE's expiration. The American Relief Act, 2025 extended some but not all telehealth flexibilities for an additional 3 months.

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

The 2025 PFS Final Rule also adopts a regulatory change that allows physical therapy assistants and occupational therapy assistants to be generally supervised by physical therapists and occupational therapists, respectively, in private practice, non-institutional settings, allowing greater flexibility in billing for those assistants' services. Additionally, the 2025 PFS Final Rule excepts a therapist-established initial plan of care (POC) for PT, OT, or SLT services from requiring a physician or non-physician provider's (NPP's) signature, provided that (1) the patient's physician or NPP referred the patient to the therapist and (2) the therapist has evidence that the POC was transmitted to the patient's physician or NPP within 30 days of the patient's initial evaluation. This flexibility applies only to the initial certification.

Finally, the 2025 PFS Final Rule reduces COVID-19 PHE-era telehealth flexibilities beginning on January 1, 2025. Under this final rule, certain restrictions on telehealth that existed prior to the COVID-19 PHE will go back into effect: most geographic and site-of-service restrictions to telehealth will return, while physicians can still provide telehealth from home, and can provide audio-only telehealth communication in specific circumstances where the patient is unable to use video technology. CMS is also establishing new coding and payment for caregiver training services, including training services provided through eligible telehealth means.

On October 29, 2024, MPASA was introduced in the House of Representatives, seeking to increase the amount paid to physicians under Medicare by 4.73%. MPASA was referred to the House Ways and Means Committee and House Committee on Energy and Commerce on October 29, 2024, and no further action has been taken on this bill. On March 9, 2024, President Biden signed the Consolidated Appropriations Act, 2024, which included a 2.93% update to the CY 2024 PFS CF for dates of service March 9, 2024 through December 31, 2024. This replaced the 1.25% update provided by the Consolidated Appropriations Act, 2023.

The 2024 PFS Final Rule was finalized in November 2023, which changed Medicare payments under the PFS and other Medicare Part B components. The CY 2024 PFS Final Rule contained a conversion factor of $32.74, which was a decrease of $1.15 from the CY 2023 PFS conversion factor of $33.89. This CY 2024 conversion factor was 3.4% lower than the CY 2023 conversion factor. The billing period started on January 1, 2024 and ran through December 31, 2024.

The 2024 PFS Final Rule made payments when physicians and NPPs, involve caregivers in implementing an individualized plan of treatment or therapy. These provisions incentivize the training of caregivers and provide additional funds to offset the costs of training these caregivers. For PT and SLP combined, the threshold for coding modifier requirements increases to $2,330 for CY 2024 with the same threshold for OT services. The KX modifier is added to medical claims to indicate the providing clinician attests that the services corresponding to that claim were medically necessary and that the justification for those services is contained within the patient's medical records.

The 2024 PFS Final Rule allowed for general supervision of therapy assistants by PTs and OTs for remote therapeutic monitoring (RTM) services. This change may affect the rate of reimbursement for PT and OT services in the future. Additionally, the 2024 PFS Final Rule added certain health and well-being coaching services that Medicare reimbursed on a temporary basis for 2024. The final rule also added risk assessments for social determinants of health to the list of telehealth services Medicare would reimburse.

Programs of All-Inclusive Care for the Elderly

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

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

Decisions Regarding Skilled Nursing Facility Payment

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

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

Patient Protection and Affordable Care Act

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

The IRA, which continued and expanded certain provisions of the ACA, extended the premium subsidies paid by the federal government, until the end of 2024, resulting in subsidies being available to offset or reduce the costs of private health insurance policies for qualifying individuals. This may aid older patients in obtaining or keeping their health insurance in order to pay for long-term care services. The CAA 2023 revised the funds available to fund Medicare in 2023 and deferred the PAYGO sequestration of Medicare expenses.

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

Requirements of Participation

CMS has requirements that providers, including SNFs, must meet in order to participate in the Medicare and Medicaid Programs. Some of these requirements can be burdensome and costly. One such requirement of participation in the Medicare and Medicaid programs involves limitations around the use of pre-dispute, binding arbitration agreements by SNFs. CMS has issued guidance and direction around arbitration that must be satisfied for any agreement to be enforceable and which may result in adverse consequences for our business if not followed.

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

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

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

Civil and Criminal Fraud and Abuse Laws and Enforcement

Various complex federal and state laws exist which govern a wide array of referrals, relationships and arrangements, and prohibit fraud by healthcare providers. Governmental agencies are devoting increasing attention and resources to such anti-fraud efforts. The Balanced Budget Act of 1997 expanded the penalties for healthcare fraud. Additionally, the government or those acting on its behalf may bring an action under the FCA, alleging that a healthcare provider has defrauded the government by submitting a claim for items or services not rendered as claimed, which may include coding errors, billing for services not provided and submitting false or erroneous cost reports. The FCA clarifies that if an item or service is provided in violation of the AKS, the claim submitted for those items or services is a false claim that may be prosecuted under the FCA as a false claim. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. The Biden-Harris Administration had also signaled an increasing focus on nursing home performance and the reimbursement nursing homes receive from federal healthcare payment programs. The change in the presidency following the 2024 presidential elections may result in a change to this focus, in whole or in part. There has not yet been public disclosure of the priorities of the new Presidential Administration, in addition to those of the anticipated new leaders of HHS and CMS, as they relate to SNFs and long-term care facilities. Many states also have a false claim prohibition that mirrors or closely tracks the federal FCA.

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

In 2021, the OIG released the result of an audit finding that Medicare overpaid millions of dollars for 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. 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. In 2023, representatives of the DOJ speaking at certain industry events, including the American Health Law Association's Fraud and Compliance Forum, have indicated that its healthcare enforcement trends would emphasize opioid prescribing, Medicare Advantage and managed care plan fraud, and COVID-19 related fraud, including under various relief programs available during and in conjunction with the pandemic. In November of 2023, OIG added to its work plan an audit of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, for which OIG expects to issue a report in FY 2025. In addition, the OIG identified the following areas as its "key goals" for oversight: (1) protecting residents from fraud, abuse, neglect, and promoting quality of care; (2) promoting emergency preparedness and emergency response efforts: (3) strengthening frontline oversight; and (4) supporting federal monitoring of nursing homes to mitigate risks to residents.

In February of 2024, the OIG added to its work plan a study regarding the use of the National Background Check Program (NBCP) in conducting background checks of prospective long-term care provider employees. The purpose of this study will be to prepare a report regarding the cost of background checks, number of applicants who received background checks, and disqualification of employees during and after NBCP participation. This report will also include information regarding the cost of background checks and any unintended consequences experienced as a result of using this program. In April of 2024, the OIG updated its work plan to study and determine 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. The OIG further updated its work plan in June 2024 to study and assess the implementation of the Special Focus Facility Program for nursing facilities based on facilities that participated in the program from 2013 through 2022.

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

Federal Healthcare Reform

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

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

In July of 2024, CMS updated the Nursing Home Five-Star Quality Rating System's Technical Users' Guide to identify and explain a change in staffing case-mix methodology to adopt a model based on PDPM, changing the measures that CMS previously froze in April of 2024. This update to the Technical Users' Guide also extended the gap period (during which no work hours are reported) for defining nurse staffing turnover from 60 days to 90 days. As a result of this update, for the three staffing turnover measures, individuals who no longer work in the nursing home are defined as eligible individuals who have a period of at least 90 consecutive days in which they do not work at all, increased from 60 days. CMS also updated the risk-adjustment models for the four claims-based measures to reflect measures of functional abilities and goals, rather than residents' functional status. Finally, CMS revised the thresholds for the staffing measures and claims-based quality measures to maintain the same distribution by points for affected staffing and quality measures, maintaining the same proportions of available five- and four-star ratings for facilities.

In April of 2024, CMS updated its Nursing Home Five-Star Quality Rating System's Technical Users' Guide in several respects. First, CMS froze four of the quality measures from any changes: (1) percentage of residents who made improvements in function (short stay); (2) percentage of residents whose need for help with activities of daily living has increased (long stay); (3) percentage of residents whose ability to move independently worsened (long stay); and (4) percentage of high-risk residents with pressure ulcers (long stay). All of these measures will be frozen until January 2025, while the short-stay functional improvement measure is replaced in October of 2024 with a new cross-setting function measure used in the SNF QRP. CMS also updated the staffing level case-mix adjustment methodology and froze three staffing level measures until July of 2024: (1) adjusted RN staffing (HPRD); (2) adjusted total nurse staffing (HPRD); and (3) adjusted total nurse staffing on weekends (HPRD). These frozen measures will not affect staff turnover measures. Additionally, beginning in April of 2024, CMS revised the staffing rating methodology to give the lowest possible score for staffing turnover measures to providers who fail to submit staffing data or submit erroneous data.

In 2023, CMS revised the nursing-home level exclusion criteria used on the administrator turnover measure, adding information regarding the staff turnover measure and an updated ratings table, which identifies the points needed for each nursing facility to obtain certain star ratings. Under these guidelines, only 10% of nursing facilities can receive a five-star rating in the state where it operates, with the bottom 20% receiving a one-star rating and the remaining 70% receiving a distribution of two-, three-, and four-star ratings.

State Legislation Concerning Nursing Home Supervision — California passed into law a bill which changes the limitations, or "caps," on non-economic damages that can be awarded in medical negligence cases filed against healthcare providers (including skilled nursing and long-term care facilities). Beginning on January 1, 2023, non-economic damages (i.e., pain and suffering) available to plaintiffs suing healthcare providers in medical malpractice and professional negligence cases increased from $0.25 million to $0.35 million, and will then increase over the following ten years up to a $0.75 million cap. Once the limit reaches $0.75 million, a 2% annual inflationary adjustment will attach beginning on January 1, 2034. In wrongful death cases that arise from claims of medical malpractice and professional negligence, the cap on non-economic damages increased from $0.25 million to $0.50 million on January 1, 2023, and increase every year thereafter for ten years until the cap on non-economic damages in such cases is $1.0 million; thereafter, this cap will also be subject to an annual 2.0% increase. The caps are separate as to each claim, meaning that there is one cap for negligence and one cap for wrongful death. The new limits on non-economic damages apply prospectively to lawsuits filed on and after January 1, 2023.

In 2022, California's Governor signed into law the Skilled Nursing Facility Ownership and Management Reform Act of 2022. This law increases the oversight authority of the California Department of Public Health, and changes several provisions regarding SNF licensing in the State of California. This includes eliminating previous regulatory provisions that permitted SNFs to operate in advance of receiving their formal license from the State. This law also requires SNF license applicants to disclose additional information in connection with a license application and evaluates more data regarding the applicant's prior operations, including prior citations, CMS sanctions and legal proceedings against the applicant or other facilities owned or managed by the applicant before issuing a license.

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

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

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

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

Monitoring Compliance in Our Independent Subsidiaries

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

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

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

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

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

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

Regulations Regarding Financial Arrangements

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

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

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

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

Regulations Regarding Patient Record Confidentiality

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

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

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

Antitrust Laws

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

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

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

Americans with Disabilities Act (ADA)

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

Civil Rights

On January 25, 2024, the Office for Civil Rights (OCR) for HHS issued guidance to hospitals and long-term care facilities, emphasizing their obligation under CMS regulations to ensure non-discriminatory visitation policies, especially during public health emergencies. This guidance, part of the U.S. National Strategy to Counter Antisemitism, clarifies that these facilities cannot discriminate based on religion or other classes or characteristics protected against discrimination under federal civil rights laws. The guidance includes examples where non-compliance occurred, such as unequal treatment based on religious affiliation or dietary restrictions, and stricter screening processes for certain religious groups. OCR offers assistance to facilities to obtain compliance with these standards and encourages residents and other affected individuals to file complaints with OCR for potential administrative or civil action in cases of civil rights violations. OCR has been increasingly involved in the monitoring and enforcement of patient and resident rights, particularly under ongoing rulemaking under Section 1557 of the ACA.

Real Estate Investment Trust (REIT) Qualification

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

REGULATIONS SPECIFIC TO SENIOR LIVING COMMUNITIES AND ANCILLARY SERVICES

As previously mentioned, senior living services revenue, which accounted for 2.1% of total revenue, is primarily derived from private pay residents and senior living revenue derived from Medicaid funds. Thus, some of the regulations discussed above applicable to Medicaid providers, also apply to senior living.

A majority of states provide, or are approved to provide, Medicaid payments for personal care and medical services to some residents in licensed senior living communities. As rates paid to senior living community operators are generally lower than rates paid to SNF operators, some states use Medicaid funding of senior living services as a means of lowering the cost of services for residents who may not need the higher level of health services provided in SNFs. States that administer Medicaid programs for services in senior living communities are responsible for monitoring the participating communities and, as a result of the growth of senior living in recent years, these states have adopted licensing standards applicable to senior living communities.

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

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

ENVIRONMENTAL MATTERS

We strive to reduce our environmental impact through initiatives to modernize our facilities, conserve water, optimize waste, work towards a paperless office and partner with green vendors. Our ongoing and planned facility modernization initiatives include solar projects, heating, ventilation and air condition (HVAC) upgrades, water systems updates, lighting retrofits and utility upgrades. Additionally, we track and evaluate the utilities used by our facilities to drive our initiatives. For the year ended December 31, 2024, we spent $158.2 million on purchases of property improvements and equipment which included facility modernization initiatives.

Risk Management and Strategy

We identify and assess environmental risk to the organization by:

- Conducting assessments of transition risks, which are risks related to the transition to a lower-carbon economy, and physical risks, which are risks related to the physical impacts of climate change.
- Identifying climate-related opportunities, which includes programs to reduce electricity usage and carbon emissions at our independent subsidiaries.
- Identifying the potential financial impact of transition risks, physical risks and climate-related opportunities.
- Developing and implementing our strategy, which focuses on monitoring environmental policy and on-going developments, ensuring community resiliency, evaluating usage of energy management systems, building operational and emergency response systems, performing hazard vulnerability assessments and tracking and responding to developing natural disasters.

Governance

Ensign's environmental management team (EMT) is part of our ESG Committee. The EMT is led by the Service Center's leadership team members including Construction and Asset Development as well as its Executive Management. The EMT is responsible for:

- Implementation and continuous execution of our environment management system and policy.
- Development of the Company's environmental management policy.
- Identification of climate related risks under the Task Force on Climate-Related Financial Disclosures framework.
- Providing structure and support to our independent subsidiaries that are led by local operators to make decisions on their capital expenditure projects at their facilities. The team advises our local field operators on best practices and identifies opportunities for them to assess priorities of projects.
- Overseeing environmental programs which include the evaluation and installation of LED lighting, solar panel, improved doors and insulation, automated HVAC controls and thermal efficiency projects related to micro-turbine, and demand control ventilation to name a few.
- Development of targets for reduction of carbon emissions, and increase ENERGY STAR scores.
- Tracking and monitoring of currently available environmental metrics such as utility usage and development of an energy management system that tracks greenhouse gas emissions and more.
- Preparing for applicable environmental audits in the future.

Our business is subject to a variety of federal, state and local environmental laws and regulations. As a healthcare provider, we face regulatory requirements in areas of air and water quality control, medical and low-level radioactive waste management and disposal, asbestos management, response to mold and lead-based paint in our facilities and employee safety.

As an owner or operator of our facilities, we also may be required to investigate and remediate hazardous substances that are located on and/or under the property, including any such substances that may have migrated off, or may have been discharged or transported from the property. Part of our operations involves the handling, use, storage, transportation, disposal and discharge of medical, biological, infectious, toxic, flammable and other hazardous materials, wastes, pollutants or contaminants. In addition, we are sometimes unable to determine with certainty whether prior uses of our facilities and properties or surrounding properties may have produced continuing environmental contamination or noncompliance, particularly where the timing or cost of making such determinations is not deemed cost-effective. These activities, as well as the possible presence of such materials in, on and under our properties, may result in damage to individuals, property or the environment; may interrupt operations or increase costs; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, penalties or other governmental agency actions; and may not be covered by insurance.

We believe that we are in material compliance with applicable environmental and occupational health and safety requirements. However, we cannot assure you that we will not encounter liabilities with respect to these regulations in the future, and such liabilities may result in material adverse consequences to our operations or financial condition.

For additional information on the EMT and our environmental sustainability efforts, please see our ESG report, which is available on our website at www.ensigngroup.net.

AVAILABLE INFORMATION

We are subject to the reporting requirements under the Securities Exchange Act of 1934, as amended (the Exchange Act). Consequently, we are required to file reports and information with the Securities and Exchange Commission (SEC), including reports on the following forms: annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act. These reports, proxy and information statements and other information concerning our company may be accessed through the SEC's website at http://www.sec.gov.

You may also find on our website at www.ensigngroup.net, electronic copies of our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act. Such filings are placed on our website as soon as reasonably possible after they are filed with the SEC. All such filings are available free of charge. The information contained in, or that can be accessed through, our website does not constitute a part of this Annual Report on Form 10-K.

Item 1A. RISK FACTORS

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

Risks Related to our Business and Industry

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

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

Risks Related to Ownership of our Common Stock

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

You should carefully consider each of the following risk factors. The risk factors generally have been separated into two categories: risks relating to our business and our industry and risks relating to our common stock. Based on the information currently known to us, we believe that the following information identifies the most significant risk factors affecting our company in each of these categories of risks. However, the risks and uncertainties we face are not limited to those set forth in the risk factors described below. Additional risks and uncertainties not presently known to us or that we currently believe to be immaterial may also adversely affect our business. 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, these events could have a material adverse effect on our business, financial condition or results of operations. In such case, the trading price of our common stock could decline. You should carefully read the following risk factors, together with the financial statements, related notes and other information contained in this Annual Report on Form 10-K. This Annual Report on Form 10-K contains forward-looking statements that contain risks and uncertainties. Please refer to the section entitled "Cautionary Note Regarding Forward-Looking Statements" on page [1] of this Annual Report on Form 10-K in connection with your consideration of the risk factors and other important factors that may affect future results described below.

Risks Related to Our Business and Industry

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

We derived 24.9% and 26.6% of our service revenue from the Medicare programs for the years ended December 31, 2024 and 2023, respectively. In addition, many other payors may use published Medicare rates as a basis for reimbursements. Accordingly, if Medicare reimbursement rates are reduced or fail to increase as quickly as our costs, if there are changes in the rules governing the Medicare program that are disadvantageous to our business or industry, or if there are delays in Medicare payments, our business and results of operations will be adversely affected.

The Medicare program and its reimbursement rates and rules are subject to frequent change, including statutory and regulatory changes, rate adjustments (including retroactive adjustments), annual caps that limit the amount that can be paid (including deductible and coinsurance amounts), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. See Item 1., under *Government Regulation*, *Sequestration of Medicare Rates,* for further information. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenue and operating margins.

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

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

- administrative or legislative changes to base rates or the bases for payment, including changes to the rates at which Medicare will reimburse services;
- 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;
- changes in staff requirements as a condition of payment or eligibility for Medicare reimbursement (See also, Item 1., under *Government Regulation*);
- the reduction or elimination of annual rate increases, implementation of reimbursement decreases, or the end of the reduced payments deferment (See also, Item 1., under *Government Regulation*); and
- an increase in co-payments or deductibles payable by beneficiaries.

Among the changes being implemented by CMS are provisions of the IMPACT Act, which imposes a stringent timeline for implementing benchmark quality measures and data metrics across facilities that include SNFs. The enactment mandates specific actions to design a unified payment methodology for post-acute providers, which CMS implements through ongoing regulations. The costs of final implementation may be significant, with potential fines and payment reductions resulting from a failure to meet CMS's implementation requirements.

Reductions in reimbursement rates or the scope of services being reimbursed could have a material, adverse effect on our revenue, financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating costs. In addition, CMS may make future adjustments to reimbursement levels and underlying reimbursement formulae as it continues to monitor the impact of current payments system on patient outcomes and budget neutrality. The Biden-Harris Administration focused on studying the nursing home industry and directed HHS to issue proposed rules based on those studies, including changes to SNF facility reimbursement and specifically, the SNF-VBP Program, which may also adversely affect our reimbursement. The change in presidency following the 2024 presidential election may result in different focuses with respect to the nursing home industry. The new Presidential Administration's policy directives and priorities regarding the nursing home industry and SNFs in particular are not yet known. These metrics potentially affecting our revenues and expenses in future government fiscal years include the SNF healthcare-associated infections (HAI) measurement, total nursing hours per resident day measures, and discharge to community - post acute care measure. The Interoperability Final Rule's implementation beginning in 2026, and to be completed by January 1, 2027, may also adversely affect our reimbursement paid through Medicare, specifically including Medicare Advantage.

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

A significant portion of reimbursement for skilled nursing services comes from Medicaid. In fact, Medicaid is our largest source of revenue, accounting for 46.0% of our revenue for both the years ended December 31, 2024 and 2023, respectively. Medicaid is a state-administered program financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets, which has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending. Since a significant portion of our revenue is generated from our skilled nursing independent subsidiaries in California, Texas and Arizona, any budget reductions or delays in these states could adversely affect our net patient service revenue and profitability. Due to recent fluctuations in state budgets many of the states in which we operate (including those with current budget surpluses), are seeking to contain costs on Medicaid outlays for SNFs, and any such decline could adversely affect our financial condition and results of operations.

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

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements commonly referred to as provider taxes. Under provider tax arrangements, states collect taxes from healthcare providers and then use the revenue to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the providers' total revenue. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures could have a significant and adverse effect on states' Medicaid expenditures, and as a result could have a material and adverse effect on our business, financial condition or results of operations.

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

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

For example, Washington state incorporates the costs of direct care, indirect care, and capital expenditures for SNF services in computing the State's Medicaid payments to nursing facilities. Using periodically updated calculations that account for factors including case acuity, fair market value of capital expenditures, inflation, and facility performance, Washington sets facility compensation so that the majority of Medicaid reimbursement paid to a skilled nursing facility is used for care-related activities, with limitations on how much a facility's reimbursement may increase from year to year. Washington state first adopted this care-based payment model in 2015 and has periodically updated it since, including in 2020, 2022, and 2023; it is expected that Washington will continue to amend this law in the future. For state fiscal year 2024, Texas requires all nursing facilities must show that a portion of funds paid to SNFs by Texas's Medicaid program, including both fee-for-service and managed care reimbursement, were expended for direct care activities, including direct care staff wages and benefits. In addition, California in the past has proposed bills that, if passed, would require nursing facilities to spend a stated percentage of revenue on direct patient-related services. While the most recent attempt by the California Assembly (Bill 1537) to impose direct spending requirements on SNFs has been placed in suspense with no action being taken, similar legislation in the future may seek to impose identical or analogous funding requirements for SNFs operating in California or other states.

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

As discussed in greater detail in Item 1., under *Government Regulation*, the ACA has resulted in significant changes to our operations and reimbursement models for services we provide. CMS continues to issue rules to implement the ACA, including most recently, new rules regarding the implementation of the anti-discrimination provisions and proposed 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 IRA in 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 outcome of the 2024 presidential election, which saw a change in control of both the Presidency and Senate to the Republican party, may signal further changes to the ACA, including reversing regulatory changes made under the Biden-Harris Administration.

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

While it is not possible to predict whether and when any such changes will occur, specific proposals discussed leading up to the 2024 presidential election, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. The ACA continues to be a salient political topic and proposed changes to it may become the subject of campaign promises, litigation, administrative action, or legislation following the 2024 presidential election. In addition, even if the ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS, have a significant impact on the implementation of the provisions of the ACA. It is expected that the incoming Presidential Administration will make changes impacting the implementation and enforcement of the ACA, which could harm our business, operating results and financial condition. We have already seen such changes with the Biden-Harris Administration's regulatory activity promulgating rules regarding anti-discrimination under Section 1557 of the ACA and recent rulemaking requiring SNFs to disclose their ownership and the ownership of service providers under Section 6101 of the ACA. It is not possible to know whether, when, or how any or all of these regulations or their implementation will be changed, the manner in which any change may be effected, and the ultimate effects of such changes on our business. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

In 2023, CMS issued a final rule requiring SNFs to disclose certain information regarding their ownership and managerial relationships which was fully implemented in November of 2024. This final rule is more invasive and comprehensive than the ownership information already disclosed through Medicare's Nursing Home Compare website. Refer to Item 1., under *Government Regulation*, for additional information. The breadth of disclosure required by this new rule may be adverse to our business interests and detrimental to our operations, revenue, and profitability and may have a chilling effect on investment due to the depth of the new reporting and transparency requirements. Similarly, California passed a comparable law requiring the disclosure of certain ownership and financial information for SNFs in 2021. On March 6, 2024, California's regulations implementing this law took effect, which may invite further scrutiny and potential legal action, whether by the state agencies or private parties, within California based on the information disclosed as required by this law and its enabling regulations.

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

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

As a result of the 2024 presidential election, changes in the Presidency and both houses of Congress may result in significant changes in, and have resulted in uncertainty with respect to, legislation, regulation, implementation or repeal of laws and rules related to government health programs, including Medicare and Medicaid. In particular, proposals regarding HHS and certain programs and regulation concerning health care, including Medicare, Medicaid, and the ACA, have indicated that the incoming Presidential Administration seeks to make changes to these programs and laws, as well as their implementation. Other pending legislation, such as the Protecting America's Seniors' Access to Care Act and Protecting America's Rural Seniors' Access Act, which seek to halt HHS and CMS from finalizing and enforcing its proposed rule for staffing requirements, indicates a bipartisan interest in restraining HHS's ability to finalize, implement and enforce regulations that may be burdensome on our independent subsidiaries, creating still more uncertainty and unpredictability in the legislative process.

Changes to existing policies and rules regarding nursing facilities, including those recently instituted, in addition to anticipated new rule proposals, may result in significant regulatory changes, increased survey frequency and scope, and increased penalties for non-compliance. With the changes in the presidential administration, we anticipate that there may be changes in legislative control and legislative priorities. As a result, future legislation may be proposed or passed that may adversely affect our business, operating results and financial condition.

We continually monitor these developments in order to respond to the changing regulatory environment impacting our business. While it is not possible to predict whether and when any such changes will occur, specific proposals discussed during and after the election, including a repeal or material amendment of the ACA or other laws affecting the provision of healthcare services, could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with the rules associated with these programs and related applicable laws and regulations, including our claims for payments submitted to those programs, which are subject to reviews by Recovery Audit Contractors, Zone Program Integrity Contractors, Program Safeguard Contractors, Unified Program Integrity Contractors, Supplemental Medical Review Contractors and Medicaid Integrity Contractors programs (collectively referred to as Reviews). In these Reviews, third-party firms engaged by CMS conduct extensive analysis of claims data and medical and other records to identify potential improper payments under the federal and state programs. As discussed above, the Biden-Harris Administration has called for HHS and CMS to increase the level of scrutiny of SNF facilities and requested those agencies to adopt rules that would impose greater penalties upon non-compliant SNF operators, and this scrutiny may not change due to a change of Presidential Administration, including changes to the leadership of HHS and CMS. The SNF PPS FY 2025 Final Rule implemented increased penalties that surveyors may impose on SNFs for perceived non-compliance with CMS's requirements for SNF participation in Medicare. In addition, in 2023, CMS updated the survey resources that CMS and state surveyors use in evaluating our SNFs' compliance with federal Requirements for Participation, incorporating recent changes to CMS's methods for surveying infection control procedures.

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

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

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

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

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

In cases where claim and documentation review by a CMS contractor results in repeated unsatisfactory results, an operation can be subjected to protracted regulatory oversight. This CMS oversight may include education and sampling of claims, extended pre-payment review, referral of the operating business to recovery audit or integrity contractors, or extrapolation of an error rate to other reimbursement made outside of specifically reviewed claims. Ongoing failure to demonstrate improvement towards meeting all claim filing and documentation requirements could ultimately lead to Medicare decertification. As of December 31, 2024 and through the filing date of this report, 18 of our independent subsidiaries had multi-claim reviews scheduled or in process, either pre- or post-payment. We anticipate that these reviews could increase in frequency in the future.

Additionally, both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, SNFs. The focus of these investigations includes, among other things, billing and cost reporting practices; quality of care provided; financial relationships with referral sources; and the medical necessity of rendered services. For example, refer to the matter discussed in Part I, Item 3., *Legal Proceedings.*

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

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

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

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

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

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

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we conduct our business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to frequent change. As noted above, the Biden-Harris Administration called upon HHS and CMS to study and propose new rules regarding staffing requirements and reimbursement for the nursing home industry, including tying reimbursement to staffing levels, salary, benefits, and retention. The change in Presidential Administration, including changes to the leadership of HHS and CMS, may not result in any change, abatement, or reduction in the enforcement of these policies, and instead could lead to even greater scrutiny. CMS's recently finalized ownership transparency rule, and similar state disclosure requirements such as California's, discussed in Item 1., under *Government Regulation*, may provide an additional basis for further investigation, administrative action and ultimately fines, penalties, or sanctions if finalized, and may dissuade parties from working with us or our independent subsidiaries due to the reporting and disclosure obligations of being an Additional Disclosable Party under that final rule.

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

As discussed in greater detail in Item 1., under *Government Regulation*, we are subject to federal and state laws intended to prevent healthcare fraud and abuse. Possible sanctions for violation of any of these laws and regulations include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations, refund payments to the government, enter into a corporate integrity agreement, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

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

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

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

CMS's efforts to enhance its enforcement powers and increase enforcement activities towards SNFs, as discussed in Item 1., under *Government Regulation*, result in state survey agencies having more accountability for their survey and enforcement efforts. Within the SNF PPS FY 2025 Final Rule, CMS obtained greater ability to impose monetary penalties upon SNFs for incident-based and day-based violations of CMS's conditions of participation. Further, the enhanced penalties against SFFs under the Biden-Harris Administration represented further federal calls for transparency, oversight and penalties for low-ranked and underperforming SNFs. These policies may prove to be popular, effective, or otherwise desirable and might not change with a new Presidential Administration, including under new leadership of HHS and CMS. These enhanced penalties and enforcement activities precedes greater focus by CMS in obtaining oversight over SFFs, and continuing that oversight even after those SFFs improve, and subjecting them to more exacting and routine oversight. The likely result may be more frequent surveys of our independent subsidiaries, with more substantial penalties, fines and other consequences if they do not perform well. For low-performing facilities in the SFF program, the standards for successfully emerging from that program and not being subject to ongoing and enhanced government oversight will be higher and measured over a longer period of time, prolonging the risks of monetary penalties, fines and potential suspension or exclusion from the Medicare and Medicaid programs.

From time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. CMS's updated guidance to these surveyors incorporate recent changes to CMS's methods for surveying infection control procedures. Additionally, CMS's recently finalized rule requiring disclosure of ownership and financial relationships between nursing facilities and property owners or management entities, as well as other state rules over ownership transparency, may provide an additional basis for further investigation, administrative action, and ultimately fines, penalties, or sanctions and could dissuade individuals and businesses from doing business with us or our independent subsidiaries.

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

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

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

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our independent subsidiaries. We have had independent subsidiaries placed on SFF status in the past and other independent subsidiaries may be identified for such status in the future. We currently have no facilities placed on SFF status.

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

As discussed in greater detail in Item 1., under *Government Regulation*, in 2022 CMS updated the SFF program with the intent to reduce the amount of time a SNF spends as an SFF and increase the number of nursing homes that progress through the SFF program. The OIG has been studying the SFF program, including its 2022 updates, to understand the program's outcomes, identify factors that aided SFFs that successfully graduated the SFF program with sustained quality improvements, and make further changes based on the data obtained in this study. In June of 2024, the OIG added the SFF program to ts Work Plan for continued attention. CMS clarified certain details of the SFF program updates in 2023 and how they are to be implemented by each state survey agency (SA). As part of the revisions to the SFF program, a priority in revising the SFF program was to address "yo-yo" noncompliance of SNFs that would graduate from the SFF program only to later see their compliance and quality measures regress after graduation, potentially requiring readmission to the SFF program. Among the measures implemented to avoid this issue of "yo-yo" noncompliance was a three-year look-back period for facilities that graduate from the SFF program to ensure that the quality and compliance improvements achieved through the SFF program were sustained. Facilities that graduate from the SFF program but continue to demonstrate poor compliance as evidenced by any SA's survey, such as for actual harm, substandard quality of care, or immediate jeopardy deficiencies, may be subject to enhanced enforcement by CMS, up to and including termination from the Medicare and/or Medicaid programs.

This three-year look-back for sustained improvements by facilities that graduate the SFF program poses risk for our independent subsidiaries, specifically those that may be subject to the SFF program or that have been subject to the SFF program in the past. As of December 31, 2024, we have three facilities that graduated from the SFF program within the past three years. First, for SNFs that are selected by CMS for participation in the SFF program, or which currently are in the SFF program, even graduation from the program is no longer an assurance that the SNF will be able to continue its operations. Even one survey with a significant compliance deficiency, such as actual harm or an immediate jeopardy deficiency, may result in CMS—acting solely within its discretion—terminating the SNF's Medicare or Medicaid participation, likely triggering the termination of other payor contracts and rendering the facility economically unviable. Second, for SNFs that have graduated from the SFF program, they are subject to a three-year period of enhanced scrutiny where adverse findings by a SA and a single survey's finding of poor compliance may result in CMS discretionally terminating that facility's Medicare and/or Medicaid participation, which would likely cause other payors to terminate their agreements with the facility as well. As a result, the financial and manpower resources needed for graduation from the SFF program may be for nothing if, in the three years following graduation from the SFF program, a SNF receives a poor survey result and CMS imposes fines and penalties up to the termination of the facility's Medicare and Medicaid participation.

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

Federal minimum staffing mandates may adversely affect our labor costs, ability to maintain desired levels of patient or resident capacity, and profitability.

On April 22, 2024, CMS issued the Staffing Rule, establishing minimum staffing standards for SNFs. As discussed in more detail in Item 1., under *Government Regulation*, the Staffing Rule contains three primary staffing requirements which are phased in over the next several years. Due to pending legislation in both the House of Representatives and the Senate, industry litigation filed to dispute the Staffing Rule's validity and enforceability, as well as the long phase-in of the Staffing Rule's requirements, the exact effects of the Staffing Rule cannot yet be ascertained. Given the pending legislation before both houses of Congress, change in control of the Presidency, changes in leadership of HHS and CMS, and change in control of the Senate following the 2024 presidential election, future developments may significantly alter or even halt the implementation of the Staffing Rule. However, we expect that the Staffing Rule in its current form will have adverse financial consequences upon our business unless or until it is repealed, enjoined, or otherwise prevented from taking effect.

We may be required to hire substantially more staff members, particularly nurse practitioners, registered nurses, and nursing aides than currently staffed. Additionally, the Staffing Rule would place similar pressure on our competitors and result in sudden, expanded demand for nursing staff across the SNF industry. This sudden demand across the SNF industry may exacerbate an already difficult labor market, with demand for nursing staff far outstripping the supply of qualified individuals, and the salary requirements of both current and prospective staff increasing markedly to increase the likelihood of recruiting and retaining skilled caregivers.

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

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

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

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

As discussed in greater detail in Item 1., under *Government Regulation*, MACRA revised the payment system for physician and non-physician services. The changes to the therapy caps imposed on Medicare Part B outpatient therapy from this law have been changed by the BBA, and are subject to future budgetary changes through rulemaking and legislation, resulting in ongoing uncertainty regarding payment for these Medicare Part B services. Under both the 2024 and 2025 PFS Final Rules, reductions in conversion factor, payments to providers and conditions imposed in exchange for higher payments may impose operational requirements and working conditions that further detract from and reduce our financial performance. Similarly, new final rules concerning the PACE program and the information it will collect from our independent subsidiaries may adversely affect the risk-adjusted reimbursement.

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

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

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

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

Healthcare businesses are increasingly the target of cyberattacks whereby hackers disrupt business operations or obtain protected health information, often demanding large ransoms. In 2024, healthcare was among the most-breached sector of the economy based on publicly disclosed information. The frequency of this activity has increased precipitously. Our business is dependent on the proper functioning and availability of our computer systems and networks. We cannot assure you that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations. Additionally, we cannot control the safety and security of our information held by third-party vendors with whom we contract. The techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect, and as such we (or third-party vendors) may be unable to anticipate these techniques or implement adequate preventive measures. In addition, hardware, software or applications we (or third-party vendors) develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise the security of information systems. Unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud or other forms of deception. Additionally, the rapid ongoing evolution and increased adoption of emerging technologies such as artificial intelligence and machine learning may make it more difficult to anticipate and implement protective measures to recognize, detect and prevent the occurrence of data breaches, including but not limited to cybersecurity breaches.

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

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

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

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

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

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

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

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

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

Federal laws and regulations, such as the Staffing Rule, may increase our costs of maintaining qualified nursing and skilled personnel, or make it more difficult for us to attract or retain qualified nurses and skilled staff members. Proposed legislation, such as the previously proposed Nursing Home Improvement Act and the proposed HCBS Access Act, may make it more expensive to compete for, hire, and retain nursing staff, if passed into law in substantially the same form as previously introduced to Congress. The Biden-Harris Administration sought to increase staffing level requirements for the nursing home industry and to tie reimbursement to the salary, benefits, and retention of staff, which may increase our labor costs. The change in Presidential Administration may not result in a change in this policy, and instead it is possible that HHS and CMS, under new leadership, could impose more stringent requirements for staffing. CMS has published guidance to surveyors addressing topics that specifically include nurse staffing and collection of payroll data to evaluate appropriate staffing levels, which may lead to future regulations that increase our staffing requirements and labor costs or lower revenues.

Similar state-level requirements in the states where our independent SNFs operate, whether such requirements are passed by statute, regulation, or executive order, may result in a shortage or inability to obtain nurses and skilled staff. Prior concerns about the COVID-19 vaccination IFR may be abated by the Omnibus Final Rule’s withdrawal of that IFR. The withdrawal of the COVID-19 vaccination IFR may allow for nursing and other personnel unwilling to receive the COVID-19 vaccination to re-enter the workforce for Medicare-certified facilities and increase the pool of hirable talent.

Increased competition for, or a shortage of, nurses or other trained personnel, or general ongoing inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from operation to operation and may adversely affect those operations' quality ratings based on data reported to CMS. In addition, state laws regarding minimum wage increases, such as California's minimum wage increases for both healthcare and fast-food workers, may intensify competition for unskilled labor in both skilled and unskilled settings. For skilled workers within the skilled care market where we operate, the costs of skilled labor, which are already greater than unskilled labor, could increase further. Similarly, the increased minimum wage of unskilled labor will not only increase the cost of unskilled labor but may also have effects that dissuade workers from training to join the skilled workforce to earn higher wage growth, resulting in a smaller pool of available skilled workers and further increased competition—and higher wages—for them. If we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations could be harmed.

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

As discussed in detail in Item 1., under *Government Regulation*, sub-heading *Part B Rehabilitation Requirements*, several government actions have been taken in recent years to try and contain the costs of rehabilitation therapy services provided under Medicare Part B, including the MPPR, institution of annual caps, mandatory medical reviews for annual claims beyond a certain monetary threshold, and a reduction in reimbursement rates. Of specific concern has been CMS efforts to lower Medicare Part B reimbursement rates for outpatient therapy services, which are reduced by 2.83% in the 2025 PFS Final Rule. Such cost-containment measures and ongoing payment changes could have an adverse effect on our revenue.

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

As discussed in greater detail in Item 1., under *Government Regulation*, Civil and Criminal Fraud and Abuse Laws and Enforcement, the OIG regularly conducts investigations regarding certain payment or compliance issues within the healthcare industry. The OIG identified SNF compliance as an issue of concern in its 2021, 2022, 2023 and 2024 semi-annual reports to Congress. In June 2024, the OIG continued to focus on SNFs, adding the SFF Program to its Work Plan. The OIG's January 2023 study regarding SNF emergency preparedness identified the need for further oversight and addition of SNF emergency readiness to the OIG's fall 2023 work plan. In November of 2023, OIG added to its work plan an audit of nursing homes' nurse staffing hours reported in CMS's payroll-based journal, for which OIG expects to issue a report in FY 2025. Nursing homes were also a topic of discussion in the OIG's 2023 semiannual report to Congress, which emphasized the continued protection and oversight of care that nursing facilities provide to residents. Among other things, the OIG recommended attention to the rate of reimbursement for professional services rendered within facilities. The OIG's reports to Congress have also recommended a reduction in the use of psychotropic drugs in nursing homes and urged CMS to evaluate the appropriateness of psychotropic drug use among residents, including the use of data to identify nursing homes with higher rates of use for potential further scrutiny and action. Based on this information, SNFs in particular are potential targets for more robust scrutiny and examination by regulators. Prior publications and statements by the Biden-Harris Administration have also called for greater scrutiny of SNF facilities. Following the 2024 presidential election, it is not yet known whether the new Presidential Administration will follow the same policies and seek further or escalating scrutiny of SNFs, or whether it will retain any or all of the Biden-Harris Administration's priorities regarding SNFs.

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

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

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

Other states that do not require certificates of need have effectively barred the expansion of existing facilities and the establishment of new ones by placing partial or complete moratoria on the number of new Medicaid beds those states will certify in certain areas or throughout the entire state. Still other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. In addition, some states require the approval of the state Attorney General for acquisition of a facility being operated by a non-profit organization.

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

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

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

Another example, California’s adoption of the Skilled Nursing Facility Ownership and Management Reform Act of 2022, discussed in Item 1., *Government Regulation*, imposes new requirements for obtaining licenses to operate SNFs. These new requirements may delay or limit the ability to obtain new SNF licenses within that state, whether through acquisition of existing facilities or opening a new facility. This new law's obligations may increase the costs of obtaining licensure, make applications more time-consuming and complex, and may result in civil penalties and other sanctions against our independent subsidiaries in the event they are not compliant with these new licensure application requirements. As a result, this new law may delay or impede growth within California. As with the bill that increases the cap of non-economic damages for medical malpractice litigation, California’s influence on other states may result in this legislation becoming a model for other states and having similar, potentially adverse effects within those jurisdictions as well.

Effective October 2024, California law SB525 increased the minimum wage for healthcare workers. However, the law will only impact SNFs upon passage of a companion bill imposing minimum direct spending requirements upon SNFs. For the 2023-2024 California legislative session, this minimum spending bill took the form of AB1537 and, as of October 2024 has been placed in suspense without further action. A future bill may still be passed that would trigger SB525's requirements for healthcare workers in SNFs to receive higher minimum wages. As discussed in Item 1., *Government Regulation*, these proposed bills would create new and costly obligations on our independent subsidiaries if they became law and if enacted, would adversely affect our business, operations, and profitability.

As another example, Texas passed a bill which partially restored Medicaid state relief funding for SNFs through August 31, 2023, while it also considered legislation that contained direct care spending requirements and ownership, similar to proposed federal rulemaking discussed in Item 1., *Government Regulation*. While this bill provided financial relief to our independent subsidiaries in Texas, other proposed bills may impose the same regulatory requirements and limitations inherent in both the proposed legislation in other states and the federally proposed rule requiring disclosure of such information in applications and change-of-ownership disclosures, which may adversely affect our business, operations, and profitability.

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

Our independent subsidiaries are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act that governs such matters as minimum wages, overtime and other working conditions, the ADA and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the EEOC, regulations of the Office of Civil Rights, regulations of state attorney generals, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Changes to federal and state regulations and laws are discussed in more detail in Item 1., under *Government Regulation.*

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

Other pending legislation, such as the HCBS Access Act, indicated a legislative priority of providing funding for care-based careers that may affect our pool of desired workers. Due to a change of political party control of both houses of Congress, though, such legislation may have a lower likelihood of passing, even if reintroduced in a subsequent congress. Rising operating costs due to labor shortages, greater compensation and incentives required to attract and retain qualified personnel and higher-than-usual inflation on items including energy, utilities, food and other goods used in our facilities and the costs for transporting these items could increase our cost and decrease our profits.

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

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

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

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

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

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

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

Our revenue is affected by the percentage of the patients of our independent subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability. We generally receive higher reimbursement rates for high acuity patients, and payors reimburse us at different rates. For the years ended December 31, 2024 and 2023, 70.9% and 72.6% of our revenue was provided by government payors that reimburse us at predetermined rates, respectively. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of the patients of our independent subsidiaries for whom we receive Medicaid reimbursement, our results of operations may be adversely affected.

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

As discussed under Item 1., *Government Regulation*, the Biden-Harris Administration requested HHS and CMS conduct studies to evaluate potential staffing, data reporting, employee compensation and retention, and resident experience regulations that may result in a reduction of our revenue from Medicare and Medicaid. CMS first requested information regarding these priorities in 2022 and subsequently published further requests for information from the public in the Federal Register to aid in studies and anticipated rulemaking. The change in Presidential Administration, including new leadership of HHS and CMS, may result in a change in these priorities, and this prior research and rulemaking may be materially altered or abandoned. Certain results of the Biden-Harris Administration’s rulemaking, including enhanced enforcement ability, may be retained under the new Presidential Administration. We continue to monitor this area and look for public disclosures from the incoming Presidential Administration and expected heads of HHS and CMS to better anticipate what policy priorities and changes we can expect regarding Medicare and Medicaid reimbursement, including payment models and factors affecting our independent subsidiaries’ reimbursement for the services they provide.

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

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

independent subsidiaries. See the risk factor titled "*Our self-insurance programs may expose us to significant and unexpected costs and losses.*"

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

We are subject to potential lawsuits under the FCA and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare or Medicaid) or other payor. Under the qui tam or "whistleblower" provisions of the FCA, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government's recovery. Due to these whistleblower incentives, qui tam lawsuits have become more frequent. For example, despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its issued CID, the involved qui tam relator moved forward with the complaint in December 2020. Refer to Part I, Item 3., *Legal Proceedings* for additional information on this case.

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

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

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

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

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

Our independent subsidiaries use arbitration agreements, which have generally been favored by the courts, to streamline the dispute resolution process and reduce our exposure to legal fees and excessive jury awards. CMS has identified these arbitration agreements as an area of focus and issued guidance to state surveyors regarding federal requirements for the use of arbitration agreements in nursing home care, with non-compliance potentially resulting in fines and other sanctions. If we are not able to secure pre-admission arbitration agreements, our litigation exposure and costs of defense in patient liability actions could increase, our liability insurance premiums could increase, and our business may be adversely affected.

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

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

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

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

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

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

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

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

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

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

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

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

During the year ended December 31, 2024, we expanded our operations through a combination of long-term leases and real estate purchases, with the addition of 28 stand-alone skilled nursing operations and three campus operations. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage operations we may acquire in the future. Also, the newly acquired operations may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such operations quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our acquisitions, and our business may suffer.

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

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those businesses, against whom we may have little or no recourse. Many operations we have historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved independent subsidiaries and patient care, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant operations into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, operations that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable.

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

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

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

As discussed in Item 1., under *Government Regulation*, CMS provides comparative public data, rating every SNF operating in each state based upon quality-of-care indicators. Certain private organizations engage in similar monitoring and ranking activities. CMS's system is the Five-Star Quality Rating System which gives each nursing home a rating of between one and five stars in various categories, with five-star ratings harder to obtain over time. The ratings are available on a consumer-facing website, Nursing Home Compare. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating and the rating may not reflect the improvements we were able to make until it is recalculated. Based on CMS's guidance and regulations, we expect more data to be collected by CMS and reported on the Nursing Home Compare website in the future. Additionally, CMS's ownership transparency final rule, which requires the disclosure of SNF ownership and affiliated parties, will ultimately provide for the public disclosure of information reported to CMS under that rule. Other states, including Iowa and California, have adopted similar statutes and regulations requiring the disclosure of this information. The publicly available information disclosed as a result of these laws and rules may result in potential residents perceiving our highly rated facilities to be less desirable if they share ownership with lower rated facilities, even if the lower rated facility is a new acquisition or has a lower score for reasons beyond our control.

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

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

In September 2023, CMS announced that it will update the staffing level case-mix adjustment methodology and freeze four of the quality measures used in the Nursing Home Five-Star Quality Rating System beginning with the April 2024 refresh of the Nursing Home Compare website data. In April 2024, CMS announced the freezing of four quality measures, with one short-stay measure updated effective October 2024 with the new Discharge Function Score Measure and the other three measures unfrozen in January 2025. CMS has unfrozen its staffing level measures with changes to the time period needed to constitute the cessation of employment for the purposes of turnover measurement. CMS announced that it is changing its staffing rating methodology to give the lowest possible score to and penalize providers that fail to provide staffing data or provide erroneous staffing data. These changes risk our independent subsidiaries' facilities being incorrectly awarded a lower star rating, or prevented from attaining a deserved higher ranking due to favorable data not being reflected in CMS's five-star ratings due to the freeze or replacement of certain measures. These lower ratings may cause potential residents to evaluate these independent subsidiaries' facilities as less desirable, and result in fewer admissions and thus reduced revenue.

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

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

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

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

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

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

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

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

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

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

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

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

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

Our independent subsidiaries located in Arizona, California, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies and real estate markets, changes in governmental rules, presence and participation of insurers, regulations and reimbursement rates or criteria, changes in demographics, state funding, 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 over 21% of our independent subsidiaries are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as electrical power shortages, fires, earthquakes or mudslides, or increased liabilities that may arise from regulations as discussed within Item 1., under *Government Regulation*.

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

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

We continue to maintain our right to inform the employees of our independent subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. Historically, the staff at our independent subsidiaries that have been approached to unionize have uniformly rejected union organizing efforts. We previously indicated there may be forthcoming proposed rules from CMS, based on the Biden-Harris Administration's executive orders discussed under *Government Regulation* in Item 1., as well as potential legislation such as the HCBS Access Act aimed toward providing more resources to those considering care-based careers, may increase the likelihood of employee unionization due to increased emphasis on care-based careers in SNF facilities. The outcome of the 2024 presidential election, including change in control of the Senate and Presidency from the Democratic to the Republican party, may result in a reversal of these orders, significant changes in HHS and CMS policy and rulemaking, and a reduced likelihood of successful legislation that seeks to provide more resources to creating pathways to care-based careers. This change in Presidential Administration may also affect the favorability of unionization efforts before the Department of Labor. If employees successfully decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

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

As of December 31, 2024, our independent subsidiaries operated 231 of our 327 facilities under long term lease arrangements. Most of our leases are triple-net leases, which means that, in addition to rent, we are required to pay for the costs related to the property (including property taxes, insurance, and maintenance and repair costs). We are responsible for paying these costs notwithstanding the fact that some of the benefits associated with paying these costs accrue to the landlords as owners of the associated facilities.

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

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

Our Credit Facility has a borrowing capacity of up to $600.0 million in aggregate principal amount. As of December 31, 2024 and through the filing date of this report, we had no outstanding borrowings under our Credit Facility. Twenty-three of our subsidiaries have mortgage loans insured with the Department of Housing and Urban Development (HUD) for an aggregate amount of $146.9 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The terms of the mortgage loans range from 25- to 35-years.

We also have one outstanding promissory note with an aggregate principal amount of approximately $1.5 million as of December 31, 2024. The term of the note is 12 years. Because this promissory note is insured with HUD, our borrower subsidiary under the note is subject to HUD oversight and periodic inspections.

In addition, we had $2.8 billion of future operating lease obligations as of December 31, 2024. We intend to continue financing our independent subsidiaries through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

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

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

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

A housing downturn could decrease demand for senior living services.

Seniors often use the proceeds of home sales to fund their admission to senior living facilities. A downturn in the housing markets, including reductions in sales prices caused by increasing mortgage interest rates, economic uncertainty, recession, or a reduction in activity in the market for residential real estate, could adversely affect seniors' ability to afford our resident fees and entrance fees. If national or local housing markets enter a persistent decline, our occupancy rates, revenues, results of operations and cash flow could be negatively impacted.

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

As of December 31, 2024, we lease 33 of our properties to third-party operators. In the future, we might expand our leasing property portfolio to additional tenants. We have very limited control over the success or failure of our tenants' and operators' businesses and, at any time, a tenant or operator may experience a downturn in its business that weakens its financial condition. If that happens, the tenant or operator may fail to make its payments to us when due. Although our lease agreements give us the right to exercise certain remedies in the event of default on the obligations owing to us, we may determine not to do so if we believe that enforcement of our rights would be more detrimental to our business than seeking alternative approaches.

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

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

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

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

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

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

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

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

The condition of the financial markets, including volatility and deterioration in the capital and credit markets, could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business, as well as negatively impact or impair the value of our current portfolio of cash, cash equivalents and investments, including U.S. Treasury securities and U.S.-backed investments.

Our cash, cash equivalents and investments are held in a variety of interest-bearing instruments, including U.S. treasury securities. As a result of the uncertain domestic and global political, economic, credit and financial market conditions, including the increases in the federal funds rate since 2021, with limited decreases in 2024, and Consumer Price Index increases above historical norms for 2024, investments in these types of financial instruments pose risks arising from liquidity and credit concerns. Given that future deterioration in the U.S. and global credit and financial markets is a possibility, no assurance can be made that losses or significant deterioration in the fair value of our cash, cash equivalents, or investments will not occur. Uncertainty surrounding the trading market for U.S. government securities or impairment of the U.S. government's ability to satisfy its obligations under such treasury securities could impact the liquidity or valuation of our current portfolio of cash, cash equivalents, and investments, a substantial portion of which were invested in U.S. treasury securities. Further, continued domestic and international political uncertainty, along with credit, and financial market uncertainty, may make it difficult for us to liquidate our investments prior to their maturity without incurring a loss, which would have a material adverse effect on our consolidated financial position, results of operations or cash flows.

We may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. U.S. capital markets can be volatile. We cannot assure you that additional capital will be available or available on terms acceptable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

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. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews.

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

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

In forty-one states, including some of the largest where we operate, state Medicaid benefits are administered through MCOs. Typically, these MCOs manage commercial health and federal Medicare Advantage benefits under a managed care contract. Nationally, more than two-thirds of all Medicaid beneficiaries receive most or all of their care from MCOs. MCOs may be more aggressive than state Medicaid and federal Medicare agencies in denying claims or seeking recoupment of payments so that their services under these managed contracts are profitable. The additional steps created by the use of MCOs in disbursement of funds creates more risk of delayed, reduced, or recouped payments for our independent subsidiaries, and additional avenues for risks that include fines and other sanctions, including suspension or exclusion from participation in various governmental programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Standard Bearer could fail to qualify to be taxed as a REIT if income it receives from our tenants is not treated as qualifying income.

Under applicable provisions of the Code, Standard Bearer will not be treated as a REIT unless it satisfies various requirements, including requirements relating to the sources of its gross income. Rents received or accrued by it from its tenants will not be treated as qualifying rent for purposes of these requirements if the leases are not respected as true leases for U.S. federal income tax purposes and are instead treated as service contracts, joint ventures or other arrangements. If the leases are not respected as true leases for U.S. federal income tax purposes, Standard Bearer will likely fail to qualify to be taxed as a REIT.

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

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

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

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

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

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

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

Risks Related to Ownership of our Common Stock

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

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

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

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

- our Board of Directors is authorized, without prior stockholder approval, to create and issue preferred stock, commonly referred to as “blank check” preferred stock, with rights senior to those of common stock;
- advance notice requirements for stockholders to nominate individuals to serve on our Board of Directors or to submit proposals that can be acted upon at stockholder meetings;
- our Board of Directors is classified so not all members of our board are elected at one time, which may make it more difficult for a person who acquires control of a majority of our outstanding voting stock to replace our directors;
- stockholder action by written consent is limited;
- special meetings of the stockholders are permitted to be called only by the chairman of our Board of Directors, our chief executive officer or by a majority of our Board of Directors;
- stockholders are not permitted to cumulate their votes for the election of directors;

- newly created directorships resulting from an increase in the authorized number of directors or vacancies on our Board of Directors are filled only by majority vote of the remaining directors;
- our Board of Directors is expressly authorized to make, alter or repeal our bylaws; and
- stockholders are permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

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

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

Item 1B. UNRESOLVED STAFF COMMENTS

None.

Item 1C. CYBERSECURITY

We utilize information technology that enables our operational leaders to access and share with their peers, both clinical and financial performance data in real time. Armed with relevant and current information, our operation leaders and their management teams can share best practices and the latest information, adjust to challenges and opportunities on a timely basis, improve quality of care, mitigate risk and improve both clinical outcomes and financial performance. We have also invested in specialized healthcare technology systems to assist our nursing and support staff. We have installed software and touch-screen interface systems in each operation to enable our clinical staff to monitor and deliver patient care and record patient information more efficiently. We believe these systems have improved the quality of our medical and billing records, while improving the productivity of our staff. Such uses of information systems give rise to cybersecurity risks, including system disruption, security breach, ransomware, theft, espionage and inadvertent release of information.

RISK MANAGEMENT AND STRATEGY

Risk Management

We assess and identify security risk to the organization by:

- conducting risk assessments to determine the likelihood and magnitude of an attack from unauthorized access, use, disclosure, disruption, modification or destruction of information systems and the related information processes, stored, or transmitted;
- performing penetration testing assessments annually and producing security assessment reports that document the results of the assessment for use and review by information technology (IT) senior leadership, including the Service Center's Chief Information Officer;
- ensuring security controls are assessed for effectiveness, are implemented correctly, operating as intended and producing the desired outcome;
- continuously scanning for vulnerabilities and remediating vulnerabilities within their service level agreements in accordance with the associated risk level; and
- reviewing third party and vendor risks to our organization through an internal interdisciplinary Technology Advisory Committee that includes members from our IT, Information Security Office (ISO), legal, compliance, clinical, finance and billing departments.

Monitoring

We have established a continuous monitoring strategy and program, which includes:

- a set of defined security metrics to be monitored;
- performance of security control assessments on an ongoing basis;
- addressing results of analysis and reporting security status to the executive team;
- monitoring information systems to detect attacks and indicators of potential attacks or compromises;
- identification of unauthorized use of the information system resources;
- deployment of monitoring systems and agents strategically within the information system environment; and
- require that third party service providers who store, process or transmit data with access to electronic Protected Health Information (ePHI) undergo an independent third-party audit to achieve system organization controls certification annually.

Data Protection

We have implemented an Information Security Management System Program to secure sensitive data protected by us. This program includes:

- establishing policies governing data security;
- monitoring data access throughout the organization’s independent subsidiaries;
- providing continuous security training and awareness;
- establishing controls over devices on the network which are actively tracked, monitored and evaluated for new, missing, or updated software needed to strengthen security on the device, patch known vulnerabilities, or stabilize software or operating system issues;
- protecting sensitive data through encryption techniques; and
- designing and implementing systems to include backup and recoverability principles, such as periodic data backups and safeguards in the case of a disaster.

Incident Management Plan

Our cybersecurity incident management plan comprises the following six-step process:

- The Service Center's Chief Information Officer and Director of Information Security lead its ISO team in the development, documentation, review and testing of security procedures and incident management procedures. Beyond initial creation, procedures are continually re-assessed, updated and tested on an ongoing basis.
- The ISO team works with the Executive Team on the identification, assessment, verification and classification of incidents to determine affected stakeholders and appropriate parties for contact.
- The Service Center's Chief Information Officer and Director of Information Security are responsible for launching the Incident Response Team (IRT) if necessary and for notification to the Executive Team, who in turn will contact the Board of Directors and the Audit Committee to validate that the response is being addressed appropriately.
- The IRT, in consultation with outside experts if needed, is responsible for the following:
    - Initial containment by making tactical changes to the computing environment to mitigate active threats based on currently known information.
    - Analysis to establish the root cause of incidents, identification and evidence collection from all affected machines and log sources, threat intelligence and other information sources. Once all appropriate information has been collected, we perform a careful analysis using forensically-sound tools and methods to prevent any contamination of evidence.
    - Incident containment by further analyzing additional information and further identifying any additional compromised machines or resources not previously identified.
    - Incident eradication by re-assessing the root cause of incidents where solutions are then implemented to solve underlying problems and prevent re-occurrence.
    - Recovery and restoring normal business functionality, which includes the reversal of any damage caused by the incident and responding as necessary.

- Review after closure of each incident and conducting a lessons learned analysis to improve prevention and help to make incident response processes more efficient and effective. Also, the IRT evaluates competency and any additional training requirements needed. A final incident report will then be provided to key stakeholders and IRT members, which includes, but is not limited to the summary of the incident and its impact, a timeline of events, a detailed description of the incident, an evaluation of the organizational response and an assessment of the damages.

We have not experienced a material cybersecurity breach in the past five years and, as a result, there have been no charges related to a breach in the past five years. Moreover, risks from cybersecurity threats have not materially affected our business strategy, results of operations, or financial condition. While we have implemented processes and procedures that we believe are tailored to address and mitigate the cybersecurity threats that our company faces, there can be no assurances that such an incident will not occur despite our efforts, as more fully described in Item 1A. *Risk Factors*.

GOVERNANCE

Our Audit Committee receives quarterly reports on our information security and cyber fraud prevention programs from the Service Center's Chief Information Officer and Director of Information Security, who each have over 24 years of experience in IT, including various leadership roles at other large corporations. One of the three members of our Audit Committee is a cybersecurity expert.

The ISO has been established by the Service Center's Chief Information Officer, with dedicated cyber security staff focusing on security monitoring, vulnerability management, incident response, risk assessments, employee training, security engineering and management of cyber security policies, standards and regulatory compliance. Like many organizations, we align to a Cyber Security Framework and take a risk-based approach during control assessment and implementation. We align to the National Institute of Standards and Technology (NIST) Special Publication 800-53 Revision 4, a globally recognized cyber security framework of Policies, Standards and Controls is comprised of five categories of defense – Identify, Protect, Detect, Respond and Recover. We are committed to the protection of our data, systems, network and continually invest in enhancements to mitigate or reduce the impact from a cyber security threat. We conduct periodic tests to maintain readiness and resiliency while regularly reviewing policies in the interest of protecting data security. External companies or agencies may be called upon to provide consulting, guidance, assistance, or some other form of support in response to a cybersecurity incident. The regular training of employees, at least annually, on the ever-present threat of cybersecurity helps maintain data security.

Item 2. PROPERTIES

Service Center — Our primary Service Center is located at our San Juan Capistrano, California campus, which we acquired for a purchase price of $31.0 million to accommodate our growing Service Center team. The property consists of approximately 108,058 square feet of usable office space. In addition, we lease a portion of the space within the campus to third-party tenants. We also have service centers located in Tempe, Arizona; San Antonio, Texas; Dallas, Texas and Salt Lake City, Utah.

Operating Facilities — We operate 327 independent subsidiaries in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin, with the operational capacity to serve approximately 37,000 patients as of December 31, 2024. Of the 327 facilities, we operate 231 facilities under long-term lease arrangements and have options to purchase 12 of those 231 facilities. The results of our independent subsidiaries are reflected in our skilled services segment for our skilled nursing operations and in the "All Other" category for our senior living operations. For more information about our subsequent acquisitions, see Part II, *Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.*

The following table provides summary information regarding the location of our facilities, operational beds and units by property type as of December 31, 2024:

	Operated Facilities							
	Leased without a Purchase Option		Leased with a Purchase Option		Owned		Total	
	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units	Facilities	Beds/Units
Texas	56	6,975	6	834	22	2,915	84	10,724
California	59	5,636	—	—	11	1,232	70	6,868
Arizona	23	3,342	—	—	15	2,198	38	5,540
Colorado	27	2,916	1	125	9	971	37	4,012
Utah	12	1,311	2	159	8	764	22	2,234
Washington	12	1,085	—	—	4	391	16	1,476
Idaho	7	540	—	—	5	470	12	1,010
Kansas	2	147	3	325	6	607	11	1,079
South Carolina	4	582	—	—	5	544	9	1,126
Nebraska	5	364	—	—	3	331	8	695
Iowa	6	399	—	—	2	158	8	557
Tennessee	3	349	—	—	3	300	6	649
Nevada	3	483	—	—	—	—	3	483
Wisconsin	—	—	—	—	3	182	3	182
	219	**24,129**	**12**	**1,443**	**96**	**11,063**	**327**	**36,635**

The following table sets forth the location of our facilities and the number of operational beds and units located at our skilled nursing, senior living and campus facilities as of December 31, 2024:

	Facility Counts				Bed / Unit Counts		
	Skilled Nursing Operations	Senior Living Communities	Campus Operations	Total	Skilled Nursing Beds	Senior Living Units	Total Beds / Units
Texas	78	1	5	84	10,120	604	10,724
California	67	—	3	70	6,671	197	6,868
Arizona	31	1	6	38	4,649	891	5,540
Colorado	31	5	1	37	3,379	633	4,012
Utah	19	2	1	22	2,071	163	2,234
Washington	15	1	—	16	1,378	98	1,476
Idaho	11	—	1	12	989	21	1,010
Kansas	3	—	8	11	828	251	1,079
South Carolina	9	—	—	9	1,126	—	1,126
Nebraska	4	1	3	8	496	199	695
Iowa	6	—	2	8	526	31	557
Tennessee	6	—	—	6	649	—	649
Nevada	3	—	—	3	483	—	483
Wisconsin	3	—	—	3	182	—	182
	286	**11**	**30**	**327**	**33,547**	**3,088**	**36,635**

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Real Estate Properties — As of December 31, 2024, we owned 129 real estate properties in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin, which include 96 of the 327 facilities that we operate and manage. Of our 129 real estate properties, 33 operations are leased to and operated by third-party operators. One senior living facility is located on the same real estate property as a skilled nursing facility that we own and operate. We further own the real estate property of our Service Center's California location and continue to lease a portion of the office space to third-party tenants. Our Standard Bearer segment reflects the results of operations for 124 of the 129 owned real estate properties.

The following table provides summary information regarding the location of our owned real estate properties as of December 31, 2024:

	Owned and Operated by Ensign[(1)]	Owned and Leased to Third-Party Operators[(1)]	Service Center	Total Properties[(1)]
Texas[(1)]	22	6	—	27
Wisconsin	3	22	—	25
Arizona	15	1	—	16
California	11	2	1	14
Colorado	9	—	—	9
Utah	8	—	—	8
Kansas	6	—	—	6
Idaho	5	—	—	5
South Carolina	5	—	—	5
Washington	4	1	—	5
Nebraska	3	—	—	3
Tennessee	3	—	—	3
Iowa	2	—	—	2
Nevada	—	1	—	1
	96	**33**	**1**	**129**

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

Item 3. LEGAL PROCEEDINGS

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

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

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

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

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

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

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

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

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

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories. We and our independent subsidiaries have been subjected to, and/or are currently involved in, class action litigation alleging violations (alone or in combination) of state and federal wage and hour law related to the alleged failure to pay wages, to timely provide and authorize meal and rest breaks, and other such similar causes of action. Additionally, in July of 2024, two of our independent subsidiaries received a subpoena to produce documents related to alleged environmental matters from the United States' Attorney's office for the Western District of Washington. Our independent subsidiaries are fully cooperating with the United States' Attorney's office in response to the subpoena. We do not believe that the ultimate resolution of this matter will have a material adverse effect on our business, cash flows, financial condition or results of operations.

We and our independent subsidiaries have been, and continue to be, subject to claims, findings and legal actions that arise in the ordinary course of the various businesses, including in connection with the delivery of healthcare and non-healthcare services. These claims include but are not limited to potential claims related to patient care and treatment (professional negligence claims) as well as employment related claims. While we have been able to settle or otherwise resolve many of these types of claims without an ongoing material adverse effect on our business, a significant increase in the number of these claims, or an increase in the amounts owing should plaintiffs be successful in their prosecution of remaining or future claims, could materially adversely affect our business, financial condition, results of operations and cash flows. In addition, these claims could impact our ability to procure insurance to cover our exposure related to the various services provided by our independent subsidiaries to their residents, customers and patients.

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

Medicare Revenue Recoupments — We and our independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments resulting from reviews conducted via RAC, various Program Safeguard Contractors and Medicaid Integrity Contractors (collectively referred to as Reviews). Reviews vary in claim selection size and processes, ranging from a single episode/claim to larger, multi-claim batches; and from single rounds of review to reviews of multiple rounds with pass/fail criteria. If an operation has a significant error or fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. We anticipate that these Reviews could increase in frequency in the future. As of December 31, 2024 and through the filing date of this report, 18 of our independent subsidiaries had multi-claim Reviews scheduled or in process.

In June 2023, CMS announced a new nationwide audit, the "SNF 5-Claim Probe & Educate Review," in which the Medicare Administrative Contractors will review five claims from each SNF to evaluate for claims compliance. In implementing this SNF 5-Claim Probe & Educate Review, CMS acknowledged that the increase in observed improper payments from 2021 to 2022 may have arisen from a "misunderstanding" by SNFs about how to appropriately bill for claims of service after October 1, 2019. All facilities that are not undergoing TPE reviews, or have not recently passed a TPE review, will be subject to the nationwide audit. MACs will complete only one round of probe-and-educate for each SNF, rather than the three rounds that typically occur in the TPE Program. Additionally, CMS's education for each SNF will be individualized and based on observed claim review errors, with rationales for denial explained to the SNF on a claim-by-claim basis. This program will apply only to claims submitted after October 1, 2019, and will exclude claims containing a COVID-19 diagnosis.

Item 4. MINE SAFETY DISCLOSURES

None.

PART II.

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

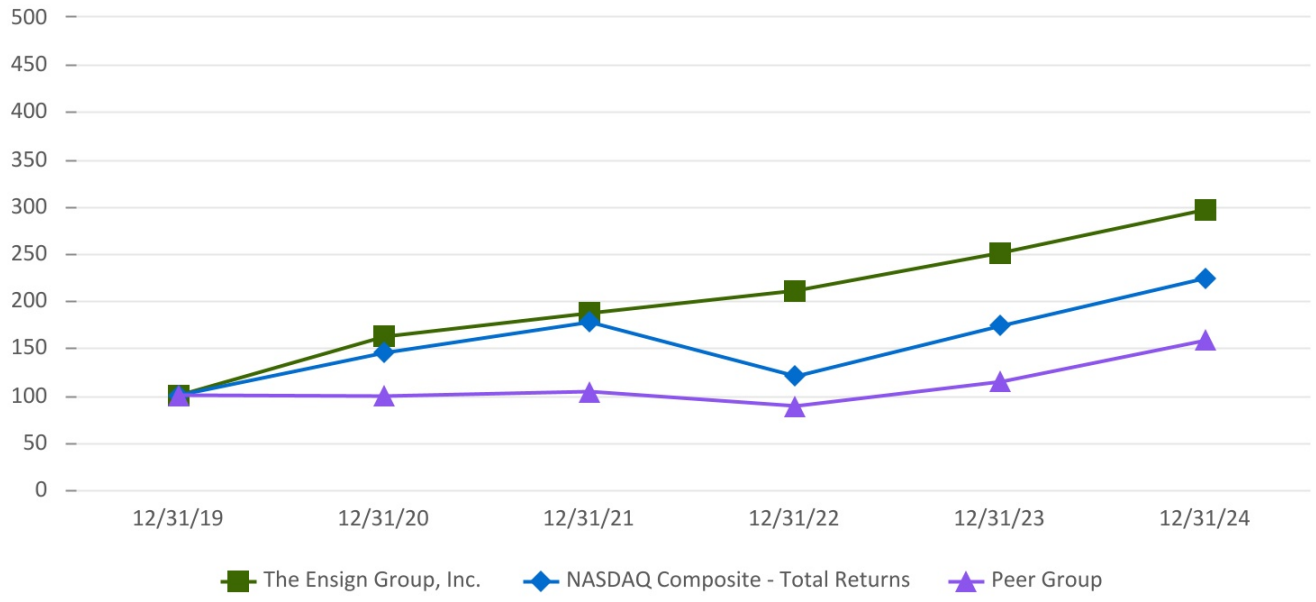
Market Information

Our common stock is traded under the symbol "ENSG" on the NASDAQ Global Select Market. As of January 31, 2025, there were approximately 359 holders of record of our common stock.

Notwithstanding anything to the contrary set forth in any of our filings under the Securities Act or the Exchange Act that might incorporate future filings, including the Annual Report on Form 10-K, in whole or in part, the Stock Performance Graph and supporting data which follows shall not be deemed to be incorporated by reference into any such filings except to the extent that we specifically incorporate any such information into any such future filings.

The graph below shows the cumulative total stockholder return of investment of $100 (and the reinvestment of any dividends thereafter) on December 31, 2019 in (i) our common stock, (ii) the Skilled Nursing Facilities Peer Group 1 and (iii) the NASDAQ Market Index. Our stock price performance shown in the graph below is not indicative of future stock price performance.

COMPARISON OF 60 MONTH CUMULATIVE TOTAL RETURN*
Among Ensign Group, the NASDAQ Composite Index and Our Peer Group
December 2024



*Assumes $100 invested on December 31, 2019 in stock in index, including reinvestment of dividends.
Fiscal year ended December 31.

	2019	2020	2021	2022	2023	2024
The Ensign Group, Inc.	$ 100.00	$ 161.37	$ 186.25	$ 210.40	$ 250.09	$ 296.63
NASDAQ Market Index	100.00	144.92	177.06	119.45	172.77	223.87
Peer Group[(1)]	100.00	98.69	103.32	87.81	114.10	157.80

(1) The current composition of our Peer Group is as follows: Amedysis, Inc., CareTrust REIT Inc., Encompass Healthcare Corp., LTC Properties, Inc., National Healthcare Corporation, National Health Investors, Inc., Omega Healthcare Investors, Inc., PACS Group, Inc., Select Medical Holdings Corp. and Welltower Inc.

Dividend Policy

We do not have a formal dividend policy, but we currently intend to continue to pay regular quarterly dividends to the holders of our common stock. We have been a dividend-paying company since 2002 and have increased our dividend every year for the last 22 years.

Issuer Repurchases of Equity Securities

Stock Repurchase Programs — On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2024. We did not purchase any shares pursuant to this stock repurchase program during the year ended December 31, 2024.

On August 29, 2023, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2023. The program terminated by its terms on August 31, 2024 and is no longer in effect. We did not purchase any shares pursuant to this stock repurchase program.

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

Item 6. [RESERVED]

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

The following discussion should be read in conjunction with the consolidated financial statements and accompanying notes, which appear elsewhere in this Annual Report on Form 10-K. This discussion contains forward-looking statements that involve risks and uncertainties. Our actual results could differ materially from those anticipated in these forward-looking statements as a result of various factors, including those discussed below and elsewhere in this Annual Report on Form 10-K. See Part I. Item 1A. Risk Factors and Cautionary Note Regarding Forward-Looking Statements.

For discussion of 2022 items and year-over-year comparisons between 2023 and 2022 that are not included in this 2024 Form 10-K, refer to "Item 7. – Management's Discussion and Analysis of Financial Condition and Results of Operations" found in our Form 10-K for the year ended December 31, 2023, that was filed with the Securities and Exchange Commission on February 1, 2024.

Overview

We are a provider of health care services across the post-acute care continuum. We engage in the operation, ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare related properties and ancillary businesses located in Alabama, Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. Our independent subsidiaries, each of which strive to be the operation of choice in the communities they serve, provide a broad spectrum of services. As of December 31, 2024, we offered skilled nursing, long term acute care, senior living and rehabilitative care services through 327 skilled nursing and senior living facilities. Our real estate portfolio includes 129 owned real estate properties, which includes 96 facilities operated and managed by us, 33 operations leased to and operated by third-party operators and the Service Center location. Of the 33 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that we own and operate.

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

Recent Activities

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

Operational Update — Our combined Same Facilities and Transitioning Facilities occupancy increased by 2.9% compared to the same period in 2023. Since the first quarter of 2024, Same Facilities skilled nursing occupancy has surpassed pre-pandemic occupancy. Our focus on rebuilding census resulted in Same Facilities occupancy of 81.3% during the year ended December 31, 2024 compared to 79.2% in the same period in 2023. These results were possible due to the innovative approaches and strategic partnerships which supported our multiple year growth in occupancy improvements and continue to enable us to gain additional market share. These key initiatives together with our dedication to our cultural and operational fundamentals resulted in strong 2024 results.

Operational and New State Expansions — During the year ended December 31, 2024, we expanded our operations with the addition of 28 stand-alone skilled nursing operations and three campus operations, which added a total of 3,030 operational skilled nursing beds and 218 operational senior living units to be operated by our independent subsidiaries. Subsequent to December 31, 2024, we added seven stand-alone skilled nursing operations, which added 682 operational skilled nursing beds to be operated by our independent subsidiary. We also invested in new ancillary services that are complementary to our existing businesses.

Twelve of the operations mentioned above are located in Tennessee and Alabama, which are new states for us. The expansion into the two new states are part of our strategic vision to further strengthen our growing national presence in both existing and new attractive markets.

Standard Bearer Update — Standard Bearer Healthcare REIT, Inc. (Standard Bearer), our captive REIT, is a holding company with subsidiaries that own a majority of our real estate portfolio. We expect the REIT structure to allow us to better demonstrate the growing value of our owned real estate and provide us with an efficient vehicle for future acquisitions of properties that could be operated by our independent subsidiaries or other third parties. This structure gives us new pathways to growth with transactions we would not have considered in the past.

During the year ended December 31, 2024, Standard Bearer added $131.9 million of real estate associated with 11 stand-alone skilled nursing operations, three stand-alone senior living operations and three campus operations. Of these additions, the stand-alone skilled nursing and campus operations are operated by 14 of our independent subsidiaries and the three stand-alone senior living operations are leased to a third-party operator. Our existing relationships with third-party operators within our industry have allowed us to expand our growing REIT structure to operators outside of our organization.

As of December 31, 2024, the fair value of Standard Bearer's real estate portfolio is approximately $1.3 billion. The fair value was determined by a third-party independent valuation specialist and incorporated each property's rental income, capitalization rate, rental yield rate and discount rate.

Subsequent to December 31, 2024, Standard Bearer added $50.9 million of real estate associated with four stand-alone skilled nursing operations and one campus operation. Four of the acquisitions were related to exercising purchase options from CareTrust REIT, Inc. (CareTrust) lease arrangements, which the operations are currently operated and managed by our independent subsidiaries. The remaining real estate acquisition was leased back to our independent subsidiaries.

Insignia Pathway — In December 2024, we funded $35.0 million to the formation of Insignia Pathway, an independent public charity, with a mission to empower, support and expand the post acute care workforce through recruiting talent, providing resources, education, housing and advocacy to enhance professional growth, job satisfaction and community impact. Insignia Pathway is dedicated to addressing workforce challenges, fostering equity and inspiring the current and next generation to join the essential field of post acute care. Insignia Pathway is currently in the process of applying for recognition of exemption as an organization under Section 501(c)(3) of the Internal Revenue Code.

Common Stock Repurchase Program — On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2024. We did not repurchase any shares during the fiscal year 2024.

Key Performance Indicators

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

Skilled Services

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

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

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

	Year Ended December 31,	
Skilled Mix:	**2024**	**2023**
Days	29.9 %	30.4 %
Revenue	48.6 %	50.2 %

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

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

	Year Ended December 31,	
Occupancy for skilled services:	**2024**	**2023**
Operational beds at end of period	33,547	30,602
Available patient days	11,710,297	10,940,320
Actual patient days	9,431,825	8,590,995
Occupancy percentage (based on operational beds)	80.5 %	78.5 %

Segments

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

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

Revenue Sources

Skilled Services — Within our skilled nursing operations, we generate revenue from Medicaid, private pay, managed care and Medicare payors. We believe that our skilled mix, which we define as the number of days Medicare, managed care and other skilled patients are receiving services at our skilled nursing operations divided by the total number of days patients are receiving services at our skilled nursing operations, from all payor sources (less days from senior living services) for any given period, is an important indicator of our success in attracting high-acuity patients because it represents the percentage of our patients who are reimbursed by Medicare, managed care and other skilled payors, for whom we receive higher reimbursement rates.

We participate in supplemental payment programs and quality improvement programs in various states that provide supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as city and county hospital districts. A number of our independent subsidiaries have entered into transactions with various hospital districts providing for the transfer of the licenses for those skilled nursing facilities to the hospital districts. Each affected independent subsidiary agreement between the hospital district and our subsidiary is terminable by either party to fully restore the prior license status.

Standard Bearer — We generate rental revenue primarily by leasing post-acute care properties that we acquired to healthcare operators under triple-net lease arrangements, whereby the tenants are solely responsible for the costs related to the property, including property taxes, insurance and maintenance and repair costs, subject to certain exceptions. As of December 31, 2024, our real estate portfolio within Standard Bearer is comprised of 124 real estate properties. Of these properties, 92 are leased to our independent subsidiaries and 33 are leased to facilities wholly-owned and managed by third-party operators. Of those 33 operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates. During the year ended December 31, 2024, we generated rental revenues of $95.1 million, of which $78.1 million was derived from our independent subsidiaries and therefore eliminated in consolidation.

Other — Within our senior living operations, we generate revenue primarily from private pay sources, with a portion earned from Medicaid payors or through other state-specific programs. Payment for these services varies and is based upon the service provided. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk.

Primary Components of Expense

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 consists 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 that are not included in facility rent - cost of services, and other general cost of services with respect to our operations.

Facility Rent - Cost of Services — Rent - cost of services consists solely of base minimum rent amounts payable under lease agreements to third-party real estate owners. Our independent subsidiaries lease and operate but do not own the underlying real estate and these amounts do not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements. Expenses related to leasing our operations are included in cost of services.

General and Administrative Expense — General and administrative expense consists primarily of payroll and related benefits and travel expenses for our Service Center personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees), costs relating to our information systems and stock-based compensation related to our Service Center employees.

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 depreciable lives of our depreciable assets:

Buildings and improvements	Minimum of three years to a maximum of 59 years, generally 45 years
Leasehold improvements	Shorter of the lease term or estimated useful life, generally 5 to 15 years
Furniture and equipment	3 to 10 years

Critical Accounting Estimates

Our discussion and analysis of our financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with U.S. Generally Accepted Accounting Principles (GAAP). The preparation of these 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 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 position and results of operations, require significant judgments and estimates on the part of management. For a summary of our significant accounting policies, including the accounting policies discussed below, see Note 2, *Summary of Significant Accounting Policies* of the Notes to the Consolidated Financial Statements.

Variable consideration within revenue recognition — Revenue recognized from healthcare services are 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. We use the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained and is included in the net revenue only to the extent 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 our estimates, we adjust these estimates, which would affect net service revenue in the period such variances become known.

Self-insurance for general and professional liability — The self-insured retention and deductible limits for general and professional liability for all states, except Kansas, are self-insured through our wholly owned captive insurance subsidiary (the Captive Insurance), the related assets and liabilities of which are included in the accompanying consolidated balance sheets. Our general and professional liability as of the years ended December 31, 2024 and 2023 was $160.1 million and $117.7 million, respectively.

Our policy is to accrue amounts equal to the actuarially 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.

RESULTS OF OPERATIONS

We believe we exist to dignify and transform post-acute care. We set out a strategy to achieve our goal of ensuring our patients are receiving the best possible care through our ability to acquire, integrate and improve our operations. Our results serve as a strong indicator that our strategy is working and our transformation is underway. Over the last five years, our total revenue increased by $2.2 billion, or 109.2%, representing a 15.9% compound annual growth rate (CAGR) while our diluted GAAP earning per share (EPS) from continuing operations grew by $3.48 from 2019 to 2024, representing a 25.6% CAGR.

Our total revenue for the year ended December 31, 2024 increased $531.1 million, or 14.2%, compared to the year ended December 31, 2023. Throughout 2024, we continued to make progress on targeted initiatives related to increasing occupancy and the level of acuity and complexity of the patients we serve in our facilities, attracting and developing our people and acquiring underperforming skilled nursing operations and integrating them with our proven cultural and operational principles. During the year ended December 31, 2024, we added 31 new operations. We consistently experience healthy growth in both revenue and overall results as we continue to work diligently with existing and recently acquired operations so that each can reach its full clinical and financial potential.

Our combined Same Facilities and Transitioning Facilities occupancy increased by 2.9% compared to the same period in 2023. Since the first quarter of 2024, Same Facilities skilled nursing occupancy has surpassed pre-pandemic occupancy. Our focus on rebuilding census resulted in Same Facilities occupancy of 81.3% during the year ended December 31, 2024 compared to 79.2% in the same period in 2023, demonstrating our ability to gain additional market share even at our more mature operations. Further, our Transitioning Facilities occupancy increased by 4.1% to 76.0% compared to the same period in 2023, highlighting our organic growth ability that results from transforming underperforming operations that we have acquired.

Throughout most of our history, our business is affected by seasonal fluctuations in occupancy and acuity, which are most prominent when comparing the summer and winter months of the calendar year. For skilled nursing occupancy and skilled mix, our historic seasonal trend tends to show stronger occupancy and acuity during the first and fourth quarters and softening in the second and third quarters. Additionally, we historically have acquired operations with lower occupancy and skilled mix. As these operations become "operations of choice" in each of their respective healthcare markets, we typically see both occupancy and skilled mix increase.

Our strength remains in our operating model, which empowers each operator to form their own market-specific strategy and adjust to the needs of their local medical communities, including methods for attracting new healthcare professionals into our workforce and retaining and developing existing staff. Despite continued labor pressures, there are positive trends on both turnover and agency usage across our operations. During 2024, we added over 4,000 full-time equivalent team members, or 11%, to our independent subsidiaries and the Service Center.

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

	Year Ended December 31,	
	2024	**2023**
REVENUE:		
Service revenue	99.5 %	99.4 %
Rental revenue	0.5	0.6
TOTAL REVENUE	**100.0 %**	**100.0 %**
Expenses:		
Cost of services	79.3	78.9
Rent—cost of services	5.1	5.3
General and administrative expense	5.3	7.1
Depreciation and amortization	1.9	1.9
TOTAL EXPENSES	**91.6 %**	**93.2 %**
Income from operations	8.4	6.8
Other income (expense):		
Interest expense	(0.2)	(0.2)
Interest income	0.7	0.5
Other income (expense)	0.2	0.2
OTHER INCOME (EXPENSE), NET	**0.7 %**	**0.5 %**
Income before provision for income taxes	9.1	7.3
Provision for income taxes	2.1	1.7
NET INCOME	**7.0 %**	**5.6 %**
Less: net income attributable to noncontrolling interests	—	—
Net income attributable to The Ensign Group, Inc.	**7.0 %**	**5.6 %**

	Year Ended December 31,	
	2024	**2023**
SEGMENT INCOME[(1)]	*(In thousands)*	
Skilled services	$ 518,463	$ 464,925
Standard Bearer[(2)]	29,335	29,065
NON-GAAP FINANCIAL MEASURES:		
PERFORMANCE METRICS		
Adjusted EBT	$ 427,976	$ 365,310
EBITDA[(3)]	449,284	333,569
Adjusted EBITDA	490,392	425,762
FFO for Standard Bearer	58,632	54,270
VALUATION METRICS		
Adjusted EBITDAR	$ 706,408	

(1) Segment income represents operating results of the reportable segments excluding gain and loss on sale of assets, real estate insurance recoveries and losses, impairment charges and provision for income taxes. Included in segment income for Standard Bearer are expenses for intercompany management fees between Standard Bearer and the Service Center and intercompany interest expense. Segment income is reconciled to the Consolidated Statement of Income in Note 8, *Business Segments* in Notes to Financial Statements of this Annual Report on Form 10-K.
(2) Standard Bearer segment income includes rental revenue and expenses from our independent subsidiaries.
(3) EBITDA includes litigation related to specific proceedings arising outside of the ordinary course of business as discussed in Item 3. *Legal Proceedings.*

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

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

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

We use the Non-GAAP Financial Measures:

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

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

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

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

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

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

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

PERFORMANCE MEASURES

Adjusted EBT

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

Adjusted EBT is income before provision for income taxes adjusted for non-core business items, which for the reported periods includes, to the extent applicable:

- stock-based compensation expense;
- litigation;
- loss (gain) on long-lived assets and gain on business interruption recoveries;
- acquisition related costs;
- costs incurred related to system implementations;
- write off of deferred financing fees; and
- amortization of patient base intangible assets.

EBITDA

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

We calculate EBITDA as net income, adjusted for net losses attributable to noncontrolling interest, before (a) interest income, (b) provision for income taxes, (c) depreciation and amortization, and (d) interest expense. EBITDA in the prior period has been recast to conform to the current period presentation.

Adjusted EBITDA

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

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

Funds from Operations (FFO)

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

VALUATION MEASURE

Adjusted EBITDAR

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

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

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

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

	Year Ended December 31,	
	2024	**2023**
Consolidated statements of income data:	*(In thousands)*	
Income before provision for income taxes	$ 386,094	$ 272,762
Stock-based compensation expense	36,226	30,767
Litigation[(1)]	(1,425)	60,781
Loss (gain) on long-lived assets and gain on business interruption recoveries	2,335	(1,132)
Acquisition related costs[(2)]	1,019	814
Costs incurred related to system implementations	2,953	963
Depreciation and amortization - patient base[(3)]	574	355
Interest expense - write off deferred financing fees[(4)]	200	—
ADJUSTED EBT	**$ 427,976**	**$ 365,310**

(1) Represents specific proceedings and adjustments arising outside of the ordinary course of business.
(2) Represents costs incurred to acquire operations that are not capitalizable.
(3) Represents amortization expenses related to patient base intangible assets at newly acquired skilled nursing and senior living facilities.
(4) Represents the write off of deferred financing fees associated with mortgage loans.

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

	Year Ended December 31,	
	2024	2023
Consolidated statements of income data:	*(In thousands)*	
Net income	$ 298,458	$ 209,850
Less: Net income attributable to noncontrolling interests	485	451
Interest income	28,749	19,216
Add: Provision for income taxes	87,636	62,912
Depreciation and amortization	84,138	72,387
Interest expense	8,286	8,087
EBITDA	**$ 449,284**	**$ 333,569**
Adjustments to EBITDA:		
Stock-based compensation expense	36,226	30,767
Litigation[1]	(1,425)	60,781
Loss (gain) on long-lived assets and gain on business interruption recoveries	2,335	(1,132)
Acquisition related costs[2]	1,019	814
Costs incurred related to system implementations	2,953	963
ADJUSTED EBITDA	**$ 490,392**	**$ 425,762**
Rent—cost of services	216,016	197,358
ADJUSTED EBITDAR	**$ 706,408**	

(1) Litigation relates to specific proceedings and adjustments arising outside of the ordinary course of business.
(2) Costs incurred to acquire operations that are not capitalizable.

Year Ended December 31, 2024 Compared to the Year Ended December 31, 2023

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

	Year Ended December 31, 2024				
	Skilled Services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 4,076,825	$ 95,086	$ 192,881	$ (104,307)	$ 4,260,485
Total expenses, including other income, net	3,558,362	65,751	352,250	(104,307)	3,872,056
Segment income (loss)	518,463	29,335	(159,369)	—	388,429
Loss on long-lived assets					(2,335)
Income before provision for income taxes					**$ 386,094**

	Year Ended December 31, 2023				
	Skilled Services	Standard Bearer	All Other	Eliminations	Consolidated
Total revenue	$ 3,578,855	$ 82,486	$ 155,804	$ (87,790)	$ 3,729,355
Total expenses, including other income, net	3,113,930	53,421	377,055	(87,790)	3,456,616
Segment income (loss)	464,925	29,065	(221,251)	—	272,739
Gain on sale of assets and insurance recoveries from real estate, net					23
Income before provision for income taxes					**$ 272,762**

Our total revenue increased by $531.1 million, or 14.2%, compared to the year ended December 31, 2023. The increase in revenue was primarily driven by an increase in occupancy of 2.7% and 4.1% from our skilled services in Same Facilities and Transitioning Facilities, respectively, coupled with increasing daily revenue rates and the impact of acquisitions. Additionally, our skilled services in Recently Acquired Facilities increased total revenue by $271.7 million, when compared to the same period in 2023.

Skilled Services Segment

Revenue

The following tables present the skilled services revenue and key performance metrics by category during the years ended December 31, 2024 and 2023:

	Year Ended December 31,			
	2024	**2023**	**Change**	**% Change**
TOTAL FACILITY RESULTS:		*(Dollars in thousands)*		
Skilled services revenue	$ 4,076,825	3,578,855	$ 497,970	13.9 %
Number of facilities at period end	286	259	27	10.4 %
Number of campuses at period end[(1)]	30	27	3	11.1 %
Actual patient days	9,431,825	8,590,995	840,830	9.8 %
Occupancy percentage — Operational beds	80.5 %	78.5 %	2.0 %	2.5 %
Skilled mix by nursing days	29.9 %	30.4 %	(0.5)%	(1.6)%
Skilled mix by nursing revenue	48.6 %	50.2 %	(1.6)%	(3.2)%

	Year Ended December 31,			
	2024	**2023**	**Change**	**% Change**
SAME FACILITY RESULTS:[(2)]		*(Dollars in thousands)*		
Skilled services revenue	$ 3,018,601	$ 2,823,314	$ 195,287	6.9 %
Number of facilities at period end	193	193	—	— %
Number of campuses at period end[(1)]	25	25	—	— %
Actual patient days	6,902,006	6,704,689	197,317	2.9 %
Occupancy percentage — Operational beds	81.3 %	79.2 %	2.1 %	2.7 %
Skilled mix by nursing days	31.7 %	31.8 %	(0.1)%	(0.3)%
Skilled mix by nursing revenue	50.2 %	51.2 %	(1.0)%	(2.0)%

	Year Ended December 31,			
	2024	**2023**	**Change**	**% Change**
TRANSITIONING FACILITY RESULTS:[(3)]		*(Dollars in thousands)*		
Skilled services revenue	$ 507,143	$ 472,808	$ 34,335	7.3 %
Number of facilities at period end	40	40	—	— %
Number of campuses at period end[(1)]	1	1	—	— %
Actual patient days	1,336,074	1,302,680	33,394	2.6 %
Occupancy percentage — Operational beds	76.0 %	73.0 %	3.0 %	4.1 %
Skilled mix by nursing days	21.8 %	20.7 %	1.1 %	5.3 %
Skilled mix by nursing revenue	38.4 %	38.4 %	— %	— %

	Year Ended December 31,			
	2024	2023	Change	% Change
RECENTLY ACQUIRED FACILITY RESULTS:[4]	*(Dollars in thousands)*			
Skilled services revenue	$ 550,507	$ 278,791	$ 271,716	NM
Number of facilities at period end	53	25	28	NM
Number of campuses at period end[1]	4	1	3	NM
Actual patient days	1,191,663	566,398	625,265	NM
Occupancy percentage — Operational beds	81.6 %	84.4 %	NM	NM
Skilled mix by nursing days	28.9 %	37.4 %	NM	NM
Skilled mix by nursing revenue	48.9 %	59.7 %	NM	NM

	Year Ended December 31,			
	2024	2023	Change	% Change
FACILITY CLOSED RESULTS:[5]	*(Dollars in thousands)*			
Skilled services revenue	$ 574	$ 3,942	$ (3,368)	NM
Actual patient days	2,082	17,228	(15,146)	NM
Occupancy percentage — Operational beds	52.6 %	90.8 %	NM	NM

(1) Campus represents a facility that offers both skilled nursing and senior living services. Revenue and expenses related to skilled nursing and senior living services have been allocated and recorded in the respective operating segment.
(2) Same Facility results represent all facilities purchased prior to January 1, 2021.
(3) Transitioning Facility results represent all facilities purchased from January 1, 2021 to December 31, 2022.
(4) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2023.
(5) Facility Closed results represent a closed operation during the year ended December 31, 2024 due to the transitioning of an intermediate care facility program to a group home setting, which is included in the All Other category. The skilled services revenue was excluded from Same Facility results for the years ended December 31, 2024 and 2023 for comparison purposes.

Skilled services revenue increased $498.0 million, or 13.9%, compared to the year ended December 31, 2023. The increases in skilled services revenue were across all payer types including increases in Medicaid revenue of $238.0 million, or 14.2%, Medicare revenue of $69.4 million, or 7.0%, managed care revenue of $123.6 million, or 18.6% and private revenue of $67.0 million, or 26.6%.

The increase in skilled services revenue was primarily driven by strong occupancy performance across our skilled services operations. Our consolidated occupancy increased by 2.5% to 80.5% during the year ended December 31, 2024 compared to the same period in 2023, as a result of an increase in long-term care Medicaid patients and an increase in managed care skilled days.

Revenue in our Same Facilities increased $195.3 million, or 6.9%, compared to the same period in 2023, due to increased occupancy from long-term care patients, strong skilled days and revenue per patient day. Our diligent efforts to strengthen our partnerships with various managed care organizations, hospitals and local communities, increased our managed care revenue by 12.1%, mainly due to increases in managed care days of 6.5% and revenue per patient day of 3.6%. We continued to see a shift in our patient population from Medicare to managed care as Medicare Advantage enrollment continues to account for a larger portion of the overall Medicare eligible population. In addition, Medicaid revenue increased by $89.8 million or 6.8%, mainly from the increases in Medicaid days and revenue per patient day. Our skilled mix days and revenue percentage decline was due to our non-skilled days and revenue growing at a faster pace than our skilled days and revenue. Both skilled and non-skilled days and revenue increased from the prior year.

Revenue generated by our Transitioning Facilities increased $34.3 million, or 7.3%, primarily due to improved occupancy growth, increases in skilled mix days and revenue per patient day. The increases in revenue were derived from managed care revenue of 25.5%, Medicare revenue of 2.1%, Medicaid revenue of 3.9% and private revenue of 16.5%. These increases demonstrate our ability to focus on increasing occupancy across payer types. Included in the year ended December 31, 2023 is the revenue related to a facility that was not operating at full capacity starting in the first quarter of 2024 due to flooding.

Skilled services revenue generated by Recently Acquired Facilities increased by approximately $271.7 million compared to the year ended December 31, 2023. The increases were primarily due to 31 operational expansions between January 1, 2024 and December 31, 2024 across ten states.

Historically, we have generally experienced lower occupancy rates and lower skilled mix at Recently Acquired Facilities and therefore, we anticipate lower overall occupancy during years of growth. Included in our metrics for Recently Acquired Facilities are 17 facilities we acquired in California in 2023 that were more mature and accordingly, had higher occupancy rates, higher skilled mix days and higher skilled mix revenue than our typical acquisitions. In the future, if we acquire additional turnaround or start-up operations, we expect to see lower occupancy rates and skilled mix and these metrics are expected to vary from period to period based upon the type of the facilities and operations that we acquire.

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

	Year Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
SKILLED NURSING AVERAGE DAILY REVENUE RATES								
Medicare	$ 757.99	$ 721.04	$ 705.71	$ 677.71	$ 846.60	$ 865.81	$ 767.72	$ 733.47
Managed care	555.11	535.95	526.01	528.10	590.50	613.57	555.37	539.25
Other skilled	628.01	595.57	537.30	494.43	627.85	424.56	620.42	575.34
Total skilled revenue	638.61	615.59	605.32	593.46	738.31	743.60	647.28	623.70
Medicaid	296.64	275.47	274.24	251.18	309.90	292.73	294.78	272.14
Private and other payors	278.20	262.93	246.18	237.11	334.92	347.70	280.24	262.93
Total skilled nursing revenue	$ 403.02	$ 382.15	$ 342.94	$ 320.41	$ 436.43	$ 466.18	$ 398.66	$ 378.02

(1) The rates are based on contractually agreed-upon amounts or rates, excluding the estimates of variable consideration under the revenue recognition standard, Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606 and state relief funding during the year ended December 31, 2023.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 5.1% and 4.1%, respectively, compared to the year ended December 31, 2023. The increase is attributable to the 4.0% and 4.2% net market basket increase that became effective in October 2023 and October 2024, respectively, and a shift toward higher acuity patients.

Our average Medicaid rates increased 8.3% due to state reimbursement increases, our participation in supplemental Medicaid payment programs and quality improvement programs in various states and changes in Medicaid mix. For example, we continue to have an increase in Medicaid days in states with higher rates, such as California. In addition, during the COVID periods from 2020 through 2023, we received state relief funding through Medicaid programs from various states such as California. These funds have been excluded from our average daily rates from 2020-2023. Starting in 2024, several of the states we operate in have incorporated the state relief funding as part of the state per diem rates or enhanced their supplemental programs. As results, these revenue are included in the 2024 average daily revenue rate. As such, the increase in Medicaid rates from 2023 to 2024 is not a lateral comparison.

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

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

	Year Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING REVENUE								
Medicare	20.5 %	22.4 %	19.4 %	20.8 %	31.4 %	42.2 %	21.9 %	23.8 %
Managed care	20.4	20.1	14.3	12.3	12.7	13.3	18.6	18.5
Other skilled	9.3	8.7	4.7	5.3	4.8	4.2	8.1	7.9
Skilled mix	**50.2 %**	**51.2 %**	**38.4 %**	**38.4 %**	**48.9 %**	**59.7 %**	**48.6 %**	**50.2 %**
Private and other payors	7.2	7.6	8.6	8.9	8.2	6.4	7.5	7.6
Medicaid	42.6	41.2	53.0	52.7	42.9	33.9	43.9	42.2
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

	Year Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2024	2023	2024	2023	2024	2023	2024	2023
PERCENTAGE OF SKILLED NURSING DAYS								
Medicare	10.9 %	11.9 %	9.4 %	9.8 %	16.2 %	22.7 %	11.4 %	12.3 %
Managed care	14.8	14.3	9.3	7.5	9.4	10.1	13.4	13.0
Other skilled	6.0	5.6	3.1	3.4	3.3	4.6	5.1	5.1
Skilled mix	**31.7 %**	**31.8 %**	**21.8 %**	**20.7 %**	**28.9 %**	**37.4 %**	**29.9 %**	**30.4 %**
Private and other payors	10.4	11.0	12.0	12.1	10.7	8.6	10.7	11.0
Medicaid	57.9	57.2	66.2	67.2	60.4	54.0	59.4	58.6
TOTAL SKILLED NURSING	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**	**100.0 %**

Cost of Services

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

	Year Ended December 31,		Change	
	2024	2023	$	%
Cost of service	$ 3,242,737	$ 2,832,012	$ 410,725	14.5 %
Revenue percentage	79.5 %	79.1 %		0.4 %

Cost of services related to our skilled services segment increased by $410.7 million, or 14.5%, from the same period in 2023. Cost of services as a percentage of revenue increased to 79.5% from 79.1%, due to increased labor costs as a result of new acquisitions in the turnaround stage, increased insurance expenses and increased expense related to the deferred compensation investment program. Our cost of services as a percentage of revenue varies depending on the volume of acquisitions during the period, which typically have higher costs during the transition period.

Standard Bearer

	Year Ended December 31,		Change	
	2024	2023	$	%
	(Dollars in thousands)			
Rental revenue generated from third-party tenants	$ 16,976	$ 15,774	$ 1,202	7.6 %
Rental revenue generated from Ensign's independent subsidiaries	78,110	66,712	11,398	17.1
TOTAL RENTAL REVENUE	**$ 95,086**	**$ 82,486**	**$ 12,600**	**15.3 %**
Segment income	29,335	29,065	270	0.9
Depreciation and amortization	29,297	25,205	4,092	16.2
FFO	**$ 58,632**	**$ 54,270**	**$ 4,362**	**8.0 %**

Rental revenue — Our rental revenue, including revenue generated from our independent subsidiaries, increased by $12.6 million, or 15.3%, to $95.1 million, compared to the year ended December 31, 2023. The increase in revenue is primarily attributable to 17 real estate purchases as well as annual rent increases since the year ended December 31, 2023.

FFO — Our FFO increased by $4.4 million, or 8.0%, to $58.6 million, compared to the year ended December 31, 2023. The increase in rental revenue of $12.6 million is offset by increases in interest expense of $7.4 million associated with the intercompany debt arrangements as Standard Bearer continues to grow its real estate portfolio.

All Other Revenue

Our other revenue increased by $37.1 million, or 23.8%, to $192.9 million, compared to the year ended December 31, 2023. Other revenue for the year ended December 31, 2024 includes senior living revenue of $90.0 million, revenue from other ancillary services of $91.1 million and rental income of $11.8 million. The increase in other revenue is primarily attributable to our senior living and other ancillary services.

Consolidated Financial Expenses

Rent-cost of services — Our rent-cost of services as a percentage of revenue decreased by 0.2% to 5.1%, as our operational expansions included a higher mix of real estate purchases.

General and administrative expense — General and administrative expense decreased by $37.9 million or 14.4%, to $225.1 million. General and administrative expense as a percentage of revenue decreased by 1.8% to 5.3%. This reduction is attributable to a settlement that was outside the ordinary course of business and finalized in 2023. Excluding the impact of the proceeding in 2023, general and administrative expense as a percentage of revenue would be at 5.4%.

Depreciation and amortization — Depreciation and amortization expense increased by $11.8 million, or 16.2%, to $84.1 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations and capital expenditures. Depreciation and amortization expense as a percentage of revenue remained consistent at 1.9%.

Other income (expense), net — Other income (expense), net as a percentage of revenue increased by 0.2%. Other income primarily includes interest income from our investments, interest expense related to our debt and deferred compensation gains and losses. Other income (expense), net increased by $10.4 million due to increases in interest income from our investments and gains in our deferred compensation plan which incurs gains or losses depending on market performance. During the years ended December 31, 2024 and 2023, the deferred compensation plan had gains of $5.2 million and $4.6 million, respectively. We also recorded an offsetting expense allocated between cost of services and general and administrative expenses.

Provision for income taxes — Our effective tax rate was 22.7% for the year ended December 31, 2024, compared to 23.1% for the same period in 2023. The effective tax rate for both periods was driven by the impact of excess tax benefits from stock-based compensation, partially offset by non-deductible expenses, including non-deductible compensation. See Note 13, *Income Taxes*, in the Financial Statements for further discussion.

Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flows from operations and long-term debt secured by our real property and our Credit Facility (defined below). Our liquidity as of December 31, 2024 is impacted by cash generated from strong operational performance offset by investments made for our operational expansions and ancillary businesses as well as capital expenditures to improve the quality of care at our existing operations.

Historically, we have primarily financed the majority of our acquisitions through mortgages on our properties, our Credit Facility and cash generated from operations. Cash paid to fund acquisitions was $156.5 million for the year ended December 31, 2024 compared to cash paid of $69.0 million for the year ended December 31, 2023. Total capital expenditures for property and equipment were $158.2 million and $106.2 million for the years ended December 31, 2024 and 2023, respectively. We currently have approximately $150.0 million budgeted for renovation projects in 2025. We believe our current cash balances, our cash flow from operations and the amounts available for borrowing under our Credit Facility 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.

Our cash and cash equivalents as of December 31, 2024 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of December 31, 2024, we held investments of approximately $203.5 million. We believe our investments that were in an unrealized loss position as of December 31, 2024 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so.

As mentioned above, our primary source of cash is from our ongoing operations. Our positive cash flows have supported our business and have allowed us to pay regular dividends to our stockholders. We currently anticipate that existing cash and total investments as of December 31, 2024, along with projected operating cash flows and available financing, will support our normal business operations for the foreseeable future.

On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2024. On August 29, 2023, the Board of Directors previously approved a stock repurchase program pursuant to which we could repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months from September 1, 2023, which the program terminated by its terms on August 31, 2024 and is no longer in effect. We did not purchase any shares pursuant to the stock repurchase programs during the year ended December 31, 2024.

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

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

	Year Ended December 31,	
	2024	**2023**
NET CASH PROVIDED BY/(USED IN):	*(In thousands)*	
Operating activities	$ 347,186	$ 376,666
Investing activities	(390,052)	(182,698)
Financing activities	(2,162)	(612)
Net (decrease) increase in cash and cash equivalents	**$ (45,028)**	**$ 193,356**
Cash and cash equivalents beginning of period	509,626	316,270
Cash and cash equivalents at end of period	**$ 464,598**	**$ 509,626**

Operating Activities

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

The $29.5 million decrease in cash provided by operating activities for the year ended December 31, 2024 compared to the same period in 2023 was due to payment of the $48.0 million related to the litigation matter discussed in Item 3., *Legal Proceedings* and we funded $35.0 million to Insignia Pathway, which is discussed in *Recent Activities*. This cash outflow was partially offset by an increase in operational performance.

Investing Activities

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

The $207.4 million increase in cash used in investing activities for the year ended December 31, 2024 compared to the same period in 2023 was primarily used for operational expansions and capital expenditures as well as increased investment activity as part of our capital strategy.

Financing Activities

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

The $1.6 million increase in cash provided by financing activities for the year ended December 31, 2024 compared to the same period in 2023, was primarily due to stock option exercises offset by the purchase of non-controlling interest in one of our ancillary businesses.

A discussion of our cash flows for the year ended December 31, 2022 is included in Part II, Item 7, Management's Discussion and Analysis of Financial Condition and Results of Operations - Liquidity and Capital Resources, included in our Annual Report on Form 10-K for the year ended December 31, 2023 filed with the Securities and Exchange Commission on February 1, 2024.

Material cash requirements from known contractual and other obligations

Total long-term debt obligations, net of debt discount, outstanding as of the end of each fiscal year were as follows:

	December 31,				
	2024	**2023**	**2022**	**2021**	**2020**
			(In thousands)		
Mortgage loans and promissory note	148,438	152,388	156,271	159,967	117,806
TOTAL	**$ 148,438**	**$ 152,388**	**$ 156,271**	**$ 159,967**	**$ 117,806**

Significant contractual obligations as of December 31, 2024 were as follows, including the future periods in which payments are expected:

	2025	**2026**	**2027**	**2028**	**2029**	**Thereafter**	**Total**
				(In thousands)			
Operating lease obligations	$ 204,909	$ 204,696	$ 204,002	$ 202,994	$ 199,144	$ 1,776,571	$ 2,792,316
Long-term debt obligations	4,086	4,227	3,897	3,779	3,896	128,553	148,438
Interest payments on long-term debt	4,487	4,346	4,207	4,091	3,974	50,463	71,568
TOTAL	**$ 213,482**	**$ 213,269**	**$ 212,106**	**$ 210,864**	**$ 207,014**	**$ 1,955,587**	**$ 3,012,322**

Not included in the table above are our actuarially determined self-insured general and professional malpractice liability, workers' compensation and medical (including prescription drugs) and dental healthcare obligations which are broken out between current and long-term liabilities in our financial statements included in this Annual Report on Form 10-K.

As part of the proceeding discussed in Item 3., *Legal Proceedings*, the parties agreed to settle the litigation for $48.0 million. The settlement funds were fully paid during the year ended December 31, 2024.

Credit Facility with a Lending Consortium Arranged by Truist

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

Mortgage Loans and Promissory Note

As of December 31, 2024, 23 of our subsidiaries had mortgage loans insured with HUD for an aggregate amount of $146.9 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates at a range of 3.1% to 4.2%, including fixed interest rates at a range of 2.4% to 3.3% per annum. In addition to the interest rate, we incur other fees for HUD placement, including but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0%, and is reduced by 3.0% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

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

Operating Leases

As of December 31, 2024, 231 of our facilities are under long-term lease arrangements, of which 99 of the operations are under nine triple-net Master Leases and one stand-alone lease with CareTrust. The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%. At our option, we can extend the Master Leases for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If we elect to renew the term of a Master Lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the Master Lease. Additionally, four of the 100 facilities leased from CareTrust include an option to purchase that we can exercise starting on December 1, 2024. Subsequent to December 31, 2024, we, through Standard Bearer, exercised the option to purchase the real estate of the four facilities from CareTrust for $44.6 million.

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

Ninety of our independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases from CareTrust, are operated under 14 separate master lease arrangements. Under these master leases, a default at a single facility could subject one or more of the other independent subsidiaries covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of our leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in our outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

Inflation

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

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

Item 7A. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

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

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

We have a Credit Facility with Truist of up to $600.0 million in aggregate principal. We have no outstanding borrowings under our Credit Facility as of December 31, 2024 and through the filing date of this report. In addition, we have outstanding indebtedness under mortgage loans insured with HUD and a promissory note payable to a third party of $148.4 million, all of which are at fixed interest rates.

Our cash and cash equivalents as of December 31, 2024 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of December 31, 2024, we held investments of approximately $203.5 million. We believe our investments that were in an unrealized loss position as of December 31, 2024 do not require an allowance for expected credit losses, nor has any event occurred subsequent to that date that would indicate so. Our market risk exposure is interest rate sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal, while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10.0% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of December 31, 2024 and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Item 8. FINANCIAL STATEMENTS AND SUPPLEMENTARY DATA

THE ENSIGN GROUP, INC.
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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Stockholders and the Board of Directors of
The Ensign Group, Inc.
San Juan Capistrano, California

Opinion on the Financial Statements

We have audited the accompanying consolidated balance sheets of The Ensign Group Inc. and subsidiaries (the "Company") as of December 31, 2024, and 2023, the related consolidated statements of income, stockholders' equity, and cash flows, for each of the three years in the period ended December 31, 2024, and the related notes (collectively referred to as the "financial statements"). In our opinion, the financial statements present fairly, in all material respects, the financial position of the Company as of December 31, 2024, and 2023, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2024, in conformity with accounting principles generally accepted in the United States of America.

We have also 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, 2024, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 5, 2025, expressed an unqualified opinion on the Company's internal control over financial reporting.

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 critical audit matters does not alter in any way our opinion on the financial statements, taken as a whole, and we are not, by communicating the critical audit matter below, providing a separate opinion on the critical audit matter or on the accounts or disclosures to which it relates.

Self-Insurance Liabilities (General and Professional Liability Claims) - Refer to Notes 2 and 18 to the financial statements

Critical Audit Matter Description

The Company's self-insurance liabilities for general and professional liability claims totaled $160.1 million at December 31, 2024. The Company develops information about the size of the ultimate claims based on historical experience, current industry information, and actuarial analysis.

The determination of reserves for general and professional liability claims is highly subjective. Given the significant judgments in estimating the general and professional liability claims, we have determined this to be a critical audit matter. This required a high degree of auditor judgment and an increased extent of effort when performing audit procedures to evaluate the reasonableness of management estimates of reserves for open claims as well as for claims that are incurred but not reported (IBNR).

How the Critical Audit Matter Was Addressed in the Audit

Our audit procedures related to management’s judgment regarding the estimation of the reserve for general and professional liability claims included the following, among others:

- We tested the effectiveness of controls over the reserve for general and professional liabilities, including those related to both the determination of reserves for open claims and estimation of the IBNR claims.
- We obtained an understanding of the factors considered and assumptions made by management and its external actuarial specialists in developing the estimate of the general and professional liability reserves, including the sources of data relevant to these factors and assumptions. We tested underlying claims data, including testing the completeness and accuracy of open cases.

- We involved our actuarial specialists to assist in our evaluation of the methodologies applied by management's specialist and to develop an independent range of expected reserves. We compared the recorded reserves to the estimated independent range.

- We performed a retrospective review in which we compared the prior-year recorded amounts for ultimate losses and current liabilities to the subsequent claim emergence.

/s/ *DELOITTE & TOUCHE LLP*

Costa Mesa, California
February 5, 2025

We have served as the Company's auditor since 1999.

THE ENSIGN GROUP, INC.

CONSOLIDATED BALANCE SHEETS

(In thousands, except par values)

	December 31, 2024	December 31, 2023
ASSETS		
Current assets:		
Cash and cash equivalents	$ 464,598	$ 509,626
Accounts receivable—less allowance for doubtful accounts of $8,435 and $9,348 at December 31, 2024 and 2023, respectively	569,897	485,039
Investments—current	62,255	17,229
Prepaid expenses and other current assets	60,882	35,036
Total current assets	**$ 1,157,632**	**$ 1,046,930**
Property and equipment, net	1,291,354	1,090,771
Right-of-use assets	1,861,071	1,756,430
Insurance subsidiary deposits and investments	141,246	92,687
Deferred tax assets	66,281	67,124
Restricted and other assets	46,499	40,205
Intangible assets, net	7,292	6,525
Goodwill	97,981	76,869
TOTAL ASSETS	**$ 4,669,356**	**$ 4,177,541**
LIABILITIES AND EQUITY		
Current liabilities:		
Accounts payable	$ 98,947	$ 92,811
Accrued wages and related liabilities	347,532	332,568
Lease liabilities—current	93,475	82,526
Accrued self-insurance liabilities—current	67,331	54,664
Other accrued liabilities	132,057	168,228
Current maturities of long-term debt	4,086	3,950
Total current liabilities	**$ 743,428**	**$ 734,747**
Long-term debt—less current maturities	141,585	145,497
Long-term lease liabilities—less current portion	1,735,325	1,639,326
Accrued self-insurance liabilities—less current portion	144,421	111,246
Other long-term liabilities	64,169	49,408
TOTAL LIABILITIES	**$ 2,828,928**	**$ 2,680,224**
Commitments and contingencies (Notes 14 and 19)		
EQUITY		
Ensign Group, Inc. stockholders' equity:		
Common stock: $0.001 par value; 150,000 shares authorized; 60,838 and 57,438 shares issued and shares outstanding at December 31, 2024, respectively, and 59,987 and 56,597 shares issued and shares outstanding at December 31, 2023, respectively	61	60
Additional paid-in capital	528,052	465,707
Retained earnings	1,426,762	1,142,653
Common stock in treasury, at cost, 3,400 and 3,390 shares at December 31, 2024 and 2023, respectively	(117,764)	(116,555)
Total Ensign Group, Inc. stockholders' equity	**$ 1,837,111**	**$ 1,491,865**
Non-controlling interest	3,317	5,452
Total equity	**$ 1,840,428**	**$ 1,497,317**
TOTAL LIABILITIES AND EQUITY	**$ 4,669,356**	**$ 4,177,541**

See accompanying notes to consolidated financial statements.

THE ENSIGN GROUP, INC.

CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2024	**2023**	**2022**
	(In thousands, except per share data)		
REVENUE			
Service revenue	$ 4,237,525	$ 3,708,071	$ 3,008,711
Rental revenue	22,960	21,284	16,757
TOTAL REVENUE	**$ 4,260,485**	**$ 3,729,355**	**$ 3,025,468**
Expense:			
Cost of services	3,376,884	2,941,238	2,354,434
Rent—cost of services	216,016	197,358	153,049
General and administrative expense	225,143	263,005	158,805
Depreciation and amortization	84,138	72,387	62,355
TOTAL EXPENSES	**$ 3,902,181**	**$ 3,473,988**	**$ 2,728,643**
Income from operations	358,304	255,367	296,825
Other income (expense):			
Interest expense	(8,286)	(8,087)	(8,931)
Interest income	28,749	19,216	5,035
Other income (expense)	7,327	6,266	(3,840)
OTHER INCOME (EXPENSE), NET	**$ 27,790**	**$ 17,395**	**$ (7,736)**
Income before provision for income taxes	386,094	272,762	289,089
Provision for income taxes	87,636	62,912	64,437
NET INCOME	**$ 298,458**	**$ 209,850**	**$ 224,652**
Less:			
Net income (loss) attributable to noncontrolling interests	485	451	(29)
NET INCOME ATTRIBUTABLE TO THE ENSIGN GROUP, INC.	**$ 297,973**	**$ 209,399**	**$ 224,681**
NET INCOME PER SHARE ATTRIBUTABLE TO THE ENSIGN GROUP INC.			
Basic	$ 5.26	$ 3.76	$ 4.09
Diluted	$ 5.12	$ 3.65	$ 3.95
WEIGHTED AVERAGE COMMON SHARES OUTSTANDING			
Basic	56,655	55,708	54,887
Diluted	58,240	57,323	56,871

See accompanying notes to consolidated financial statements.

THE ENSIGN GROUP, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(In thousands)	Common Stock Shares	Common Stock Amount	Additional Paid-In Capital	Retained Earnings	Treasury Stock Shares	Treasury Stock Amount	Non-Controlling Interest	Total
BALANCE - JANUARY 1, 2022	**55,190**	**$ 58**	**$ 369,760**	**$ 733,992**	**2,944**	**$ (83,042)**	**$ 946**	**$ 1,021,714**
Issuance of common stock to employees and directors resulting from the exercise of stock options	688	1	12,676	—	—	—	—	12,677
Issuance of restricted stock, net of forfeitures	207	—	5,241	—	—	—	—	5,241
Shares of common stock used to satisfy tax withholding obligations	(20)	—	—	—	20	(1,702)	—	(1,702)
Dividends declared ($0.2225 per share)	—	—	—	(12,334)	—	—	—	(12,334)
Employee stock award compensation	—	—	22,720	—	—	—	—	22,720
Repurchase of common stock (Note 20)	(404)	—	—	—	404	(29,882)	—	(29,882)
Acquisition of noncontrolling interest shares	—	—	(1,539)	—	—	—	835	(704)
Issuance of noncontrolling interests through subsidiary equity plan	—	—	6,693	—	—	—	—	6,693
Net loss attributable to noncontrolling interest	—	—	—	—	—	—	(29)	(29)
Noncontrolling interest attributable to subsidiary equity plan	—	—	9	—	—	—	(284)	(275)
Net income attributable to the Ensign Group, Inc.	—	—	—	224,681	—	—	—	224,681
BALANCE - DECEMBER 31, 2022	**55,661**	**$ 59**	**$ 415,560**	**$ 946,339**	**3,368**	**$ (114,626)**	**$ 1,468**	**$ 1,248,800**
Issuance of common stock to employees and directors resulting from the exercise of stock options	759	1	18,368	—	—	—	—	18,369
Issuance of restricted stock, net of forfeitures	199	—	5,068	—	—	—	—	5,068
Shares of common stock used to satisfy tax withholding obligations	(22)	—	—	—	22	(1,929)	—	(1,929)
Dividends declared ($0.2325 per share)	—	—	—	(13,085)	—	—	—	(13,085)
Employee stock award compensation	—	—	30,754	—	—	—	—	30,754
Acquisition of noncontrolling interest shares	—	—	(256)	—	—	—	—	(256)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	451	451
Noncontrolling interest attributable to subsidiary equity plan	—	—	(3,787)	—	—	—	3,533	(254)
Net income attributable to the Ensign Group, Inc.	—	—	—	209,399	—	—	—	209,399
BALANCE - DECEMBER 31, 2023	**56,597**	**$ 60**	**$ 465,707**	**$ 1,142,653**	**3,390**	**$ (116,555)**	**$ 5,452**	**$ 1,497,317**
Issuance of common stock to employees and directors resulting from the exercise of stock options	632	1	22,285	—	—	—	—	22,286
Issuance of restricted stock, net of forfeitures	219	—	6,165	—	—	—	—	6,165
Shares of common stock used to satisfy tax withholding obligations	(10)	—	—	—	10	(1,209)	—	(1,209)
Dividends declared ($0.2425 per share)	—	—	—	(13,864)	—	—	—	(13,864)
Employee stock award compensation	—	—	36,183	—	—	—	—	36,183
Acquisition of noncontrolling interest shares	—	—	(2,426)	—	—	—	(2,024)	(4,450)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	485	485
Noncontrolling interest attributable to subsidiary equity plan	—	—	138	—	—	—	(596)	(458)
Net income attributable to the Ensign Group, Inc.	—	—	—	297,973	—	—	—	297,973
BALANCE - DECEMBER 31, 2024	**57,438**	**$ 61**	**$ 528,052**	**$ 1,426,762**	**3,400**	**$ (117,764)**	**$ 3,317**	**$ 1,840,428**

See accompanying notes to consolidated financial statements.

THE ENSIGN GROUP, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS

(In thousands)	Year Ended December 31, 2024	2023	2022
Cash flows from operating activities:			
Net income	$ 298,458	$ 209,850	$ 224,652
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	84,138	72,387	62,355
Amortization of deferred financing fees	1,061	1,067	1,036
Non-cash leasing arrangement	808	870	493
Impairment of long-lived assets	1,849	—	—
Write-off of deferred financing fees	200	—	566
Deferred income taxes	635	(27,481)	(6,496)
Provision for doubtful accounts	1,739	3,408	2,390
Stock-based compensation	36,226	30,767	22,720
Cash received from insurance proceeds	199	1,396	1,282
Loss (gain) on sale of assets	486	(123)	(3,467)
Loss (gain) on insurance claims and asset disposals	833	(550)	(627)
Litigation	(4,289)	47,182	4,553
Change in operating assets and liabilities			
Accounts receivable	(84,397)	(79,818)	(82,426)
Prepaid income taxes	(9,227)	814	809
Prepaid expenses and other assets	(19,055)	6,993	(9,141)
Deferred employer portion of social security taxes (Note 3)	—	—	(24,155)
Cash surrender value of life insurance policy premiums	(14,833)	(16,072)	(7,614)
Deferred compensation liability	14,986	16,044	7,637
Operating lease obligations	287	(6,564)	345
Accounts payable	2,835	15,924	17,870
Accrued wages and related liabilities	19,992	47,967	38,982
Other accrued liabilities	(30,670)	23,828	3,010
Accrued self-insurance liabilities	44,014	28,827	17,785
Other long-term liabilities	911	(50)	(46)
NET CASH PROVIDED BY OPERATING ACTIVITIES	**$ 347,186**	**$ 376,666**	**$ 272,513**
Cash flows from investing activities:			
Purchase of property and equipment	(158,240)	(106,180)	(87,545)
Cash payments for acquisitions	(156,547)	(69,014)	(101,136)
Cash from insurance proceeds	3,334	2,029	1,339
Cash proceeds from the sale of assets	2,818	248	8,630
Purchases of investments	(105,149)	(29,603)	(21,975)
Maturities of investments	26,397	18,852	14,356
Other restricted assets	(2,665)	970	149
NET CASH USED IN INVESTING ACTIVITIES	**$ (390,052)**	**$ (182,698)**	**$ (186,182)**
Cash flows from financing activities:			
Proceeds from debt (Note 14)	400	150	411
Payments on debt	(4,350)	(4,033)	(4,106)
Issuance of common stock upon exercise of options	22,286	18,369	12,677
Repurchase of shares of common stock to satisfy tax withholding obligations	(1,209)	(1,929)	(1,702)
Repurchase of shares of common stock (Note 20)	—	—	(29,882)
Dividends paid	(13,671)	(12,890)	(12,168)
Proceeds from sale of subsidiary shares (Note 6)	—	—	6,693
Non-controlling interest distribution	(543)	(4)	(284)
Purchase of non-controlling interest	(4,450)	(256)	(704)
Payment of contingent consideration	(625)	—	—
Payments of deferred financing costs	—	(19)	(3,197)
NET CASH USED IN FINANCING ACTIVITIES	**$ (2,162)**	**$ (612)**	**$ (32,262)**
Net (decrease) increase in cash and cash equivalents	(45,028)	193,356	54,069
Cash and cash equivalents beginning of period	509,626	316,270	262,201
Cash and cash equivalents end of period	**$ 464,598**	**$ 509,626**	**$ 316,270**

(In thousands)	Year Ended December 31, 2024	2023	2022
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION			
Cash paid during the period for:			
Interest	$ 7,063	$ 7,025	$ 7,604
Income taxes	96,337	89,730	70,055
Lease liabilities	215,677	196,942	151,870
Non-cash financing and investing activity			
Accrued capital expenditures	$ 7,900	$ 4,600	$ 4,800
Accrued dividends declared	3,589	3,396	3,201
Right-of-use assets obtained in exchange for new and modified operating lease obligations	232,918	376,550	370,753

See accompanying notes to consolidated financial statements.

THE ENSIGN GROUP, INC.

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS

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

1. DESCRIPTION OF BUSINESS

The Company — The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. The Company's independent subsidiaries provide health care services across the post-acute care continuum and engage in the ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare-related properties and ancillary businesses. As of December 31, 2024, the Company's independent subsidiaries operated 327 facilities and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Tennessee, Texas, Utah, Washington and Wisconsin. The Company's independent subsidiaries have a collective capacity of approximately 33,500 operational skilled nursing beds and 3,100 senior living units. As of December 31, 2024, the Company's independent subsidiaries operated 231 facilities under long-term lease arrangements and had options to purchase 12 of those 231 facilities. The Company's real estate portfolio consists of 129 owned real estate properties, which includes 96 facilities operated and managed by the Company's independent subsidiaries, 33 operations leased to and operated by third-party operators and the Service Center (defined below) location. Of those 33 third-party operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

Certain of the Company’s wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide specific accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other independent subsidiaries. The Company also has a wholly-owned captive insurance subsidiary that provides some claims-made coverage to the Company’s independent subsidiaries for general and professional liabilities, as well as coverage for certain workers’ compensation insurance liabilities.

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

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

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Reclassifications — Certain amounts in the prior period statements of income and statements of cash flows have been reclassified to conform to the presentation of the current period financial statements. These reclassifications had no effect on the previously reported net income.

Estimates and Assumptions — The preparation of the Financial Statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Financial Statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company’s Financial Statements relate to revenue, acquired property and equipment, intangible assets and goodwill, right-of-use assets and lease liabilities, impairment of long-lived assets, as well as general and professional liabilities, workers' compensation and healthcare claims included in accrued self-insurance liabilities. Actual results could differ from those estimates.

Fair Value Considerations —The Company's financial instruments consist principally of cash and cash equivalents, debt security investments, accounts receivable, insurance subsidiary deposits, deferred compensation investment funds, equity investments, accounts payable and borrowings. The Company believes all of the financial instruments' recorded values approximate fair values because of their nature or respective short durations.

Fair value measurements are based on a three-tier hierarchy that prioritizes the inputs used to measure fair value. These tiers include: Level 1, defined as observable inputs such as quoted market prices in active markets; Level 2, defined as inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and Level 3, defined as unobservable inputs for which little or no market data exists, therefore requiring an entity to develop its own assumptions. See Note 5, *Fair Value Measurements* for additional information.

The Company's non-financial assets, which includes goodwill, intangible assets, property and equipment and right-of-use assets, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, the Company assesses its long-lived assets for impairment. When impairment has occurred, such long-lived assets are written down to fair value.

Service Revenue Recognition — The Company recognizes revenue in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606, *Revenue from Contracts with Customers* (ASC 606). The Company's service revenue is derived primarily from providing healthcare services to its patients. Revenue is recognized when services are provided to patients at the amount that reflects the consideration that the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care. The healthcare services provided pursuant to skilled patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct. Additionally, there may be ancillary services that are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

Revenue recognized from healthcare services are 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 on a per day basis, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration that is included in the transaction price may be constrained and is included in net revenue only to the extent 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, the Company adjusts these estimates, which would affect net revenue in the period such variances become known.

As the Company's contracts with its patients have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by FASB ASC Topic 340, *Other Assets and Deferred Costs*, and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

Rental Revenue Recognition — The Company's rental revenues are primarily generated by leasing healthcare-related properties through triple-net lease arrangements, under which the tenant is solely responsible for the costs related to the property. Revenue for operating leases is recognized on a straight-line basis over the lease term when collectability of all minimum lease payments is probable in accordance with FASB ASC Topic 842, *Leases* (ASC 842). The Company has elected the single component practical expedient, which allows a lessor, by class of underlying asset, not to allocate the total consideration to the lease and non-lease components based on their relative stand-alone selling prices where certain criteria are met.

Tenant reimbursements related to property taxes and insurance are neither considered lease nor non-lease components under ASC 842. Lessee payments for taxes and insurance paid directly to a third party, on behalf of the Company, are excluded from variable lease payments and rental revenue in the Company's consolidated statements of income. Otherwise, tenant reimbursements for taxes and insurance that are paid by the Company directly to a third party are classified as additional rental revenue and expense and recognized by the Company on a gross basis.

Accounts Receivable — Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration.

Cash and Cash Equivalents — Cash and cash equivalents consist of bank term deposits, money market funds and treasury bill related investments with original maturities of three months or less at time of purchase and therefore approximate fair value. The fair value of money market funds is determined based on “Level 1” inputs, which consist of unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets. The Company places its cash and short-term investments with high credit quality financial institutions.

Insurance Subsidiary Deposits and Other 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 short-term and long-term assets based on the timing of expected future payments of the Company's captive insurance liabilities. The majority of these deposits and investments are currently held in AA, A and BBB rated debt security investments and the remainder is held in a bank account with a high credit quality financial institution. Investments classified as held-to-maturity are financial instruments that the Company has the intent and ability to hold to maturity and are reported net of any related amortization and are not remeasured to fair value on a recurring basis.

The Company's non-qualified deferred compensation plan's (the DCP) contracts insuring the lives of certain employees who are eligible to participate in the DCP are held in a rabbi trust. Cash surrender value of the contracts is based on funds that shadow the investment allocations specified by participants in the deferred compensation plan.

When evaluating an investment for its current expected credit losses, the Company reviews factors such as historical experience with defaults, losses, credit ratings, term, market sector and macroeconomic trends, including current conditions and forecasts to the extent they are reasonable and supportable.

Property and Equipment — Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 59 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Leases — The Company leases skilled nursing facilities, senior living facilities and commercial office space. The Company determines if an arrangement is a lease and performs an evaluation to determine whether the lease should be classified as an operating or finance lease at the inception of the lease. As of December 31, 2024, the Company has three financing lease that are not material to the consolidated balance sheet. Rights and obligations of the operating leases are included as right-of-use assets and current and long-term lease liabilities on the Company's consolidated balance sheets. As the Company's leases do not provide an implicit rate, the Company uses its incremental borrowing rate based on the information available at lease commencement date in determining the present value of future lease payments. The Company utilizes a third-party credit specialist to assist in estimating the incremental borrowing rate.

The Company records rent expense for operating leases on a straight-line basis over the term of the lease. The lease term used for straight-line rent expense 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 assured at the inception of the lease. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements.

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 ten to 15 years. Exercise of the 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. The Company reassesses the renewal option using a "reasonably certain" threshold, which is understood to be a high threshold. For leases where the Company is reasonably certain to exercise its renewal option, the option periods are included within the lease term and, therefore, the measurement of the right-of-use asset and lease liability. The Company's leases generally contain annual escalation clauses that are either fixed or variable in nature, some of which are dependent upon published indices. The Company recognizes lease expense for leases with an initial term of 12 months or less on a straight-line basis over the lease term. These leases are not recorded on the consolidated balance sheets. Certain of the Company's lease agreements include rental payments that are adjusted periodically for inflation. The lease agreements do not contain any material residual value guarantees or material restrictive covenants.

The Company subleases skilled nursing facilities to third-party operators and considers the subleases to be separate contracts as the Company is not relieved of its primary obligation under its operating lease. The rental income from third-parties related to these subleases is presented on a gross basis from the rent expense associated with the Company's lease obligations and is not material to the consolidated statements of income.

Impairment of Long-Lived Assets — The Company reviews the carrying value of long-lived assets that are held and used in the Company's independent subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the independent subsidiaries to which the assets relate, utilizing management's best estimate, appropriate assumptions and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset.

Intangible Assets and Goodwill — Definite-lived intangible assets consist primarily of patient base, facility trade names and customer relationships. Patient base is amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date. Trade names at independent subsidiaries are amortized over 30 years and customer relationships are amortized over a period of up to 20 years.

The Company's indefinite-lived intangible assets consist of trade names and Medicare and Medicaid licenses. The Company tests 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.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. The Company tests goodwill during the fourth quarter of each year or more often if events or circumstances indicate there may be impairment. The Company performs its analysis for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment, in accordance with the provisions of FASB ASC Topic 350, *Intangibles—Goodwill and Other* (ASC 350). This guidance provides the option to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value. If, based on a review of qualitative factors, it is more likely than not that the fair value of a reporting unit is less than its carrying value, the Company performs a goodwill impairment test by comparing the carrying value of each reporting unit to its respective fair value. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. The fair value of the reporting unit is the implied fair value of goodwill. In the event a reporting unit's carrying value exceeds its fair value, an impairment loss will be recognized. An impairment loss is measured by the difference between the carrying value of the reporting unit and its fair value. The Company anticipates that the majority of goodwill recognized will be fully deductible for tax purposes as of December 31, 2024.

Self-Insurance — 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 $1,500 for the Company's independent subsidiaries in California. For the independent subsidiaries not in California, the self-insured claim is $650 per claim, subject to an additional one-time, deductible of $1,400. For all independent subsidiaries, except those located in Colorado, the third-party coverage above these limits is $1,000 per claim, $3,000 per operation, with a $10,000 aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits is $1,000 per claim and $3,000 per operation, which is independent of the aforementioned aggregate limits that apply outside of Colorado. Subsequent to December 31, 2024, the combined self-insured retention is $1,000 per claim ($750 if an enforceable arbitration agreement applies), subject to an additional one-time deductible of $2,950 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 $4,500.

The majority of the self-insured retention and deductible limits for general and professional liabilities and workers' compensation liabilities are self-insured through the captive insurance subsidiary, the related assets and liabilities of which are included in the accompanying 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.

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

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

The Company believes that adequate provision has been made in the Financial Statements for liabilities that may arise out of patient care, workers' compensation, healthcare benefits 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. Using data obtained from this monitoring and the Company's assumptions about emerging trends, the Company, with the assistance of an independent actuary, develops information about the size of ultimate claims based on the Company's historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay 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.

Income Taxes — Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The Company generally expects to fully utilize its deferred tax assets; 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.

In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

Standard Bearer was organized, has operated and intends to continue to operate in a manner to qualify for taxation as a REIT. In order to qualify as a REIT, Standard Bearer must meet certain organizational and operational requirements, including a requirement to distribute to its shareholders, which in this case is the Company, at least 90% of its annual taxable income. As a REIT, Standard Bearer generally will not be subject to federal income tax to the extent it distributes as qualifying dividends, all of its REIT taxable income to its shareholders. If Standard Bearer fails to qualify as a REIT in any taxable year, it will be subject to federal income tax on its taxable income at regular corporate income tax rates and generally will not be permitted to qualify for treatment as a REIT for federal income tax purposes for the four taxable years following the year during which qualification is lost unless the Internal Revenue Service grants the Company relief under certain statutory provisions.

Noncontrolling Interest — The noncontrolling interest in a subsidiary is initially recognized at estimated fair value on the acquisition date and is presented within total equity in the Company's consolidated balance sheets. The Company presents the noncontrolling interest and the amount of consolidated net income attributable to The Ensign Group, Inc. in its consolidated statements of income. Net income per share is calculated based on net income attributable to The Ensign Group, Inc.'s stockholders. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

Stock-Based Compensation — The Company measures and recognizes compensation expense for all stock-based payment awards made to employees and directors including employee stock options and restricted stock awards based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the fair value of all stock options and restricted stock awards issued, the amount of which is based upon the number of grants and other variables. As stock-based compensation expense recognized in the Company's consolidated statements of income was based on awards expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

Comprehensive Income — The Company does not have any components of other comprehensive income recorded within its Financial Statements and, therefore, does not separately present a statement of comprehensive income in its Financial Statements.

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

Recent Accounting Standards Adopted by the Company — In November 2023, the FASB issued Accounting Standards Update (ASU) 2023-07 "*Segment Reporting (Topic 280): Improvements to Reportable Segment Disclosures,*" which requires the Company to expand the breadth and frequency of segment disclosures to include additional information about significant segment expenses, the chief operating decision maker (CODM) and other items, and also require the annual disclosures on an interim basis. This guidance was effective for annual periods beginning with the Company's fiscal year 2024, and in interim periods within the Company's fiscal year 2025. The Company adopted the requirements of this ASU in Note 8, *Business Segments* of this Annual Report.

Recently Issued Accounting Pronouncements Not Yet Adopted — In October 2023, the FASB issued ASU 2023-06 *"Codification Amendments in Response to the SEC's Disclosure Update and Simplification Initiative,"* which amends U.S. GAAP to include 14 disclosure requirements that are currently required under SEC Regulation S-X or Regulation S-K. Each amendment will be effective on the date on which the SEC removes the related disclosure requirement from SEC Regulation S-X or Regulation S-K. The adoption is not expected to have a material impact on the Company's Financial Statements as these requirements were previously incorporated under the SEC Regulations.

In December 2023, the FASB issued ASU 2023-09 "*Income Taxes (Topic 740): Improvements to Income Tax Disclosures,*" which requires the Company to disclose disaggregated jurisdictional and categorical information for the tax rate reconciliation, income taxes paid and other income tax related amounts. ASU 2023-09 is effective for annual periods beginning with the Company's fiscal year 2025, with early adoption permitted. The Company is currently evaluating the impact of this ASU on its Notes to the Consolidated Financial Statements.

In November 2024, the FASB issued ASU 2024-03 "*Disaggregation of Income Statement Expenses,*" which requires the Company to disaggregate key expense categories such as employee compensation, depreciation and intangible asset amortization within its financial statements. ASU 2024-03 is effective for annuals periods beginning with the Company's fiscal year 2027, and interim periods within the Company's fiscal year 2028, with early adoption permitted. The Company is currently evaluating the impact of this ASU on its Notes to the Consolidated Financial Statements.

3. REVENUE AND ACCOUNTS RECEIVABLE

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

Disaggregation of Revenue

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

Revenue by Payor

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

Revenue from the Medicare and Medicaid programs accounted for 70.9%, 72.6% and 73.7% for the years ended December 31, 2024, 2023 and 2022, respectively. Settlements with Medicare and Medicaid payors for retroactive adjustments due to audits and reviews are considered variable consideration and are included in the determination of the estimated transaction price. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company's historical settlement activity. Consistent with healthcare industry practices, any changes to these revenue estimates are recorded in the period the change or adjustment becomes known based on the final settlement. The Company recorded adjustments to revenue which were not material to the Company's revenue for the years ended December 31, 2024, 2023 and 2022.

Service revenue for the years ended December 31, 2024, 2023 and 2022 is summarized in the following tables:

	Year Ended December 31,					
	2024		2023		2022	
	Revenue	% of Revenue	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid[1][2]	$ 1,682,344	39.7 %	$ 1,459,449	39.4 %	$ 1,183,156	39.3 %
Medicare	1,055,226	24.9	985,749	26.6	832,160	27.7
Medicaid — skilled	266,738	6.3	245,663	6.6	200,878	6.7
Total Medicaid and Medicare	**$ 3,004,308**	**70.9 %**	**$ 2,690,861**	**72.6 %**	**$ 2,216,194**	**73.7 %**
Managed care	789,643	18.6	666,129	18.0	525,710	17.5
Private and other[3]	443,574	10.5	351,081	9.4	266,807	8.8
SERVICE REVENUE	**$ 4,237,525**	**100.0 %**	**$ 3,708,071**	**100.0 %**	**$ 3,008,711**	**100.0 %**

(1) Medicaid payor includes revenue for senior living operations.
(2) Medicaid payor includes revenue related to state relief funding during the year ended December 31, 2023 and 2022.
(3) Private and other also includes revenue from senior living operations and all revenue generated in other ancillary services.

In addition to the service revenue above, the Company's rental revenue derived from triple-net lease arrangements with third parties is $22,960, $21,284 and $16,757 for the years ended December 31, 2024, 2023 and 2022.

State relief funding

The Company received state relief funding through Medicaid programs from various states, including healthcare relief funding under the American Rescue Plan Act (ARPA), increases in the Federal Medical Assistance Percentage (FMAP) under the Families First Coronavirus Response Act (FFCRA) and other state specific relief programs. The funding generally incorporates specific use requirements primarily for direct patient care including labor related expenses that are attributable to the COVID-19 pandemic or are associated with providing patient care.

Due to the expiration of the COVID-19 Public Health Emergency in May 2023, the Company did not receive additional funding during the year ended December 31, 2024.

Revenues from these additional payments are recognized in accordance with ASC 606, subject to variable consideration constraints. In certain operations where the Company received additional payments that exceeded expenses incurred related to specific qualifiers, the Company recorded deferred revenue for the excess amount until additional expenses are incurred for recognition. Accordingly, the amount of state relief revenue recognized is limited to the actual related expenses incurred. As of years ended December 31, 2023 and 2022, the Company had $486 and $1,001 in unapplied state relief funds, respectively. During the years ended December 31, 2023 and 2022, the Company received an additional $64,238, and $81,057 in state relief funding and recognized $64,753, and $81,837, respectively, as revenue.

Federal relief funding

As part of the Coronavirus Aid, Relief, and Economic Security Act of 2020 (CARES Act), the Company deferred payment of the employer portion of social security taxes related to 2020. For the year ended December 31, 2022, the Company paid $24,155, which was the second and final payment associated with the deferred amount from 2020.

Balance Sheet Impact

Included in the Company's consolidated balance sheets are contract balances, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no material contract liabilities and contract assets as of December 31, 2024 and 2023, or activity during the years ended December 31, 2024, 2023 and 2022.

Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration and doubtful accounts. Accounts receivable as of December 31, 2024 and 2023, is summarized in the following table:

	December 31,	
	2024	**2023**
Medicaid	$ 228,872	$ 178,285
Managed care	139,711	125,907
Medicare	77,056	85,512
Private and other payors	132,693	104,683
	$ 578,332	**$ 494,387**
Less: allowance for doubtful accounts	(8,435)	(9,348)
ACCOUNTS RECEIVABLE, NET	**$ 569,897**	**$ 485,039**

4. COMPUTATION OF NET INCOME PER COMMON SHARE

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

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

	Year Ended December 31,		
	2024	2023	2022
NUMERATOR:			
Net income	$ 298,458	$ 209,850	$ 224,652
Less: net income (loss) attributable to noncontrolling interests	485	451	(29)
Net income attributable to The Ensign Group, Inc.	**$ 297,973**	**$ 209,399**	**$ 224,681**
DENOMINATOR:			
Weighted average shares outstanding for basic net income per share	56,655	55,708	54,887
Basic net income per common share:	**$ 5.26**	**$ 3.76**	**$ 4.09**

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

	Year Ended December 31,		
	2024	2023	2022
NUMERATOR:			
Net income	$ 298,458	$ 209,850	$ 224,652
Less: net income (loss) attributable to noncontrolling interests	485	451	(29)
Net income attributable to The Ensign Group, Inc.	**$ 297,973**	**$ 209,399**	**$ 224,681**
DENOMINATOR:			
Weighted average common shares outstanding	56,655	55,708	54,887
Plus: incremental shares from assumed conversion [(1)]	1,585	1,615	1,984
Adjusted weighted average common shares outstanding	**58,240**	**57,323**	**56,871**
Diluted net income per common share:	**$ 5.12**	**$ 3.65**	**$ 3.95**

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 914, 1,429 and 780 for the years ended December 31, 2024, 2023 and 2022, respectively.

5. FAIR VALUE MEASUREMENTS

The Company's financial assets include held-to-maturity investments carried at amortized cost basis of $138,600 and $59,530, of which $65,831 and $59,530 are designated to support long-term insurance subsidiary liabilities, both as of December 31, 2024 and 2023, respectively. As of December 31, 2024 and 2023, the amortized cost basis of these financial assets are considered to approximate fair value and are derived using Level 2 inputs. The Company believes its amortized cost basis investments that were in an unrealized loss position as of December 31, 2024 and 2023 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

The Company's financial assets also include the contracts insuring the lives of certain employees who are eligible to participate in non-qualified deferred compensation plans that are held in a rabbi trust. The cash surrender value of these contracts is based on funds that shadow the investment allocations specified by participants in the deferred compensation plan and are held at fair value. As of December 31, 2024 and 2023, the fair value of the investment funds was $56,049 and $41,216, respectively, which are derived using Level 2 inputs.

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

6. STANDARD BEARER

Standard Bearer's real estate portfolio consists of 124 of the Company's 129 owned real estate properties, of which 92 are operated and managed by the Company's independent subsidiaries and 33 are leased to and operated by third-party operators. Of those 33 operations, one senior living operation is located on the same real estate property as a skilled nursing operation that an independent subsidiary operates.

During the year ended December 31, 2024, Standard Bearer added $131,927 of real estate assets associated with 11 stand-alone skilled nursing operations, three stand-alone senior living operations and three campus operations. These new additions for the stand-alone skilled nursing and campus operations are operated by 14 of the Company's independent subsidiaries and the three stand-alone senior living operations are leased to a third-party operator. Refer to Note 7, *Operation Expansions*, for additional information.

Subsequent to December 31, 2024, Standard Bearer added $50,853 of real estate assets associated with four stand-alone skilled nursing operations and one campus operation. Four of the acquisitions were related to exercising purchase options under an existing lease arrangement from CareTrust REIT, Inc. (CareTrust). These locations are currently operated by the Company's independent subsidiaries. The remaining one real estate acquisition was leased back to the Company's independent subsidiaries. Refer to Note 7, *Operation Expansions*, for additional information.

During the year ended December 31, 2023, Standard Bearer added $65,899 of real estate assets associated with three stand-alone skilled nursing facilities and two campus operations. Of these additions, the three skilled nursing facilities and one campus operation acquired are operated by the Company's independent subsidiaries and the other campus operation is leased to a third-party operator.

During the year ended December 31, 2022, Standard Bearer added $84,656 of real estate assets associated with ten skilled nursing facilities, three of which were previously operated and managed by the Company's independent subsidiaries. Refer to Note 7, *Operation Expansions*, for additional information.

As part of the formation of Standard Bearer, certain of the Company's independent subsidiaries, Standard Bearer and Standard Bearer's independent real estate subsidiaries entered into several agreements that include leasing, management services and debt arrangements between the operations. All intercompany transactions have been eliminated in consolidation. Refer to Note 8, *Business Segments*, for additional information related to these intercompany eliminations as well as Standard Bearer as a reportable segment.

Intercompany master lease agreements

Certain of the Company's independent subsidiaries and 92 Standard Bearer independent real estate subsidiaries have entered into six triple-net master lease agreements (collectively, the Standard Bearer Master Leases). The lease periods range from 15 to 19 years with three five-year renewal options beyond the initial term, on the same terms and conditions. The rent structure under the Standard Bearer Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the independent subsidiaries are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties; (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Intercompany rental revenue generated from Ensign affiliated operations was $78,110, $66,712, and $57,967 for the years ended December 31, 2024, 2023 and 2022, respectively, which has been eliminated in consolidation.

Intercompany management agreement

Standard Bearer has no employees. The Service Center provides personnel and services to Standard Bearer pursuant to the management agreement between Standard Bearer and the Service Center. The management agreement provides for a base management fee that is equal to 5.0% of total rental revenue and an incentive management fee that is equal to 5.0% of funds from operations (FFO) and is capped at 1.0% of total rental revenue, for a total of 6.0%. Management fee generated between Standard Bearer and the Service Center for the years ended December 31, 2024, 2023 and 2022 was $5,707, $4,948 and $4,367, respectively, which has been eliminated in consolidation.

Intercompany debt arrangements

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

In addition, as the Department of Housing and Urban Development (HUD) mortgage loans and promissory note are entered into by real estate subsidiaries of Standard Bearer, the interest expense incurred from these debts are included in Standard Bearer's segment income. Refer to Note 14, *Debt*, for additional information related to these debts.

Equity Instrument Denominated in the Shares of a Subsidiary

As part of the formation of Standard Bearer in 2022, the Company established the Standard Bearer Healthcare REIT, Inc. 2022 Omnibus Incentive Plan (Standard Bearer Equity Plan). The Company may grant stock options and restricted stock awards under the Standard Bearer Equity Plan to employees and management of Ensign's independent subsidiaries. These awards generally vest over a period of five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of Standard Bearer, which is determined based on an independent valuation of Standard Bearer. The Company can also call the awards, generally upon employee termination. The Company granted 39 restricted stock awards during the year ended December 31, 2024. During the years ended December 31, 2023 and 2022, the Company did not grant any stock options or restricted shares under the Standard Bearer Equity Plan. During the years ended December 31, 2024, 2023 and 2022, there were no restricted stock awards vested for the periods.

The grant-date fair value of the awards is recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interests. The grant value was determined based on an independent valuation of the subsidiary shares. For the year ended December 31, 2024, the Standard Bearer Equity Plan's share-based compensation expense was not material. There was no expense during the years ended December 31, 2023 and 2022.

During the year ended December 31, 2022, Standard Bearer sold fully vested common shares from the Standard Bearer Equity Plan to shareholders for cash of $6,544. Also, during the year ended December 31, 2022, Standard Bearer established shareholders of its preferred shares through contributions of cash of $149. These preferred shares were fully vested at the time of the contributions by the shareholders. The value of Standard Bearer common and preferred shares held by the Company are eliminated in consolidation and the value held by other shareholders are classified as noncontrolling interests on the Company's consolidated balance sheets.

7. OPERATION EXPANSIONS

The expansion focus of the Company's independent subsidiaries is to purchase or lease operations that are complementary to the current operations, accretive to the business, or otherwise advance the Company's strategy. The results of all independent subsidiaries are included in the Financial Statements subsequent to the date of acquisition. Acquisitions are accounted for using the acquisition method of accounting. In connection with the new operations obtained through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company also entered into a separate operations transfer agreement with each prior operator as part of each transaction. The Company's independent subsidiaries also enter into long-term leases that may include options to purchase the facilities. As a result, from time to time, an independent real estate subsidiary may acquire the property of facilities that have previously been operated under third-party leases.

2024 Expansions

During the year ended December 31, 2024, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of 28 stand-alone skilled nursing operations, including a long-term acute care hospital and three campus operations. Of these additions, Standard Bearer acquired the real estate of 14 of these operations, all of which were leased back to the Company's independent subsidiaries. Refer to Note 6, *Standard Bearer,* for additional information on the purchase of real estate properties. These new operations added a total of 3,030 operational skilled nursing beds, including 43 long-term acute care beds and 218 operational senior living units to be operated by the Company's independent subsidiaries. The Company also invested in new ancillary services that are complementary to its existing businesses.

Subsequent to December 31, 2024, the Company expanded its operations with the addition of seven stand-alone skilled nursing operations. Of these additions, Standard Bearer acquired the real estate of one of these operations, which was leased back to the Company's independent subsidiary. Refer to Note 6, *Standard Bearer,* for additional information on the purchase of the real estate property. The new operations added 682 operational skilled nursing beds to be operated by the Company's independent subsidiaries.

2023 Expansions

During the year ended December 31, 2023, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of 25 stand-alone skilled nursing operations and one campus operation. Of these additions, Standard Bearer acquired the real estate of three of the stand-alone skilled nursing operations and one campus operation, which were leased back to the Company's independent subsidiaries. Refer to Note 6, *Standard Bearer,* for additional information on the purchase of real estate properties. These new operations added a total of 2,483 operational skilled nursing beds and 94 operational senior living units to be operated by the Company's independent subsidiaries.

2022 Expansions

During the year ended December 31, 2022, the Company expanded its operations and real estate portfolio through a combination of long-term leases and real estate purchases, with the addition of 23 stand-alone skilled nursing operations and one campus operation. Of these additions, Standard Bearer acquired the real estate of seven of the stand-alone skilled nursing operations, which were leased back to Ensign's independent subsidiaries. Refer to Note 6, *Standard Bearer*, for additional information on the purchases of real estate properties. In addition, the Company added five senior living operations that were transferred from The Pennant Group, Inc. (Pennant), three of which are part of campuses operated by the Company's independent subsidiaries. These new operations added a total of 3,058 operational skilled nursing beds and 674 operational senior living units to be operated by the Company's independent subsidiaries. The Company also invested in new ancillary services that are complementary to its existing businesses.

The table below presents the allocation of the purchase price for the operations acquired during the years ended December 31, 2024, 2023 and 2022:

	Year Ended December 31,		
	2024	**2023**	**2022**
Land	$ 20,547	$ 7,794	$ 15,527
Building and improvements	108,709	57,488	65,070
Equipment, furniture, and fixtures	2,937	1,840	1,618
Assembled occupancy	1,210	346	367
Goodwill	21,112	—	16,400
Leased asset	—	—	1,909
Other indefinite-lived intangible assets	364	330	245
TOTAL ACQUISITIONS	**$ 154,879**	**$ 67,798**	**$ 101,136**

The Company’s acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return. The operations added by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not a meaningful representation of the Company’s current operating results or indicative of the integration potential of its newly acquired independent subsidiaries. The operations added during the year ended December 31, 2024 were not material to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These additions have been included in the consolidated balance sheets of the Company, and the operating results have been included in the consolidated statements of income of the Company since the date the Company gained effective control.

8. BUSINESS SEGMENTS

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

As of December 31, 2024, the skilled services segment includes 286 skilled nursing and 30 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. The Company's Standard Bearer segment consists of 124 owned real estate properties.

The Company also reports an “All Other” category that includes results from its senior living operations, which includes 11 stand-alone senior living operations and the senior living operations at 30 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. In addition, the "All Other" category includes mobile diagnostics, medical transportation, other real estate, other ancillary operations and the Service Center. Services included in the “All Other” category are insignificant individually, and therefore do not constitute a reportable segment.

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

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

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

The following tables set forth financial information for the segments:

	Year Ended December 31, 2024		
	Skilled Services	**Standard Bearer**	**Total**
Service revenue[1]	$ 4,076,825	$ —	$ 4,076,825
Rental revenue	—	95,086	95,086
Segment revenue	**$ 4,076,825**	**$ 95,086**	**$ 4,171,911**
Reconciliation of revenue:			
All other revenue[2]			192,881
Elimination of intercompany revenue[3]			(104,307)
TOTAL CONSOLIDATED REVENUE			**$ 4,260,485**
Less:			
Other segment items[4]	3,513,167	9,152	
Depreciation and amortization	45,195	29,297	
Interest expense[5]	—	27,302	
Segment income	**$ 518,463**	**$ 29,335**	**$ 547,798**
Reconciliation of profit or loss:			
All other loss			(161,704)
INCOME BEFORE PROVISION FOR INCOME TAXES			**$ 386,094**

(1) Skilled services service revenue does not include intercompany service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in "Elimination of intercompany revenue".
(2) All other revenue includes $181,066 of service revenue and $11,815 of rental revenue for the year ended December 31, 2024, both of which include intercompany revenue that is eliminated in "Elimination of intercompany revenue".
(3) Elimination of intercompany revenue includes the elimination of intercompany rental revenue of $83,941 and intercompany service revenue of $20,366 for the year ended December 31, 2024.

(4) Other segment items includes cost of services and rent expense for the skilled services segment and cost of services, rent expense and general and administrative expenses for the Standard Bearer segment. Additionally, there are intercompany expenses of $104,307 during the year ended December 31, 2024, which are eliminated in consolidation.
(5) Included in interest expense in Standard Bearer is interest from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. of $20,285 during the year ended December 31, 2024, which is eliminated in consolidation.

	Year Ended December 31, 2023		
	Skilled Services	**Standard Bearer**	**Total**
Service revenue[1]	$ 3,578,855	$ —	$ 3,578,855
Rental revenue	—	82,486	82,486
Segment revenue	**$ 3,578,855**	**$ 82,486**	**$ 3,661,341**
Reconciliation of revenue:			
All other revenue[2]			155,804
Elimination of intercompany revenue[3]			(87,790)
TOTAL CONSOLIDATED REVENUE			**$ 3,729,355**
Less:			
Other segment items[4]	3,075,164	8,455	
Depreciation and amortization	38,766	25,205	
Interest expense[5]	—	19,761	
Segment income	**$ 464,925**	**$ 29,065**	**$ 493,990**
Reconciliation of profit or loss:			
All other loss			(221,228)
INCOME BEFORE PROVISION FOR INCOME TAXES			**$ 272,762**

(1) Skilled services service revenue does not include intercompany service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in "Elimination of intercompany revenue".
(2) All Other revenue includes $144,667 of service revenue and $11,137 of rental revenue for the year ended December 31, 2023, both of which include intercompany revenue that is eliminated in "Elimination of intercompany revenue".
(3) Elimination of intercompany revenue includes the elimination intercompany rental revenue of $72,339 and intercompany service revenue of $15,451 for the year ended December 31, 2023.
(4) Other segment items includes cost of services and rent expense for the skilled services segment and cost of services, rent expense and general and administrative expenses for the Standard Bearer segment. Additionally, there are intercompany expenses of $87,790 during the year ended December 31, 2023, which is eliminated in consolidation.
(5) Included in interest expense in Standard Bearer is interest from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. of $12,902 during the year ended December 31, 2023, which is eliminated in consolidation.

	Year Ended December 31, 2022		
	Skilled Services	Standard Bearer	Total
Service revenue[1]	$ 2,906,215	$ —	$ 2,906,215
Rental revenue	—	72,937	72,937
Segment revenue	**$ 2,906,215**	**$ 72,937**	**$ 2,979,152**
Reconciliation of revenue:			
All other revenue[2]			122,610
Elimination of intercompany revenue[3]			(76,294)
TOTAL CONSOLIDATED REVENUE			**$ 3,025,468**
Less:			
Other segment items[4]	2,464,259	7,746	
Depreciation and amortization	33,224	21,613	
Interest expense[5]	—	15,707	
Segment income	**$ 408,732**	**$ 27,871**	**$ 436,603**
Reconciliation of profit or loss:			
All other loss			(147,514)
INCOME BEFORE PROVISION FOR INCOME TAXES			**$ 289,089**

(1) Skilled services service revenue does not include intercompany service revenue generated by ancillary operations provided to the Company's independent subsidiaries and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in "Elimination of intercompany revenue".
(2) All Other revenue includes $115,214 of service revenue and $7,396 of rental revenue for the year ended December 31, 2022, both of which include intercompany revenue that is eliminated in "Elimination of intercompany revenue".
(3) Elimination of intercompany revenue includes the elimination of intercompany rental revenue of $63,576 and intercompany service revenue of $12,718 for the year ended December 31, 2022.
(4) Other segment items includes cost of services and rent expense for the skilled services segment and cost of services, rent expense and general and administrative expenses for the Standard Bearer segment. Additionally, there are intercompany expenses of $76,294 during the year ended December 31, 2022, which is eliminated in consolidation.
(5) Included in interest expense in Standard Bearer is interest from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. of $8,646 during the year ended December 31, 2022, which is eliminated in consolidation.

Service revenue by major payor source were as follows:

	Year Ended December 31, 2024			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 1,646,422	$ 35,922	$ 1,682,344	39.7 %
Medicare	1,055,226	—	1,055,226	24.9
Medicaid-skilled	266,738	—	266,738	6.3
Subtotal	**$ 2,968,386**	**$ 35,922**	**$ 3,004,308**	**70.9 %**
Managed care	789,643	—	789,643	18.6
Private and other[2]	318,796	124,778	443,574	10.5
TOTAL SERVICE REVENUE	**$ 4,076,825**	**$ 160,700**	**$ 4,237,525**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations.
(2) Private and other payors also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

	Year Ended December 31, 2023			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 1,429,473	$ 29,976	$ 1,459,449	39.4 %
Medicare	985,749	—	985,749	26.6
Medicaid-skilled	245,663	—	245,663	6.6
Subtotal	**$ 2,660,885**	**$ 29,976**	**$ 2,690,861**	**72.6 %**
Managed care	666,129	—	666,129	18.0
Private and other[2]	251,841	99,240	351,081	9.4
TOTAL SERVICE REVENUE	**$ 3,578,855**	**$ 129,216**	**$ 3,708,071**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.
(2) Private and other payors also includes revenue from senior living operations and all revenue generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

	Year Ended December 31, 2022			
	Skilled Services	All Other [3]	Total Service Revenue	Revenue %
Medicaid[1]	$ 1,158,309	$ 24,847	$ 1,183,156	39.3 %
Medicare	832,160	—	832,160	27.7
Medicaid-skilled	200,878	—	200,878	6.7
Subtotal	**2,191,347**	**24,847**	**2,216,194**	**73.7**
Managed care	525,710	—	525,710	17.5
Private and other[2]	189,158	77,649	266,807	8.8
TOTAL SERVICE REVENUE	**$ 2,906,215**	**$ 102,496**	**$ 3,008,711**	**100.0 %**

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to state relief funding.
(2) Private and other payors also includes revenue from senior living operations and all payors generated in other ancillary services.
(3) All Other incorporates intercompany eliminations.

9. PROPERTY AND EQUIPMENT - NET

Property and equipment, net consists of the following:

	December 31,	
	2024	2023
Land	$ 162,873	$ 142,656
Buildings and improvements	933,790	803,155
Leasehold improvements	212,603	172,064
Equipment	396,018	339,383
Furniture and fixtures	4,349	4,192
Construction in progress	41,209	25,563
	$ 1,750,842	**$ 1,487,013**
Less: accumulated depreciation	(459,488)	(396,242)
PROPERTY AND EQUIPMENT, NET	**$ 1,291,354**	**$ 1,090,771**

The Company completed the sale of assets for a sale price of $8,607 and recorded a gain of $3,467 within the Company's consolidated statement of income as cost of services during the year ended December 31, 2022. The Company recorded gain and losses related to sale of assets, which were not material during the years ended December 31, 2024 and 2023. Management evaluated its long-lived assets and recorded an impairment charge of $1,849 within the Company's consolidated statement of income as cost of services during the year ended December 31, 2024. The Company determined there was no impairment during the year ended December 31, 2023 and 2022.

10. INTANGIBLE ASSETS - NET

		December 31,						
		2024			2023			
Intangible Assets	Weighted Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Assembled occupancy	0.4	$ 1,991	$ (1,316)	$ 675	$ 781	$ (742)	$ 39
Facility trade name	30.0	733	(462)	271	733	(439)	294
Customer relationships	18.4	4,582	(2,902)	1,680	4,582	(2,692)	1,890
TOTAL		**$ 7,306**	**$ (4,680)**	**$ 2,626**	**$ 6,096**	**$ (3,873)**	**$ 2,223**

During the years ended December 31, 2024, 2023 and 2022, amortization expense was $2,019, $1,790 and $1,714, respectively, of which $1,212, $1,202, and $1,160 was related to the amortization of right-of-use assets, respectively. The Company did not record any impairment charge to intangible assets during the years ended December 31, 2024, 2023 and 2022.

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

Year	Amount
2025	911
2026	234
2027	234
2028	234
2029	234
Thereafter	779
	$ 2,626

Other indefinite-lived intangible assets consist of the following:

	December 31,	
	2024	2023
Trade name	$ 889	$ 889
Medicare and Medicaid licenses	3,777	3,413
TOTAL	**$ 4,666**	**$ 4,302**

During the year ended December 31, 2024, the Company acquired $364 in Medicare and Medicaid licenses compared to $330 and $245 in the fiscal years 2023 and 2022, respectively.

11. GOODWILL

Provided that goodwill corresponds to the acquisition of a business and not merely the acquisition of real estate property, the Company's Standard Bearer segment appropriately does not carry a goodwill balance. The following table represents activity in goodwill by skilled service segment and "all other" category as of December 31, 2024, 2023 and 2022:

	Goodwill		
	Skilled Services	All Other	Total
January 1, 2022	**$ 51,486**	**$ 8,983**	**$ 60,469**
Additions	16,400	—	16,400
December 31, 2022	**$ 67,886**	**$ 8,983**	**$ 76,869**
December 31, 2023	**$ 67,886**	**$ 8,983**	**$ 76,869**
Additions	20,740	372	21,112
December 31, 2024	**$ 88,626**	**$ 9,355**	**$ 97,981**

Management has evaluated its goodwill and intangible assets and determined there was no impairment during the years ended December 31, 2024, 2023 and 2022. The Company has recognized cumulative goodwill impairment losses of $7,410, since inception in 1999.

12. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	December 31,	
	2024	2023
Quality assurance fee	$ 12,667	$ 14,035
Refunds payable	56,755	51,248
Resident advances	18,818	10,834
Cash held in trust for patients	6,370	6,215
Dividends payable	3,589	3,396
Property taxes	15,400	12,875
Accrued litigation (Note 19)	—	51,734
Other	18,458	17,891
OTHER ACCRUED LIABILITIES	**$ 132,057**	**$ 168,228**

Quality assurance fee represents the aggregate of amounts payable to Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Tennessee, Utah, Washington and Wisconsin as a result of a mandated fee based on patient days or licensed beds. Refunds payable includes payables related to overpayments, duplicate payments and credit balances from various payor sources. Resident advances occur when the Company receives payments in advance of services provided. Cash held in trust for patients reflects monies received from or on behalf of patients. Maintaining a trust account for patients is a regulatory requirement and, while the trust assets offset the liabilities, the Company assumes a fiduciary responsibility for these funds. The cash balance related to this liability is included in other current assets in the consolidated balance sheets.

13. INCOME TAXES

The provision for income taxes for the years ended December 31, 2024, 2023 and 2022 is summarized as follows:

	Year Ended December 31,		
	2024	2023	2022
Current:			
Federal	$ 70,144	$ 73,092	$ 56,717
State	16,857	17,301	14,216
	$ 87,001	**$ 90,393**	**$ 70,933**
Deferred:			
Federal	582	(22,280)	(5,158)
State	53	(5,201)	(1,338)
	$ 635	**$ (27,481)**	**$ (6,496)**
TOTAL	**$ 87,636**	**$ 62,912**	**$ 64,437**

A reconciliation of the federal statutory rate to the effective tax rate for net income for the years ended December 31, 2024, 2023 and 2022, respectively, is comprised as follows:

	December 31,		
	2024	**2023**	**2022**
Income tax expense at statutory rate	21.0 %	21.0 %	21.0 %
State income taxes - net of federal benefit	3.5	3.5	3.5
Non-deductible expenses	1.8	3.4	2.0
Equity compensation	(3.3)	(4.2)	(3.6)
Other adjustments	(0.3)	(0.6)	(0.6)
TOTAL INCOME TAX PROVISION	**22.7 %**	**23.1 %**	**22.3 %**

The Company's effective tax rate was 22.7% for the year ended December 31, 2024, compared to 23.1% for the same period in 2023 and 22.3% in 2022. The lower effective tax rate is due to lower non-deductible expenses included but not limited to tax benefits from stock based compensation.

The Company's deferred tax assets and liabilities as of December 31, 2024 and 2023 are summarized below.

	December 31,	
	2024	**2023**
Deferred tax assets (liabilities):		
Accrued expenses	$ 76,419	$ 81,502
Revenue related reserves	27,023	23,714
Tax credits	597	1,192
Insurance	24,817	16,864
Lease liability	470,313	444,590
	$ 599,169	**$ 567,862**
Valuation allowance	(93)	(789)
TOTAL DEFERRED TAX ASSETS	**$ 599,076**	**$ 567,073**
State taxes	(197)	(280)
Depreciation and amortization	(57,253)	(52,334)
Prepaid expenses	(6,390)	(4,113)
Right-of-use asset	(468,955)	(443,222)
TOTAL DEFERRED TAX LIABILITIES	**$ (532,795)**	**$ (499,949)**
NET DEFERRED TAX ASSETS	**$ 66,281**	**$ 67,124**

The Company had state credit carryforwards as of December 31, 2024 and 2023 of $597 and $1,192, respectively. These carryforwards almost entirely relate to state limitations on the application of Enterprise Zone employment-related tax credits. Unless the Company uses the Enterprise Zone credits beforehand, the carryforward began to expire in 2023. The remainder of these carryforwards relate to credits against the Texas margin tax and is expected to carryforward until 2027. As of December 31, 2024 and 2023, the valuation allowance of $93 and $789, respectively, was primarily recorded against the Enterprise Zone credits as the Company believes it is more likely than not that some of the benefit of the credits will not be realized.

The Company's operating loss carry forwards for states were not material during the years ended December 31, 2024 and 2023.

As of December 31, 2024, 2023 and 2022, the Company did not have any unrecognized tax benefits, net of its state benefits that would affect the Company's effective tax rate. The Company classifies interest and/or penalties on income tax liabilities or refunds as additional income tax expense or income. Such amounts are not material.

The federal statutes of limitations on the Company's 2020, 2019, and 2018 income tax years lapsed during the third quarter of 2024, 2023, and 2022, respectively. During the fourth quarter of each year, various state statutes of limitations also lapsed. The lapses during the years ended December 31, 2024 and 2023 had no impact on the Company's unrecognized tax benefits.

14. DEBT

Debt consists of the following:

	December 31,	
	2024	2023
Mortgage loans and promissory note	$ 148,438	$ 152,388
Less: current maturities	(4,086)	(3,950)
Less: debt issuance costs, net	(2,767)	(2,941)
LONG-TERM DEBT LESS CURRENT MATURITIES	**$ 141,585**	**$ 145,497**

Credit Facility with a Lending Consortium Arranged by Truist

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

Borrowings made under the Credit Facility are guaranteed, jointly and severally, by certain of the Company's wholly-owned subsidiaries, and are secured by a pledge of stock of the Company's material independent subsidiaries as well as a first lien on substantially all of such independent subsidiaries' personal property. The Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its independent subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the terms of the Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of (i) a maximum consolidated total net debt to consolidated EBITDA ratio (which shall not be greater than 3.75:1.00; provided that if the aggregate consideration for approved acquisitions in a six month period is greater than $50,000, then the ratio can be increased at the election of the Company with notice to the administrative agent to 4.25:1.00 for the first fiscal quarter and the immediately following three fiscal quarters), and (ii) a minimum interest/rent coverage ratio (which cannot be less than 1.50:1.00). As of December 31, 2024, there was no outstanding debt under the Credit Facility. The Company was in compliance with all loan covenants as of December 31, 2024.

Mortgage Loans and Promissory Note

As of December 31, 2024, the Company has 23 subsidiaries that have mortgage loans insured with HUD in the aggregate amount of $146,898, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates in a range of 3.1% to 4.2%, including fixed interest rates in a range of 2.4% to 3.3% per annum. In addition to the interest rate, the Company incurs other fees for HUD placement, including, but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees based on the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0% and is reduced by 3.0% in the fourth year of the loan and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

In addition to the HUD mortgage loans above, the Company has a promissory note of $1,540 that bears a fixed interest rate of 5.3% per annum and has a term of 12 years. The note, which was assumed as part of an acquisition, is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

Future principal payments due under the long-term debt arrangements discussed above are as follows:

Years Ending December 31,	Amount
2025	$ 4,086
2026	4,227
2027	3,897
2028	3,779
2029	3,896
Thereafter	128,553
	$ 148,438

Based on Level 2 inputs, the carrying value of the Company's long-term debt is considered to approximate the fair value of such debt for all periods presented based upon the interest rates that the Company believes it can currently obtain for similar debt.

Off-Balance Sheet Arrangements

As of December 31, 2024, the Company had approximately $27,893 of borrowing capacity under the Credit Facility pledged as collateral to secure outstanding letters of credit, which increased by $21,638 from December 31, 2023. The Company believes that its outstanding letters of credit as of December 31, 2024 do not require an allowance for expected credit losses, nor has any event occurred through the filing date of this report that would indicate differently.

15. OPTIONS AND AWARDS

2022 Omnibus Incentive Plan (2022 Plan) — The Company has one stock incentive plan, the 2022 Omnibus Incentive Plan (the 2022 Plan), pursuant to which grants of the Company's securities may currently be made. Including the shares rolled over from the 2017 Omnibus Incentive Plan, the 2022 Plan provides for the issuance of 3,452 shares of common stock. The number of shares available to be issued under the 2022 Plan will be reduced by (i) one share for each share that relates to an option or stock appreciation right award and (ii) two shares for each share which relates to an award other than a stock option or stock appreciation right award (a full-value award). Non-employee director options, to the extent granted, will vest and become exercisable in three equal annual installments, or the length of the term if less than three years, on the completion of each year of service measured from the grant date. All other options generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. At December 31, 2024, the total number of shares available for issuance under the 2022 Plan was 346.

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

- The expected option term is calculated by the average of the contractual term of the options and the weighted average vesting period for all options. The calculation of the expected option term is based on the Company's experience due to sufficient history.
- The Company utilizes its own experience to calculate estimated volatility for options granted.
- The dividend yield is based on the Company's historical pattern of dividends as well as expected dividend patterns.
- The risk-free rate is based on the implied yield of U.S. Treasury notes as of the grant date with a remaining term approximately equal to the expected term.
- Estimated forfeiture rate of approximately 4.86% per year is based on the Company's historical forfeiture activity of unvested stock options.

Stock Options

The Company granted 704, 1,008 and 581 stock options during the years ended December 31, 2024, 2023 and 2022, respectively. The Company used the following assumptions for stock options granted during the years ended December 31, 2024, 2023 and 2022:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2024	704	4.3%	6.2 years	40.5%	0.2%
2023	1,008	4.3%	6.2 years	41.3%	0.2%
2022	581	2.8%	6.2 years	42.1%	0.3%

For the years ended December 31, 2024, 2023 and 2022, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2024	704	$ 132.46	$ 60.37
2023	1,008	$ 95.05	$ 43.85
2022	581	$ 85.74	$ 37.83

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended December 31, 2024, 2023 and 2022 and therefore, the intrinsic value was $0 at the date of grant.

The following table represents the employee stock option activity during the years ended December 31, 2024, 2023 and 2022:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2022	4,038	$ 36.60	2,183	$ 21.02
Granted	581	85.74		
Forfeited	(98)	59.52		
Exercised	(688)	18.43		
December 31, 2022	3,833	$ 46.72	2,069	$ 28.87
Granted	1,008	95.05		
Forfeited	(91)	71.44		
Exercised	(759)	24.21		
December 31. 2023	**3,991**	$ 62.65	1,887	$ 39.58
Granted	704	132.46		
Forfeited	(76)	86.92		
Exercised	(632)	35.28		
December 31, 2024	**3,987**	$ 78.84	1,895	$ 52.64

The following table represents the employee stock option activity during the year ended December 31, 2024:

		Stock Options Outstanding			Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2015	$18.20 - $21.39	69	$ 537	1	69
2016	15.93 - 16.86	112	667	2	112
2017	15.80 - 19.41	148	867	3	148
2018	22.49 - 32.71	241	2,557	4	241
2019	41.07 - 45.76	417	6,557	5	417
2020	44.84 - 59.49	406	8,020	6	301
2021	73.47 - 83.64	458	15,041	7	251
2022	79.79 - 94.88	489	18,601	8	176
2023	89.83 - 98.83	951	41,753	9	180
2024	$119.19 - $146.37	696	42,024	10	—
TOTAL		**3,987**	**$ 136,624**		**1,895**

The aggregate intrinsic value of options outstanding, vested and expected to vest as of December 31, 2024, 2023 and 2022 is as follows:

	December 31,		
Options	2024	2023	2022
Outstanding	$ 219,309	$ 197,819	$ 183,593
Vested	152,011	137,048	136,000
Expected to vest	63,243	56,759	43,232

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options. At December 31, 2024, 2023 and 2022, the aggregate intrinsic value of options that vested during the years ended December 31, 2024, 2023 and 2022 was $37,700, $31,658, and $27,955, respectively. The total intrinsic value of options exercised during the years ended December 31, 2024, 2023 and 2022 was $60,358, $56,186, and $47,441, respectively.

Restricted Stock Awards

The Company granted 232, 219 and 233 restricted stock awards during the years ended December 31, 2024, 2023 and 2022, respectively. All awards were granted at an issue price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the years ended December 31, 2024, 2023 and 2022 ranged from $116.65 to $149.12, $89.83 to $98.31 and $73.17 to $94.88, respectively. The fair value per share includes quarterly stock awards to non-employee directors. Included in the restricted stock award grants are $6,165 and $5,068 of annual bonuses that were settled in vested restricted stock awards during the years ended December 31, 2024 and 2023, respectively.

A summary of the status of the Company's non-vested restricted stock awards as of December 31, 2024 and changes during the years ended December 31, 2024, 2023 and 2022 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2022	**549**	$ 52.16
Granted	233	81.57
Vested	(269)	54.06
Forfeited	(26)	57.29
Nonvested at December 31, 2022	**487**	$ 64.92
Granted	219	92.04
Vested	(255)	64.21
Forfeited	(20)	71.53
Nonvested at December 31, 2023	**431**	$ 78.91
Granted	232	131.26
Vested	(215)	86.97
Forfeited	(13)	83.12
Nonvested at December 31, 2024	**435**	$ 102.71

During the year ended December 31, 2024, the Company granted 16 quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards ranged from $116.65 to $149.12 based on the market price on the grant date.

Long-Term Incentive Plan

On August 27, 2019, the Board approved the Long-Term Incentive Plan (the 2019 LTI Plan). The 2019 LTI Plan provides that certain employees of the Company who assisted in the consummation of the spin-off of Pennant from the Company in 2019 were granted shares of restricted stock upon successful completion of the spin-off. The 2019 LTI Plan provides for the issuance of 500 shares of Pennant restricted stock. As of December 31, 2024, the 2019 LTI Plan was fully vested. The total stock-based compensation related to the 2019 LTI Plan was $546, $827, and $836 for the years ended December 31, 2024, 2023 and 2022, respectively.

Stock-based compensation expense

Stock-based compensation expense recognized for the Company's equity incentive plans and long-term incentive plan for the years ended December 31, 2024, 2023 and 2022 was as follows:

	Year Ended December 31,		
	2024	**2023**	**2022**
Stock-based compensation expense related to stock options	$ 22,439	$ 17,221	$ 11,361
Stock-based compensation expense related to restricted stock awards	11,662	11,845	9,920
Stock-based compensation expense related to restricted stock awards to non-employee directors	2,082	1,688	1,439
TOTAL	**$ 36,183**	**$ 30,754**	**$ 22,720**

In future periods, the Company expects to recognize approximately $84,914 and $38,434 in stock-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of December 31, 2024. Future stock-based compensation expense will be recognized over 3.8 and 3.7 weighted average years for unvested options and restricted stock awards, respectively. There were 2,092 unvested and outstanding options as of December 31, 2024, of which 1,925 shares are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest as of December 31, 2024 was 6.7 years.

16. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 100 independent skilled nursing and senior living facilities used in the Company's operations, 99 of which are under nine "triple-net" master lease agreements (collectively, the Master Leases), which range in terms from 13 to 20 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases is subject to termination prior to the expiration of the current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases. If the Company elects to renew the term of a Master Lease, the renewal will be effective to all, but not less than all, of the leased property then subject to the Master Lease. During the year ended December 31, 2024, the Company amended two of the Master Leases by adding three operations and extending the terms to 15 and 20 years, respectively. These amendments increased the lease liabilities and right-of-use assets by $72,503 to reflect the new lease obligations. Additionally, four of the 100 facilities leased from CareTrust include an option to purchase that the Company can exercise starting on December 1, 2024. Subsequent to December 31, 2024, the Company purchased the real estate of the four facilities from CareTrust for $44,575.

The Company does not have the ability to terminate the obligations under a Master Lease prior to its expiration without CareTrust's consent. If a Master Lease is terminated prior to its expiration other than with CareTrust's consent, the Company may be liable for damages and incur charges such as continued payment of rent through the end of the lease term as well as maintenance and repair costs for the leased property.

The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The terms and conditions of the one stand-alone lease are substantially the same as those for the master leases described above. Total rent expense under the Master Leases was approximately $69,399, $66,439 and $64,178 for the years ended December 31, 2024, 2023 and 2022, respectively.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. The Company is in compliance with requirements of the Master Leases as of December 31, 2024.

The Company leases facilities where its independent subsidiaries operate and certain administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from 15 to 20 years. In addition, the Company leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense for continuing operations inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $216,716, $197,856 and $153,174 for the years ended December 31, 2024, 2023 and 2022, respectively.

Ninety of the Company's independent subsidiaries, excluding the subsidiaries that are operated under the Master Leases with CareTrust, are operated under 14 separate master lease arrangements. During the year ended December 31, 2024, the Company amended one of the separate master lease arrangements to add two stand-alone skilled nursing operations operated by the Company's independent subsidiaries and extended the term to 20 years. In addition, the Company entered into one new master lease arrangement to add six stand-alone skilled nursing operations operated by the Company's independent subsidiaries with an initial term of 15 years. The amended and new master lease arrangements increased the lease liabilities and right-of-use assets by $71,616 to reflect the new lease obligations. Under the master leases, a default at a single facility could subject one or more of the other facilities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in the Company's outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord. The components of operating lease expense are as follows:

	Year Ended December 31,		
	2024	2023	2022
Rent - cost of services[1]	$ 216,016	$ 197,358	$ 153,049
Cost of services[2]	24,297	20,454	16,938
General and administrative expense	700	498	125
Depreciation and amortization[3]	1,212	1,202	1,160
	$ 242,225	**$ 219,512**	**$ 171,272**

(1) Rent- cost of services includes accrued rent expense adjustments of $808, $870 and $493 for the years ended December 31, 2024, 2023 and 2022, respectively. Additionally, rent- cost of services includes other variable lease costs such as consumer price index increases and short-term leases of $14,013, $10,259, $5,878 for the years ended December 31, 2024, 2023, and 2022 respectively.

(2) Cost of services includes variable lease costs, which consists of property taxes and insurance.

(3) Depreciation and amortization is related to the amortization of favorable and direct lease costs.

Future minimum lease payments for all third-party leases as of December 31, 2024 are as follows:

Year	Amount
2025	$ 204,909
2026	204,696
2027	204,002
2028	202,994
2029	199,144
Thereafter	1,776,571
TOTAL LEASE PAYMENTS	**$ 2,792,316**
Less: present value adjustment	(963,516)
PRESENT VALUE OF TOTAL LEASE LIABILITIES	**$ 1,828,800**
Less: current lease liabilities	(93,475)
LONG-TERM OPERATING LEASE LIABILITIES	**$ 1,735,325**

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at the lease commencement date. As of December 31, 2024 and 2023, the weighted average remaining lease term is 14.5 years and 14.9 years, respectively, and the weighted average discount rate used to determine the operating lease liabilities is 6.3% and 6.5%, respectively.

Subsequent to December 31, 2024, the Company expanded its operations through a new master lease with the addition of six standalone skilled nursing operations. The aggregate impact to the carrying value of lease liabilities and right-of-use assets related to the long-term leases is estimated to be approximately $67,572.

Lessor Activities

The Company leases its owned real estate properties to third-party operators, of which 32 senior living operations are operated by Pennant. All of these properties are triple-net leases, whereby the respective tenants are responsible for all costs at the properties including: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The initial terms range from 14 to 16 years.

During 2024, the Company expanded its operations through a separate master lease arrangement for three stand-alone senior living operations with a third-party operator for an initial lease term of 15 years.

During 2023, the Company entered into a sublease agreement for three stand-alone skilled nursing operations with a third-party operator with an initial lease term of 18 years. Additionally, during the year, the Company entered into a lease agreement with a third-party operator for one campus operation with an initial lease term of 15 years.

Total rental income from all third-party sources for the years ended December 31, 2024, 2023 and 2022 is as follows:

	Year Ended December 31,		
	2024	2023	2022
Pennant[1]	$ 15,480	$ 15,048	$ 14,915
Other third-party[2]	7,480	6,236	1,842
TOTAL	**$ 22,960**	**$ 21,284**	**$ 16,757**

(1) Pennant rental income includes variable rent such as property taxes of $1,235, $1,296, and $1,318 during the year ended December 31, 2024, 2023, and 2022.
(2) Other third-party includes rental revenue associated with the Company's subleases to third parties of $4,347 and $3,897 for the years ended December 31, 2024 and 2023. There was no sublease rental revenue for the year ended December 31, 2022.

Future annual rental income for all third-party leases as of December 31, 2024 were as follows:

Year	Amount[1]
2025	$ 23,664
2026	23,179
2027	22,736
2028	22,535
2029	22,511
Thereafter	119,811
TOTAL	**$ 234,436**

(1) Annual rental income includes base rents and variable rental income pursuant to existing leases as of December 31, 2024.

17. DEFINED CONTRIBUTION PLANS

The Company has a 401(k) defined contribution plan (the 401(k) Plan), whereby eligible employees may contribute up to 90% of their annual basic earnings, subject to applicable annual Internal Revenue Code limits. Additionally, the 401(k) Plan provides for discretionary matching contributions (as defined in the 401(k) Plan) by the Company. The Company expensed matching contributions to the 401(k) Plan of $3,532, $2,836, and $2,418 during the years ended December 31, 2024, 2023 and 2022, respectively.

The Company has a non-qualified deferred compensation plan (DCP), whereby certain highly compensated employees who are otherwise ineligible to participate in the Company's 401(k) plan, may defer the receipt of a portion of their base compensation and, for certain employees, up to 100% of their eligible bonuses. Additionally, the DCP allows for the employee deferrals to be deposited into a rabbi trust and the funds are generally invested in individual variable life insurance contracts owned by the Company that are specifically designed to fund savings plans of this nature.

As of December 31, 2024 and 2023, the Company accrued $63,051 and $49,201, respectively, as long term deferred compensation in other long term liabilities on the consolidated balance sheets. Cash surrender value of the contracts is based on investment funds that shadow the investment allocations specified by participants in the deferred compensation plan. Refer to Note 5, *Fair Value Measurements* for more information on the funds.

For the years ended December 31, 2024 and 2023, the Company recorded gains related to its DCP of $5,157 and $4,634, respectively, which are included in other income (expense), and recorded offsetting expenses of $5,559 and $4,887, which are allocated between cost of services and general and administrative expenses. For the year ended December 31, 2022, the Company recorded a loss related to its DCP of $4,188, which is included in other income (expense), and recorded an offsetting reduction in expense of $4,051, which is allocated between cost of services and general and administrative expenses.

18. SELF INSURANCE LIABILITIES

The following table represents the Company's self-insurance insurance liabilities, on an undiscounted basis, inclusive of anticipated insurance recoveries, as of December 31, 2024 and 2023:

	December 31, 2024	December 31, 2023
Accrued general liability and professional malpractice liabilities	$ 160,149	$ 117,744
Accrued workers' compensation liabilities	37,291	33,352
Accrued health benefits	14,312	14,814
TOTAL SELF-INSURANCE LIABILITIES	**$ 211,752**	**$ 165,910**
Less: current self-insurance liabilities	67,331	54,664
LONG-TERM SELF-INSURANCE LIABILITIES	**$ 144,421**	**$ 111,246**

The following table represents activity in the Company's self-insurance liabilities as of and for the years ended December 31, 2024 and 2023:

	Amount
Balance January 1, 2023	$ 131,682
Current year provisions	164,627
Claims paid and direct expenses	(135,799)
Change in long-term insurance losses recoverable	5,400
Balance December 31, 2023	**$ 165,910**
Current year provisions	217,631
Claims paid and direct expenses	(173,617)
Change in long-term insurance losses recoverable	1,828
Balance December 31, 2024	**$ 211,752**

The anticipated insurance recoveries included in the self-insurance liabilities are presented gross rather than net with the corresponding asset of $17,741 and $15,913 as of December 31, 2024 and 2023, respectively, included in Restricted and other assets on the consolidated balance sheets.

19. COMMITMENTS AND CONTINGENCIES

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

Litigation and Regulatory Matters — The Company and its independent subsidiaries are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business. Such claims may be related to, but are not limited to, the Health Insurance Portability and Accountability Act of 1996, alleged Medicare or Medicaid false claims, qui tam or "whistleblower" provisions of the False Claims Act and/or the Anti-Kickback Statute, alleged violations of state and federal wage and hour laws, environmental matters, investigations, examinations, audits, site visits and surveys or other claims in connection with the delivery of healthcare and non-healthcare services. Refer to *Part I. Item 3. Legal Proceedings* for additional information on litigation and regulatory matters.

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

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

In 2018, the Company, on behalf of its independent subsidiaries, received a CID from the DOJ stating that it was investigating to determine whether there had been a violation of the False Claims Act (FCA) and/or the Anti-Kickback Statute (AKS) with respect to the relationships between certain of the Company's independent subsidiaries and persons who serve or have served as medical directors. In 2020, the Company was advised that the DOJ declined to intervene in any subsequent action filed in connection with the subject matter of this investigation. Despite the decision of the DOJ to decline to participate in litigation based on the subject matter of its previously issued CID, the involved qui tam relator moved forward with the complaint in 2020. In 2024, the Company mediated with the involved parties and agreed to settle the civil case for $48,000 and recorded the accrual as of December 31, 2023. Following the finalization of the settlement documents and payment of the settlement funds during the year ended December 31, 2024, the qui tam complaint was dismissed and the matter was resolved.

Medicare Revenue Recoupments — The Company's independent subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments as a result of Recovery Audit Contractors (RAC), various Program Safeguard Contractors, and Medicaid Integrity Contractor programs (collectively referred to as Reviews). Reviews vary in claim selection size and processes, ranging from a single episode/claim month to larger, multi-claim batches; and from single rounds of review to reviews of multiple rounds with pass/fail criteria. If an operation has a significant error rate or fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. The Company anticipates that these Reviews could increase in frequency in the future. As of December 31, 2024 and through the filing date of this report, 18 of the Company's independent subsidiaries had multi-claim Reviews scheduled or in process.

Concentrations

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

The Company's receivables from Medicare and Medicaid payor programs accounted for 52.9% and 53.4% of its total accounts receivable as of December 31, 2024 and 2023, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 70.9%, 72.6% and 73.7% of the Company's revenue for the years ended December 31, 2024, 2023 and 2022, respectively.

20. COMMON STOCK REPURCHASE PROGRAM

On May 16, 2024, the Board of Directors approved a stock repurchase program pursuant to which the Company may repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months from September 1, 2024. The Company did not purchase any shares pursuant to this stock repurchase program during the year ended December 31, 2024.

On August 29, 2023, the Board of Directors approved a stock repurchase program pursuant to which the Company could repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months from September 1, 2023. The stock repurchase program expired on August 31, 2024 and is no longer in effect. The Company did not purchase any shares pursuant to this stock repurchase program.

On July 28, 2022, the Board of Directors approved a stock repurchase program pursuant to which the Company could repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months from August 2, 2022. The stock repurchase program expired on August 2, 2023 and is no longer in effect. The Company did not purchase any shares pursuant to this stock repurchase program.

In addition, the Company repurchased 404 shares of its common stock for $29,882 during the year ended December 31, 2022, related to two separate stock repurchase programs that are no longer in effect.

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

Item 9. CHANGES IN AND DISAGREEMENTS WITH ACCOUNTANTS ON ACCOUNTING AND FINANCIAL DISCLOSURE

None.

Item 9A. CONTROLS AND PROCEDURES

(a) Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

The Company maintains disclosure controls and procedures that are designed to ensure that information we are required to disclose in reports that we file or submit under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to its management, including its principal executive and principal financial officers, or persons performing similar functions, as appropriate to allow timely decisions regarding required disclosure. In designing and evaluating our disclosure controls and procedures, our management recognized that any system of controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, as ours are designed to do, and management necessarily was required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

In connection with the preparation of this Annual Report on Form 10-K our management evaluated, with the participation of our Chief Executive Officer and our Chief Financial Officer, the effectiveness of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Exchange Act. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures were effective as of the end of the period covered by this Annual Report on Form 10-K.

(b) Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rule 13a-15(f) promulgated under the Exchange Act. 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. 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.

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, evaluated the effectiveness of our internal control over financial reporting using the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in *Internal Control - Integrated Framework (2013).* As a result of this assessment, management concluded that, as of December 31, 2024, our internal control over financial reporting was effective in providing reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles.

Our independent registered public accounting firm, Deloitte & Touche LLP, has audited the consolidated financial statements included in this Annual Report on Form 10-K and, as part of their audit, has issued an audit report, included herein, on the effectiveness of our internal control over financial reporting. Their report is set forth below.

(c) Changes in Internal Control over Financial Reporting

There were no changes in our internal control over financial reporting, as defined in Rule 13a-15(f) promulgated under the Exchange Act, that occurred during the fourth quarter of fiscal 2024 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

(d) Report of Independent Registered Public Accounting Firm

To the Stockholders and the Board of Directors of The Ensign Group, Inc.

Opinion on Internal Control over Financial Reporting

We have audited the internal control over financial reporting of The Ensign Group, Inc. and subsidiaries (the "Company") as of December 31, 2024, based on criteria established in Internal Control — Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2024, based on criteria established in Internal Control — Integrated Framework (2013) issued by COSO.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated financial statements as of and for the year ended December 31, 2024, of the Company and our report dated February 5, 2025, expressed an unqualified opinion on those financial statements.

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 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/ DELOITTE & TOUCHE LLP

Costa Mesa, California February 5, 2025

Item 9B. OTHER INFORMATION

Rule 10b5-1 Plan Elections

Dr. Ann S. Blouin, a member of our Board of Directors, entered into a Rule 10b5-1 trading arrangement on November 12, 2024. Dr. Blouin's 10b5-1 Plan provides for the sale of up to 450 shares of the Company's common stock between February 11, 2025 and November 11, 2025.

Suzanne D. Snapper, Chief Financial Officer, Executive Vice President, and Director, entered into a Rule 10b5-1 trading arrangement on November 15, 2024. Ms. Snapper's 10b5-1 Plan provides for the potential exercise of vested stock options and the associated sale of up to 10,618 shares of the Company's common stock between February 18, 2025 and July 28, 2025.

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

Item 9C. DISCLOSURE REGARDING FOREIGN JURISDICTIONS THAT PREVENT INSPECTIONS

Not applicable.

PART III.

Item 10. DIRECTORS, EXECUTIVE OFFICERS AND CORPORATE GOVERNANCE

The information required by this Item is hereby incorporated by reference to our definitive proxy statement for the 2025 Annual Meeting of Stockholders.

We have adopted a code of ethics and business conduct that applies to all employees, including our Chief Executive Officer (our principal executive officer) and Chief Financial Officer (our principal financial officer), and employees of our subsidiaries, as well as each member of our Board of Directors. The code of ethics and business conduct is available on our website at www.ensigngroup.net under the Investor Relations section. The information contained in, or that can be accessed through, our website does not constitute a part of this Annual Report on Form 10-K. We intend to satisfy any disclosure requirement under Item 5.05 of Form 8-K regarding an amendment to, or waiver from, a provision of the code of ethics by posting such information on our website, at the address specified above.

Item 11. EXECUTIVE COMPENSATION

The information required by this Item is hereby incorporated by reference to our definitive proxy statement for the 2025 Annual Meeting of Stockholders.

Item 12. SECURITY OWNERSHIP OF CERTAIN BENEFICIAL OWNERS AND MANAGEMENT AND RELATED STOCKHOLDER MATTERS

The information required by this Item is hereby incorporated by reference to our definitive proxy statement for the 2025 Annual Meeting of Stockholders.

Item 13. CERTAIN RELATIONSHIPS AND RELATED TRANSACTIONS AND DIRECTOR INDEPENDENCE

The information required by this Item is hereby incorporated by reference to our definitive proxy statement for the 2025 Annual Meeting of Stockholders.

Item 14. PRINCIPAL ACCOUNTANT FEES AND SERVICES

The information required by this Item is hereby incorporated by reference to our definitive proxy statement for the 2025 Annual Meeting of Stockholders. Our principal accountant is Deloitte & Touche LLP (PCAOB ID No.34).

PART IV.

Item 15. EXHIBITS AND FINANCIAL STATEMENT SCHEDULES

The following documents are filed as a part of this report:

(a) (1) *Financial Statements:*

The Financial Statements described in Part II. Item 8 and beginning on page 91 are filed as part of this Annual Report on Form 10-K.

(a) (3) *Exhibits:* The following exhibits are filed or furnished with or incorporated by reference this Annual Report on Form 10-K.

Exhibit No.	Exhibit Description*	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
3.1	Fifth Amended and Restated Certificate of Incorporation of the Corporation, filed with the Delaware Secretary of State on November 15, 2007, and all Certificates of Amendment thereto filed with the Delaware Secretary of State through May 23, 2024.	10-Q	001-33757	3.1	7/25/2024	
3.2	Amended and Restated Bylaws of The Ensign Group, Inc.	10-Q	001-33757	3.2	12/21/2007	
3.3	Amendment to the Amended and Restated Bylaws, dated August 5, 2014	8-K	001-33757	3.2	8/8/2014	
4.1	Description of the Common stock of The Ensign Group, Inc.	10-K	001-33757	4.1	2/5/2020	
4.2	Specimen common stock certificate	S-1	333-142897	4.1	10/5/2007	
10.1 +	The Ensign Group, Inc. 2007 Omnibus Incentive Plan	S-1	333-142897	10.3	10/5/2007	
10.2 +	Amendment to The Ensign Group, Inc. 2007 Omnibus Incentive Plan	8-K	001-33757	99.2	7/28/2009	
10.3 +	Form of 2007 Omnibus Incentive Plan Notice of Grant of Stock Options; and form of Non-Incentive Stock Option Award Terms and Conditions	S-1	333-142797	10.4	10/5/2007	
10.4 +	Form of 2007 Omnibus Incentive Plan Restricted Stock Agreement	S-1	333-142897	10.5	10/5/2007	
10.5 +	Form of Indemnification Agreement entered into between The Ensign Group, Inc. and its directors, officers and certain key employees	S-1	333-142897	10.6	10/5/2007	
10.6	Form of Independent Consulting and Centralized Services Agreement between Ensign Facility Services, Inc. and certain of its subsidiaries	S-1	333-142897	10.41	5/14/2007	
10.7	Form of Health Insurance Benefit Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Medicare program	S-1	333-142897	10.48	10/19/2007	
10.8	Form of Medi-Cal Provider Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the California Medicaid program	S-1	333-142897	10.49	10/19/2007	
10.9	Form of Provider Participation Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Arizona Medicaid program	S-1	333-142897	10.50	10/19/2007	
10.10	Form of Contract to Provide Nursing Facility Services under the Texas Medical Assistance Program pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Texas Medicaid program	S-1	333-142897	10.51	10/19/2007	
10.11	Form of Client Service Contract pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Washington Medicaid program	S-1	333-142897	10.52	10/19/2007	

Exhibit No.	Exhibit Description*	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.12	Form of Provider Agreement for Medicaid and UMAP pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Utah Medicaid program	S-1	333-142897	10.53	10/19/2007	
10.13	Form of Medicaid Provider Agreement pursuant to which a subsidiary of The Ensign Group, Inc. participates in the Idaho Medicaid program	S-1	333-142897	10.54	10/19/2007	
10.14	Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and The Ensign Group, Inc. dated October 1, 2013.	10-K	001-33757	10.74	2/13/2014	
10.15	Settlement agreement dated October 1, 2013, entered into among the United States of America, acting through the United States Department of Justice and on behalf of the Office of Inspector General (OIG-HHS) of the Department of Health and Human Services (HHS) (collectively the "United States") and the Company.	8-K	001-33757	10.75	5/8/2014	
10.16	Form of Master Lease by and among certain subsidiaries of The Ensign Group, Inc. and certain subsidiaries of CareTrust REIT, Inc.	8-K	001-33757	10.1	6/5/2014	
10.17	Form of Guaranty of Master Lease by The Ensign Group, Inc. in favor of certain subsidiaries of CareTrust REIT, Inc., as landlords under the Master Leases	8-K	001-33757	10.2	6/5/2014	
10.18	Amended and Restated Credit Agreement as of February 5, 2016, by and among The Ensign Group, Inc., SunTrust Bank, now known as Truist, as administrative agent, and the lenders party thereto	8-K	001-33757	10.1	2/8/2016	
10.19	Second Amended Credit Agreement as of July 19, 2016, by and among The Ensign Group, Inc., SunTrust Bank, now known as Truist, as administrative agent, and the lenders party thereto	8-K	001-33757	10.1	7/25/2016	
10.20	The Ensign Group, Inc. 2017 Omnibus Incentive Plan	DEF 14A	001-33757	A	4/13/2017	
10.21	Form of 2017 Omnibus Incentive Plan Notice of Grant of Stock Options; and form of Non-Incentive Stock Option Award Terms and Conditions	10-K	001-33757	10.87	2/8/2018	
10.22	Form of 2017 Omnibus Incentive Plan Restricted Stock Agreement	10-K	001-33757	10.88	2/8/2018	
10.23	Form of U.S. Department of Housing and Urban Development Healthcare Facility Note and schedule of individual subsidiary loans, by and among The Ensign Group, Inc.'s subsidiaries listed therein and U.S. Department of Housing and Urban Development	8-K	001-33757	10.1	1/3/2018	
10.24	Form of U.S. Department of Housing and Urban Development Security Instrument/Mortgage/Deed of Trust	8-K	001-33757	10.2	1/3/2018	
10.25	Third Amended and Restated Credit Agreement, dated as of October 1, 2019, by and among The Ensign Group, Inc., SunTrust Bank, now known as Truist, as administrative agent, and the lenders party thereto	8-K	001-33757	10.4	10/1/2019	
10.26	Lease Agreement, dated as of October 1, 2019, by and between The Ensign Group, Inc. and The Pennant Group, Inc.	8-K	001-33757	10.5	10/1/2019	
10.27 +	The Ensign Services, Inc. Deferred Compensation Plan	10-K	001-33757	10.1	2/3/2021	
10.28 +	First Amendment to The Ensign Services, Inc. Deferred Compensation Plan	10-K	001-33757	10.2	2/3/2021	

Exhibit No.	Exhibit Description*	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.29	First Amendment to Third Amended and Restated Credit Agreement, dated as of February 8, 2022, by and among The Ensign Group, Inc., Standard Bearer Healthcare REIT, Inc., Truist Bank (as successor by merger to SunTrust Bank), as administrative agent, and the lenders party thereto	10-K	001-33757	10.1	2/9/2022	
10.30	Second Amendment to Third Amended and Restated Credit Agreement, dated as of April 8, 2022, by and among The Ensign Group, Inc. and Truist Bank, as administrative agent, and the lenders party thereto.	8-K	001-33757	10.1	4/12/2022	
10.31 +	The Ensign Group, Inc. 2022 Omnibus Incentive Plan	DEF 14A	001-33757	A	4/14/2022	
10.32 +	Form of 2022 Omnibus Incentive Plan Notice of Grant of Stock Options; and form of Non-Incentive Stock Option Award Terms and Conditions	10-K	001-33757	10.32	2/2/2023	
10.33 +	Form of 2022 Omnibus Incentive Plan Restricted Stock Agreement	10-K	001-33757	10.33	2/2/2023	
13.1	Annual Report to Security Holders	ARS	001-33757	ARS	4/5/2024	
19.1	Statement of Company Policy Regarding Insider Trading					X
19.2	Addendum to Statement of Company Policy Regarding Insider Trading					X
21.1	Subsidiaries of The Ensign Group, Inc., as amended					X
23.1	Consent of Deloitte & Touche LLP					X
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
97.1 +	Policy for Recovery of Erroneously Awarded Incentive-Based Compensation	10-K	001-33757	97.0	2/1/2024	
101	Interactive data file (furnished electronically herewith pursuant to Rule 406T of Regulations S-T)					
104	Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)					

\+ Indicates management contract or compensatory plan.

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

Item 16. FORM 10-K SUMMARY

Not applicable

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

THE ENSIGN GROUP, INC.

February 5, 2025 BY: /s/ SUZANNE D. SNAPPER

Suzanne D. Snapper
Chief Financial Officer, Executive Vice President and Director
(Principal Financial Officer and Principal Accounting 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/ BARRY R. PORT Barry R. Port	Chief Executive Officer and Director (principal executive officer)	February 5, 2025
/s/ SUZANNE D. SNAPPER Suzanne D. Snapper	Chief Financial Officer, Executive Vice President and Director (principal financial officer and principal accounting officer)	February 5, 2025
/s/ CHRISTOPHER R. CHRISTENSEN Christopher R. Christensen	Executive Chairman and Chairman of the Board	February 5, 2025
/s/ ANN S. BLOUIN Ann S. Blouin	Director	February 5, 2025
/s/ SWATI B. ABBOTT Swati B. Abbott	Director	February 5, 2025
/s/ DAREN J. SHAW Daren J. Shaw	Director	February 5, 2025
/s/ JOHN O. AGWUNOBI John O. Agwunobi	Director	February 5, 2025
/s/ BARRY M. SMITH Barry M. Smith	Director	February 5, 2025
/s/ MARK V. PARKINSON Mark V. Parkinson	Director	February 5, 2025

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM ON SUPPLEMENTAL INFORMATION

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM ON SUPPLEMENTAL INFORMATION

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Southland Care	Southland Home	The Orchard	Downey Post Acute	Broadway by the Sea
Asset					
Total Current Assets	$ 59,116	$ 2,606	$ 44,226	$ 8,078	$ 1,532
Total Other Assets	$ 11,542	$ 2,144	$ 233	$ 7,329	$ 15,298
Total Assets	**$ 70,658**	**$ 4,750**	**$ 44,459**	**$ 15,407**	**$ 16,830**
Liability					
Total Current Liabilities	$ 3,108	$ 281	$ 2,797	$ 1,926	$ 1,928
Total Long Term Liabilities	$ 10,284	$ 1,311	$ -	$ 6,025	$ 13,832
Total Liabilities	**$ 13,392**	**$ 1,592**	**$ 2,797**	**$ 7,952**	**$ 15,760**
Equity	$ 57,266	$ 3,158	$ 41,662	$ 7,455	$ 1,070
Total Equity	**$ 57,266**	**$ 3,158**	**$ 41,662**	**$ 7,455**	**$ 1,070**
Total Liabilities and Equity	**$ 70,658**	**$ 4,750**	**$ 44,459**	**$ 15,407**	**$ 16,830**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Whittier Hills	Brookfield	Rose Villa	Camino Healthcare	Lomita Post-Acute Care Center
Asset					
Total Current Assets	$ 40,802	$ 29,174	$ 18,198	$ 2,696	$ 3,459
Total Other Assets	$ 7,015	$ 9,178	$ 4,510	$ 6,406	$ 12,078
Total Assets	**$ 47,817**	**$ 38,353**	**$ 22,709**	**$ 9,102**	**$ 15,537**
Liability					
Total Current Liabilities	$ 3,789	$ 844	$ 2,316	$ 2,238	$ 1,424
Total Long Term Liabilities	$ 5,539	$ 8,049	$ 2,879	$ 5,065	$ 11,336
Total Liabilities	**$ 9,328**	**$ 8,894**	**$ 5,195**	**$ 7,303**	**$ 12,759**
Equity	$ 38,489	$ 29,459	$ 17,513	$ 1,799	$ 2,777
Total Equity	**$ 38,489**	**$ 29,459**	**$ 17,513**	**$ 1,799**	**$ 2,777**
Total Liabilities and Equity	**$ 47,817**	**$ 38,353**	**$ 22,709**	**$ 9,102**	**$ 15,537**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Atlantic	Shoreline	Alamitos Belmont Rehabilitation Hospital	Edgewater Skilled Nursing Center	Golden Hill Post Acute
Asset					
Total Current Assets	$ 31,109	$ 21,004	$ 4,176	$ 1,681	$ (4,454,855)
Total Other Assets	$ 6,171	$ 7,719	$ 15,501	$ 12,975	$ 9,425
Total Assets	**$ 37,280**	**$ 28,723**	**$ 19,677**	**$ 14,656**	**$ 4,971**
Liability					
Total Current Liabilities	$ 2,293	$ 1,709	$ 2,252	$ 544	$ 441
Total Long Term Liabilities	$ 5,338	$ 6,868	$ 14,253	$ 12,236	$ 7,237
Total Liabilities	**$ 7,631**	**$ 8,577**	**$ 16,505**	**$ 12,781**	**$ 7,678**
Equity	$ 29,648	$ 20,146	$ 3,172	$ 1,876	$ (2,707,437)
Total Equity	**$ 29,648**	**$ 20,146**	**$ 3,172**	**$ 1,876**	**$ (2,707,437)**
Total Liabilities and Equity	**$ 37,280**	**$ 28,723**	**$ 19,677**	**$ 14,656**	**$ 4,971**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Vista Knoll	Arroyo Vista	Magnolia	The Cove	Grossmont
Asset					
Total Current Assets	$ 52,031	$ 21,955	$ 3,926	$ 5,334	$ 25,166
Total Other Assets	$ 10,737	$ 2,038	$ 991	$ 8,256	$ 104
Total Assets	**$ 62,768**	**$ 23,993**	**$ 4,917**	**$ 13,590**	**$ 25,270**
Liability					
Total Current Liabilities	$ 3,360	$ 1,141	$ 1,581	$ 921	$ 2,163
Total Long Term Liabilities	$ 6,874	$ 1,568	$ 0	$ 2,425	$ -
Total Liabilities	**$ 10,234**	**$ 2,709**	**$ 1,581**	**$ 3,346**	**$ 2,163**
Equity	$ 52,535	$ 21,284	$ 3,336	$ 10,244	$ 23,107
Total Equity	**$ 52,535**	**$ 21,284**	**$ 3,336**	**$ 10,244**	**$ 23,107**
Total Liabilities and Equity	**$ 62,768**	**$ 23,993**	**$ 4,917**	**$ 13,590**	**$ 25,270**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Victoria Post Acute	Parkside	Somerset	South Bay	Palomar Vista
Asset					
Total Current Assets	$ 11,832	$ 9,257	$ 9,105	$ 8,658	$ 8,070
Total Other Assets	$ 5,943	$ 588	$ 162	$ 9,011	$ 4,166
Total Assets	**$ 17,775**	**$ 9,845**	**$ 9,267**	**$ 17,669**	**$ 12,236**
Liability					
Total Current Liabilities	$ 1,951	$ (493,671)	$ 3,410	$ 2,347	$ 1,402
Total Long Term Liabilities	$ 145	$ 101	$ -	$ 7,659	$ 3,035
Total Liabilities	**$ 2,096**	**$ (392,568)**	**$ 3,410**	**$ 10,006**	**$ 4,437**
Equity	$ 15,680	$ 10,238	$ 5,857	$ 7,663	$ 7,799
Total Equity	**$ 15,680**	**$ 10,238**	**$ 5,857**	**$ 7,663**	**$ 7,799**
Total Liabilities and Equity	**$ 17,775**	**$ 9,845**	**$ 9,267**	**$ 17,669**	**$ 12,236**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Lemon Grove	La Jolla The Springs	Mission Hills	Victoria CM	Palm Terrace
Asset					
Total Current Assets	$ 28,651	$ 14,323	$ 11,044	$ 23,289	$ 35,756
Total Other Assets	$ 3,384	$ 113	$ 8,606	$ 2,014	$ 3,589
Total Assets	**$ 32,035**	**$ 14,436**	**$ 19,650**	**$ 25,303**	**$ 39,345**
Liability					
Total Current Liabilities	$ 4,256	$ 1,200	$ 1,446	$ 660	$ 3,705
Total Long Term Liabilities	$ 2,127	$ 287	$ 3,014	$ 946	$ 2,482
Total Liabilities	**$ 6,383**	**$ 1,488**	**$ 4,460**	**$ 1,606**	**$ 6,187**
Equity	$ 25,652	$ 12,948	$ 15,189	$ 23,697	$ 33,158
Total Equity	**$ 25,652**	**$ 12,948**	**$ 15,189**	**$ 23,697**	**$ 33,158**
Total Liabilities and Equity	**$ 32,035**	**$ 14,436**	**$ 19,650**	**$ 25,303**	**$ 39,345**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Coventry Court Health Center	The Hills Post Acute	New Orange Hills	St. Catherine Healthcare	Mainplace Post Acute
Asset					
Total Current Assets	$ 3,459	$ 5,279	$ 4,053	$ 13,958	$ 9,920
Total Other Assets	$ 17,662	$ 10,425	$ 25,022	$ 8,107	$ 14,935
Total Assets	**$ 21,120**	**$ 15,704**	**$ 29,075**	**$ 22,064**	**$ 24,855**
Liability					
Total Current Liabilities	$ 1,697	$ 2,585	$ 2,368	$ 2,169	$ 2,352
Total Long Term Liabilities	$ 16,821	$ 8,657	$ 23,647	$ 6,985	$ 12,592
Total Liabilities	**$ 18,518**	**$ 11,242**	**$ 26,015**	**$ 9,153**	**$ 14,944**
Equity	$ 2,602	$ 4,462	$ 3,060	$ 12,911	$ 9,911
Total Equity	**$ 2,602**	**$ 4,462**	**$ 3,060**	**$ 12,911**	**$ 9,911**
Total Liabilities and Equity	**$ 21,120**	**$ 15,704**	**$ 29,075**	**$ 22,064**	**$ 24,855**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	St. Elizabeth Health and Rehab	Sea Cliff Assisted Living	Sea Cliff	Beachside Nursing Center	Pacific Coast Topside
Asset					
Total Current Assets	$ 10,261	$ 398	$ 39,614	$ 2,465	$ (4,164,966)
Total Other Assets	$ 5,546	$ 315	$ 224	$ 11,380	$ -
Total Assets	**$ 15,807**	**$ 713**	**$ 39,837**	**$ 13,846**	**$ (4,164,966)**
Liability					
Total Current Liabilities	$ 1,663	$ 156	$ 2,239	$ 1,305	$ 687
Total Long Term Liabilities	$ 4,839	$ -	$ -	$ 10,725	$ -
Total Liabilities	**$ 6,501**	**$ 156**	**$ 2,239**	**$ 12,029**	**$ 687**
Equity	$ 9,306	$ 557	$ 37,598	$ 1,816	$ (4,851,679)
Total Equity	**$ 9,306**	**$ 557**	**$ 37,598**	**$ 1,816**	**$ (4,851,679)**
Total Liabilities and Equity	**$ 15,807**	**$ 713**	**$ 39,837**	**$ 13,846**	**$ (4,164,966)**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Empire Topside	Premier Care	Brookside	Desert Mountain Care Center	Grand Terrace Healthcare Center
Asset					
Total Current Assets	$ (5,670,900)	$ 21,678	$ 20,872	$ (5,386,936)	$ 1,787
Total Other Assets	$ 37	$ 300	$ 357	$ 11,862	$ 10,081
Total Assets	**$ (5,634,213)**	**$ 21,978**	**$ 21,229**	**$ 6,476**	**$ 11,868**
Liability					
Total Current Liabilities	$ 377	$ 1,350	$ 1,752	$ 1,385	$ 995
Total Long Term Liabilities	$ -	$ -	$ -	$ 2,390	$ 9,354
Total Liabilities	**$ 377**	**$ 1,350**	**$ 1,752**	**$ 3,775**	**$ 10,349**
Equity	$ (6,010,840)	$ 20,628	$ 19,476	$ 2,700	$ 1,519
Total Equity	**$ (6,010,840)**	**$ 20,628**	**$ 19,476**	**$ 2,700**	**$ 1,519**
Total Liabilities and Equity	**$ (5,634,213)**	**$ 21,978**	**$ 21,229**	**$ 6,476**	**$ 11,868**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Arrowhead Springs Post Acute	The Grove SNF	Glenwood	Victoria Ventura	Camarillo
Asset					
Total Current Assets	$ (6,939,202)	$ 7,819	$ 41,677	$ 31,430	$ 35,684
Total Other Assets	$ 8,355	$ 1,976	$ 12,517	$ 11,516	$ 10,505
Total Assets	**$ 1,415**	**$ 9,794**	**$ 54,194**	**$ 42,947**	**$ 46,189**
Liability					
Total Current Liabilities	$ 1,277	$ 3,167	$ 2,704	$ 3,402	$ 2,440
Total Long Term Liabilities	$ -	$ 925	$ 7,937	$ 8,595	$ 9,163
Total Liabilities	**$ 1,277**	**$ 4,092**	**$ 10,641**	**$ 11,997**	**$ 11,603**
Equity	$ 139	$ 5,703	$ 43,554	$ 30,950	$ 34,585
Total Equity	**$ 139**	**$ 5,703**	**$ 43,554**	**$ 30,950**	**$ 34,585**
Total Liabilities and Equity	**$ 1,415**	**$ 9,794**	**$ 54,194**	**$ 42,947**	**$ 46,189**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Channel Islands Post Acute	Villa Maria Post Acute	Summerfield	Park View	Danville Post-Acute Rehab
Asset					
Total Current Assets	$ 12,263	$ 10,535	$ 26,048	$ 42,597	$ 2,590
Total Other Assets	$ 7,645	$ 10,035	$ 5,504	$ 18,549	$ 12,088
Total Assets	**$ 19,908**	**$ 20,570**	**$ 31,551**	**$ 61,146**	**$ 14,679**
Liability					
Total Current Liabilities	$ 2,799	$ 1,464	$ 1,246	$ 2,356	$ 1,473
Total Long Term Liabilities	$ 4,573	$ 7,921	$ 4,753	$ 16,042	$ 11,376
Total Liabilities	**$ 7,372**	**$ 9,385**	**$ 5,999**	**$ 18,398**	**$ 12,850**
Equity	$ 12,536	$ 11,184	$ 25,552	$ 42,749	$ 1,829
Total Equity	**$ 12,536**	**$ 11,184**	**$ 25,552**	**$ 42,749**	**$ 1,829**
Total Liabilities and Equity	**$ 19,908**	**$ 20,570**	**$ 31,551**	**$ 61,146**	**$ 14,679**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Fairmont Rehabilitation Hospital	Pacifica Nursing and Rehabilitation Center	Cloverdale	Broadway Villa	Valley of the Moon Post Acute
Asset					
Total Current Assets	$ 3,167	$ 6,266	$ 8,809	$ 13,624	$ 12,455
Total Other Assets	$ 10,853	$ 15,493	$ 3,448	$ 1,150	$ 87
Total Assets	**$ 14,021**	**$ 21,758**	**$ 12,257**	**$ 14,774**	**$ 12,542**
Liability					
Total Current Liabilities	$ 1,352	$ 2,396	$ 1,293	$ 1,725	$ 1,475
Total Long Term Liabilities	$ 10,352	$ 14,422	$ 1,604	$ (16,578)	$ -
Total Liabilities	**$ 11,705**	**$ 16,819**	**$ 2,898**	**$ 1,708**	**$ 1,475**
Equity	$ 2,316	$ 4,940	$ 9,359	$ 13,066	$ 11,067
Total Equity	**$ 2,316**	**$ 4,940**	**$ 9,359**	**$ 13,066**	**$ 11,067**
Total Liabilities and Equity	**$ 14,021**	**$ 21,758**	**$ 12,257**	**$ 14,774**	**$ 12,542**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Ukiah	Northbrook	Fairfield Post-Acute Rehab	Mission Care	Claremont
Asset					
Total Current Assets	$ 5,663	$ 3,819	$ 5,782	$ 20,492	$ 20,946
Total Other Assets	$ 4,706	$ 1,981	$ 19,710	$ 20	$ 5,529
Total Assets	**$ 10,369**	**$ 5,800**	**$ 25,493**	**$ 20,511**	**$ 26,475**
Liability					
Total Current Liabilities	$ 871	$ 519	$ 2,165	$ 1,536	$ 1,855
Total Long Term Liabilities	$ 3,679	$ 1,226	$ 18,592	$ (0)	$ 4,173
Total Liabilities	**$ 4,550**	**$ 1,746**	**$ 20,758**	**$ 1,536**	**$ 6,028**
Equity	$ 5,819	$ 4,054	$ 4,735	$ 18,976	$ 20,447
Total Equity	**$ 5,819**	**$ 4,054**	**$ 4,735**	**$ 18,976**	**$ 20,447**
Total Liabilities and Equity	**$ 10,369**	**$ 5,800**	**$ 25,493**	**$ 20,511**	**$ 26,475**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Ramona Nursing and Rehabilitation Center	Garden View Post-Acute Rehabilitation	Palm Terrace Care Center	Arbor Glen	Panorama Gardens
Asset					
Total Current Assets	$ 1,923	$ 4,370	$ 5,145	$ 16,466	$ 41,525
Total Other Assets	$ 22,030	$ 19,500	$ 16,214	$ 5,364	$ 266
Total Assets	**$ 23,953**	**$ 23,870**	**$ 21,360**	**$ 21,831**	**$ 41,791**
Liability					
Total Current Liabilities	$ 2,155	$ 1,897	$ 1,834	$ 1,509	$ 1,169
Total Long Term Liabilities	$ 20,521	$ 18,531	$ 15,124	$ 4,404	$ 87
Total Liabilities	**$ 22,677**	**$ 20,428**	**$ 16,958**	**$ 5,913**	**$ 1,256**
Equity	$ 1,276	$ 3,442	$ 4,402	$ 15,917	$ 40,535
Total Equity	**$ 1,276**	**$ 3,442**	**$ 4,402**	**$ 15,917**	**$ 40,535**
Total Liabilities and Equity	**$ 23,953**	**$ 23,870**	**$ 21,360**	**$ 21,831**	**$ 41,791**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Chatsworth Park Healthcare Center	Lake Balboa Care Center	Carmel Mountain Sub Acute	Carmel Mountain	Alamitos West Health and Rehabilitation
Asset					
Total Current Assets	$ 3,475	$ 6,672	$ (6,222)	$ 26,467	$ (7,480)
Total Other Assets	$ 24,350	$ 9,955	$ -	$ 16,513	$ 2
Total Assets	**$ 27,825**	**$ 16,628**	**$ (6,222)**	**$ 42,979**	**$ (5,871)**
Liability					
Total Current Liabilities	$ 1,738	$ 1,820		$ 2,433	
Total Long Term Liabilities	$ 22,789	$ 9,344	$ -	$ 15,090	$ -
Total Liabilities	**$ 24,527**	**$ 11,164**		**$ 17,523**	
Equity	$ 3,298	$ 5,463	$ (6,222)	$ 25,456	$ (5,871)
Total Equity	**$ 3,298**	**$ 5,463**	**$ (6,222)**	**$ 25,456**	**$ (5,871)**
Total Liabilities and Equity	**$ 27,825**	**$ 16,628**	**$ (6,222)**	**$ 42,979**	**$ (5,871)**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

	Katella Senior Living Community	The Grove Assisted Living	The Grove ILF	Upland
Asset				
Total Current Assets	$ (5,682)	$ 1,039	$ 610	$ 38,877
Total Other Assets	$ -	$ 2,743	$ -	$ 17,262
Total Assets	**$ (5,682)**	**$ 3,782**	**$ 610**	**$ 56,139**
Liability				
Total Current Liabilities		$ 576	$ 3	$ 3,788
Total Long Term Liabilities	$ -	$ 2,364	$ -	$ 14,958
Total Liabilities		**$ 2,940**	**$ 3**	**$ 18,746**
Equity	$ (5,682)	$ 842	$ 607	$ 37,393
Total Equity	**$ (5,682)**	**$ 842**	**$ 607**	**$ 37,393**
Total Liabilities and Equity	**$ (5,682)**	**$ 3,782**	**$ 610**	**$ 56,139**

THE ENSIGN GROUP, INC.

Condensed Combined Balance Sheet as of December 31, 2024

		Other		Consolidated
Asset				
Total Current Assets	$	56,034	$	1,157,632
Total Other Assets	$	2,912,380	$	3,511,724
Total Assets	**$**	**2,968,413**	**$**	**4,669,356**
Liability				
Total Current Liabilities	$	606,969	$	743,428
Total Long Term Liabilities	$	1,600,042	$	2,085,500
Total Liabilities	**$**	**2,207,011**	**$**	**2,828,928**
Equity	$	761,402	$	1,840,428
Total Equity	**$**	**761,402**	**$**	**1,840,428**
Total Liabilities and Equity	**$**	**2,968,413**	**$**	**4,669,356**

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Southland Care	Southland Home	The Orchard
Service Revenue	**$ 23,885**	**$ 3,315**	**$ 24,692**
Rental Revenue			
TOTAL REVENUE	**$ 23,885**	**$ 3,315**	**$ 24,692**
Cost of Services	$ 18,034	$ 2,015	$ 19,315
General and adminstrative expense	$ 1,194	$ 166	$ 1,235
Rent - cost of services	$ 1,567	$ 203	$ 1,295
Depreciation and amortization	$ 211	$ 74	$ 70
TOTAL EXPENSES	**$ 21,007**	**$ 2,457**	**$ 21,914**
Other (income)expense, net	**(9)**		**(16)**
Income before provision for income taxes	$ 2,887	$ 858	$ 2,794
Provision for income taxes	$ 736	$ 219	$ 712
NET INCOME	**$ 2,151**	**$ 639**	**$ 2,082**

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Downey Post Acute	Broadway by the Sea	Whittier Hills
Service Revenue	**$ 16,748**	**$ 14,993**	**$ 25,138**
Rental Revenue			
TOTAL REVENUE	**$ 16,748**	**$ 14,993**	**$ 25,138**
Cost of Services	$ 12,590	$ 12,147	$ 20,103
General and adminstrative expense	$ 837	$ 750	$ 1,257
Rent - cost of services	$ 808	$ 1,409	$ 1,181
Depreciation and amortization	$ 123	$ 99	$ 173
TOTAL EXPENSES	**$ 14,360**	**$ 14,404**	**$ 22,714**
Other (income)expense, net			
Income before provision for income taxes	$ 2,399	$ 599	$ 2,433
Provision for income taxes	$ 612	$ 153	$ 621
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Brookfield	Rose Villa	Camino Healthcare
Service Revenue	**$ 15,454**	**$ 11,292**	**$ 14,181**
Rental Revenue			
TOTAL REVENUE	**$ 15,454**	**$ 11,292**	**$ 14,181**
Cost of Services	$ 10,756	$ 7,913	$ 12,430
General and adminstrative expense	$ 773	$ 565	$ 709
Rent - cost of services	$ 863	$ 424	$ 729
Depreciation and amortization	$ 140	$ 292	$ 154
TOTAL EXPENSES	**$ 12,532**	**$ 9,194**	**$ 14,021**
Other (income)expense, net			
Income before provision for income taxes	$ 2,931	$ 2,100	$ 177
Provision for income taxes	$ 748	$ 536	$ 45
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	**Lomita Post-Acute Care Center**	**Atlantic**	**Shoreline**
Service Revenue	**$ 13,477**	**$ 18,367**	**$ 12,741**
Rental Revenue			
TOTAL REVENUE	**$ 13,477**	**$ 18,367**	**$ 12,741**
Cost of Services	$ 9,671	$ 13,176	$ 9,446
General and adminstrative expense	$ 674	$ 918	$ 637
Rent - cost of services	$ 1,154	$ 757	$ 712
Depreciation and amortization	$ 59	$ 152	$ 71
TOTAL EXPENSES	**$ 11,558**	**$ 15,003**	**$ 10,866**
Other (income)expense, net			
Income before provision for income taxes	$ 1,922	$ 3,370	$ 1,887
Provision for income taxes	$ 490	$ 859	$ 481
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Alamitos Belmont Rehabilitation	Edgewater Skilled Nursing Center	Golden Hill Post Acute
Service Revenue	**$ 17,025**	**$ 12,558**	**$ 1,443**
Rental Revenue			
TOTAL REVENUE	**$ 17,025**	**$ 12,558**	**$ 1,443**
Cost of Services	$ 12,782	$ 9,730	$ 3,352
General and adminstrative expense	$ 851	$ 628	$ 72
Rent - cost of services	$ 1,451	$ 1,156	$ 1,041
Depreciation and amortization	$ 95	$ 58	$ 178
TOTAL EXPENSES	**$ 15,179**	**$ 11,572**	**$ 4,643**
Other (income)expense, net			
Income before provision for income taxes	$ 1,850	$ 989	$ (3,174,810)
Provision for income taxes	$ 472	$ 252	$ (809,576)
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	**Vista Knoll**	**Arroyo Vista**	**Magnolia**
Service Revenue	**$ 24,395**	**$ 11,062**	**$ 15,735**
Rental Revenue			
TOTAL REVENUE	**$ 24,395**	**$ 11,062**	**$ 15,735**
Cost of Services	$ 17,053	$ 7,768	$ 12,885
General and adminstrative expense	$ 1,220	$ 553	$ 787
Rent - cost of services	$ 974	$ 217	$ 1,022
Depreciation and amortization	$ 280	$ 125	$ 39
TOTAL EXPENSES	**$ 19,526**	**$ 8,663**	**$ 14,732**
Other (income)expense, net			
Income before provision for income taxes	$ 4,880	$ 2,400	$ 1,008
Provision for income taxes	$ 1,244	$ 612	$ 257
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	The Cove	Grossmont	Victoria Post Acute
Service Revenue	**$ 12,543**	**$ 19,978**	**$ 19,533**
Rental Revenue			
TOTAL REVENUE	**$ 12,543**	**$ 19,978**	**$ 19,533**
Cost of Services	$ 9,618	$ 14,428	$ 15,537
General and adminstrative expense	$ 627	$ 999	$ 977
Rent - cost of services	$ 505	$ 1,201	$ 259
Depreciation and amortization	$ 282	$ 20	$ 874
TOTAL EXPENSES	**$ 11,031**	**$ 16,647**	**$ 17,647**
Other (income)expense, net			
Income before provision for income taxes	$ 1,513	$ 3,338	$ 1,908
Provision for income taxes	$ 386	$ 851	$ 487
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Parkside	Somerset	South Bay
Service Revenue	**$ 10,000**	**$ 9,532**	**$ 15,275**
Rental Revenue			
TOTAL REVENUE	**$ 10,000**	**$ 9,532**	**$ 15,275**
Cost of Services	$ 7,162	$ 10,061	$ 12,618
General and adminstrative expense	$ 500	$ 477	$ 764
Rent - cost of services	$ 120	$ 485	$ 1,238
Depreciation and amortization	$ 202	$ 57	$ 227
TOTAL EXPENSES	**$ 7,985**	**$ 11,079**	**$ 14,847**
Other (income)expense, net			
Income before provision for income taxes	$ 2,019	$ (1,544,769)	$ 432
Provision for income taxes	$ 515	$ (393,916)	$ 110
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Palomar Vista	Lemon Grove	La Jolla The Springs
Service Revenue	**$ 12,308**	**$ 24,459**	**$ 15,898**
Rental Revenue			
TOTAL REVENUE	**$ 12,308**	**$ 24,459**	**$ 15,898**
Cost of Services	$ 10,106	$ 18,088	$ 11,858
General and adminstrative expense	$ 615	$ 1,223	$ 795
Rent - cost of services	$ 319	$ 1,094	$ 1,108
Depreciation and amortization	$ 168	$ 95	$ 43
TOTAL EXPENSES	**$ 11,208**	**$ 20,499**	**$ 13,804**
Other (income)expense, net			
Income before provision for income taxes	$ 1,104	$ 3,973	$ 2,095
Provision for income taxes	$ 282	$ 1,013	$ 534
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Mission Hills	Victoria CM	Palm Terrace
Service Revenue	**$ 13,121**	**$ 16,354**	**$ 19,406**
Rental Revenue			
TOTAL REVENUE	**$ 13,121**	**$ 16,354**	**$ 19,406**
Cost of Services	$ 11,189	$ 11,773	$ 15,242
General and adminstrative expense	$ 656	$ 818	$ 970
Rent - cost of services	$ 407	$ 480	$ 664
Depreciation and amortization	$ 305	$ 267	$ 149
TOTAL EXPENSES	**$ 12,557**	**$ 13,338**	**$ 17,025**
Other (income)expense, net			
Income before provision for income taxes	$ 571	$ 3,018	$ 2,384
Provision for income taxes	$ 146	$ 770	$ 608
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Coventry Court Health Center	The Hills Post Acute	New Orange Hills
Service Revenue	**$ 16,968**	**$ 23,022**	**$ 25,454**
Rental Revenue			
TOTAL REVENUE	**$ 16,968**	**$ 23,022**	**$ 25,454**
Cost of Services	$ 12,522	$ 19,736	$ 20,287
General and adminstrative expense	$ 848	$ 1,151	$ 1,273
Rent - cost of services	$ 1,589	$ 1,264	$ 2,233
Depreciation and amortization	$ 67	$ 117	$ 91
TOTAL EXPENSES	**$ 15,026**	**$ 22,267**	**$ 23,884**
Other (income)expense, net			
Income before provision for income taxes	$ 1,947	$ 757	$ 1,581
Provision for income taxes	$ 496	$ 193	$ 403
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	St. Catherine Healthcare	Mainplace Post Acute	St. Elizabeth Health and Rehab
Service Revenue	**$ 18,242**	**$ 27,135**	**$ 12,045**
Rental Revenue			
TOTAL REVENUE	**$ 18,242**	**$ 27,135**	**$ 12,045**
Cost of Services	$ 12,498	$ 21,024	$ 9,228
General and adminstrative expense	$ 912	$ 1,357	$ 602
Rent - cost of services	$ 1,003	$ 1,824	$ 703
Depreciation and amortization	$ 148	$ 143	$ 57
TOTAL EXPENSES	**$ 14,561**	**$ 24,348**	**$ 10,589**
Other (income)expense, net			
Income before provision for income taxes	$ 3,681	$ 2,792	$ 1,466
Provision for income taxes	$ 939	$ 712	$ 374
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Sea Cliff Assisted Living	Sea Cliff	Beachside Nursing Center
Service Revenue	**$ 2,423**	**$ 26,676**	**$ 12,373**
Rental Revenue			
TOTAL REVENUE	**$ 2,423**	**$ 26,676**	**$ 12,373**
Cost of Services	$ 1,542	$ 20,514	$ 9,429
General and adminstrative expense	$ 121	$ 1,334	$ 619
Rent - cost of services	$ 259	$ 1,405	$ 1,092
Depreciation and amortization	$ 38	$ 99	$ 50
TOTAL EXPENSES	**$ 1,960**	**$ 23,352**	**$ 11,189**
Other (income)expense, net			
Income before provision for income taxes	$ 462	$ 3,325	$ 1,184
Provision for income taxes	$ 118	$ 848	$ 302
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	**Premier Care**	**Brookside**	**Desert Mountain Care Center**
Service Revenue	**$ 14,947**	**$ 15,193**	**$ 16,119**
Rental Revenue			
TOTAL REVENUE	**$ 14,947**	**$ 15,193**	**$ 16,119**
Cost of Services	$ 11,674	$ 12,239	$ 13,652
General and adminstrative expense	$ 747	$ 760	$ 806
Rent - cost of services	$ 631	$ 545	$ 584
Depreciation and amortization	$ 63	$ 85	$ 124
TOTAL EXPENSES	**$ 13,116**	**$ 13,628**	**$ 15,167**
Other (income)expense, net			
Income before provision for income taxes	$ 1,833	$ 1,567	$ 957
Provision for income taxes	$ 467	$ 400	$ 244
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Grand Terrace Healthcare Center	Arrowhead Springs Post Acute	The Grove SNF
Service Revenue	**$ 10,630**	**$ 17,518**	**$ 8,091**
Rental Revenue			
TOTAL REVENUE	**$ 10,630**	**$ 17,518**	**$ 8,091**
Cost of Services	$ 8,305	$ 13,953	$ 6,449
General and adminstrative expense	$ 531	$ 876	$ 405
Rent - cost of services	$ 883	$ 1,510	$ 197
Depreciation and amortization	$ 84	$ 54	$ 311
TOTAL EXPENSES	**$ 9,804**	**$ 16,392**	**$ 7,361**
Other (income)expense, net			
Income before provision for income taxes	$ 828	$ 1,132	$ 731
Provision for income taxes	$ 211	$ 289	$ 186
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Glenwood	Victoria Ventura	Camarillo
Service Revenue	**$ 19,861**	**$ 31,203**	**$ 20,210**
Rental Revenue			
TOTAL REVENUE	**$ 19,861**	**$ 31,203**	**$ 20,210**
Cost of Services	$ 14,174	$ 23,444	$ 14,228
General and adminstrative expense	$ 993	$ 1,560	$ 1,011
Rent - cost of services	$ 1,488	$ 1,250	$ 1,220
Depreciation and amortization	$ 304	$ 467	$ 221
TOTAL EXPENSES	**$ 16,959**	**$ 26,722**	**$ 16,679**
Other (income)expense, net			
Income before provision for income taxes	$ 2,903	$ 4,483	$ 3,540
Provision for income taxes	$ 740	$ 1,143	$ 903
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Channel Islands Post Acute	Villa Maria Post Acute	Summerfield
Service Revenue	**$ 24,945**	**$ 15,569**	**$ 16,829**
Rental Revenue			
TOTAL REVENUE	**$ 24,945**	**$ 15,569**	**$ 16,829**
Cost of Services	$ 19,369	$ 11,080	$ 10,927
General and adminstrative expense	$ 1,247	$ 778	$ 841
Rent - cost of services	$ 783	$ 1,149	$ 508
Depreciation and amortization	$ 330	$ 179	$ 137
TOTAL EXPENSES	**$ 21,729**	**$ 13,185**	**$ 12,414**
Other (income)expense, net			
Income before provision for income taxes	$ 3,217	$ 2,384	$ 4,415
Provision for income taxes	$ 820	$ 608	$ 1,126
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*		Park View		Danville Post-Acute Reh		Fairmont Rehabilitation Hospital
Service Revenue	**$**	**26,965**	**$**	**11,346**	**$**	**12,498**
Rental Revenue						
TOTAL REVENUE	**$**	**26,965**	**$**	**11,346**	**$**	**12,498**
Cost of Services	$	19,492	$	8,441	$	9,635
General and adminstrative expense	$	1,348	$	567	$	625
Rent - cost of services	$	2,157	$	1,219	$	1,011
Depreciation and amortization	$	208	$	44	$	47
TOTAL EXPENSES	**$**	**23,206**	**$**	**10,272**	**$**	**11,318**
Other (income)expense, net						
Income before provision for income taxes	$	3,760	$	1,079	$	1,181
Provision for income taxes	$	959	$	275	$	301
NET INCOME						

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Pacifica Nursing and Rehabilitation Cente	Cloverdale	Broadway Villa
Service Revenue	**$ 22,256**	**$ 10,633**	**$ 23,140**
Rental Revenue			
TOTAL REVENUE	**$ 22,256**	**$ 10,633**	**$ 23,140**
Cost of Services	$ 16,722	$ 8,036	$ 18,151
General and adminstrative expense	$ 1,113	$ 532	$ 1,157
Rent - cost of services	$ 1,410	$ 373	$ 755
Depreciation and amortization	$ 103	$ 194	$ 67
TOTAL EXPENSES	**$ 19,348**	**$ 9,134**	**$ 20,130**
Other (income)expense, net			
Income before provision for income taxes	$ 2,910	$ 1,502	$ 3,013
Provision for income taxes	$ 742	$ 383	$ 768
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Valley of the Moon Post Acute	Ukiah	Northbrook
Service Revenue	**$ 7,776**	**$ 8,211**	**$ 5,964**
Rental Revenue			
TOTAL REVENUE	**$ 7,776**	**$ 8,211**	**$ 5,964**
Cost of Services	$ 4,724	$ 7,220	$ 5,171
General and adminstrative expense	$ 389	$ 411	$ 298
Rent - cost of services		$ 328	$ 131
Depreciation and amortization	$ 23	$ 143	$ 103
TOTAL EXPENSES	**$ 5,135**	**$ 8,102**	**$ 5,703**
Other (income)expense, net			
Income before provision for income taxes	$ 2,641	$ 108	$ 261
Provision for income taxes	$ 673	$ 28	$ 66
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	**Fairfield Post-Acute Rehab**	**Northern California TopSide**	**Mission Care**
Service Revenue	**$ 20,689**	**$ -**	**$ 11,614**
Rental Revenue			
TOTAL REVENUE	**$ 20,689**		**$ 11,614**
Cost of Services	$ 14,846	$ 4,347	$ 8,379
General and adminstrative expense	$ 1,034	$ -	$ 581
Rent - cost of services	$ 1,893	$ 28	$ 905
Depreciation and amortization	$ 70	$ 8	$ 38
TOTAL EXPENSES	**$ 17,844**	**$ 4,383**	**$ 9,903**
Other (income)expense, net			
Income before provision for income taxes	$ 2,847	$ (4,383,285)	$ 1,718
Provision for income taxes	$ 726	$ (1,117,738)	$ 438
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Claremont	a Nursing and Rehabilitation Center	Gateway Post-Acute Rehabilitation
Service Revenue	**$ 16,346**	**$ 20,437**	**$ 16,752**
Rental Revenue			
TOTAL REVENUE	**$ 16,346**	**$ 20,437**	**$ 16,752**
Cost of Services	$ 12,668	$ 16,743	$ 12,159
General and adminstrative expense	$ 817	$ 1,022	$ 838
Rent - cost of services	$ 597	$ 2,089	$ 1,750
Depreciation and amortization	$ 313	$ 111	$ 65
TOTAL EXPENSES	**$ 14,395**	**$ 19,965**	**$ 14,812**
Other (income)expense, net	**(7)**	**(18)**	**(9)**
Income before provision for income taxes	$ 1,958	$ 490	$ 1,950
Provision for income taxes	$ 499	$ 125	$ 497
NET INCOME	**$ 1,458**	**$ 365**	**$ 1,452**

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Palm Terrace Care Center	Arbor Glen	Panorama Gardens
Service Revenue	**$ 16,443**	**$ 14,624**	**$ 20,411**
Rental Revenue			
TOTAL REVENUE	**$ 16,443**	**$ 14,624**	**$ 20,411**
Cost of Services	$ 11,363	$ 11,731	$ 15,170
General and adminstrative expense	$ 822	$ 731	$ 1,021
Rent - cost of services	$ 1,428	$ 394	$ 1,021
Depreciation and amortization	$ 57	$ 181	$ 36
TOTAL EXPENSES	**$ 13,670**	**$ 13,038**	**$ 17,248**
Other (income)expense, net			
Income before provision for income taxes	$ 2,774	$ 1,591	$ 3,168
Provision for income taxes	$ 707	$ 406	$ 808
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Chatsworth Park Healthcare Cen	Lake Balboa Care Center	Carmel Mountain
Service Revenue	**$ 20,768**	**$ 15,698**	**$ 25,154**
Rental Revenue			
TOTAL REVENUE	**$ 20,768**	**$ 15,698**	**$ 25,154**
Cost of Services	$ 15,783	$ 10,574	$ 19,774
General and adminstrative expense	$ 1,038	$ 785	$ 1,258
Rent - cost of services	$ 2,152	$ 951	$ 1,434
Depreciation and amortization	$ 106	$ 54	$ 256
TOTAL EXPENSES	**$ 19,079**	**$ 12,364**	**$ 22,722**
Other (income)expense, net			
Income before provision for income taxes	$ 1,691	$ 3,335	$ 2,443
Provision for income taxes	$ 431	$ 851	$ 623
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	Alamitos West Health and Rehabilitation	Kalispell Senior Living Community	The Grove Assisted Living
Service Revenue	**$ -**	**$ -**	**$ 3,274**
Rental Revenue			
TOTAL REVENUE			**$ 3,274**
Cost of Services	$ 6	$ 6	$ 2,188
General and adminstrative expense	$ -	$ -	$ 164
Rent - cost of services			$ 358
Depreciation and amortization	$ 0		$ 16
TOTAL EXPENSES	**$ 6**	**$ 6**	**$ 2,726**
Other (income)expense, net			
Income before provision for income taxes	$ (5,871)	$ (5,682)	$ 548
Provision for income taxes	$ (1,497)	$ (1,449)	$ 140
NET INCOME			

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*	**The Grove ILF**	**Upland**
Service Revenue	**$ 354**	**$ 34,759**
Rental Revenue		
TOTAL REVENUE	**$ 354**	**$ 34,759**
Cost of Services	$ 152	$ 27,885
General and adminstrative expense	$ 18	$ 1,738
Rent - cost of services	$ 89	$ 1,983
Depreciation and amortization		$ 350
TOTAL EXPENSES	**$ 259**	**$ 31,956**
Other (income)expense, net		
Income before provision for income taxes	$ 94	$ 2,825
Provision for income taxes	$ 24	$ 720
NET INCOME		

THE ENSIGN GROUP, INC.

Combined Income Statement as of December 31, 2024

Total *(in thousands)*		**Other**		**Consolidated**
Service Revenue	$	3,031,053	$	4,237,525
Rental Revenue	$	22,960	$	22,960
TOTAL REVENUE	**$**	**3,054,013**	**$**	**4,260,485**
Cost of Services	$	2,450,402	$	3,376,884
General and adminstrative expense	$	164,819	$	225,143
Rent - cost of services	$	144,596	$	216,016
Depreciation and amortization	$	73,295	$	84,138
TOTAL EXPENSES	**$**	**2,833,112**	**$**	**3,902,181**
Other (income)expense, net				
Income before provision for income taxes	$	248,293	$	386,094
Provision for income taxes	$	52,497	$	87,636
NET INCOME				

CONSOLIDATED CALIFORNIA SKILLED NURSING OPERATIONS
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 191,610,408	$ 130,013,712	$ 35,967,107	$ 429,735,694	$ -	$ 14,553,494	$ 11,930,055	$ 35,759,847	$ 849,570,317
10	Intermediate Care	$ -	$ -	$ -	$ 88,100	$ -	$ -	$ -	$ -	$ 88,100
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 2,039,590	$ 2,520,107	$ 1,872,465	$ 30,960,546	$ -	$ 974,768	$ 112,833	$ 786,339	$ 39,266,649
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 193,649,998	$ 132,533,819	$ 37,839,573	$ 460,784,340	$ -	$ 15,528,262	$ 12,042,888	$ 36,546,186	$ 888,925,066
	Ancillary Services:									
105	Patient Supplies	$ 1,261,997	$ 1,439,903	$ 188,802	$ 2,654,080	$ -	$ 156,075	$ 114,548	$ 110,434	$ 5,925,839
110	Specialized Support Surfaces	$ 233,477	$ 90,620	$ 33,217	$ 373,599	$ -	$ 6,284	$ 10,791	$ 21,007	$ 768,996
115	Physical Therapy	$ 49,845,870	$ 29,619,422	$ 160,982	$ 50,878,611	$ -	$ 2,945,055	$ 303,666	$ 1,010,070	$ 134,763,675
120	Respiratory Therapy	$ 418,320	$ 342,270	$ 385,380	$ 4,481,910	$ -	$ 223,875	$ -	$ 89,235	$ 5,940,990
125	Occupational Therapy	$ 55,050,270	$ 27,851,074	$ 124,253	$ 48,515,032	$ -	$ 2,620,530	$ 162,847	$ 963,135	$ 135,287,141
130	Speech Pathology	$ 24,508,215	$ 6,124,109	$ 36,559	$ 11,114,434	$ -	$ 525,120	$ 47,729	$ 235,710	$ 42,591,875
135	Pharmacy	$ 25,194,069	$ 16,513,555	$ 124,403	$ 2,593,291	$ -	$ 1,970,280	$ 14,053	$ 1,066,086	$ 47,475,737
140	Laboratory	$ 2,598,141	$ 1,918,518	$ 81,801	$ 693,780	$ -	$ 166,703	$ 9,347	$ 72,666	$ 5,540,958
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 2,588,953	$ 3,282,258	$ 35,847	$ 1,952,026	$ -	$ 263,166	$ 1,914	$ 58,780	$ 8,182,944
170	Subtotal (Lines 105 through 155)	$ 161,699,312	$ 87,181,731	$ 1,171,244	$ 123,256,763	$ -	$ 8,877,089	$ 664,895	$ 3,627,123	$ 386,478,156
175	**Total Gross Revenue (Line 70 + 170)**	**$ 345,790,391**	**$ 219,715,550**	**$ 39,010,816**	**$ 584,041,103**	**$ -**	**$ 24,405,350**	**$ 12,658,218**	**$ 40,173,308**	**$ 1,275,403,222**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 2,079,094	$ -	$ (298)	$ -	$ (2,171,252)	$ (278,665)	$ -	$ (371,120)
215	Contractual Adjustments - Medicare	$ (63,466,587)	$ 9,022,679	$ -	$ -	$ -	$ (435)	$ -	$ -	$ (54,444,344)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 9,774,910	$ 125,053,304	$ -	$ -	$ (16,666)	$ -	$ 134,811,548
222	Contractual Adjustments - Commercial Coverage	$ 22,162	$ -	$ -	$ -	$ -	$ (1,326,181)	$ 1,045	$ 3,964	$ (1,299,009)
225	Contractual Adjustments - Other	$ 24	$ -	$ 1,307	$ 67,472	$ -	$ -	$ (24,920)	$ (349,428)	$ (305,546)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (63,444,401)**	**$ 11,101,773**	**$ 9,776,216**	**$ 125,120,478**	**$ -**	**$ (3,497,868)**	**$ (319,205)**	**$ (345,464)**	**$ 78,391,530**
250	**Net Patient Revenue (line 175 - 240)**	**$ 414,519,231**	**$ 208,613,777**	**$ 29,234,600**	**$ 458,920,625**	**$ -**	**$ 27,903,218**	**$ 12,977,423**	**$ 40,518,772**	**$ 1,197,011,692**

CONSOLIDATED CALIFORNIA SKILLED NURSING OPERATIONS
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	456575	305799	107591	1171975	0	31400	28538	97684	2199562
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	3483	4261	3954	44571	0	1364	615	676	58924
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	460058	310060	111545	1216546	0	32764	29153	98360	2258486

Alamitos Belmont Rehabilitation Hospital
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,048,000	$ 1,538,066	$ 1,194,816	$ 4,686,170	$ -	$ 47,250	$ 488,035	$ 445,463	$ 12,447,800
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,048,000	$ 1,538,066	$ 1,194,816	$ 4,686,170	$ -	$ 47,250	$ 488,035	$ 445,463	$ 12,447,800
	Ancillary Services:									
105	Patient Supplies	$ 186	$ 12,312	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,498
110	Specialized Support Surfaces	$ 72	$ 528	$ -	$ 136	$ -	$ -	$ -	$ -	$ 736
115	Physical Therapy	$ 962,865	$ 308,475	$ 3,150	$ 1,166,760	$ -	$ 8,910	$ 21,645	$ 225	$ 2,472,030
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,008,270	$ 302,760	$ 1,440	$ 1,120,320	$ -	$ 8,595	$ 12,510	$ 90	$ 2,453,985
130	Speech Pathology	$ 450,945	$ 94,410	$ 720	$ 176,625	$ -	$ 5,940	$ 6,750	$ 225	$ 735,615
135	Pharmacy	$ 181,478	$ 77,792	$ -	$ 3,618	$ -	$ 4,469	$ -	$ 278	$ 267,634
140	Laboratory	$ 6,866	$ 3,170	$ 131	$ 282	$ -	$ 131	$ -	$ -	$ 10,579
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 54,174	$ 21,772	$ 463	$ 25,964	$ -	$ 64	$ 225	$ -	$ 102,661
170	Subtotal (Lines 105 through 155)	$ 2,664,857	$ 821,218	$ 5,903	$ 2,493,705	$ -	$ 28,108	$ 41,130	$ 818	$ 6,055,738
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,628,032**	**$ 2,359,284**	**$ 1,200,719**	**$ 7,179,875**	**$ -**	**$ 75,358**	**$ 529,165**	**$ 446,281**	**$ 18,503,538**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (13,597)	$ -	$ -	$ -	$ 4,249	$ 19,304	$ -	$ 9,957
215	Contractual Adjustments - Medicare	$ (437,997)	$ 74,842	$ -	$ -	$ -	$ -	$ -	$ -	$ (363,154)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 147,458	$ 1,635,602	$ -	$ -	$ -	$ -	$ 1,783,059
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 10,745	$ -	$ -	$ 10,745
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 39,306	$ 39,306
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (437,997)**	**$ 61,246**	**$ 147,458**	**$ 1,635,602**	**$ -**	**$ 14,994**	**$ 19,304**	**$ 39,306**	**$ 1,479,912**
250	**Net Patient Revenue (line 175 - 240)**	**$ 7,111,357**	**$ 2,298,038**	**$ 1,053,261**	**$ 5,544,273**	**$ -**	**$ 60,364**	**$ 509,861**	**$ 406,975**	**$ 17,023,626**

Alamitos Belmont Rehabilitation Hospital
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	8240	3993	3486	13050	0	133	1258	1278	31438
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	8240	3993	3486	13050	0	133	1258	1278	31438

Arbor Glen
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,084,200	$ 1,560,050	$ 397,274	$ 5,171,979	$ -	$ 188,275	$ 27,997	$ 593,350	$ 10,023,125
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,084,200	$ 1,560,050	$ 397,274	$ 5,171,979	$ -	$ 188,275	$ 27,997	$ 593,350	$ 10,023,125
	Ancillary Services:									
105	Patient Supplies	$ 8,016	$ 2,594	$ 4,912	$ 21,794	$ -	$ -	$ -	$ 16,550	$ 53,866
110	Specialized Support Surfaces	$ -	$ 28,575	$ -	$ -	$ -	$ -	$ -	$ -	$ 28,575
115	Physical Therapy	$ 686,880	$ 470,790	$ 135	$ 470,925	$ -	$ 47,160	$ 3,420	$ 90	$ 1,679,400
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 726,030	$ 405,990	$ 135	$ 459,900	$ -	$ 42,210	$ 3,510	$ 90	$ 1,637,865
130	Speech Pathology	$ 339,390	$ 80,685	$ 135	$ 73,305	$ -	$ 5,580	$ 1,485	$ -	$ 500,580
135	Pharmacy	$ 340,234	$ 251,342	$ 2,071	$ 25,971	$ -	$ 22,570	$ -	$ 2,687	$ 644,874
140	Laboratory	$ 27,007	$ 91,367	$ 115	$ 1,138	$ -	$ 3,077	$ -	$ -	$ 122,704
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 37,227	$ 72,829	$ -	$ 4,610	$ -	$ 6,756	$ -	$ 460	$ 121,882
170	Subtotal (Lines 105 through 155)	$ 2,164,783	$ 1,404,172	$ 7,503	$ 1,057,644	$ -	$ 127,353	$ 8,415	$ 19,878	$ 4,789,746
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,248,983**	**$ 2,964,222**	**$ 404,777**	**$ 6,229,623**	**$ -**	**$ 315,628**	**$ 36,412**	**$ 613,228**	**$ 14,812,871**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 1,923	$ -	$ -	$ -	$ (473)	$ 285	$ -	$ 1,735
215	Contractual Adjustments - Medicare	$ (1,198,292)	$ 95,850	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,102,442)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 74,188	$ 1,079,652	$ -	$ -	$ -	$ -	$ 1,153,839
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 45,562	$ -	$ -	$ 45,562
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 89,782	$ 89,782
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,198,292)**	**$ 97,772**	**$ 74,188**	**$ 1,079,652**	**$ -**	**$ 45,089**	**$ 285**	**$ 89,782**	**$ 188,476**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,447,275**	**$ 2,866,449**	**$ 330,589**	**$ 5,149,971**	**$ -**	**$ 270,539**	**$ 36,127**	**$ 523,445**	**$ 14,624,395**

Arbor Glen
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6148	4742	1459	15937	0	484	80	1824	30674
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6148	4742	1459	15937	0	484	80	1824	30674

Arrowhead Springs Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,492,380	$ 3,393,420	$ 1,195,431	$ 8,359,689	$ -	$ 310,010	$ 83,340	$ 735,272	$ 15,569,542
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,492,380	$ 3,393,420	$ 1,195,431	$ 8,359,689	$ -	$ 310,010	$ 83,340	$ 735,272	$ 15,569,542
	Ancillary Services:									
105	Patient Supplies	$ 440	$ 10,196	$ 2,548	$ 33,956	$ -	$ -	$ 600	$ -	$ 47,740
110	Specialized Support Surfaces	$ 3,373	$ 6,886	$ 317	$ 8,649	$ -	$ 476	$ 496	$ 1,673	$ 21,870
115	Physical Therapy	$ 431,730	$ 696,510	$ 2,115	$ 612,630	$ -	$ 58,365	$ 5,405	$ 20,070	$ 1,826,825
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 600,795	$ 596,970	$ 2,070	$ 557,190	$ -	$ 49,950	$ 90	$ 20,745	$ 1,827,810
130	Speech Pathology	$ 536,175	$ 148,185	$ 360	$ 85,365	$ -	$ 4,455	$ -	$ 7,335	$ 781,875
135	Pharmacy	$ 495,742	$ 1,352,270	$ 553	$ 6,769	$ -	$ 163,283	$ -	$ 47,566	$ 2,066,183
140	Laboratory	$ 12,557	$ 33,266	$ 478	$ 6,459	$ -	$ 3,761	$ -	$ 838	$ 57,359
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 18,930	$ 132,628	$ 3,532	$ 58,492	$ -	$ 9,815	$ -	$ 939	$ 224,336
170	Subtotal (Lines 105 through 155)	$ 2,099,742	$ 2,976,911	$ 11,972	$ 1,369,509	$ -	$ 290,106	$ 6,591	$ 99,167	$ 6,853,999
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,592,122**	**$ 6,370,331**	**$ 1,207,403**	**$ 9,729,198**	**$ -**	**$ 600,116**	**$ 89,931**	**$ 834,439**	**$ 22,423,541**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (3,432)	$ -	$ -	$ -	$ (324)	$ (7)	$ -	$ (3,763)
215	Contractual Adjustments - Medicare	$ 499,508	$ 1,070,749	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,570,257
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 435,283	$ 2,560,527	$ -	$ -	$ 43	$ -	$ 2,995,853
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 134,130	$ -	$ -	$ 134,130
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 210,268	$ 210,268
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 499,508**	**$ 1,067,317**	**$ 435,283**	**$ 2,560,527**	**$ -**	**$ 133,806**	**$ 36**	**$ 210,268**	**$ 4,906,745**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,092,614**	**$ 5,303,014**	**$ 772,121**	**$ 7,168,671**	**$ -**	**$ 466,310**	**$ 89,895**	**$ 624,171**	**$ 17,516,796**

Arrowhead Springs Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3875	8638	3112	22493	0	816	288	1946	41168
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3875	8638	3112	22493	0	816	288	1946	41168

Arroyo Vista
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,216,500	$ 1,610,750	$ 101,219	$ 2,546,101	$ -	$ 33,300	$ 12,018	$ 736,937	$ 6,256,825
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,216,500	$ 1,610,750	$ 101,219	$ 2,546,101	$ -	$ 33,300	$ 12,018	$ 736,937	$ 6,256,825
	Ancillary Services:									
105	Patient Supplies	$ 12,816	$ 25,376	$ 2,118	$ 34,071	$ -	$ 408	$ -	$ 9,389	$ 84,178
110	Specialized Support Surfaces	$ 1,488	$ 2,001	$ -	$ 7,165	$ -	$ -	$ -	$ 67	$ 10,722
115	Physical Therapy	$ 322,245	$ 431,595	$ -	$ 355,275	$ -	$ 8,685	$ -	$ 76,590	$ 1,194,390
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 354,105	$ 412,515	$ -	$ 329,805	$ -	$ 7,920	$ -	$ 73,260	$ 1,177,605
130	Speech Pathology	$ 191,655	$ 94,815	$ -	$ 61,830	$ -	$ 540	$ -	$ 27,225	$ 376,065
135	Pharmacy	$ 200,426	$ 326,439	$ -	$ 168,328	$ -	$ 8,630	$ -	$ 80,271	$ 784,095
140	Laboratory	$ 18,382	$ 23,676	$ 1,343	$ 10,804	$ -	$ 934	$ -	$ 4,483	$ 59,622
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 12,490	$ 17,239	$ 355	$ 15,942	$ -	$ 457	$ -	$ 2,573	$ 49,056
170	Subtotal (Lines 105 through 155)	$ 1,113,608	$ 1,333,656	$ 3,816	$ 983,220	$ -	$ 27,573	$ -	$ 273,860	$ 3,735,733
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,330,108**	**$ 2,944,406**	**$ 105,035**	**$ 3,529,321**	**$ -**	**$ 60,873**	**$ 12,018**	**$ 1,010,797**	**$ 9,992,558**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ (4,025)	$ 4,025	$ -	$ -
215	Contractual Adjustments - Medicare	$ (443,369)	$ (317,106)	$ -	$ -	$ -	$ -	$ -	$ -	$ (760,475)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 15,253	$ (42,542)	$ -	$ -	$ -	$ -	$ (27,289)
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (2,786)	$ -	$ -	$ (2,786)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ (176)	$ (278,031)	$ (278,207)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (443,369)**	**$ (317,106)**	**$ 15,253**	**$ (42,542)**	**$ -**	**$ (6,811)**	**$ 3,849**	**$ (278,031)**	**$ (1,068,757)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,773,477**	**$ 3,261,512**	**$ 89,782**	**$ 3,571,863**	**$ -**	**$ 67,684**	**$ 8,169**	**$ 1,288,828**	**$ 11,061,315**

Arroyo Vista
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3268	4542	294	7249	0	102	44	1945	17444
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3268	4542	294	7249	0	102	44	1945	17444

Atlantic
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,722,775	$ 1,574,887	$ 399,909	$ 5,709,491	$ -	$ 121,338	$ 286,303	$ 310,105	$ 11,124,808
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,722,775	$ 1,574,887	$ 399,909	$ 5,709,491	$ -	$ 121,338	$ 286,303	$ 310,105	$ 11,124,808
	Ancillary Services:									
105	Patient Supplies	$ 10,111	$ 16,809	$ -	$ 1,568	$ -	$ -	$ -	$ -	$ 28,488
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 775,170	$ 488,835	$ 2,250	$ 1,404,585	$ -	$ 30,735	$ 1,395	$ 405	$ 2,703,375
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 861,255	$ 471,285	$ 2,385	$ 1,528,920	$ -	$ 31,680	$ 270	$ 540	$ 2,896,335
130	Speech Pathology	$ 472,590	$ 165,105	$ -	$ 143,190	$ -	$ 11,745	$ 1,845	$ 540	$ 795,015
135	Pharmacy	$ 143,553	$ 80,973	$ -	$ 2,777	$ -	$ 3,762	$ -	$ 93	$ 231,159
140	Laboratory	$ 9,766	$ 360	$ 10	$ 900	$ -	$ -	$ -	$ -	$ 11,037
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 24,624	$ 32,055	$ -	$ 12,299	$ -	$ 657	$ -	$ -	$ 69,634
170	Subtotal (Lines 105 through 155)	$ 2,297,070	$ 1,255,422	$ 4,645	$ 3,094,238	$ -	$ 78,579	$ 3,510	$ 1,578	$ 6,735,042
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,998,875**	**$ 2,830,309**	**$ 404,555**	**$ 8,803,729**	**$ -**	**$ 199,917**	**$ 289,813**	**$ 311,683**	**$ 17,859,851**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (34,020)	$ -	$ -	$ -	$ -	$ (14,625)	$ -	$ (48,645)
215	Contractual Adjustments - Medicare	$ (2,248,941)	$ (341,775)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,590,715)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 59,162	$ 2,006,213	$ -	$ -	$ 0	$ -	$ 2,065,375
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 35,482	$ -	$ -	$ 35,482
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ (4,067)	$ -	$ -	$ -	$ 35,987	$ 31,920
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,248,941)**	**$ (375,795)**	**$ 59,162**	**$ 2,002,146**	**$ -**	**$ 35,482**	**$ (14,625)**	**$ 35,987**	**$ (506,583)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 7,258,430**	**$ 3,206,104**	**$ 345,393**	**$ 6,801,582**	**$ -**	**$ 164,435**	**$ 304,438**	**$ 275,697**	**$ 18,366,434**

Atlantic
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7840	4661	1406	16703	0	351	908	901	32770
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7840	4661	1406	16703	0	351	908	901	32770

Beachside Nursing Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,777,500	$ 2,262,385	$ 104,528	$ 1,629,422	$ -	$ -	$ 473,665	$ 194,100	$ 7,441,600
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,777,500	$ 2,262,385	$ 104,528	$ 1,629,422	$ -	$ -	$ 473,665	$ 194,100	$ 7,441,600
	Ancillary Services:									
105	Patient Supplies	$ 12,546	$ 28,981	$ -	$ -	$ -	$ -	$ -	$ 4,350	$ 45,876
110	Specialized Support Surfaces	$ 38,271	$ 6,442	$ -	$ 8,480	$ -	$ -	$ 2,497	$ 1,325	$ 57,015
115	Physical Therapy	$ 729,315	$ 588,510	$ -	$ 200,572	$ -	$ -	$ 22,660	$ -	$ 1,541,056
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 916,155	$ 573,422	$ -	$ 184,590	$ -	$ -	$ 19,251	$ -	$ 1,693,418
130	Speech Pathology	$ 337,995	$ 128,417	$ -	$ 25,740	$ -	$ -	$ 1,578	$ -	$ 493,730
135	Pharmacy	$ 568,900	$ 122,972	$ 126	$ 7,403	$ -	$ -	$ 283	$ -	$ 699,683
140	Laboratory	$ 39,110	$ 75,479	$ 57	$ -	$ -	$ -	$ 290	$ 564	$ 115,500
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 42,188	$ 64,340	$ -	$ 171	$ -	$ -	$ -	$ -	$ 106,699
170	Subtotal (Lines 105 through 155)	$ 2,684,479	$ 1,588,561	$ 183	$ 426,957	$ -	$ -	$ 46,558	$ 6,239	$ 4,752,976
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,461,979**	**$ 3,850,946**	**$ 104,711**	**$ 2,056,379**	**$ -**	**$ -**	**$ 520,223**	**$ 200,339**	**$ 12,194,576**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 283	$ -	$ -	$ -	$ -	$ (28,266)	$ -	$ (27,983)
215	Contractual Adjustments - Medicare	$ (507,224)	$ (68,261)	$ -	$ -	$ -	$ -	$ -	$ -	$ (575,485)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 13,920	$ 399,416	$ -	$ -	$ -	$ -	$ 413,336
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,599	$ 11,599
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (507,224)**	**$ (67,978)**	**$ 13,920**	**$ 399,416**	**$ -**	**$ -**	**$ (28,266)**	**$ 11,599**	**$ (178,532)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,969,204**	**$ 3,918,923**	**$ 90,790**	**$ 1,656,963**	**$ -**	**$ -**	**$ 548,489**	**$ 188,739**	**$ 12,373,108**

Beachside Nursing Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7430	6240	359	4528	0	0	1240	545	20342
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7430	6240	359	4528	0	0	1240	545	20342

Broadway by the Sea
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,058,395	$ 823,923	$ 729,621	$ 4,810,531	$ -	$ 338,222	$ 76,970	$ 1,502,053	$ 9,339,716
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,058,395	$ 823,923	$ 729,621	$ 4,810,531	$ -	$ 338,222	$ 76,970	$ 1,502,053	$ 9,339,716
	Ancillary Services:									
105	Patient Supplies	$ 2,862	$ 17,076	$ 7,576	$ 1,576	$ -	$ 8,838	$ -	$ 746	$ 38,674
110	Specialized Support Surfaces	$ 19,526	$ 3,346	$ 10,143	$ 34,977	$ -	$ 4,019	$ -	$ 12,806	$ 84,817
115	Physical Therapy	$ 462,375	$ 335,115	$ 4,545	$ 999,540	$ -	$ 108,720	$ 9,405	$ 131,985	$ 2,051,685
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 435,645	$ 340,830	$ 270	$ 1,248,840	$ -	$ 108,135	$ 2,475	$ 117,540	$ 2,253,735
130	Speech Pathology	$ 139,500	$ 33,930	$ 90	$ 46,530	$ -	$ 11,655	$ -	$ 22,545	$ 254,250
135	Pharmacy	$ 144,276	$ 128,028	$ 612	$ 3,271	$ -	$ 57,230	$ 296	$ 86,657	$ 420,370
140	Laboratory	$ 16,643	$ 3,189	$ 625	$ 224	$ -	$ 1,885	$ 791	$ 1,466	$ 24,823
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 19,724	$ 24,867	$ 836	$ 32,320	$ -	$ 9,055	$ -	$ 10,394	$ 97,196
170	Subtotal (Lines 105 through 155)	$ 1,240,551	$ 886,381	$ 24,697	$ 2,367,278	$ -	$ 309,536	$ 12,968	$ 384,138	$ 5,225,549
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,298,946**	**$ 1,710,305**	**$ 754,319**	**$ 7,177,809**	**$ -**	**$ 647,758**	**$ 89,938**	**$ 1,886,192**	**$ 14,565,265**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (43,475)	$ -	$ -	$ -	$ (690)	$ (3,900)	$ -	$ (48,065)
215	Contractual Adjustments - Medicare	$ (502,670)	$ (156,052)	$ -	$ -	$ -	$ -	$ -	$ -	$ (658,722)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 27,087	$ 1,149,060	$ -	$ -	$ -	$ -	$ 1,176,148
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (31,473)	$ -	$ -	$ (31,473)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (864,654)	$ (864,654)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (502,670)**	**$ (199,527)**	**$ 27,087**	**$ 1,149,060**	**$ -**	**$ (32,163)**	**$ (3,900)**	**$ (864,654)**	**$ (426,767)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,801,616**	**$ 1,909,832**	**$ 727,231**	**$ 6,028,749**	**$ -**	**$ 679,921**	**$ 93,838**	**$ 2,750,845**	**$ 14,992,032**

Broadway by the Sea
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3335	2685	2700	15944	0	1061	197	5524	31446
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3335	2685	2700	15944	0	1061	197	5524	31446

Broadway Villa
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,929,200	$ 1,466,684	$ 1,485,159	$ 13,540,991	$ -	$ 252,077	$ 76,838	$ 2,111,708	$ 20,862,658
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,929,200	$ 1,466,684	$ 1,485,159	$ 13,540,991	$ -	$ 252,077	$ 76,838	$ 2,111,708	$ 20,862,658
	Ancillary Services:									
105	Patient Supplies	$ -	$ 5,218	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,218
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 339,930	$ 470,115	$ 1,800	$ 431,010	$ -	$ 45,630	$ -	$ 89,595	$ 1,378,080
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 390,555	$ 398,194	$ 2,205	$ 301,635	$ -	$ 42,210	$ 11	$ 72,360	$ 1,207,170
130	Speech Pathology	$ 90,540	$ 61,155	$ 585	$ 117,675	$ -	$ 8,820	$ (0)	$ 23,490	$ 302,265
135	Pharmacy	$ 184,167	$ 131,538	$ 15,333	$ 44,196	$ -	$ 48,163	$ 21	$ 104,929	$ 528,348
140	Laboratory	$ 89,370	$ 69,663	$ 13,499	$ 72,019	$ -	$ 16,428	$ -	$ 27,542	$ 288,521
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 37,048	$ 31,400	$ 7,591	$ 57,442	$ -	$ 3,342	$ -	$ 7,264	$ 144,087
170	Subtotal (Lines 105 through 155)	$ 1,131,609	$ 1,167,283	$ 41,014	$ 1,023,978	$ -	$ 164,593	$ 31	$ 325,180	$ 3,853,689
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,060,809**	**$ 2,633,967**	**$ 1,526,173**	**$ 14,564,969**	**$ -**	**$ 416,670**	**$ 76,870**	**$ 2,436,888**	**$ 24,716,347**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (10,557)	$ -	$ -	$ -	$ 58,870	$ 1,485	$ -	$ 49,798
215	Contractual Adjustments - Medicare	$ (1,289,333)	$ (345,783)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,635,116)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 710,189	$ 4,078,428	$ -	$ -	$ -	$ -	$ 4,788,618
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 31,422	$ (170)	$ 3,705	$ 34,957
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,659,813)	$ (1,659,813)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,289,333)**	**$ (356,340)**	**$ 710,189**	**$ 4,078,428**	**$ -**	**$ 90,292**	**$ 1,315**	**$ (1,656,108)**	**$ 1,578,444**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,350,142**	**$ 2,990,307**	**$ 815,983**	**$ 10,486,541**	**$ -**	**$ 326,378**	**$ 75,555**	**$ 4,092,996**	**$ 23,137,903**

Broadway Villa
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total	
5	Skilled Nursing	4130	3145	3736	29395	0	558	164	7016	48144	
10	Intermediate Care										
15	Mentally Disordered										
20	Developmentally Disabled										
25	Sub-Acute	0	0	0	0	0	0	0	0	0	
30	Sub-Acute Pediatric										
35	Transitional Inpatient Care										
40	Hospice Inpatient Care										
45	Other Routine										
70	Subtotal	4130	3145	3736	29395	0	558	164	7016	48144	

Brookfield
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,489,750	$ 800,013	$ 87,073	$ 3,989,927	$ -	$ 25,200	$ 197,150	$ 11,750	$ 9,600,863
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,489,750	$ 800,013	$ 87,073	$ 3,989,927	$ -	$ 25,200	$ 197,150	$ 11,750	$ 9,600,863
	Ancillary Services:									
105	Patient Supplies	$ 3,227	$ 7,933	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,160
110	Specialized Support Surfaces	$ 7,336	$ 96	$ -	$ -	$ -	$ 44	$ -	$ -	$ 7,475
115	Physical Therapy	$ 1,029,195	$ 193,140	$ 675	$ 842,136	$ -	$ 5,940	$ -	$ -	$ 2,071,086
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,264,050	$ 188,505	$ 540	$ 686,205	$ -	$ 5,670	$ -	$ -	$ 2,144,970
130	Speech Pathology	$ 690,705	$ 55,305	$ -	$ 261,000	$ -	$ 1,710	$ -	$ -	$ 1,008,720
135	Pharmacy	$ 511,796	$ 80,124	$ -	$ 5,330	$ -	$ 2,241	$ -	$ -	$ 599,491
140	Laboratory	$ 43,305	$ 660	$ -	$ 163	$ -	$ 166	$ -	$ -	$ 44,294
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 66,151	$ 33,598	$ -	$ 9,799	$ -	$ -	$ -	$ -	$ 109,549
170	Subtotal (Lines 105 through 155)	$ 3,615,765	$ 559,361	$ 1,215	$ 1,804,633	$ -	$ 15,771	$ -	$ -	$ 5,996,745
175	**Total Gross Revenue (Line 70 + 170)**	**$ 8,105,515**	**$ 1,359,373**	**$ 88,288**	**$ 5,794,561**	**$ -**	**$ 40,971**	**$ 197,150**	**$ 11,750**	**$ 15,597,607**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 7,468	$ -	$ -	$ -	$ -	$ (2,680)	$ -	$ 4,788
215	Contractual Adjustments - Medicare	$ (1,513,957)	$ 123	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,513,834)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 6,884	$ 1,636,243	$ -	$ -	$ -	$ -	$ 1,643,127
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 5,673	$ -	$ -	$ 5,673
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,763	$ 2,763
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,513,957)**	**$ 7,591**	**$ 6,884**	**$ 1,636,243**	**$ -**	**$ 5,673**	**$ (2,680)**	**$ 2,763**	**$ 142,516**
250	**Net Patient Revenue (line 175 - 240)**	**$ 9,619,472**	**$ 1,351,782**	**$ 81,403**	**$ 4,158,318**	**$ -**	**$ 35,298**	**$ 199,830**	**$ 8,987**	**$ 15,455,091**

Brookfield
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	10939	2103	248	9919	0	63	444	27	23743
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	10939	2103	248	9919	0	63	444	27	23743

Brookside
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,681,785	$ 2,068,173	$ 592,288	$ 4,084,887	$ -	$ 93,887	$ 34,705	$ 589,015	$ 10,144,740
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,681,785	$ 2,068,173	$ 592,288	$ 4,084,887	$ -	$ 93,887	$ 34,705	$ 589,015	$ 10,144,740
	Ancillary Services:									
105	Patient Supplies	$ 2,468	$ 1,801	$ -	$ 1,080	$ -	$ -	$ -	$ 508	$ 5,857
110	Specialized Support Surfaces	$ 8	$ 16	$ -	$ -	$ -	$ -	$ -	$ -	$ 24
115	Physical Therapy	$ 722,070	$ 542,754	$ -	$ 413,055	$ -	$ 24,750	$ -	$ 110,430	$ 1,813,059
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,046,880	$ 564,030	$ -	$ 394,605	$ -	$ 24,165	$ -	$ 115,335	$ 2,145,015
130	Speech Pathology	$ 167,850	$ 16,110	$ 675	$ 30,330	$ -	$ -	$ -	$ 13,275	$ 228,240
135	Pharmacy	$ 593,566	$ 167,298	$ -	$ 3,964	$ -	$ 17,088	$ -	$ 119,436	$ 901,352
140	Laboratory	$ 41,425	$ 17,405	$ 700	$ 25	$ -	$ 595	$ 31	$ 168	$ 60,348
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 59,860	$ 41,484	$ -	$ 5,353	$ -	$ 1,592	$ -	$ 3,846	$ 112,135
170	Subtotal (Lines 105 through 155)	$ 2,634,127	$ 1,350,897	$ 1,375	$ 848,412	$ -	$ 68,190	$ 31	$ 362,998	$ 5,266,029
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,315,912**	**$ 3,419,070**	**$ 593,663**	**$ 4,933,299**	**$ -**	**$ 162,077**	**$ 34,736**	**$ 952,013**	**$ 15,410,769**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (16,272)	$ -	$ -	$ -	$ (643)	$ -	$ -	$ (16,915)
215	Contractual Adjustments - Medicare	$ (668,203)	$ 330,452	$ -	$ -	$ -	$ -	$ -	$ -	$ (337,751)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 64,361	$ 845,448	$ -	$ -	$ -	$ -	$ 909,808
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 11,734	$ -	$ -	$ 11,734
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (346,655)	$ (346,655)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (668,203)**	**$ 314,180**	**$ 64,361**	**$ 845,448**	**$ -**	**$ 11,091**	**$ -**	**$ (346,655)**	**$ 220,222**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,984,115**	**$ 3,104,890**	**$ 529,302**	**$ 4,087,851**	**$ -**	**$ 150,986**	**$ 34,736**	**$ 1,298,667**	**$ 15,190,547**

Brookside
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7633	6260	1928	12509	0	332	109	2348	31119
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7633	6260	1928	12509	0	332	109	2348	31119

Camarillo
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,632,220	$ 1,599,167	$ 685,016	$ 7,811,954	$ -	$ 26,865	$ 238,333	$ 236,290	$ 14,229,845
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,632,220	$ 1,599,167	$ 685,016	$ 7,811,954	$ -	$ 26,865	$ 238,333	$ 236,290	$ 14,229,845
	Ancillary Services:									
105	Patient Supplies	$ 3,118	$ 6,985	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,103
110	Specialized Support Surfaces	$ 1,808	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,808
115	Physical Therapy	$ 1,048,995	$ 385,245	$ 4,185	$ 1,243,035	$ -	$ 6,165	$ 9,945	$ -	$ 2,697,570
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 857,835	$ 288,720	$ 360	$ 510,030	$ -	$ 5,040	$ 6,075	$ -	$ 1,668,060
130	Speech Pathology	$ 295,650	$ 73,935	$ 225	$ 145,620	$ -	$ 1,170	$ 4,860	$ -	$ 521,460
135	Pharmacy	$ 185,736	$ 68,665	$ -	$ 3,946	$ -	$ 1,285	$ -	$ -	$ 259,631
140	Laboratory	$ 51,813	$ 29,081	$ 417	$ 243	$ -	$ 363	$ -	$ -	$ 81,917
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 39,452	$ 54,430	$ -	$ 7,502	$ -	$ -	$ -	$ -	$ 101,384
170	Subtotal (Lines 105 through 155)	$ 2,484,406	$ 907,062	$ 5,187	$ 1,910,377	$ -	$ 14,023	$ 20,880	$ -	$ 5,341,934
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,969,026**	**$ 2,506,229**	**$ 690,203**	**$ 9,722,330**	**$ -**	**$ 40,888**	**$ 259,213**	**$ 236,290**	**$ 19,571,779**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (1,219)	$ -	$ -	$ -	$ -	$ (6,728)	$ -	$ (7,947)
215	Contractual Adjustments - Medicare	$ (2,388,130)	$ (492,367)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,880,497)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 151,670	$ 2,118,430	$ -	$ -	$ -	$ -	$ 2,270,101
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (46,091)	$ -	$ -	$ (46,091)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,764)	$ 40,472	$ 38,708
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,388,130)**	**$ (493,586)**	**$ 151,670**	**$ 2,118,430**	**$ -**	**$ (46,091)**	**$ (8,492)**	**$ 40,472**	**$ (625,726)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,437,149**	**$ 2,999,815**	**$ 538,533**	**$ 7,603,900**	**$ -**	**$ 86,978**	**$ 267,705**	**$ 195,818**	**$ 20,197,505**

Camarillo
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9862	4391	2249	20959	0	74	592	735	38862
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9862	4391	2249	20959	0	74	592	735	38862

Camino Healthcare
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,087,202	$ 849,800	$ 745,691	$ 7,368,254	$ -	$ 112,692	$ 36,810	$ 203,337	$ 10,403,786
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,087,202	$ 849,800	$ 745,691	$ 7,368,254	$ -	$ 112,692	$ 36,810	$ 203,337	$ 10,403,786
	Ancillary Services:									
105	Patient Supplies	$ -	$ 6,136	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,136
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 289,530	$ 296,100	$ 1,980	$ 1,026,900	$ -	$ 33,165	$ -	$ -	$ 1,647,675
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 365,130	$ 275,895	$ 2,160	$ 999,225	$ -	$ 31,545	$ -	$ -	$ 1,673,955
130	Speech Pathology	$ 188,325	$ 53,190	$ 45	$ 207,045	$ -	$ 945	$ -	$ -	$ 449,550
135	Pharmacy	$ 112,322	$ 102,220	$ 6,129	$ 98,165	$ -	$ 17,120	$ 1,098	$ 401	$ 337,455
140	Laboratory	$ 9,655	$ 4,326	$ 109	$ 3,930	$ -	$ 263	$ -	$ -	$ 18,284
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 12,177	$ 19,882	$ -	$ 57,075	$ -	$ 3,484	$ -	$ -	$ 92,617
170	Subtotal (Lines 105 through 155)	$ 977,139	$ 757,750	$ 10,423	$ 2,392,340	$ -	$ 86,522	$ 1,098	$ 401	$ 4,225,672
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,064,341**	**$ 1,607,550**	**$ 756,114**	**$ 9,760,594**	**$ -**	**$ 199,214**	**$ 37,908**	**$ 203,738**	**$ 14,629,458**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 63,696	$ -	$ -	$ -	$ (4,200)	$ 35,773	$ -	$ 95,269
215	Contractual Adjustments - Medicare	$ (693,363)	$ (689,330)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,382,694)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 135,451	$ 1,559,368	$ -	$ -	$ -	$ -	$ 1,694,819
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 45,017	$ -	$ -	$ 45,017
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,769	$ (7,981)	$ (4,212)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (693,363)**	**$ (625,635)**	**$ 135,451**	**$ 1,559,368**	**$ -**	**$ 40,817**	**$ 39,542**	**$ (7,981)**	**$ 448,199**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,757,704**	**$ 2,233,185**	**$ 620,663**	**$ 8,201,226**	**$ -**	**$ 158,396**	**$ (1,634)**	**$ 211,719**	**$ 14,181,259**

Camino Healthcare
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3295	2707	2947	23723	0	361	105	697	33835
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3295	2707	2947	23723	0	361	105	697	33835

Carmel Mountain
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,212,200	$ 4,712,939	$ 546,962	$ 5,598,688	$ -	$ 317,061	$ 110,125	$ 594,805	$ 14,092,780
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 317,325	$ 316,451	$ 212,130	$ 5,240,016	$ -	$ 339,903	$ 10,450	$ 45,675	$ 6,481,950
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,529,525	$ 5,029,390	$ 759,092	$ 10,838,704	$ -	$ 656,964	$ 120,575	$ 640,480	$ 20,574,730
	Ancillary Services:									
105	Patient Supplies	$ 46,349	$ 74,323	$ 19,319	$ 490,624	$ -	$ 26,742	$ 48	$ 7,862	$ 665,267
110	Specialized Support Surfaces	$ -	$ -	$ 1,395	$ 195,030	$ -	$ -	$ -	$ 2,835	$ 199,260
115	Physical Therapy	$ 548,190	$ 1,155,465	$ 2,025	$ 136,109	$ -	$ 74,880	$ -	$ 17,595	$ 1,934,264
120	Respiratory Therapy	$ 38,790	$ 8,640	$ 16,740	$ 601,470	$ -	$ 34,650	$ -	$ 5,400	$ 705,690
125	Occupational Therapy	$ 568,635	$ 1,129,590	$ 450	$ 100,080	$ -	$ 73,710	$ 390	$ 18,540	$ 1,891,395
130	Speech Pathology	$ 465,435	$ 336,690	$ -	$ 30,465	$ -	$ 19,665	$ 10,325	$ 3,600	$ 866,180
135	Pharmacy	$ 163,188	$ 268,940	$ -	$ 6,547	$ -	$ 47,393	$ -	$ 11,049	$ 497,117
140	Laboratory	$ 5,364	$ -	$ 144	$ -	$ -	$ 311	$ -	$ 79	$ 5,897
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 28,880	$ 43,866	$ 713	$ 157,401	$ -	$ 5,624	$ -	$ 2,128	$ 238,612
170	Subtotal (Lines 105 through 155)	$ 1,864,830	$ 3,017,514	$ 40,786	$ 1,717,726	$ -	$ 282,975	$ 10,763	$ 69,089	$ 7,003,682
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,105,620**	**$ 8,046,904**	**$ 799,878**	**$ 12,556,430**	**$ -**	**$ 939,939**	**$ 126,548**	**$ 709,568**	**$ 27,578,412**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (6,938)	$ -	$ -	$ -	$ (4,557)	$ (8,690)	$ -	$ (20,185)
215	Contractual Adjustments - Medicare	$ (457,727)	$ 209,525	$ -	$ -	$ -	$ -	$ -	$ -	$ (248,202)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 194,328	$ 2,488,807	$ -	$ -	$ -	$ -	$ 2,683,135
222	Contractual Adjustments - Commercial Coverage	$ 434	$ -	$ -	$ -	$ -	$ (90,374)	$ -	$ -	$ (89,940)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 99,970	$ 99,970
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (457,293)**	**$ 202,587**	**$ 194,328**	**$ 2,488,807**	**$ -**	**$ (94,931)**	**$ (8,690)**	**$ 99,970**	**$ 2,424,778**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,701,318**	**$ 7,844,317**	**$ 605,550**	**$ 10,067,623**	**$ -**	**$ 1,034,871**	**$ 135,238**	**$ 609,598**	**$ 25,153,634**

Carmel Mountain
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4950	10677	1443	12884	0	747	253	1369	32323
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	529	401	258	7835	0	518	14	65	9620
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	5479	11078	1701	20719	0	1265	267	1434	41943

Channel Islands Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,231,040	$ 156,240	$ 1,331,796	$ 16,578,068	$ -	$ -	$ 306,656	$ 1,821,447	$ 23,425,247
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,231,040	$ 156,240	$ 1,331,796	$ 16,578,068	$ -	$ -	$ 306,656	$ 1,821,447	$ 23,425,247
	Ancillary Services:									
105	Patient Supplies	$ -	$ 6,655	$ -	$ 9,500	$ -	$ -	$ -	$ -	$ 16,155
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 519,705	$ 32,310	$ 2,610	$ 1,286,640	$ -	$ -	$ 450	$ 70,785	$ 1,912,500
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 670,770	$ 35,220	$ 2,790	$ 1,254,780	$ -	$ -	$ 735	$ 74,115	$ 2,038,410
130	Speech Pathology	$ 409,815	$ 5,265	$ -	$ 303,705	$ -	$ -	$ -	$ 26,235	$ 745,020
135	Pharmacy	$ 299,576	$ 12,508	$ -	$ 17,566	$ -	$ -	$ -	$ 79,684	$ 409,335
140	Laboratory	$ 50,345	$ 2,260	$ -	$ 3,490	$ -	$ -	$ -	$ 9,303	$ 65,398
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 19,049	$ 943	$ 280	$ 85,748	$ -	$ -	$ -	$ 5,833	$ 111,852
170	Subtotal (Lines 105 through 155)	$ 1,969,260	$ 95,161	$ 5,680	$ 2,961,429	$ -	$ -	$ 1,185	$ 265,955	$ 5,298,670
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,173,795**	**$ 251,401**	**$ 1,337,476**	**$ 19,539,497**	**$ -**	**$ -**	**$ 307,841**	**$ 2,087,402**	**$ 28,723,916**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ 137,272	$ -	$ 137,272
215	Contractual Adjustments - Medicare	$ (1,742,381)	$ (478)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,742,859)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 327,268	$ 4,940,782	$ -	$ -	$ (15,748)	$ -	$ 5,252,302
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 135,211	$ 135,211
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,742,381)**	**$ (478)**	**$ 327,268**	**$ 4,940,782**	**$ -**	**$ -**	**$ 121,524**	**$ 135,211**	**$ 3,781,926**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,930,839**	**$ 251,879**	**$ 1,010,207**	**$ 14,598,715**	**$ -**	**$ -**	**$ 186,317**	**$ 1,952,191**	**$ 24,941,990**

Channel Islands Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7522	372	3518	38320	0	0	724	3955	54411
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7522	372	3518	38320	0	0	724	3955	54411

Chatsworth Park Healthcare Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,969,100	$ 1,022,750	$ 937,528	$ 10,898,147	$ -	$ 67,562	$ 410,214	$ 750,275	$ 19,055,575
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,969,100	$ 1,022,750	$ 937,528	$ 10,898,147	$ -	$ 67,562	$ 410,214	$ 750,275	$ 19,055,575
	Ancillary Services:									
105	Patient Supplies	$ 9,232	$ 5,251	$ 680	$ 3,040	$ -	$ -	$ -	$ 68	$ 18,271
110	Specialized Support Surfaces	$ 17,333	$ 2,785	$ 4,935	$ 19,330	$ -	$ 238	$ -	$ 589	$ 45,209
115	Physical Therapy	$ 1,013,850	$ 209,250	$ -	$ 1,372,770	$ -	$ 16,695	$ 8,280	$ 135	$ 2,620,980
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,153,350	$ 163,665	$ 720	$ 1,460,070	$ -	$ 14,400	$ 6,525	$ 135	$ 2,798,865
130	Speech Pathology	$ 474,525	$ 30,195	$ 585	$ 161,910	$ -	$ 1,845	$ 3,420	$ 405	$ 672,885
135	Pharmacy	$ 803,706	$ 192,704	$ 9,779	$ 49,312	$ -	$ 14,321	$ 1,604	$ 2,163	$ 1,073,590
140	Laboratory	$ 55,852	$ 17,378	$ 3,782	$ 27,307	$ -	$ 103	$ 1,584	$ 520	$ 106,525
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 63,544	$ 40,469	$ 571	$ 40,858	$ -	$ 164	$ -	$ -	$ 145,606
170	Subtotal (Lines 105 through 155)	$ 3,591,391	$ 661,698	$ 21,052	$ 3,134,596	$ -	$ 47,766	$ 21,413	$ 4,015	$ 7,481,930
175	**Total Gross Revenue (Line 70 + 170)**	**$ 8,560,491**	**$ 1,684,448**	**$ 958,579**	**$ 14,032,744**	**$ -**	**$ 115,328**	**$ 431,627**	**$ 754,290**	**$ 26,537,505**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (3,704)	$ -	$ -	$ -	$ (20,273)	$ (672)	$ -	$ (24,649)
215	Contractual Adjustments - Medicare	$ (214,098)	$ 411,710	$ -	$ -	$ -	$ -	$ -	$ -	$ 197,612
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 499,692	$ 4,806,248	$ -	$ -	$ -	$ -	$ 5,305,941
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 29,035	$ -	$ -	$ 29,035
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 260,622	$ 260,622
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (214,098)**	**$ 408,006**	**$ 499,692**	**$ 4,806,248**	**$ -**	**$ 8,762**	**$ (672)**	**$ 260,622**	**$ 5,768,561**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,774,588**	**$ 1,276,442**	**$ 458,887**	**$ 9,226,495**	**$ -**	**$ 106,566**	**$ 432,299**	**$ 493,667**	**$ 20,768,944**

Chatsworth Park Healthcare Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	10466	2071	2440	25067	0	199	876	1668	42787
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	10466	2071	2440	25067	0	199	876	1668	42787

Claremont
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,111,225	$ 3,327,330	$ 580,908	$ 7,387,942	$ -	$ 229,358	$ 118,606	$ 571,375	$ 14,326,743
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,111,225	$ 3,327,330	$ 580,908	$ 7,387,942	$ -	$ 229,358	$ 118,606	$ 571,375	$ 14,326,743
	Ancillary Services:									
105	Patient Supplies	$ 8,410	$ 17,404	$ -	$ 5,778	$ -	$ 3,400	$ -	$ -	$ 34,992
110	Specialized Support Surfaces	$ 5,906	$ 7,476	$ 1,856	$ 763	$ -	$ 1,099	$ -	$ 52	$ 17,150
115	Physical Therapy	$ 403,200	$ 865,530	$ 1,485	$ 473,805	$ -	$ 54,225	$ 3,375	$ -	$ 1,801,620
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 541,125	$ 845,685	$ 1,485	$ 500,085	$ -	$ 52,245	$ 1,170	$ -	$ 1,941,795
130	Speech Pathology	$ 154,575	$ 82,170	$ 180	$ 99,135	$ -	$ 7,875	$ -	$ -	$ 343,935
135	Pharmacy	$ 283,060	$ 127,714	$ 894	$ 31,304	$ -	$ 32,978	$ -	$ -	$ 475,951
140	Laboratory	$ 37,126	$ 110,797	$ 3,715	$ 27,048	$ -	$ 4,065	$ -	$ 77	$ 182,827
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 33,698	$ 103,406	$ 507	$ 5,304	$ -	$ 3,870	$ -	$ -	$ 146,785
170	Subtotal (Lines 105 through 155)	$ 1,467,099	$ 2,160,182	$ 10,123	$ 1,143,222	$ -	$ 159,756	$ 4,545	$ 129	$ 4,945,056
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,578,324**	**$ 5,487,512**	**$ 591,031**	**$ 8,531,164**	**$ -**	**$ 389,114**	**$ 123,151**	**$ 571,504**	**$ 19,271,799**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (23,862)	$ -	$ -	$ -	$ -	$ -	$ -	$ (23,862)
215	Contractual Adjustments - Medicare	$ (648,328)	$ 331,464	$ -	$ -	$ -	$ -	$ -	$ -	$ (316,863)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 229,604	$ 2,760,887	$ -	$ -	$ -	$ -	$ 2,990,491
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 120,556	$ -	$ -	$ 120,556
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 156,217	$ 156,217
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (648,328)**	**$ 307,602**	**$ 229,604**	**$ 2,760,887**	**$ -**	**$ 120,556**	**$ -**	**$ 156,217**	**$ 2,926,539**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,226,651**	**$ 5,179,910**	**$ 361,427**	**$ 5,770,277**	**$ -**	**$ 268,557**	**$ 123,151**	**$ 415,287**	**$ 16,345,260**

Claremont
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4759	7544	1690	16503	0	545	268	1318	32627
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4759	7544	1690	16503	0	545	268	1318	32627

Cloverdale
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,933,900	$ 594,800	$ 380,364	$ 4,476,840	$ -	$ 19,550	$ 66,826	$ 570,400	$ 8,042,680
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,933,900	$ 594,800	$ 380,364	$ 4,476,840	$ -	$ 19,550	$ 66,826	$ 570,400	$ 8,042,680
	Ancillary Services:									
105	Patient Supplies	$ -	$ 4,212	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,212
110	Specialized Support Surfaces	$ 2,988	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,988
115	Physical Therapy	$ 433,170	$ 94,050	$ 945	$ 636,324	$ -	$ 3,240	$ 3,465	$ -	$ 1,171,194
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 410,040	$ 82,980	$ 1,755	$ 484,650	$ -	$ 4,995	$ 3,195	$ -	$ 987,615
130	Speech Pathology	$ 205,335	$ 19,485	$ -	$ 196,155	$ -	$ -	$ 90	$ -	$ 421,065
135	Pharmacy	$ 108,588	$ 37,584	$ 2,226	$ 5,623	$ -	$ 1,160	$ 122	$ 0	$ 155,302
140	Laboratory	$ 45,964	$ 7,710	$ -	$ 3,756	$ -	$ 1,382	$ -	$ 1,471	$ 60,283
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 6,784	$ 4,479	$ -	$ 17,321	$ -	$ -	$ -	$ -	$ 28,584
170	Subtotal (Lines 105 through 155)	$ 1,212,869	$ 250,499	$ 4,926	$ 1,343,828	$ -	$ 10,777	$ 6,872	$ 1,471	$ 2,831,242
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,146,769**	**$ 845,299**	**$ 385,290**	**$ 5,820,668**	**$ -**	**$ 30,327**	**$ 73,698**	**$ 571,871**	**$ 10,873,922**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Contractual Adjustments - Medicare	$ (1,152,016)	$ (139,623)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,291,639)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 79,344	$ 1,298,520	$ -	$ -	$ -	$ -	$ 1,377,865
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 7,324	$ -	$ -	$ 7,324
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,458	$ 150,458
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,152,016)**	**$ (139,623)**	**$ 79,344**	**$ 1,298,520**	**$ -**	**$ 7,324**	**$ -**	**$ 150,458**	**$ 244,008**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,298,785**	**$ 984,923**	**$ 305,945**	**$ 4,522,148**	**$ -**	**$ 23,003**	**$ 73,698**	**$ 421,413**	**$ 10,629,914**

Cloverdale
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4031	1139	1087	9723	0	73	112	1228	17393
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4031	1139	1087	9723	0	73	112	1228	17393

Coventry Court Health Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,667,000	$ 1,647,680	$ 423,087	$ 7,668,413	$ -	$ 425,820	$ 97,600	$ 704,164	$ 13,633,764
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,667,000	$ 1,647,680	$ 423,087	$ 7,668,413	$ -	$ 425,820	$ 97,600	$ 704,164	$ 13,633,764
	Ancillary Services:									
105	Patient Supplies	$ 10,068	$ 4,115	$ -	$ 20,093	$ -	$ 4,257	$ 155	$ -	$ 38,688
110	Specialized Support Surfaces	$ 5,385	$ 1,389	$ 267	$ 16,582	$ -	$ 9	$ 369	$ -	$ 24,000
115	Physical Therapy	$ 678,015	$ 336,150	$ 3,285	$ 1,122,615	$ -	$ 92,790	$ 10,575	$ 2,835	$ 2,246,265
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 727,875	$ 329,175	$ 2,970	$ 983,385	$ -	$ 91,620	$ -	$ 2,970	$ 2,137,995
130	Speech Pathology	$ 244,080	$ 47,745	$ 1,125	$ 155,565	$ -	$ 16,740	$ -	$ 135	$ 465,390
135	Pharmacy	$ 401,066	$ 71,439	$ 710	$ 154,994	$ -	$ 18,572	$ 0	$ 1,227	$ 648,007
140	Laboratory	$ 23,890	$ 23,520	$ 683	$ 12,927	$ -	$ 5,644	$ 49	$ 478	$ 67,191
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 32,660	$ 37,584	$ -	$ 25,654	$ -	$ 6,075	$ -	$ -	$ 101,973
170	Subtotal (Lines 105 through 155)	$ 2,123,038	$ 851,117	$ 9,040	$ 2,491,815	$ -	$ 235,707	$ 11,148	$ 7,645	$ 5,729,510
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,790,038**	**$ 2,498,797**	**$ 432,127**	**$ 10,160,228**	**$ -**	**$ 661,527**	**$ 108,748**	**$ 711,808**	**$ 19,363,274**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 7,470	$ -	$ -	$ -	$ (0)	$ 1,859	$ -	$ 9,329
215	Contractual Adjustments - Medicare	$ (512,508)	$ 43,204	$ -	$ -	$ -	$ -	$ -	$ -	$ (469,304)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 129,117	$ 2,624,767	$ -	$ -	$ -	$ -	$ 2,753,884
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (3,802)	$ -	$ -	$ (3,802)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,422	$ 107,422
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (512,508)**	**$ 50,674**	**$ 129,117**	**$ 2,624,767**	**$ -**	**$ (3,802)**	**$ 1,859**	**$ 107,422**	**$ 2,397,529**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,302,546**	**$ 2,448,123**	**$ 303,010**	**$ 7,535,461**	**$ -**	**$ 665,329**	**$ 106,889**	**$ 604,386**	**$ 16,965,745**

Coventry Court Health Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6124	3885	1180	18658	0	1001	243	1733	32824
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6124	3885	1180	18658	0	1001	243	1733	32824

Danville Post-Acute Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,787,825	$ 820,935	$ 271,503	$ 2,854,977	$ -	$ 188,505	$ 506,445	$ 109,725	$ 7,539,915
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,787,825	$ 820,935	$ 271,503	$ 2,854,977	$ -	$ 188,505	$ 506,445	$ 109,725	$ 7,539,915
	Ancillary Services:									
105	Patient Supplies	$ -	$ 1,480	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,480
110	Specialized Support Surfaces	$ 9,488	$ 772	$ -	$ -	$ -	$ -	$ (0)	$ -	$ 10,259
115	Physical Therapy	$ 446,040	$ 104,040	$ -	$ 148,635	$ -	$ 3,735	$ 2,415	$ -	$ 704,865
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 619,965	$ 112,455	$ -	$ 59,985	$ -	$ 2,205	$ 2,790	$ -	$ 797,400
130	Speech Pathology	$ 707,760	$ 87,615	$ -	$ 235,575	$ -	$ 1,575	$ 2,145	$ -	$ 1,034,670
135	Pharmacy	$ 136,701	$ 29,138	$ 120	$ -	$ -	$ 8,143	$ 252	$ -	$ 174,355
140	Laboratory	$ 6,357	$ 1,639	$ -	$ -	$ -	$ 258	$ -	$ -	$ 8,254
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 15,871	$ 3,136	$ -	$ -	$ -	$ -	$ -	$ -	$ 19,008
170	Subtotal (Lines 105 through 155)	$ 1,942,182	$ 340,275	$ 120	$ 444,195	$ -	$ 15,916	$ 7,602	$ -	$ 2,750,291
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,730,007**	**$ 1,161,210**	**$ 271,623**	**$ 3,299,172**	**$ -**	**$ 204,421**	**$ 514,047**	**$ 109,725**	**$ 10,290,206**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (8,147)	$ -	$ -	$ -	$ -	$ (44,316)	$ -	$ (52,463)
215	Contractual Adjustments - Medicare	$ (1,662,838)	$ (386,996)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,049,834)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 98,507	$ 967,764	$ -	$ -	$ -	$ -	$ 1,066,271
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (53,441)	$ -	$ -	$ (53,441)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 33,772	$ 33,772
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,662,838)**	**$ (395,143)**	**$ 98,507**	**$ 967,764**	**$ -**	**$ (53,441)**	**$ (44,316)**	**$ 33,772**	**$ (1,055,695)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,392,845**	**$ 1,556,353**	**$ 173,117**	**$ 2,331,408**	**$ -**	**$ 257,863**	**$ 558,363**	**$ 75,953**	**$ 11,345,900**

Danville Post-Acute Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	5624	1696	617	5969	0	383	1029	229	15547
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	5624	1696	617	5969	0	383	1029	229	15547

Desert Mountain Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,063,640	$ 2,190,587	$ 293,529	$ 4,645,941	$ -	$ 80,383	$ 15,770	$ 229,113	$ 8,518,963
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 480,820	$ 911,820	$ 643,386	$ 6,704,280	$ -	$ 154,154	$ -	$ -	$ 8,894,460
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,544,460	$ 3,102,407	$ 936,916	$ 11,350,221	$ -	$ 234,537	$ 15,770	$ 229,113	$ 17,413,423
	Ancillary Services:									
105	Patient Supplies	$ 7,280	$ 20,563	$ 3,366	$ 55,956	$ -	$ 760	$ -	$ -	$ 87,925
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 232,335	$ 407,835	$ 1,260	$ 319,365	$ -	$ 23,805	$ 1,460	$ 17,415	$ 1,003,475
120	Respiratory Therapy	$ -	$ 1,305	$ -	$ 19,215	$ -	$ -	$ -	$ -	$ 20,520
125	Occupational Therapy	$ 262,530	$ 441,810	$ 675	$ 285,030	$ -	$ 26,550	$ 180	$ 17,325	$ 1,034,100
130	Speech Pathology	$ 139,500	$ 59,895	$ -	$ 63,090	$ -	$ 2,700	$ -	$ 5,940	$ 271,125
135	Pharmacy	$ 433,170	$ 787,187	$ (0)	$ 22,484	$ -	$ 58,694	$ -	$ 18,925	$ 1,320,459
140	Laboratory	$ 6,412	$ 3,265	$ (0)	$ 1,171	$ -	$ 386	$ -	$ 190	$ 11,423
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 27,150	$ 52,104	$ 3,025	$ 138,222	$ -	$ 2,666	$ -	$ 1,553	$ 224,721
170	Subtotal (Lines 105 through 155)	$ 1,108,376	$ 1,773,964	$ 8,326	$ 904,533	$ -	$ 115,561	$ 1,640	$ 61,348	$ 3,973,748
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,652,836**	**$ 4,876,371**	**$ 945,242**	**$ 12,254,753**	**$ -**	**$ 350,098**	**$ 17,410**	**$ 290,461**	**$ 21,387,171**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 482	$ -	$ -	$ -	$ (1,718)	$ (51,450)	$ -	$ (52,686)
215	Contractual Adjustments - Medicare	$ (274,992)	$ 1,573,187	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,298,195
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 275,903	$ 3,539,782	$ -	$ -	$ -	$ -	$ 3,815,685
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 254,432	$ -	$ -	$ 254,432
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ (31,380)	$ (15,229)	$ (46,609)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (274,992)**	**$ 1,573,669**	**$ 275,903**	**$ 3,539,782**	**$ -**	**$ 252,714**	**$ (82,830)**	**$ (15,229)**	**$ 5,269,017**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,927,828**	**$ 3,302,701**	**$ 669,339**	**$ 8,714,971**	**$ -**	**$ 97,384**	**$ 100,240**	**$ 305,690**	**$ 16,118,154**

Desert Mountain Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2140	4113	758	11924	0	157	29	550	19671
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	978	1882	917	9213	0	248	5	92	13335
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3118	5995	1675	21137	0	405	34	642	33006

Downey Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,067,750	$ 1,332,564	$ 386,532	$ 6,667,218	$ -	$ 115,901	$ 27,475	$ 264,975	$ 10,862,415
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,067,750	$ 1,332,564	$ 386,532	$ 6,667,218	$ -	$ 115,901	$ 27,475	$ 264,975	$ 10,862,415
	Ancillary Services:									
105	Patient Supplies	$ 5,298	$ 11,916	$ -	$ 11,982	$ -	$ -	$ -	$ -	$ 29,196
110	Specialized Support Surfaces	$ 3,435	$ 1,669	$ -	$ 3,652	$ -	$ -	$ -	$ -	$ 8,756
115	Physical Therapy	$ 708,525	$ 360,765	$ 855	$ 1,067,580	$ -	$ 30,195	$ 135	$ 90	$ 2,168,145
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 748,845	$ 362,205	$ 720	$ 1,059,300	$ -	$ 30,150	$ 90	$ 360	$ 2,201,670
130	Speech Pathology	$ 700,380	$ 173,565	$ 450	$ 632,475	$ -	$ 9,495	$ -	$ 315	$ 1,516,680
135	Pharmacy	$ 387,392	$ 250,844	$ 718	$ 17,547	$ -	$ 33,006	$ -	$ 389	$ 689,895
140	Laboratory	$ 14,713	$ 23,205	$ -	$ 1,664	$ -	$ 1,306	$ -	$ -	$ 40,888
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 25,616	$ 100,132	$ 0	$ 69,509	$ -	$ 4,775	$ -	$ 227	$ 200,259
170	Subtotal (Lines 105 through 155)	$ 2,594,205	$ 1,284,301	$ 2,743	$ 2,863,708	$ -	$ 108,927	$ 225	$ 1,382	$ 6,855,490
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,661,955**	**$ 2,616,865**	**$ 389,275**	**$ 9,530,926**	**$ -**	**$ 224,827**	**$ 27,700**	**$ 266,357**	**$ 17,717,905**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 1,709	$ -	$ -	$ -	$ 1,031	$ -	$ -	$ 2,740
215	Contractual Adjustments - Medicare	$ (1,076,370)	$ 4,039	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,072,331)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 84,100	$ 2,020,858	$ -	$ -	$ -	$ -	$ 2,104,958
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (80,074)	$ -	$ -	$ (80,074)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,904	$ 15,904
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,076,370)**	**$ 5,748**	**$ 84,100**	**$ 2,020,858**	**$ -**	**$ (79,043)**	**$ -**	**$ 15,904**	**$ 971,197**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,738,325**	**$ 2,611,117**	**$ 305,175**	**$ 7,510,068**	**$ -**	**$ 303,870**	**$ 27,700**	**$ 250,453**	**$ 16,746,708**

Downey Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total	
5	Skilled Nursing	6183	4185	1178	19901	0	397	76	775	32695	
10	Intermediate Care										
15	Mentally Disordered										
20	Developmentally Disabled										
25	Sub-Acute	0	0	0	0	0	0	0	0	0	
30	Sub-Acute Pediatric										
35	Transitional Inpatient Care										
40	Hospice Inpatient Care										
45	Other Routine										
70	Subtotal	6183	4185	1178	19901	0	397	76	775	32695	

Edgewater Skilled Nursing Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,675,100	$ 288,290	$ 710,761	$ 6,083,241	$ -	$ 72,800	$ 164,850	$ 222,300	$ 9,217,342
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,675,100	$ 288,290	$ 710,761	$ 6,083,241	$ -	$ 72,800	$ 164,850	$ 222,300	$ 9,217,342
	Ancillary Services:									
105	Patient Supplies	$ 5,039	$ 191	$ 434	$ 12,187	$ -	$ -	$ -	$ -	$ 17,850
110	Specialized Support Surfaces	$ 788	$ -	$ -	$ 3,246	$ -	$ -	$ -	$ -	$ 4,035
115	Physical Therapy	$ 417,510	$ 74,880	$ 9,225	$ 1,398,420	$ -	$ 16,470	$ -	$ -	$ 1,916,505
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 457,695	$ 73,080	$ 10,620	$ 1,542,060	$ -	$ 15,660	$ -	$ -	$ 2,099,115
130	Speech Pathology	$ 196,470	$ 11,160	$ -	$ 410,450	$ -	$ 1,845	$ -	$ -	$ 619,925
135	Pharmacy	$ 321,986	$ 96,189	$ 11,984	$ 83,962	$ -	$ 28,227	$ 2,605	$ 6,258	$ 551,212
140	Laboratory	$ 7,137	$ 1,275	$ 953	$ 7,813	$ -	$ 1,080	$ 102	$ 289	$ 18,650
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 13,917	$ 3,421	$ 278	$ 2,935	$ -	$ 292	$ 509	$ -	$ 21,352
170	Subtotal (Lines 105 through 155)	$ 1,420,542	$ 260,196	$ 33,494	$ 3,461,073	$ -	$ 63,575	$ 3,216	$ 6,547	$ 5,248,644
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,095,642**	**$ 548,486**	**$ 744,256**	**$ 9,544,314**	**$ -**	**$ 136,375**	**$ 168,066**	**$ 228,847**	**$ 14,465,986**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 17,062	$ -	$ -	$ -	$ -	$ (9,979)	$ -	$ 7,083
215	Contractual Adjustments - Medicare	$ (783,146)	$ 54,241	$ -	$ -	$ -	$ -	$ -	$ -	$ (728,905)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 120,800	$ 2,437,492	$ -	$ -	$ -	$ -	$ 2,558,292
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 33,561	$ -	$ -	$ 33,561
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 39,408	$ 39,408
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (783,146)**	**$ 71,303**	**$ 120,800**	**$ 2,437,492**	**$ -**	**$ 33,561**	**$ (9,979)**	**$ 39,408**	**$ 1,909,439**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,878,788**	**$ 477,183**	**$ 623,455**	**$ 7,106,822**	**$ -**	**$ 102,814**	**$ 178,045**	**$ 189,440**	**$ 12,556,547**

Edgewater Skilled Nursing Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4471	852	2360	18004	0	208	471	689	27055
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4471	852	2360	18004	0	208	471	689	27055

Fairfield Post-Acute Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,351,975	$ 763,903	$ 559,064	$ 5,202,961	$ -	$ 121,650	$ 244,447	$ 2,439,734	$ 12,683,734
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,351,975	$ 763,903	$ 559,064	$ 5,202,961	$ -	$ 121,650	$ 244,447	$ 2,439,734	$ 12,683,734
	Ancillary Services:									
105	Patient Supplies	$ 15,101	$ 18,009	$ 6,998	$ 5,352	$ -	$ -	$ -	$ 2,325	$ 47,785
110	Specialized Support Surfaces	$ 6,248	$ 2,604	$ 260	$ 27,879	$ -	$ -	$ 7,940	$ 712	$ 45,643
115	Physical Therapy	$ 792,945	$ 211,275	$ 2,745	$ 275,895	$ -	$ 29,970	$ 855	$ 41,355	$ 1,355,040
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 648,405	$ 128,340	$ 1,620	$ 153,900	$ -	$ 17,955	$ 1,845	$ 31,185	$ 983,250
130	Speech Pathology	$ 635,220	$ 73,485	$ 90	$ 82,755	$ -	$ 3,555	$ 135	$ 21,375	$ 816,615
135	Pharmacy	$ 285,795	$ 41,581	$ 1,287	$ 12,840	$ -	$ 4,361	$ -	$ 3,878	$ 349,743
140	Laboratory	$ 145,984	$ 28,428	$ 2,216	$ 7,359	$ -	$ 2,330	$ 837	$ 4,488	$ 191,642
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 73,090	$ 31,506	$ -	$ 898	$ -	$ 639	$ -	$ 1,739	$ 107,872
170	Subtotal (Lines 105 through 155)	$ 2,602,789	$ 535,228	$ 15,216	$ 566,878	$ -	$ 58,811	$ 11,612	$ 107,057	$ 3,897,591
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,954,764**	**$ 1,299,131**	**$ 574,279**	**$ 5,769,840**	**$ -**	**$ 180,461**	**$ 256,059**	**$ 2,546,791**	**$ 16,581,325**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 66,407	$ -	$ -	$ -	$ 12,348	$ 8,415	$ -	$ 87,170
215	Contractual Adjustments - Medicare	$ (3,527,249)	$ (696,608)	$ -	$ -	$ -	$ (435)	$ -	$ -	$ (4,224,292)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 82,870	$ 328,088	$ -	$ -	$ -	$ -	$ 410,959
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (158,270)	$ 1,890	$ -	$ (156,380)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (225,040)	$ (225,040)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (3,527,249)**	**$ (630,201)**	**$ 82,870**	**$ 328,088**	**$ -**	**$ (146,357)**	**$ 10,305**	**$ (225,040)**	**$ (4,107,583)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 9,482,013**	**$ 1,929,333**	**$ 491,409**	**$ 5,441,751**	**$ -**	**$ 326,818**	**$ 245,754**	**$ 2,771,831**	**$ 20,688,908**

Fairfield Post-Acute Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7882	2139	1887	14521	0	342	686	5721	33178
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7882	2139	1887	14521	0	342	686	5721	33178

Fairmont Rehabilitation Hospital
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,496,050	$ 649,850	$ 793,036	$ 3,247,341	$ -	$ 101,700	$ 425,673	$ 418,500	$ 9,132,150
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,496,050	$ 649,850	$ 793,036	$ 3,247,341	$ -	$ 101,700	$ 425,673	$ 418,500	$ 9,132,150
	Ancillary Services:									
105	Patient Supplies	$ 1,705	$ 7,104	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,809
110	Specialized Support Surfaces	$ 21,515	$ 1,064	$ 9,470	$ 358	$ -	$ -	$ (1,335)	$ 948	$ 32,020
115	Physical Therapy	$ 758,970	$ 129,960	$ 1,755	$ 343,530	$ -	$ 16,110	$ 9,990	$ -	$ 1,260,315
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 933,480	$ 114,570	$ 810	$ 234,945	$ -	$ 15,345	$ 6,975	$ -	$ 1,306,125
130	Speech Pathology	$ 420,615	$ 42,390	$ 585	$ 27,585	$ -	$ 5,580	$ 2,025	$ 405	$ 499,185
135	Pharmacy	$ 269,874	$ 51,443	$ 4,217	$ 3,315	$ -	$ 11,543	$ -	$ 1,206	$ 341,597
140	Laboratory	$ 15,869	$ 5,177	$ 403	$ 122	$ -	$ 183	$ -	$ -	$ 21,754
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 38,878	$ 8,017	$ 260	$ 150	$ -	$ 1,030	$ -	$ -	$ 48,336
170	Subtotal (Lines 105 through 155)	$ 2,460,906	$ 359,726	$ 17,499	$ 610,005	$ -	$ 49,791	$ 17,655	$ 2,558	$ 3,518,141
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,956,956**	**$ 1,009,576**	**$ 810,535**	**$ 3,857,346**	**$ -**	**$ 151,491**	**$ 443,328**	**$ 421,058**	**$ 12,650,291**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (11,048)	$ -	$ -	$ -	$ 10,604	$ (4,748)	$ -	$ (5,191)
215	Contractual Adjustments - Medicare	$ (1,560,114)	$ 76,029	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,484,086)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 279,377	$ 1,294,118	$ -	$ -	$ -	$ -	$ 1,573,495
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (51,075)	$ -	$ -	$ (51,075)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 119,965	$ 119,965
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,560,114)**	**$ 64,981**	**$ 279,377**	**$ 1,294,118**	**$ -**	**$ (40,470)**	**$ (4,748)**	**$ 119,965**	**$ 153,108**
250	**Net Patient Revenue (line 175 - 240)**	**$ 7,517,075**	**$ 944,595**	**$ 531,158**	**$ 2,563,228**	**$ -**	**$ 191,962**	**$ 448,076**	**$ 301,094**	**$ 12,497,183**

Fairmont Rehabilitation Hospital
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7768	1467	1928	7073	0	226	879	930	20271
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7768	1467	1928	7073	0	226	879	930	20271

Garden View Post-Acute Rehabilitation
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,602,100	$ 276,765	$ 524,297	$ 6,425,786	$ -	$ 116,460	$ 100,242	$ 73,500	$ 11,119,150
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,602,100	$ 276,765	$ 524,297	$ 6,425,786	$ -	$ 116,460	$ 100,242	$ 73,500	$ 11,119,150
	Ancillary Services:									
105	Patient Supplies	$ -	$ 5,895	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,895
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,076,355	$ 64,215	$ 1,485	$ 588,285	$ -	$ 23,355	$ -	$ -	$ 1,753,695
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 913,815	$ 64,260	$ 1,980	$ 667,440	$ -	$ 23,670	$ -	$ -	$ 1,671,165
130	Speech Pathology	$ 236,295	$ 3,960	$ 360	$ 101,610	$ -	$ 4,545	$ -	$ -	$ 346,770
135	Pharmacy	$ 574,434	$ 21,835	$ 11	$ 2,311	$ -	$ 13,025	$ -	$ -	$ 611,616
140	Laboratory	$ 36,451	$ 2,519	$ 2,457	$ 13,955	$ -	$ 1,046	$ -	$ -	$ 56,429
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 46,417	$ 9,814	$ 310	$ 44,504	$ -	$ 1,019	$ -	$ -	$ 102,063
170	Subtotal (Lines 105 through 155)	$ 2,883,767	$ 172,498	$ 6,603	$ 1,418,105	$ -	$ 66,660	$ -	$ -	$ 4,547,633
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,485,867**	**$ 449,263**	**$ 530,900**	**$ 7,843,891**	**$ -**	**$ 183,120**	**$ 100,242**	**$ 73,500**	**$ 15,666,783**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ 8,100	$ 1,125	$ -	$ 9,225
215	Contractual Adjustments - Medicare	$ (2,440,574)	$ (23,989)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,464,564)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 160,466	$ 1,168,805	$ -	$ -	$ -	$ -	$ 1,329,271
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 25,132	$ -	$ -	$ 25,132
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,936	$ 15,936
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,440,574)**	**$ (23,989)**	**$ 160,466**	**$ 1,168,805**	**$ -**	**$ 33,232**	**$ 1,125**	**$ 15,936**	**$ (1,084,999)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,926,441**	**$ 473,252**	**$ 370,434**	**$ 6,675,086**	**$ -**	**$ 149,888**	**$ 99,117**	**$ 57,564**	**$ 16,751,783**

Garden View Post-Acute Rehabilitation
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9783	733	1837	18693	0	295	163	196	31700
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9783	733	1837	18693	0	295	163	196	31700

Glenwood
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,079,880	$ 1,851,130	$ 213,721	$ 5,504,108	$ -	$ 85,260	$ 226,130	$ 133,200	$ 12,093,429
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,079,880	$ 1,851,130	$ 213,721	$ 5,504,108	$ -	$ 85,260	$ 226,130	$ 133,200	$ 12,093,429
	Ancillary Services:									
105	Patient Supplies	$ 59,677	$ 27,883	$ -	$ 5,486	$ -	$ 1,129	$ -	$ -	$ 94,174
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,580,850	$ 445,635	$ 1,035	$ 627,120	$ -	$ 66,150	$ 585	$ -	$ 2,721,375
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,298,160	$ 519,030	$ 1,350	$ 595,305	$ -	$ 24,525	$ 315	$ -	$ 2,438,685
130	Speech Pathology	$ 591,570	$ 76,500	$ -	$ 68,175	$ -	$ 1,755	$ -	$ -	$ 738,000
135	Pharmacy	$ 541,339	$ 190,836	$ -	$ 35,395	$ -	$ 17,967	$ -	$ -	$ 785,538
140	Laboratory	$ 88,632	$ 43,524	$ (0)	$ 680	$ -	$ 2,431	$ 51	$ -	$ 135,319
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 43,773	$ 61,508	$ -	$ 19,571	$ -	$ 806	$ -	$ -	$ 125,658
170	Subtotal (Lines 105 through 155)	$ 4,204,001	$ 1,364,918	$ 2,385	$ 1,351,732	$ -	$ 114,763	$ 951	$ -	$ 7,038,750
175	**Total Gross Revenue (Line 70 + 170)**	**$ 7,625,486**	**$ 3,216,048**	**$ 216,106**	**$ 6,855,840**	**$ -**	**$ 200,023**	**$ 227,081**	**$ 133,200**	**$ 19,132,179**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 4,550	$ -	$ -	$ -	$ -	$ 34,085	$ -	$ 38,635
215	Contractual Adjustments - Medicare	$ (1,712,392)	$ (408,623)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,121,015)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 45,190	$ 1,258,975	$ -	$ -	$ -	$ -	$ 1,304,165
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 31,473	$ -	$ -	$ 31,473
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 18,215	$ 18,215
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,712,392)**	**$ (404,073)**	**$ 45,190**	**$ 1,258,975**	**$ -**	**$ 31,473**	**$ 34,085**	**$ 18,215**	**$ (728,526)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 9,695,574**	**$ 3,620,120**	**$ 170,916**	**$ 5,596,865**	**$ -**	**$ 168,551**	**$ 192,997**	**$ 114,985**	**$ 19,860,705**

Glenwood
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	11246	5132	862	15129	0	226	610	370	33575
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	11246	5132	862	15129	0	226	610	370	33575

Golden Hill Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 20,884	$ 49,175	$ 28,467	$ 396,717	$ -	$ 4,922	$ -	$ 24,500	$ 524,664
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ 43,314	$ 159,652	$ 266,778	$ -	$ 24,286	$ -	$ -	$ 494,030
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 20,884	$ 92,489	$ 188,119	$ 663,495	$ -	$ 29,207	$ -	$ 24,500	$ 1,018,694
	Ancillary Services:									
105	Patient Supplies	$ 828	$ 2,080	$ 4,128	$ 19,316	$ -	$ 620	$ -	$ -	$ 26,972
110	Specialized Support Surfaces	$ -	$ -	$ 1,611	$ 2,666	$ -	$ -	$ -	$ -	$ 4,277
115	Physical Therapy	$ 3,420	$ 13,770	$ -	$ 70,425	$ -	$ 1,890	$ -	$ -	$ 89,505
120	Respiratory Therapy	$ -	$ 1,845	$ -	$ 1,035	$ -	$ 1,575	$ -	$ -	$ 4,455
125	Occupational Therapy	$ 3,780	$ 13,770	$ -	$ 62,190	$ -	$ 1,080	$ -	$ -	$ 80,820
130	Speech Pathology	$ 4,545	$ 3,330	$ 360	$ 21,510	$ -	$ 450	$ -	$ -	$ 30,195
135	Pharmacy	$ 1,340	$ 26,453	$ 424	$ 4,279	$ -	$ 1,862	$ -	$ 9	$ 34,367
140	Laboratory	$ 383	$ 2,415	$ -	$ 2,471	$ -	$ 652	$ -	$ -	$ 5,920
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ -	$ 13,861	$ -	$ 31,526	$ -	$ 1,082	$ -	$ -	$ 46,469
170	Subtotal (Lines 105 through 155)	$ 14,296	$ 77,524	$ 6,523	$ 215,417	$ -	$ 9,211	$ -	$ 9	$ 322,980
175	**Total Gross Revenue (Line 70 + 170)**	**$ 35,180**	**$ 170,012**	**$ 194,642**	**$ 878,912**	**$ -**	**$ 38,419**	**$ -**	**$ 24,509**	**$ 1,341,674**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (1,337)	$ -	$ (301)	$ -	$ (645)	$ (826)	$ -	$ (3,109)
215	Contractual Adjustments - Medicare	$ 2,524	$ (46,790)	$ -	$ -	$ -	$ -	$ -	$ -	$ (44,266)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (8,619)	$ (108,566)	$ -	$ -	$ -	$ -	$ (117,184)
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 52,831	$ -	$ -	$ 52,831
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,975	$ 4,033	$ 10,007
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 2,524**	**$ (48,127)**	**$ (8,619)**	**$ (108,867)**	**$ -**	**$ 52,186**	**$ 5,149**	**$ 4,033**	**$ (101,721)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 32,656**	**$ 218,139**	**$ 203,261**	**$ 987,779**	**$ -**	**$ (13,767)**	**$ (5,149)**	**$ 20,476**	**$ 1,443,395**

Golden Hill Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	53	124	93	1004	0	15	0	70	1359
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	3	48	211	401	0	35	0	0	698
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	56	172	304	1405	0	50	0	70	2057

Grand Terrace Healthcare Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,316,425	$ 1,624,982	$ 314,627	$ 3,103,633	$ -	$ 120,873	$ 83,460	$ 59,075	$ 7,623,075
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,316,425	$ 1,624,982	$ 314,627	$ 3,103,633	$ -	$ 120,873	$ 83,460	$ 59,075	$ 7,623,075
	Ancillary Services:									
105	Patient Supplies	$ 9,792	$ 8,306	$ 10,127	$ 2,062	$ -	$ -	$ 256	$ -	$ 30,543
110	Specialized Support Surfaces	$ 5,969	$ 1,082	$ 2,964	$ 3,343	$ -	$ 400	$ -	$ -	$ 13,758
115	Physical Therapy	$ 517,680	$ 368,055	$ 8,190	$ 442,440	$ -	$ 29,700	$ 2,655	$ -	$ 1,368,720
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 559,890	$ 368,325	$ 1,980	$ 356,220	$ -	$ 30,105	$ 3,105	$ -	$ 1,319,625
130	Speech Pathology	$ 219,825	$ 62,685	$ 360	$ 52,515	$ -	$ 3,375	$ 3,105	$ -	$ 341,865
135	Pharmacy	$ 518,342	$ 133,686	$ 1,817	$ 10,941	$ -	$ 16,329	$ 3,264	$ -	$ 684,379
140	Laboratory	$ 33,523	$ 1,188	$ 1,697	$ 3,494	$ -	$ -	$ 322	$ -	$ 40,224
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 23,669	$ 31,680	$ 255	$ 7,113	$ -	$ 1,809	$ -	$ -	$ 64,525
170	Subtotal (Lines 105 through 155)	$ 1,888,690	$ 975,007	$ 27,390	$ 878,128	$ -	$ 81,718	$ 12,707	$ -	$ 3,863,639
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,205,115**	**$ 2,599,989**	**$ 342,017**	**$ 3,981,761**	**$ -**	**$ 202,591**	**$ 96,167**	**$ 59,075**	**$ 11,486,714**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 3,080	$ -	$ -	$ -	$ -	$ (675)	$ -	$ 2,405
215	Contractual Adjustments - Medicare	$ (577,979)	$ 246,526	$ -	$ -	$ -	$ -	$ -	$ -	$ (331,453)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 91,363	$ 1,067,529	$ -	$ -	$ -	$ -	$ 1,158,892
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 19,411	$ -	$ -	$ 19,411
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,317)	$ 9,055	$ 7,739
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (577,979)**	**$ 249,606**	**$ 91,363**	**$ 1,067,529**	**$ -**	**$ 19,411**	**$ (1,992)**	**$ 9,055**	**$ 856,994**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,783,093**	**$ 2,350,383**	**$ 250,654**	**$ 2,914,232**	**$ -**	**$ 183,180**	**$ 98,159**	**$ 50,020**	**$ 10,629,721**

Grand Terrace Healthcare Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	5537	4283	1034	8638	0	323	114	166	20095
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	5537	4283	1034	8638	0	323	114	166	20095

Grossmont
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,521,700	$ 6,712,359	$ 453,190	$ 1,687,106	$ -	$ 514,641	$ 102,774	$ 99,900	$ 13,091,670
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,521,700	$ 6,712,359	$ 453,190	$ 1,687,106	$ -	$ 514,641	$ 102,774	$ 99,900	$ 13,091,670
	Ancillary Services:									
105	Patient Supplies	$ 47,828	$ 98,394	$ 4,131	$ 12,598	$ -	$ 7,580	$ 644	$ 1,470	$ 172,644
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 830,025	$ 1,797,795	$ 1,440	$ 11,610	$ -	$ 132,840	$ 2,565	$ -	$ 2,776,275
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,046,610	$ 1,769,715	$ 360	$ 9,810	$ -	$ 125,550	$ -	$ -	$ 2,952,045
130	Speech Pathology	$ 963,270	$ 300,375	$ 90	$ 10,485	$ -	$ 8,460	$ -	$ -	$ 1,282,680
135	Pharmacy	$ 603,214	$ 1,190,234	$ 65	$ 4,476	$ -	$ 115,582	$ -	$ -	$ 1,913,572
140	Laboratory	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 72,872	$ 122,429	$ 477	$ 4,081	$ -	$ 14,849	$ -	$ -	$ 214,708
170	Subtotal (Lines 105 through 155)	$ 3,563,820	$ 5,278,941	$ 6,563	$ 53,061	$ -	$ 404,861	$ 3,209	$ 1,470	$ 9,311,924
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,982,785**	**$ 11,991,300**	**$ 459,753**	**$ 1,740,166**	**$ -**	**$ 919,502**	**$ 103,418**	**$ 101,370**	**$ 22,403,594**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (7,776)	$ -	$ -	$ -	$ (654)	$ (11,266)	$ -	$ (19,696)
215	Contractual Adjustments - Medicare	$ 394,334	$ 1,399,169	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,793,503
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 139,516	$ 394,082	$ -	$ -	$ -	$ -	$ 533,598
222	Contractual Adjustments - Commercial Coverage	$ 3,152	$ -	$ -	$ -	$ -	$ 94,100	$ -	$ -	$ 97,252
225	Contractual Adjustments - Other	$ 24	$ -	$ -	$ -	$ -	$ -	$ -	$ 22,328	$ 22,352
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 397,509**	**$ 1,391,393**	**$ 139,516**	**$ 394,082**	**$ -**	**$ 93,446**	**$ (11,266)**	**$ 22,328**	**$ 2,427,008**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,637,903**	**$ 10,599,907**	**$ 320,237**	**$ 1,346,084**	**$ -**	**$ 826,056**	**$ 114,684**	**$ 79,042**	**$ 19,976,586**

Grossmont
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7866	14851	1071	3700	0	1171	213	211	29083
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7866	14851	1071	3700	0	1171	213	211	29083

La Jolla The Springs
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 8,112,600	$ 3,143,191	$ -	$ 327,648	$ -	$ 341,949	$ 222,030	$ 15,000	$ 12,162,418
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 8,112,600	$ 3,143,191	$ -	$ 327,648	$ -	$ 341,949	$ 222,030	$ 15,000	$ 12,162,418
	Ancillary Services:									
105	Patient Supplies	$ 86,816	$ 41,629	$ -	$ 2,594	$ -	$ 4,586	$ 2,182	$ 42	$ 137,850
110	Specialized Support Surfaces	$ 26,320	$ 141	$ -	$ -	$ -	$ -	$ -	$ -	$ 26,461
115	Physical Therapy	$ 1,580,535	$ 434,340	$ -	$ 28,743	$ -	$ 101,430	$ 3,015	$ -	$ 2,148,063
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,753,785	$ 426,915	$ -	$ 27,630	$ -	$ 43,740	$ 2,970	$ -	$ 2,255,040
130	Speech Pathology	$ 480,780	$ 79,830	$ -	$ 2,880	$ -	$ 5,445	$ 315	$ -	$ 569,250
135	Pharmacy	$ 1,720,221	$ 683,885	$ -	$ 14,239	$ -	$ 88,093	$ (0)	$ 68	$ 2,506,506
140	Laboratory	$ 60,402	$ 23,235	$ -	$ 562	$ -	$ 2,231	$ 47	$ 26	$ 86,503
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 104,210	$ 50,122	$ -	$ 1,458	$ -	$ 4,819	$ -	$ -	$ 160,609
170	Subtotal (Lines 105 through 155)	$ 5,813,070	$ 1,740,096	$ -	$ 78,107	$ -	$ 250,344	$ 8,529	$ 136	$ 7,890,281
175	**Total Gross Revenue (Line 70 + 170)**	**$ 13,499,651**	**$ 4,883,287**	**$ -**	**$ 405,755**	**$ -**	**$ 592,293**	**$ 230,559**	**$ 15,136**	**$ 20,052,699**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (3,361)	$ -	$ -	$ -	$ -	$ (43,389)	$ -	$ (46,750)
215	Contractual Adjustments - Medicare	$ 2,592,734	$ 1,366,831	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,959,565
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ -	$ 101,427	$ -	$ -	$ -	$ -	$ 101,427
222	Contractual Adjustments - Commercial Coverage	$ 14,708	$ -	$ -	$ -	$ -	$ 131,236	$ -	$ -	$ 145,944
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (5,317)	$ (5,317)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 2,607,442**	**$ 1,363,470**	**$ -**	**$ 101,427**	**$ -**	**$ 131,236**	**$ (43,389)**	**$ (5,317)**	**$ 4,154,869**
250	**Net Patient Revenue (line 175 - 240)**	**$ 11,108,045**	**$ 3,519,817**	**$ -**	**$ 304,328**	**$ -**	**$ 461,057**	**$ 273,948**	**$ 20,452**	**$ 15,897,830**

La Jolla The Springs
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	13383	5159	0	717	0	629	337	25	20250
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	13383	5159	0	717	0	629	337	25	20250

Lake Balboa Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 8,965,300	$ 643,875	$ 14,794	$ 61,600	$ -	$ 154,200	$ 110,031	$ 34,300	$ 9,984,100
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 8,965,300	$ 643,875	$ 14,794	$ 61,600	$ -	$ 154,200	$ 110,031	$ 34,300	$ 9,984,100
	Ancillary Services:									
105	Patient Supplies	$ 14,849	$ 7,910	$ -	$ -	$ -	$ -	$ -	$ -	$ 22,759
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,457,775	$ 116,415	$ 315	$ 44,145	$ -	$ 27,405	$ 1,395	$ -	$ 1,647,450
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,886,445	$ 113,040	$ 315	$ 34,650	$ -	$ 23,940	$ 1,305	$ -	$ 2,059,695
130	Speech Pathology	$ 586,620	$ 18,765	$ -	$ 3,105	$ -	$ 1,755	$ -	$ -	$ 610,245
135	Pharmacy	$ 1,123,999	$ 83,103	$ 1,056	$ -	$ -	$ 13,919	$ 126	$ 18	$ 1,222,220
140	Laboratory	$ 200,557	$ 18,354	$ 267	$ -	$ -	$ 4,480	$ 69	$ 409	$ 224,136
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 178,956	$ 14,628	$ -	$ 186	$ -	$ 3,244	$ -	$ -	$ 197,015
170	Subtotal (Lines 105 through 155)	$ 5,449,202	$ 372,215	$ 1,953	$ 82,086	$ -	$ 74,743	$ 2,895	$ 427	$ 5,983,520
175	**Total Gross Revenue (Line 70 + 170)**	**$ 14,414,502**	**$ 1,016,090**	**$ 16,747**	**$ 143,686**	**$ -**	**$ 228,943**	**$ 112,925**	**$ 34,727**	**$ 15,967,620**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 4,936	$ -	$ -	$ -	$ -	$ (110,215)	$ -	$ (105,279)
215	Contractual Adjustments - Medicare	$ 273,897	$ 67,066	$ -	$ -	$ -	$ -	$ -	$ -	$ 340,963
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 9,315	$ 64,555	$ -	$ -	$ -	$ -	$ 73,870
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (53,741)	$ -	$ -	$ (53,741)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,503	$ 16,503
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 273,897**	**$ 72,002**	**$ 9,315**	**$ 64,555**	**$ -**	**$ (53,741)**	**$ (110,215)**	**$ 16,503**	**$ 272,316**
250	**Net Patient Revenue (line 175 - 240)**	**$ 14,140,605**	**$ 944,088**	**$ 7,432**	**$ 79,131**	**$ -**	**$ 282,685**	**$ 223,140**	**$ 18,224**	**$ 15,695,303**

Lake Balboa Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	15369	1165	31	109	0	266	186	49	17175
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	15369	1165	31	109	0	266	186	49	17175

Lemon Grove
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,877,100	$ 2,361,041	$ 849,947	$ 10,936,578	$ -	$ 931,625	$ 5,900	$ 675,956	$ 17,638,147
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,877,100	$ 2,361,041	$ 849,947	$ 10,936,578	$ -	$ 931,625	$ 5,900	$ 675,956	$ 17,638,147
	Ancillary Services:									
105	Patient Supplies	$ 19,480	$ 20,318	$ 4,199	$ 48,216	$ -	$ 1,731	$ -	$ 2,282	$ 96,227
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 489,465	$ 222,075	$ 8,640	$ 1,252,035	$ -	$ 68,265	$ 90	$ 135	$ 2,040,705
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 545,175	$ 218,385	$ 5,490	$ 1,496,970	$ -	$ 67,455	$ -	$ 90	$ 2,333,565
130	Speech Pathology	$ 527,085	$ 89,505	$ 945	$ 417,960	$ -	$ 32,535	$ -	$ -	$ 1,068,030
135	Pharmacy	$ 265,412	$ 154,488	$ 619	$ 188,427	$ -	$ 53,402	$ -	$ -	$ 662,349
140	Laboratory	$ 26,569	$ 12,422	$ 992	$ 16,430	$ -	$ 7,703	$ -	$ -	$ 64,115
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 22,929	$ 30,102	$ 213	$ 33,257	$ -	$ 11,640	$ -	$ -	$ 98,142
170	Subtotal (Lines 105 through 155)	$ 1,896,116	$ 747,295	$ 21,099	$ 3,453,294	$ -	$ 242,731	$ 90	$ 2,507	$ 6,363,132
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,754,676**	**$ 3,108,336**	**$ 871,046**	**$ 14,389,872**	**$ -**	**$ 1,174,356**	**$ 5,990**	**$ 678,463**	**$ 24,001,279**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 2,181,556	$ -	$ -	$ -	$ (2,250,594)	$ 14,395	$ -	$ (54,643)
215	Contractual Adjustments - Medicare	$ (841,710)	$ (68,478)	$ -	$ -	$ -	$ -	$ -	$ -	$ (910,189)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 213,574	$ 674,589	$ -	$ -	$ 900	$ -	$ 889,063
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (555,313)	$ -	$ -	$ (555,313)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 174,931	$ 174,931
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (841,710)**	**$ 2,113,078**	**$ 213,574**	**$ 674,589**	**$ -**	**$ (2,805,908)**	**$ 15,295**	**$ 174,931**	**$ (456,151)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 4,606,001**	**$ 995,258**	**$ 657,472**	**$ 13,715,284**	**$ -**	**$ 3,980,264**	**$ (9,306)**	**$ 503,532**	**$ 24,457,430**

Lemon Grove
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	5847	2596	3305	37713	0	3097	17	2321	54896
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	5847	2596	3305	37713	0	3097	17	2321	54896

Lomita Post-Acute Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,602,500	$ 26,250	$ 271,815	$ 3,382,835	$ -	$ 194,250	$ 315,350	$ 451,500	$ 8,244,500
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,602,500	$ 26,250	$ 271,815	$ 3,382,835	$ -	$ 194,250	$ 315,350	$ 451,500	$ 8,244,500
	Ancillary Services:									
105	Patient Supplies	$ -	$ 702	$ -	$ -	$ -	$ 2,252	$ -	$ -	$ 2,954
110	Specialized Support Surfaces	$ 13,069	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,069
115	Physical Therapy	$ 1,131,300	$ 16,740	$ -	$ 637,830	$ -	$ 48,780	$ -	$ -	$ 1,834,650
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 983,115	$ 17,730	$ -	$ 685,575	$ -	$ 46,350	$ -	$ -	$ 1,732,770
130	Speech Pathology	$ 316,080	$ 3,645	$ -	$ 176,805	$ -	$ 6,705	$ -	$ -	$ 503,235
135	Pharmacy	$ 162,465	$ 236	$ -	$ 36	$ -	$ 10,136	$ -	$ -	$ 172,873
140	Laboratory	$ 64,742	$ 509	$ -	$ -	$ -	$ 3,020	$ -	$ -	$ 68,271
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 57,496	$ -	$ -	$ -	$ -	$ 4,944	$ -	$ -	$ 62,440
170	Subtotal (Lines 105 through 155)	$ 2,728,267	$ 39,562	$ -	$ 1,500,246	$ -	$ 122,186	$ -	$ -	$ 4,390,261
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,330,767**	**$ 65,812**	**$ 271,815**	**$ 4,883,081**	**$ -**	**$ 316,436**	**$ 315,350**	**$ 451,500**	**$ 12,634,761**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (9,213)	$ -	$ -	$ -	$ -	$ (7,700)	$ -	$ (16,913)
215	Contractual Adjustments - Medicare	$ (1,790,276)	$ 885	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,789,391)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (2,464)	$ 929,858	$ -	$ -	$ -	$ -	$ 927,394
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (5,814)	$ -	$ -	$ (5,814)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 42,335	$ 42,335
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,790,276)**	**$ (8,328)**	**$ (2,464)**	**$ 929,858**	**$ -**	**$ (5,814)**	**$ (7,700)**	**$ 42,335**	**$ (842,389)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,121,043**	**$ 74,140**	**$ 274,279**	**$ 3,953,223**	**$ -**	**$ 322,250**	**$ 323,050**	**$ 409,165**	**$ 13,477,151**

Lomita Post-Acute Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9547	75	792	9321	0	555	901	1290	22481
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9547	75	792	9321	0	555	901	1290	22481

Magnolia
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,656,500	$ 1,280,069	$ 271,553	$ 8,598,466	$ -	$ 153,331	$ 16,750	$ 1,266,100	$ 13,242,769
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,656,500	$ 1,280,069	$ 271,553	$ 8,598,466	$ -	$ 153,331	$ 16,750	$ 1,266,100	$ 13,242,769
	Ancillary Services:									
105	Patient Supplies	$ 1,050	$ 7,035	$ -	$ 2,483	$ -	$ -	$ -	$ 2,335	$ 12,903
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 398,655	$ 278,345	$ -	$ 763,062	$ -	$ 32,895	$ -	$ 135	$ 1,473,092
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 484,470	$ 282,735	$ -	$ 738,000	$ -	$ 34,245	$ -	$ 540	$ 1,539,990
130	Speech Pathology	$ 469,755	$ 136,685	$ -	$ 285,525	$ -	$ 11,295	$ -	$ 630	$ 903,890
135	Pharmacy	$ 109,593	$ 83,179	$ 938	$ 63,502	$ -	$ 4,014	$ -	$ 710	$ 261,935
140	Laboratory	$ 30,950	$ 12,415	$ -	$ 480	$ -	$ -	$ -	$ -	$ 43,845
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 9,745	$ 14,607	$ 409	$ 31,155	$ -	$ 619	$ -	$ 419	$ 56,955
170	Subtotal (Lines 105 through 155)	$ 1,504,218	$ 815,001	$ 1,346	$ 1,884,208	$ -	$ 83,068	$ -	$ 4,769	$ 4,292,611
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,155,588**	**$ 2,095,070**	**$ 272,899**	**$ 10,482,674**	**$ -**	**$ 236,399**	**$ 16,750**	**$ 1,270,869**	**$ 17,535,380**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (1,275)	$ -	$ -	$ -	$ (767)	$ 645	$ -	$ (1,397)
215	Contractual Adjustments - Medicare	$ (554,071)	$ (212,088)	$ -	$ -	$ -	$ -	$ -	$ -	$ (766,159)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 94,173	$ 2,184,611	$ -	$ -	$ -	$ -	$ 2,278,784
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (28,789)	$ -	$ -	$ (28,789)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ 874	$ 317,811	$ 318,685
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (554,071)**	**$ (213,363)**	**$ 94,173**	**$ 2,184,611**	**$ -**	**$ (29,556)**	**$ 1,519**	**$ 317,811**	**$ 1,801,124**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,711,935**	**$ 2,308,433**	**$ 178,726**	**$ 8,298,064**	**$ -**	**$ 265,955**	**$ 15,231**	**$ 953,059**	**$ 15,734,256**

Magnolia
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4045	3166	711	22514	0	376	49	3133	33994
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4045	3166	711	22514	0	376	49	3133	33994

Mainplace Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,997,130	$ 1,917,811	$ 844,249	$ 10,729,298	$ -	$ 420,826	$ 34,240	$ 949,522	$ 17,893,075
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,997,130	$ 1,917,811	$ 844,249	$ 10,729,298	$ -	$ 420,826	$ 34,240	$ 949,522	$ 17,893,075
	Ancillary Services:									
105	Patient Supplies	$ 18,204	$ 15,052	$ 158	$ 22,846	$ -	$ 2,480	$ 4	$ 841	$ 59,585
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,652,625	$ 417,013	$ 990	$ 2,069,526	$ -	$ 86,040	$ 9,360	$ 585	$ 4,236,139
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,748,385	$ 412,127	$ 1,080	$ 2,148,165	$ -	$ 83,520	$ 8,640	$ 495	$ 4,402,411
130	Speech Pathology	$ 484,155	$ 70,560	$ 405	$ 242,100	$ -	$ 12,195	$ 900	$ -	$ 810,315
135	Pharmacy	$ 515,015	$ 256,165	$ 3,842	$ 125,045	$ -	$ 87,569	$ -	$ 2,066	$ 989,701
140	Laboratory	$ 76,856	$ 75,699	$ 4,657	$ 47,142	$ -	$ 11,164	$ 120	$ 14	$ 215,652
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 79,383	$ 81,256	$ -	$ 33,796	$ -	$ 26,422	$ -	$ -	$ 220,857
170	Subtotal (Lines 105 through 155)	$ 4,574,624	$ 1,327,871	$ 11,133	$ 4,688,621	$ -	$ 309,389	$ 19,024	$ 4,000	$ 10,934,662
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,903,919**	**$ 3,245,682**	**$ 855,381**	**$ 15,417,918**	**$ -**	**$ 730,215**	**$ 53,264**	**$ 953,522**	**$ 28,827,737**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 17,909	$ -	$ -	$ -	$ -	$ (11,501)	$ -	$ 6,408
215	Contractual Adjustments - Medicare	$ (919,324)	$ (213,832)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,133,156)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 98,153	$ 2,773,495	$ -	$ -	$ -	$ -	$ 2,871,648
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (65,376)	$ -	$ -	$ (65,376)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,305	$ 13,305
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (919,324)**	**$ (195,923)**	**$ 98,153**	**$ 2,773,495**	**$ -**	**$ (65,376)**	**$ (11,501)**	**$ 13,305**	**$ 1,692,829**
250	**Net Patient Revenue (line 175 - 240)**	**$ 7,808,049**	**$ 3,441,605**	**$ 757,228**	**$ 12,644,423**	**$ -**	**$ 795,591**	**$ 64,765**	**$ 940,217**	**$ 27,134,908**

Mainplace Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9209	5955	2886	33267	0	1330	107	2966	55720
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9209	5955	2886	33267	0	1330	107	2966	55720

Mission Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,343,650	$ 2,429,550	$ 25,227	$ 1,513,273	$ -	$ 33,605	$ 167,170	$ 284,150	$ 7,796,625
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,343,650	$ 2,429,550	$ 25,227	$ 1,513,273	$ -	$ 33,605	$ 167,170	$ 284,150	$ 7,796,625
	Ancillary Services:									
105	Patient Supplies	$ 1,296	$ 1,171	$ -	$ 252	$ -	$ -	$ 12,488	$ -	$ 15,207
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 601,065	$ 534,015	$ -	$ 216,135	$ -	$ 10,980	$ 5,130	$ -	$ 1,367,325
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 610,875	$ 455,715	$ 135	$ 247,005	$ -	$ 11,520	$ 2,520	$ -	$ 1,327,770
130	Speech Pathology	$ 219,825	$ 67,680	$ -	$ 7,965	$ -	$ 720	$ -	$ -	$ 296,190
135	Pharmacy	$ 304,580	$ 393,746	$ -	$ 7,526	$ -	$ 2,956	$ -	$ 331	$ 709,139
140	Laboratory	$ 95,566	$ 80,935	$ -	$ 5,788	$ -	$ 399	$ 36	$ -	$ 182,724
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 36,626	$ 54,908	$ -	$ 11,903	$ -	$ 753	$ -	$ -	$ 104,189
170	Subtotal (Lines 105 through 155)	$ 1,869,833	$ 1,588,170	$ 135	$ 496,574	$ -	$ 27,328	$ 20,174	$ 331	$ 4,002,544
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,213,483**	**$ 4,017,720**	**$ 25,362**	**$ 2,009,847**	**$ -**	**$ 60,933**	**$ 187,344**	**$ 284,481**	**$ 11,799,169**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (12,775)	$ -	$ -	$ -	$ -	$ 3,785	$ -	$ (8,990)
215	Contractual Adjustments - Medicare	$ (182,963)	$ 130,602	$ -	$ -	$ -	$ -	$ -	$ -	$ (52,361)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (26,418)	$ 254,383	$ -	$ -	$ -	$ -	$ 227,965
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 4,820	$ -	$ -	$ 4,820
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,185	$ 14,185
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (182,963)**	**$ 117,827**	**$ (26,418)**	**$ 254,383**	**$ -**	**$ 4,820**	**$ 3,785**	**$ 14,185**	**$ 185,618**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,396,446**	**$ 3,899,893**	**$ 51,780**	**$ 1,755,464**	**$ -**	**$ 56,113**	**$ 183,559**	**$ 270,296**	**$ 11,613,551**

Mission Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6221	6453	73	4379	0	116	349	804	18395
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6221	6453	73	4379	0	116	349	804	18395

Mission Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,387,620	$ 2,464,565	$ 154,484	$ 3,299,016	$ -	$ 2,566,795	$ 78,940	$ 317,860	$ 10,269,280
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,387,620	$ 2,464,565	$ 154,484	$ 3,299,016	$ -	$ 2,566,795	$ 78,940	$ 317,860	$ 10,269,280
	Ancillary Services:									
105	Patient Supplies	$ 14,075	$ 6,407	$ 1,384	$ 29,551	$ -	$ 4,708	$ -	$ 520	$ 56,645
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 356,940	$ 550,710	$ 24,947	$ 532,738	$ -	$ 485,505	$ 2,925	$ -	$ 1,953,765
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 394,425	$ 501,030	$ 22,553	$ 481,627	$ -	$ 405,180	$ 1,215	$ -	$ 1,806,030
130	Speech Pathology	$ 288,360	$ 215,370	$ 8,074	$ 172,421	$ -	$ 96,075	$ 135	$ -	$ 780,435
135	Pharmacy	$ 61,743	$ 137,348	$ 99	$ 2,113	$ -	$ 67,629	$ -	$ -	$ 268,932
140	Laboratory	$ 10,916	$ 29,640	$ -	$ -	$ -	$ 20,573	$ -	$ -	$ 61,130
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 13,869	$ 27,598	$ 1,538	$ 32,835	$ -	$ 15,319	$ -	$ -	$ 91,160
170	Subtotal (Lines 105 through 155)	$ 1,140,329	$ 1,468,104	$ 58,594	$ 1,251,285	$ -	$ 1,094,990	$ 4,275	$ 520	$ 5,018,096
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,527,949**	**$ 3,932,669**	**$ 213,078**	**$ 4,550,301**	**$ -**	**$ 3,661,785**	**$ 83,215**	**$ 318,380**	**$ 15,287,376**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ 46,670	$ -	$ 46,670
215	Contractual Adjustments - Medicare	$ (363,138)	$ 2,909,880	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,546,743
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 34,311	$ 732,710	$ -	$ -	$ -	$ -	$ 767,021
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (1,249,599)	$ -	$ -	$ (1,249,599)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 57,716	$ 57,716
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (363,138)**	**$ 2,909,880**	**$ 34,311**	**$ 732,710**	**$ -**	**$ (1,249,599)**	**$ 46,670**	**$ 57,716**	**$ 2,168,550**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,891,087**	**$ 1,022,788**	**$ 178,768**	**$ 3,817,591**	**$ -**	**$ 4,911,384**	**$ 36,545**	**$ 260,664**	**$ 13,118,826**

Mission Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3674	6258	583	12450	0	2057	176	995	26193
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3674	6258	583	12450	0	2057	176	995	26193

New Orange Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,777,140	$ 2,532,782	$ 1,403,113	$ 11,935,967	$ -	$ 129,958	$ 216,540	$ 196,020	$ 18,191,520
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 213,840	$ 156,614	$ 511,346	$ 7,889,420	$ -	$ -	$ -	$ -	$ 8,771,220
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,990,980	$ 2,689,396	$ 1,914,459	$ 19,825,387	$ -	$ 129,958	$ 216,540	$ 196,020	$ 26,962,740
	Ancillary Services:									
105	Patient Supplies	$ 21,032	$ 25,763	$ 21,630	$ 285,468	$ -	$ 2,442	$ -	$ 380	$ 356,715
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 390,375	$ 536,437	$ 5,940	$ 953,190	$ -	$ 16,185	$ 941	$ -	$ 1,903,069
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 359,595	$ 417,161	$ 4,140	$ 758,385	$ -	$ 15,120	$ 305	$ -	$ 1,554,706
130	Speech Pathology	$ 160,065	$ 71,776	$ 2,025	$ 71,235	$ -	$ 4,560	$ 223	$ -	$ 309,884
135	Pharmacy	$ 227,962	$ 160,693	$ -	$ 3,789	$ -	$ 9,717	$ -	$ -	$ 402,161
140	Laboratory	$ 20,383	$ 34,442	$ 6,746	$ 60,497	$ -	$ 1,450	$ 778	$ 61	$ 124,358
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 27,676	$ 30,414	$ 948	$ 12,324	$ -	$ 1,528	$ -	$ 272	$ 73,163
170	Subtotal (Lines 105 through 155)	$ 1,207,088	$ 1,276,687	$ 41,430	$ 2,144,888	$ -	$ 51,002	$ 2,247	$ 713	$ 4,724,055
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,198,068**	**$ 3,966,083**	**$ 1,955,888**	**$ 21,970,275**	**$ -**	**$ 180,960**	**$ 218,787**	**$ 196,733**	**$ 31,686,795**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (65,622)	$ -	$ 0	$ -	$ -	$ 27,804	$ -	$ (37,818)
215	Contractual Adjustments - Medicare	$ (52,608)	$ 1,112,510	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,059,902
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 628,167	$ 4,470,891	$ -	$ -	$ -	$ -	$ 5,099,057
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 47,112	$ -	$ -	$ 47,112
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 65,403	$ 65,403
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (52,608)**	**$ 1,046,888**	**$ 628,167**	**$ 4,470,891**	**$ -**	**$ 47,112**	**$ 27,804**	**$ 65,403**	**$ 6,233,657**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,250,677**	**$ 2,919,195**	**$ 1,327,722**	**$ 17,499,384**	**$ -**	**$ 133,848**	**$ 190,983**	**$ 131,330**	**$ 25,453,138**

New Orange Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3079	4055	2832	21608	0	263	81	363	32281
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	621	600	1039	15028	0	21	354	0	17663
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3700	4655	3871	36636	0	284	435	363	49944

Northbrook
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 848,300	$ 120,700	$ 27,156	$ 2,994,764	$ -	$ 18,700	$ 144,500	$ 24,480	$ 4,178,600
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 848,300	$ 120,700	$ 27,156	$ 2,994,764	$ -	$ 18,700	$ 144,500	$ 24,480	$ 4,178,600
	Ancillary Services:									
105	Patient Supplies	$ -	$ 840	$ -	$ -	$ -	$ -	$ -	$ -	$ 840
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 300,555	$ 33,975	$ 540	$ 361,530	$ -	$ -	$ -	$ -	$ 696,600
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 319,500	$ 25,245	$ 225	$ 306,135	$ -	$ -	$ -	$ -	$ 651,105
130	Speech Pathology	$ 87,975	$ 4,140	$ -	$ 214,425	$ -	$ -	$ -	$ -	$ 306,540
135	Pharmacy	$ 85,809	$ 11,405	$ -	$ -	$ -	$ -	$ -	$ -	$ 97,213
140	Laboratory	$ 87,647	$ 17,014	$ -	$ -	$ -	$ -	$ -	$ -	$ 104,661
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 7,370	$ 1,320	$ -	$ 7,844	$ -	$ -	$ -	$ -	$ 16,534
170	Subtotal (Lines 105 through 155)	$ 888,855	$ 93,939	$ 765	$ 889,934	$ -	$ -	$ -	$ -	$ 1,873,494
175	**Total Gross Revenue (Line 70 + 170)**	**$ 1,737,155**	**$ 214,639**	**$ 27,921**	**$ 3,884,698**	**$ -**	**$ 18,700**	**$ 144,500**	**$ 24,480**	**$ 6,052,094**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Contractual Adjustments - Medicare	$ (388,024)	$ (6,176)	$ -	$ -	$ -	$ -	$ -	$ -	$ (394,200)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 3,400	$ 486,700	$ -	$ -	$ -	$ -	$ 490,101
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (10,000)	$ -	$ -	$ (10,000)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,534	$ 2,534
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (388,024)**	**$ (6,176)**	**$ 3,400**	**$ 486,700**	**$ -**	**$ (10,000)**	**$ -**	**$ 2,534**	**$ 88,435**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,125,180**	**$ 220,815**	**$ 24,520**	**$ 3,397,998**	**$ -**	**$ 28,700**	**$ 144,500**	**$ 21,946**	**$ 5,963,659**

Northbrook
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2496	355	109	8779	0	55	425	72	12291
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	2496	355	109	8779	0	55	425	72	12291

Pacifica Nursing and Rehabilitation Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 6,789,475	$ 6,753,692	$ 8,500	$ -	$ -	$ 74,925	$ 491,183	$ -	$ 14,117,775
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 6,789,475	$ 6,753,692	$ 8,500	$ -	$ -	$ 74,925	$ 491,183	$ -	$ 14,117,775
	Ancillary Services:									
105	Patient Supplies	$ 21,408	$ 24,175	$ -	$ -	$ -	$ -	$ 75,813	$ -	$ 121,396
110	Specialized Support Surfaces	$ 24,378	$ 23,750	$ -	$ -	$ -	$ -	$ 824	$ -	$ 48,951
115	Physical Therapy	$ 1,104,885	$ 1,063,935	$ -	$ 3,383	$ -	$ 9,045	$ 30,960	$ -	$ 2,212,208
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,220,985	$ 1,036,350	$ -	$ 1,395	$ -	$ 9,540	$ 17,820	$ -	$ 2,286,090
130	Speech Pathology	$ 379,350	$ 138,330	$ -	$ -	$ -	$ 630	$ 1,005	$ -	$ 519,315
135	Pharmacy	$ 510,744	$ 655,566	$ 210	$ -	$ -	$ 9,815	$ 1,201	$ -	$ 1,177,537
140	Laboratory	$ 31,317	$ 104,971	$ 38	$ -	$ -	$ 710	$ 2,325	$ -	$ 139,361
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 53,676	$ 83,002	$ -	$ -	$ -	$ 2,167	$ 915	$ -	$ 139,759
170	Subtotal (Lines 105 through 155)	$ 3,346,742	$ 3,130,079	$ 248	$ 4,778	$ -	$ 31,907	$ 130,863	$ -	$ 6,644,617
175	**Total Gross Revenue (Line 70 + 170)**	**$ 10,124,427**	**$ 9,883,771**	**$ 8,748**	**$ 4,778**	**$ -**	**$ 106,832**	**$ 622,046**	**$ -**	**$ 20,762,392**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (24,514)	$ -	$ -	$ -	$ -	$ (218,638)	$ -	$ (243,152)
215	Contractual Adjustments - Medicare	$ (1,493,903)	$ 256,757	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,237,146)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (513)	$ 314	$ -	$ -	$ -	$ -	$ (199)
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (10,405)	$ -	$ -	$ (10,405)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ (900)	$ 144	$ (756)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,493,903)**	**$ 232,243**	**$ (513)**	**$ 314**	**$ -**	**$ (10,405)**	**$ (219,538)**	**$ 144**	**$ (1,491,658)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 11,622,987**	**$ 9,651,528**	**$ 9,261**	**$ 4,464**	**$ -**	**$ 117,238**	**$ 841,584**	**$ (144)**	**$ 22,254,051**

Pacifica Nursing and Rehabilitation Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9741	11098	17	0	0	111	720	0	21687
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9741	11098	17	0	0	111	720	0	21687

Palm Terrace Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,831,560	$ 1,050,950	$ 676,955	$ 2,202,315	$ -	$ -	$ 12,440	$ 537,417	$ 9,311,637
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,831,560	$ 1,050,950	$ 676,955	$ 2,202,315	$ -	$ -	$ 12,440	$ 537,417	$ 9,311,637
	Ancillary Services:									
105	Patient Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,418,895	$ 314,775	$ 11,925	$ 366,885	$ -	$ -	$ 3,060	$ 141,750	$ 2,257,290
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,905,930	$ 252,405	$ 3,825	$ 413,550	$ -	$ -	$ 2,430	$ 139,320	$ 2,717,460
130	Speech Pathology	$ 302,895	$ 22,680	$ 1,170	$ 30,240	$ -	$ -	$ 225	$ 13,185	$ 370,395
135	Pharmacy	$ 826,273	$ 89,358	$ 54	$ 5,843	$ -	$ -	$ -	$ 142,758	$ 1,064,285
140	Laboratory	$ 20,833	$ 2,928	$ -	$ -	$ -	$ -	$ -	$ -	$ 23,761
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 100,205	$ 26,088	$ 1,919	$ 15,711	$ -	$ -	$ -	$ 7,329	$ 151,251
170	Subtotal (Lines 105 through 155)	$ 4,575,030	$ 708,234	$ 18,892	$ 832,229	$ -	$ -	$ 5,715	$ 444,342	$ 6,584,442
175	**Total Gross Revenue (Line 70 + 170)**	**$ 9,406,590**	**$ 1,759,184**	**$ 695,847**	**$ 3,034,545**	**$ -**	**$ -**	**$ 18,155**	**$ 981,759**	**$ 15,896,080**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ 350	$ -	$ 350
215	Contractual Adjustments - Medicare	$ (1,265,551)	$ (235,870)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,501,422)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 237,601	$ 1,035,467	$ -	$ -	$ -	$ -	$ 1,273,069
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (317,735)	$ (317,735)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,265,551)**	**$ (235,870)**	**$ 237,601**	**$ 1,035,467**	**$ -**	**$ -**	**$ 350**	**$ (317,735)**	**$ (545,738)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 10,672,142**	**$ 1,995,054**	**$ 458,246**	**$ 1,999,077**	**$ -**	**$ -**	**$ 17,805**	**$ 1,299,494**	**$ 16,441,818**

Palm Terrace Care Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	12511	2795	2060	5637	0	0	31	1708	24742
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	12511	2795	2060	5637	0	0	31	1708	24742

Palm Terrace
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,585,050	$ 3,409,556	$ 671,579	$ 5,390,421	$ -	$ 176,366	$ 476,153	$ 447,750	$ 15,156,875
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,585,050	$ 3,409,556	$ 671,579	$ 5,390,421	$ -	$ 176,366	$ 476,153	$ 447,750	$ 15,156,875
	Ancillary Services:									
105	Patient Supplies	$ 37,982	$ 24,873	$ 6,397	$ 17,127	$ -	$ 1,571	$ 2,225	$ 744	$ 90,919
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 973,755	$ 756,495	$ 450	$ 801,339	$ -	$ 31,095	$ 16,065	$ -	$ 2,579,199
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,131,570	$ 742,590	$ 360	$ 893,385	$ -	$ 29,250	$ 405	$ 135	$ 2,797,695
130	Speech Pathology	$ 409,860	$ 138,375	$ 270	$ 80,145	$ -	$ 6,840	$ 270	$ -	$ 635,760
135	Pharmacy	$ 485,207	$ 419,324	$ 1,922	$ 28,567	$ -	$ 30,521	$ 634	$ 318	$ 966,493
140	Laboratory	$ 69,904	$ 69,544	$ 2,169	$ 13,025	$ -	$ 3,151	$ 689	$ 70	$ 158,552
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 79,054	$ 79,879	$ 298	$ 38,598	$ -	$ 2,263	$ 194	$ -	$ 200,286
170	Subtotal (Lines 105 through 155)	$ 3,187,332	$ 2,231,080	$ 11,867	$ 1,872,186	$ -	$ 104,691	$ 20,482	$ 1,267	$ 7,428,905
175	**Total Gross Revenue (Line 70 + 170)**	**$ 7,686,027**	**$ 5,640,636**	**$ 683,446**	**$ 7,262,607**	**$ -**	**$ 281,057**	**$ 496,635**	**$ 449,017**	**$ 22,585,780**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 5,341	$ -	$ -	$ -	$ (1,312)	$ (11,014)	$ -	$ (6,985)
215	Contractual Adjustments - Medicare	$ (499,349)	$ 1,222,433	$ -	$ -	$ -	$ -	$ -	$ -	$ 723,085
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 150,556	$ 2,097,657	$ -	$ -	$ -	$ -	$ 2,248,213
222	Contractual Adjustments - Commercial Coverage	$ (44)	$ -	$ -	$ -	$ -	$ 101,806	$ -	$ -	$ 101,762
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 114,215	$ 114,215
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (499,393)**	**$ 1,227,774**	**$ 150,556**	**$ 2,097,657**	**$ -**	**$ 100,494**	**$ (11,014)**	**$ 114,215**	**$ 3,180,290**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,233,003**	**$ 4,412,862**	**$ 532,891**	**$ 5,164,950**	**$ -**	**$ 180,563**	**$ 507,649**	**$ 334,803**	**$ 19,405,490**

Palm Terrace
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9949	7572	1586	11842	0	376	885	999	33209
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9949	7572	1586	11842	0	376	885	999	33209

Palomar Vista
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 690,400	$ 1,491,127	$ 173,574	$ 4,930,426	$ -	$ 43,248	$ 109,475	$ 774,007	$ 8,212,257
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 690,400	$ 1,491,127	$ 173,574	$ 4,930,426	$ -	$ 43,248	$ 109,475	$ 774,007	$ 8,212,257
	Ancillary Services:									
105	Patient Supplies	$ 1,826	$ 1,448	$ -	$ 32,582	$ -	$ -	$ -	$ 1,414	$ 37,270
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 224,055	$ 386,505	$ 945	$ 753,255	$ -	$ 11,115	$ 16,020	$ 44,595	$ 1,436,490
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 292,590	$ 406,035	$ 900	$ 708,705	$ -	$ 11,475	$ 180	$ 44,010	$ 1,463,895
130	Speech Pathology	$ 135,990	$ 104,355	$ 720	$ 118,260	$ -	$ 4,140	$ 630	$ 12,060	$ 376,155
135	Pharmacy	$ 85,461	$ 200,962	$ 47	$ 121,651	$ -	$ 37,980	$ 41	$ 37,820	$ 483,961
140	Laboratory	$ 2,195	$ 4,826	$ -	$ 1,451	$ -	$ 81	$ -	$ 638	$ 9,191
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 7,720	$ 20,467	$ -	$ 23,846	$ -	$ -	$ -	$ 788	$ 52,820
170	Subtotal (Lines 105 through 155)	$ 749,837	$ 1,124,599	$ 2,612	$ 1,759,749	$ -	$ 64,791	$ 16,871	$ 141,324	$ 3,859,782
175	**Total Gross Revenue (Line 70 + 170)**	**$ 1,440,237**	**$ 2,615,726**	**$ 176,185**	**$ 6,690,175**	**$ -**	**$ 108,039**	**$ 126,346**	**$ 915,331**	**$ 12,072,039**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Contractual Adjustments - Medicare	$ (333,645)	$ (283,637)	$ -	$ -	$ -	$ -	$ -	$ -	$ (617,282)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 2,465	$ 465,942	$ -	$ -	$ -	$ -	$ 468,407
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (12,791)	$ -	$ -	$ (12,791)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (72,879)	$ (72,879)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (333,645)**	**$ (283,637)**	**$ 2,465**	**$ 465,942**	**$ -**	**$ (12,791)**	**$ -**	**$ (72,879)**	**$ (234,544)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 1,773,882**	**$ 2,899,362**	**$ 173,720**	**$ 6,224,233**	**$ -**	**$ 120,830**	**$ 126,346**	**$ 988,211**	**$ 12,306,584**

Palomar Vista
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2184	4721	599	15804	0	145	346	1936	25735
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	2184	4721	599	15804	0	145	346	1936	25735

Panorama Gardens
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,054,700	$ 599,400	$ 389,939	$ 12,035,222	$ -	$ 36,600	$ 80,600	$ 288,000	$ 15,484,462
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,054,700	$ 599,400	$ 389,939	$ 12,035,222	$ -	$ 36,600	$ 80,600	$ 288,000	$ 15,484,462
	Ancillary Services:									
105	Patient Supplies	$ -	$ 5,860	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,860
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 657,135	$ 175,725	$ -	$ 1,311,525	$ -	$ 10,035	$ 1,755	$ 90	$ 2,156,265
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 478,215	$ 107,730	$ -	$ 1,234,215	$ -	$ 5,670	$ 315	$ -	$ 1,826,145
130	Speech Pathology	$ 427,050	$ 71,497	$ 675	$ 430,650	$ -	$ 3,735	$ 818	$ 90	$ 934,515
135	Pharmacy	$ 288,849	$ 83,051	$ 157	$ 12,169	$ -	$ 15,218	$ -	$ -	$ 399,445
140	Laboratory	$ 60,252	$ 19,854	$ -	$ 3,528	$ -	$ 1,413	$ -	$ -	$ 85,047
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 42,021	$ 50,443	$ 801	$ 9,874	$ -	$ -	$ -	$ -	$ 103,139
170	Subtotal (Lines 105 through 155)	$ 1,953,521	$ 514,160	$ 1,633	$ 3,001,962	$ -	$ 36,071	$ 2,888	$ 180	$ 5,510,415
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,897,881**	**$ 1,113,560**	**$ 391,572**	**$ 15,037,184**	**$ -**	**$ 72,671**	**$ 83,488**	**$ 288,180**	**$ 20,994,877**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 4,800	$ -	$ -	$ -	$ -	$ (3,195)	$ -	$ 1,605
215	Contractual Adjustments - Medicare	$ (2,100,823)	$ (364,874)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,465,697)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 92,027	$ 2,904,300	$ -	$ -	$ -	$ -	$ 2,996,327
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 17,910	$ -	$ -	$ 17,910
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 38,852	$ 38,852
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,100,823)**	**$ (360,074)**	**$ 92,027**	**$ 2,904,300**	**$ -**	**$ 17,910**	**$ (3,195)**	**$ 38,852**	**$ 588,998**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,057,435**	**$ 1,473,634**	**$ 299,545**	**$ 12,132,884**	**$ -**	**$ 54,761**	**$ 86,683**	**$ 249,328**	**$ 20,405,879**

Panorama Gardens
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6828	2010	1702	39853	0	122	255	960	51730
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6828	2010	1702	39853	0	122	255	960	51730

Park View
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,454,560	$ 3,289,480	$ 201,355	$ 6,741,650	$ -	$ 180,855	$ 173,765	$ 586,295	$ 14,627,960
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,454,560	$ 3,289,480	$ 201,355	$ 6,741,650	$ -	$ 180,855	$ 173,765	$ 586,295	$ 14,627,960
	Ancillary Services:									
105	Patient Supplies	$ 65,923	$ 89,167	$ 1,846	$ 98,432	$ -	$ 4,523	$ -	$ -	$ 259,892
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 916,740	$ 870,615	$ -	$ 247,905	$ -	$ 35,910	$ 135	$ -	$ 2,071,305
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 976,500	$ 941,670	$ -	$ 173,025	$ -	$ 38,160	$ 135	$ -	$ 2,129,490
130	Speech Pathology	$ 281,070	$ 153,990	$ -	$ 106,065	$ -	$ 2,970	$ -	$ -	$ 544,095
135	Pharmacy	$ 611,314	$ 495,171	$ 1,300	$ 12,391	$ -	$ 36,513	$ 78	$ -	$ 1,156,767
140	Laboratory	$ 31,043	$ 41,426	$ 455	$ 5,863	$ -	$ 2,265	$ -	$ -	$ 81,053
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 57,149	$ 75,112	$ 616	$ 40,876	$ -	$ 2,064	$ -	$ -	$ 175,817
170	Subtotal (Lines 105 through 155)	$ 2,939,739	$ 2,667,151	$ 4,218	$ 684,558	$ -	$ 122,405	$ 348	$ -	$ 6,418,419
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,394,299**	**$ 5,956,631**	**$ 205,573**	**$ 7,426,208**	**$ -**	**$ 303,260**	**$ 174,113**	**$ 586,295**	**$ 21,046,379**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ (4,748)	$ -	$ (4,748)
215	Contractual Adjustments - Medicare	$ (4,167,248)	$ (1,499,038)	$ -	$ -	$ -	$ -	$ -	$ -	$ (5,666,286)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (8,228)	$ (171,973)	$ -	$ -	$ -	$ -	$ (180,201)
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (84,765)	$ -	$ -	$ (84,765)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 28,744	$ 28,744
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (4,167,248)**	**$ (1,499,038)**	**$ (8,228)**	**$ (171,973)**	**$ -**	**$ (84,765)**	**$ (4,748)**	**$ 28,744**	**$ (5,907,255)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 10,561,547**	**$ 7,455,669**	**$ 213,801**	**$ 7,598,181**	**$ -**	**$ 388,025**	**$ 178,861**	**$ 557,551**	**$ 26,953,634**

Park View
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9179	8843	633	18791	0	477	475	1643	40041
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9179	8843	633	18791	0	477	475	1643	40041

Parkside
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 91,790	$ 3,212,488	$ 1,548,896	$ 4,699,189	$ -	$ -	$ -	$ -	$ 9,552,363
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 91,790	$ 3,212,488	$ 1,548,896	$ 4,699,189	$ -	$ -	$ -	$ -	$ 9,552,363
	Ancillary Services:									
105	Patient Supplies	$ -	$ 2,364	$ 364	$ 68,780	$ -	$ -	$ -	$ -	$ 71,508
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 19,035	$ -	$ 135	$ 547,020	$ -	$ -	$ -	$ -	$ 566,190
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 21,870	$ -	$ 135	$ 602,280	$ -	$ -	$ -	$ -	$ 624,285
130	Speech Pathology	$ 22,275	$ -	$ 405	$ 115,020	$ -	$ -	$ -	$ -	$ 137,700
135	Pharmacy	$ 5,591	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,591
140	Laboratory	$ 269	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 269
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ -	$ -	$ -	$ 482	$ -	$ -	$ -	$ -	$ 482
170	Subtotal (Lines 105 through 155)	$ 69,040	$ 2,364	$ 1,039	$ 1,333,582	$ -	$ -	$ -	$ -	$ 1,406,025
175	**Total Gross Revenue (Line 70 + 170)**	**$ 160,830**	**$ 3,214,852**	**$ 1,549,935**	**$ 6,032,771**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 10,958,387**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Contractual Adjustments - Medicare	$ (95,119)	$ (1)	$ -	$ -	$ -	$ -	$ -	$ -	$ (95,120)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 125,975	$ 927,345	$ -	$ -	$ -	$ -	$ 1,053,319
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (95,119)**	**$ (1)**	**$ 125,975**	**$ 927,345**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 958,200**
250	**Net Patient Revenue (line 175 - 240)**	**$ 255,949**	**$ 3,214,853**	**$ 1,423,960**	**$ 5,105,426**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 10,000,188**

Parkside
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	274	0	4636	14000	0	0	0	0	18910
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	274	0	4636	14000	0	0	0	0	18910

Premier Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,457,375	$ 3,009,393	$ 366,251	$ 5,301,749	$ -	$ 13,242	$ 34,649	$ 1,095,942	$ 11,278,601
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,457,375	$ 3,009,393	$ 366,251	$ 5,301,749	$ -	$ 13,242	$ 34,649	$ 1,095,942	$ 11,278,601
	Ancillary Services:									
105	Patient Supplies	$ -	$ 5,948	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,948
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 419,895	$ 619,290	$ 1,575	$ 461,311	$ -	$ 2,340	$ 6,455	$ 47,970	$ 1,558,836
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 445,230	$ 539,460	$ 1,620	$ 379,800	$ -	$ 1,755	$ 585	$ 43,650	$ 1,412,100
130	Speech Pathology	$ 150,525	$ 78,480	$ -	$ 69,378	$ -	$ -	$ -	$ 2,745	$ 301,128
135	Pharmacy	$ 508,784	$ 1,079,656	$ 3,359	$ 38,169	$ -	$ 9,331	$ 360	$ 96,921	$ 1,736,581
140	Laboratory	$ 19,015	$ 118,963	$ 2,795	$ 10,542	$ -	$ 418	$ -	$ 6,267	$ 158,000
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 7,935	$ 42,376	$ 307	$ 42,399	$ -	$ 417	$ -	$ 1,248	$ 94,682
170	Subtotal (Lines 105 through 155)	$ 1,551,384	$ 2,484,173	$ 9,656	$ 1,001,600	$ -	$ 14,261	$ 7,400	$ 198,801	$ 5,267,274
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,993,774**	**$ 5,493,566**	**$ 375,907**	**$ 6,303,349**	**$ -**	**$ 27,503**	**$ 42,049**	**$ 1,294,743**	**$ 16,545,875**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (850)	$ -	$ -	$ -	$ 4,005	$ -	$ -	$ 3,155
215	Contractual Adjustments - Medicare	$ (328,258)	$ 578,331	$ -	$ -	$ -	$ -	$ -	$ -	$ 250,074
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 81,255	$ 1,249,152	$ -	$ -	$ -	$ -	$ 1,330,407
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 9,168	$ -	$ 259	$ 9,428
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,228	$ 6,228
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (328,258)**	**$ 577,481**	**$ 81,255**	**$ 1,249,152**	**$ -**	**$ 13,173**	**$ -**	**$ 6,488**	**$ 1,599,292**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,330,040**	**$ 4,916,085**	**$ 294,652**	**$ 5,054,196**	**$ -**	**$ 14,330**	**$ 42,049**	**$ 1,288,255**	**$ 14,946,583**

Premier Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4109	8684	1263	15875	0	37	99	3116	33183
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4109	8684	1263	15875	0	37	99	3116	33183

Ramona Nursing and Rehabilitation Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,072,350	$ 367,522	$ 380,360	$ 13,715,240	$ -	$ 99,028	$ 26,600	$ 780,150	$ 17,441,250
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,072,350	$ 367,522	$ 380,360	$ 13,715,240	$ -	$ 99,028	$ 26,600	$ 780,150	$ 17,441,250
	Ancillary Services:									
105	Patient Supplies	$ 8,894	$ 15,031	$ -	$ 4,470	$ -	$ 1,620	$ 874	$ 7,662	$ 38,551
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 574,470	$ 101,745	$ -	$ 2,079,990	$ -	$ 31,995	$ -	$ 90	$ 2,788,290
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 679,140	$ 99,270	$ -	$ 2,038,770	$ -	$ 27,360	$ -	$ 90	$ 2,844,630
130	Speech Pathology	$ 296,010	$ 23,670	$ -	$ 206,190	$ -	$ 8,460	$ -	$ -	$ 534,330
135	Pharmacy	$ 272,310	$ 9,461	$ -	$ 791	$ -	$ 15,746	$ -	$ -	$ 298,309
140	Laboratory	$ 16,716	$ 3,006	$ 634	$ 23,185	$ -	$ 958	$ -	$ 435	$ 44,933
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 28,487	$ 10,413	$ 222	$ 11,825	$ -	$ 2,142	$ -	$ -	$ 53,088
170	Subtotal (Lines 105 through 155)	$ 1,876,027	$ 262,596	$ 856	$ 4,365,220	$ -	$ 88,281	$ 874	$ 8,277	$ 6,602,131
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,943,067**	**$ 630,118**	**$ 381,216**	**$ 18,080,461**	**$ -**	**$ 187,309**	**$ 27,474**	**$ 788,427**	**$ 24,043,381**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (24,485)	$ -	$ -	$ -	$ 24,775	$ 495	$ -	$ 785
215	Contractual Adjustments - Medicare	$ (1,133,323)	$ 79,764	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,053,559)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 104,799	$ 4,421,560	$ -	$ -	$ -	$ -	$ 4,526,359
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 23,536	$ -	$ -	$ 23,536
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 109,452	$ 109,452
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,133,323)**	**$ 55,279**	**$ 104,799**	**$ 4,421,560**	**$ -**	**$ 48,311**	**$ 495**	**$ 109,452**	**$ 3,606,573**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,079,180**	**$ 574,839**	**$ 276,417**	**$ 13,658,900**	**$ -**	**$ 138,998**	**$ 26,979**	**$ 678,975**	**$ 20,436,808**

Ramona Nursing and Rehabilitation Center
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	5921	1046	1232	39039	0	287	76	2228	49829
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	5921	1046	1232	39039	0	287	76	2228	49829

Rose Villa
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,855,200	$ 394,181	$ 287,565	$ 3,919,685	$ -	$ 178,751	$ 95,400	$ 1,000	$ 8,731,782
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,855,200	$ 394,181	$ 287,565	$ 3,919,685	$ -	$ 178,751	$ 95,400	$ 1,000	$ 8,731,782
	Ancillary Services:									
105	Patient Supplies	$ 1,328	$ 4,694	$ -	$ 1,626	$ -	$ -	$ -	$ -	$ 7,648
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 783,720	$ 70,020	$ -	$ 761,618	$ -	$ 29,925	$ 90	$ -	$ 1,645,373
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 927,990	$ 74,205	$ -	$ 857,340	$ -	$ 31,590	$ 90	$ -	$ 1,891,215
130	Speech Pathology	$ 391,680	$ 23,760	$ -	$ 112,860	$ -	$ 6,975	$ -	$ -	$ 535,275
135	Pharmacy	$ 374,252	$ 43,792	$ 2,786	$ 10,509	$ -	$ 19,665	$ (0)	$ -	$ 451,004
140	Laboratory	$ 17,581	$ -	$ -	$ 906	$ -	$ -	$ -	$ -	$ 18,487
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 26,914	$ 16,887	$ 428	$ 27,389	$ -	$ 2,683	$ (0)	$ -	$ 74,299
170	Subtotal (Lines 105 through 155)	$ 2,523,466	$ 233,358	$ 3,213	$ 1,772,247	$ -	$ 90,838	$ 180	$ -	$ 4,623,302
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,378,666**	**$ 627,540**	**$ 290,778**	**$ 5,691,932**	**$ -**	**$ 269,589**	**$ 95,580**	**$ 1,000**	**$ 13,355,084**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 3,888	$ -	$ 3	$ -	$ -	$ -	$ -	$ 3,891
215	Contractual Adjustments - Medicare	$ (576,231)	$ 121,433	$ -	$ -	$ -	$ -	$ -	$ -	$ (454,799)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 118,244	$ 2,341,761	$ -	$ -	$ -	$ -	$ 2,460,005
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 55,417	$ -	$ -	$ 55,417
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ 0	$ -	$ -	$ -	$ (1,000)	$ (1,000)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (576,231)**	**$ 125,321**	**$ 118,244**	**$ 2,341,764**	**$ -**	**$ 55,417**	**$ -**	**$ (1,000)**	**$ 2,063,514**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,954,909**	**$ 502,219**	**$ 172,535**	**$ 3,350,168**	**$ -**	**$ 214,172**	**$ 95,580**	**$ 2,000**	**$ 11,291,570**

Rose Villa
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7765	792	699	7773	0	351	194	2	17576
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7765	792	699	7773	0	351	194	2	17576

Sea Cliff
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,362,200	$ 1,976,302	$ 509,793	$ 12,159,132	$ -	$ 25,898	$ 423,600	$ 891,964	$ 18,348,889
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,362,200	$ 1,976,302	$ 509,793	$ 12,159,132	$ -	$ 25,898	$ 423,600	$ 891,964	$ 18,348,889
	Ancillary Services:									
105	Patient Supplies	$ 4,001	$ 4,185	$ -	$ 19,496	$ -	$ -	$ -	$ 1,808	$ 29,490
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 780,930	$ 790,648	$ 5,625	$ 1,807,335	$ -	$ 10,440	$ 6,750	$ 270	$ 3,401,998
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 989,325	$ 737,821	$ 4,995	$ 1,788,885	$ -	$ 9,495	$ 6,030	$ -	$ 3,536,551
130	Speech Pathology	$ 484,335	$ 186,584	$ 1,800	$ 222,075	$ -	$ 1,485	$ 405	$ 135	$ 896,819
135	Pharmacy	$ 258,302	$ 72,944	$ 4,118	$ 38,356	$ -	$ 1,774	$ -	$ 4,598	$ 380,091
140	Laboratory	$ 16,941	$ 28,062	$ 750	$ 7,535	$ -	$ 608	$ -	$ 353	$ 54,250
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 25,241	$ 79,538	$ 1,035	$ 99,368	$ -	$ 1,045	$ -	$ 741	$ 206,967
170	Subtotal (Lines 105 through 155)	$ 2,559,074	$ 1,899,782	$ 18,323	$ 3,983,050	$ -	$ 24,846	$ 13,185	$ 7,905	$ 8,506,166
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,921,274**	**$ 3,876,084**	**$ 528,116**	**$ 16,142,182**	**$ -**	**$ 50,744**	**$ 436,785**	**$ 899,870**	**$ 26,855,055**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 10,421	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,421
215	Contractual Adjustments - Medicare	$ (1,758,236)	$ (540,927)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,299,163)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 62,146	$ 2,426,717	$ -	$ -	$ -	$ -	$ 2,488,863
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 63	$ -	$ -	$ 63
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ 210	$ -	$ -	$ -	$ (14,919)	$ (14,708)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,758,236)**	**$ (530,506)**	**$ 62,146**	**$ 2,426,928**	**$ -**	**$ 63**	**$ -**	**$ (14,919)**	**$ 185,477**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,679,510**	**$ 4,406,590**	**$ 465,970**	**$ 13,715,254**	**$ -**	**$ 50,681**	**$ 436,785**	**$ 914,789**	**$ 26,669,578**

Sea Cliff
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7798	6573	2009	40313	0	100	1413	3015	61221
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7798	6573	2009	40313	0	100	1413	3015	61221

Shoreline
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,379,160	$ 2,287,366	$ 260,663	$ 4,007,757	$ -	$ 307,404	$ 32,790	$ -	$ 8,275,140
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,379,160	$ 2,287,366	$ 260,663	$ 4,007,757	$ -	$ 307,404	$ 32,790	$ -	$ 8,275,140
	Ancillary Services:									
105	Patient Supplies	$ 130,641	$ 244,201	$ 22,066	$ 370,797	$ -	$ 39,275	$ -	$ -	$ 806,981
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 386,190	$ 691,470	$ 1,125	$ 844,380	$ -	$ 99,720	$ -	$ -	$ 2,022,885
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 501,570	$ 637,605	$ 900	$ 831,645	$ -	$ 96,210	$ -	$ -	$ 2,067,930
130	Speech Pathology	$ 129,645	$ 96,750	$ -	$ 220,185	$ -	$ 13,860	$ -	$ -	$ 460,440
135	Pharmacy	$ 419,594	$ 712,507	$ 2,525	$ 39,699	$ -	$ 66,471	$ 6	$ -	$ 1,240,804
140	Laboratory	$ 9,577	$ 307	$ -	$ 388	$ -	$ -	$ -	$ -	$ 10,272
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 22,759	$ 82,438	$ -	$ 15,169	$ -	$ 17,604	$ -	$ -	$ 137,969
170	Subtotal (Lines 105 through 155)	$ 1,599,977	$ 2,465,278	$ 26,616	$ 2,322,263	$ -	$ 333,140	$ 6	$ -	$ 6,747,281
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,979,137**	**$ 4,752,645**	**$ 287,279**	**$ 6,330,020**	**$ -**	**$ 640,544**	**$ 32,796**	**$ -**	**$ 15,022,421**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (11,490)	$ -	$ -	$ -	$ 628	$ -	$ -	$ (10,862)
215	Contractual Adjustments - Medicare	$ (438,390)	$ 687,527	$ -	$ -	$ -	$ -	$ -	$ -	$ 249,136
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 78,333	$ 1,952,438	$ -	$ -	$ -	$ -	$ 2,030,771
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 12,609	$ -	$ -	$ 12,609
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (438,390)**	**$ 676,037**	**$ 78,333**	**$ 1,952,438**	**$ -**	**$ 13,237**	**$ -**	**$ -**	**$ 2,281,654**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,417,528**	**$ 4,076,608**	**$ 208,947**	**$ 4,377,582**	**$ -**	**$ 627,307**	**$ 32,796**	**$ -**	**$ 12,740,767**

Shoreline
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3861	6521	882	11796	0	894	114	0	24068
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3861	6521	882	11796	0	894	114	0	24068

Somerset
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 31,185	$ 74,350	$ 330,423	$ 446,787	$ -	$ 7,920	$ -	$ -	$ 890,665
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 353,405	$ 381,908	$ (42,098)	$ 7,440,035	$ -	$ 326,075	$ -	$ -	$ 8,459,325
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 384,590	$ 456,258	$ 288,325	$ 7,886,822	$ -	$ 333,995	$ -	$ -	$ 9,349,990
	Ancillary Services:									
105	Patient Supplies	$ 17,860	$ 34,844	$ 15,492	$ 199,284	$ -	$ 8,018	$ 3,056	$ -	$ 278,554
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 73,530	$ 43,740	$ 2,520	$ 55,665	$ -	$ 28,440	$ 270	$ -	$ 204,165
120	Respiratory Therapy	$ 157,545	$ 126,855	$ 246,465	$ 2,937,375	$ -	$ 148,005	$ -	$ -	$ 3,616,245
125	Occupational Therapy	$ 105,795	$ 43,560	$ (225)	$ 23,940	$ -	$ 27,315	$ 540	$ -	$ 200,925
130	Speech Pathology	$ 165,735	$ 45,045	$ 2,790	$ 44,730	$ -	$ 17,055	$ -	$ -	$ 275,355
135	Pharmacy	$ 19,427	$ 24,840	$ -	$ 7,986	$ -	$ 19,231	$ -	$ -	$ 71,484
140	Laboratory	$ 8,760	$ 6,900	$ 300	$ 3,915	$ -	$ 5,100	$ -	$ -	$ 24,975
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 6,973	$ 97,476	$ 349	$ 36,755	$ -	$ 4,244	$ -	$ -	$ 145,796
170	Subtotal (Lines 105 through 155)	$ 555,624	$ 423,260	$ 267,691	$ 3,309,650	$ -	$ 257,408	$ 3,866	$ -	$ 4,817,499
175	**Total Gross Revenue (Line 70 + 170)**	**$ 940,214**	**$ 879,518**	**$ 556,016**	**$ 11,196,472**	**$ -**	**$ 591,402**	**$ 3,866**	**$ -**	**$ 14,167,489**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,866	$ -	$ 3,866
215	Contractual Adjustments - Medicare	$ 153,318	$ 72,552	$ -	$ -	$ -	$ -	$ -	$ -	$ 225,870
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 574,081	$ 3,854,222	$ -	$ -	$ -	$ -	$ 4,428,303
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (22,292)	$ -	$ -	$ (22,292)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 153,318**	**$ 72,552**	**$ 574,081**	**$ 3,854,222**	**$ -**	**$ (22,292)**	**$ 3,866**	**$ -**	**$ 4,635,748**
250	**Net Patient Revenue (line 175 - 240)**	**$ 786,896**	**$ 806,966**	**$ (18,065)**	**$ 7,342,250**	**$ -**	**$ 613,694**	**$ 0**	**$ -**	**$ 9,531,741**

Somerset
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	569	446	102	6589	0	394	0	0	8100
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	114	146	640	4789	0	142	0	0	5831
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	683	592	742	11378	0	536	0	0	13931

South Bay
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,918,100	$ 2,103,221	$ 352,709	$ 8,835,784	$ -	$ 1,592,583	$ 200,821	$ 848,334	$ 15,851,553
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,918,100	$ 2,103,221	$ 352,709	$ 8,835,784	$ -	$ 1,592,583	$ 200,821	$ 848,334	$ 15,851,553
	Ancillary Services:									
105	Patient Supplies	$ 13,597	$ 34,436	$ 907	$ 11,358	$ -	$ 896	$ -	$ 1,815	$ 63,009
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 422,685	$ 414,225	$ -	$ 797,191	$ -	$ 84,060	$ 1,170	$ 405	$ 1,719,736
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 421,155	$ 354,465	$ -	$ 578,700	$ -	$ 57,960	$ 1,125	$ 225	$ 1,413,630
130	Speech Pathology	$ 170,775	$ 82,890	$ 405	$ 216,540	$ -	$ 9,000	$ -	$ 495	$ 480,105
135	Pharmacy	$ 159,556	$ 244,875	$ 548	$ 370,964	$ -	$ 50,207	$ -	$ -	$ 826,150
140	Laboratory	$ 2,380	$ -	$ -	$ -	$ -	$ 1,462	$ -	$ -	$ 3,843
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 12,525	$ 33,505	$ -	$ 15,038	$ -	$ 1,282	$ -	$ -	$ 62,350
170	Subtotal (Lines 105 through 155)	$ 1,202,673	$ 1,164,396	$ 1,861	$ 1,989,790	$ -	$ 204,867	$ 2,295	$ 2,940	$ 4,568,823
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,120,773**	**$ 3,267,617**	**$ 354,570**	**$ 10,825,575**	**$ -**	**$ 1,797,451**	**$ 203,116**	**$ 851,273**	**$ 20,420,375**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 2,400	$ -	$ -	$ -	$ 1,500	$ 18,256	$ -	$ 22,156
215	Contractual Adjustments - Medicare	$ 105,837	$ 1,646,779	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,752,616
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 138,997	$ 3,299,603	$ -	$ -	$ -	$ -	$ 3,438,600
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (345,862)	$ -	$ -	$ (345,862)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 281,199	$ 281,199
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 105,837**	**$ 1,649,179**	**$ 138,997**	**$ 3,299,603**	**$ -**	**$ (344,362)**	**$ 18,256**	**$ 281,199**	**$ 5,148,711**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,014,936**	**$ 1,618,438**	**$ 215,573**	**$ 7,525,971**	**$ -**	**$ 2,141,812**	**$ 184,860**	**$ 570,074**	**$ 15,271,665**

South Bay
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	3576	4446	1705	21074	0	953	318	2152	34224
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	3576	4446	1705	21074	0	953	318	2152	34224

Southland Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 5,804,800	$ 3,348,750	$ 1,508,227	$ 10,128,423	$ -	$ 122,200	$ 156,050	$ 213,500	$ 21,281,950
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 5,804,800	$ 3,348,750	$ 1,508,227	$ 10,128,423	$ -	$ 122,200	$ 156,050	$ 213,500	$ 21,281,950
	Ancillary Services:									
105	Patient Supplies	$ 45,900	$ 2,758	$ 61	$ 65	$ -	$ -	$ -	$ -	$ 48,784
110	Specialized Support Surfaces	$ 17,018	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 17,018
115	Physical Therapy	$ 2,063,925	$ 720,585	$ 900	$ 1,522,800	$ -	$ 25,605	$ 20,340	$ 135	$ 4,354,290
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 2,315,205	$ 543,465	$ 585	$ 1,487,430	$ -	$ 17,550	$ 20,115	$ 135	$ 4,384,485
130	Speech Pathology	$ 719,775	$ 78,795	$ -	$ 305,865	$ -	$ 1,350	$ 270	$ 225	$ 1,106,280
135	Pharmacy	$ 494,939	$ 22,060	$ 432	$ 6,706	$ -	$ 45	$ -	$ -	$ 524,182
140	Laboratory	$ 11,640	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,640
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 50,402	$ 13,256	$ -	$ 16,049	$ -	$ -	$ -	$ -	$ 79,706
170	Subtotal (Lines 105 through 155)	$ 5,718,805	$ 1,380,919	$ 1,978	$ 3,338,915	$ -	$ 44,550	$ 40,725	$ 495	$ 10,526,386
175	**Total Gross Revenue (Line 70 + 170)**	**$ 9,438,620**	**$ 4,729,669**	**$ 1,510,205**	**$ 13,467,338**	**$ -**	**$ 166,750**	**$ 159,335**	**$ 213,995**	**$ 31,808,336**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 550	$ -	$ -	$ -	$ -	$ (12,600)	$ -	$ (12,050)
215	Contractual Adjustments - Medicare	$ 1,000,684	$ 332,863	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,333,547
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 687,694	$ 5,838,981	$ -	$ -	$ -	$ -	$ 6,526,675
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 6,480	$ -	$ -	$ 6,480
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 68,833	$ 68,833
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 1,000,684**	**$ 333,413**	**$ 687,694**	**$ 5,838,981**	**$ -**	**$ 6,480**	**$ (12,600)**	**$ 68,833**	**$ 7,923,485**
250	**Net Patient Revenue (line 175 - 240)**	**$ 9,571,476**	**$ 4,396,256**	**$ 822,511**	**$ 7,628,357**	**$ -**	**$ 160,270**	**$ 171,935**	**$ 145,162**	**$ 23,884,851**

Southland Care
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	10824	7120	2924	19564	0	303	347	467	41549
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	10824	7120	2924	19564	0	303	347	467	41549

St. Elizabeth Health and Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,944,618	$ 1,391,284	$ 341,084	$ 1,894,039	$ -	$ 176,694	$ 68,694	$ 330,484	$ 6,146,897
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,944,618	$ 1,391,284	$ 341,084	$ 1,894,039	$ -	$ 176,694	$ 68,694	$ 330,484	$ 6,146,897
	Ancillary Services:									
105	Patient Supplies	$ -	$ 259	$ -	$ -	$ -	$ -	$ -	$ -	$ 259
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,484,010	$ 395,460	$ 45	$ 493,335	$ -	$ 51,075	$ 5,310	$ 58,770	$ 2,488,005
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,701,270	$ 315,270	$ 45	$ 433,890	$ -	$ 45,270	$ 2,880	$ 54,315	$ 2,552,940
130	Speech Pathology	$ 481,770	$ 77,355	$ -	$ 71,370	$ -	$ 11,160	$ 765	$ 20,070	$ 662,490
135	Pharmacy	$ 371,484	$ 135,592	$ -	$ 6,272	$ -	$ 19,492	$ -	$ 33,584	$ 566,425
140	Laboratory	$ 45,228	$ 44,402	$ 428	$ 4,149	$ -	$ 3,657	$ 162	$ 4,787	$ 102,812
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 51,658	$ 52,821	$ -	$ 22,566	$ -	$ 3,492	$ -	$ 3,266	$ 133,803
170	Subtotal (Lines 105 through 155)	$ 4,135,420	$ 1,021,160	$ 518	$ 1,031,582	$ -	$ 134,146	$ 9,117	$ 174,791	$ 6,506,734
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,485,823**	**$ 2,412,444**	**$ 341,602**	**$ 2,925,621**	**$ -**	**$ 310,839**	**$ 76,326**	**$ 505,275**	**$ 12,653,630**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 666	$ -	$ -	$ -	$ (1,657)	$ (639)	$ -	$ (1,630)
215	Contractual Adjustments - Medicare	$ 155,456	$ 29,842	$ -	$ -	$ -	$ -	$ -	$ -	$ 185,297
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (14,203)	$ 505,237	$ -	$ -	$ -	$ -	$ 491,034
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 41,921	$ -	$ -	$ 41,921
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (106,585)	$ (106,585)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 155,456**	**$ 30,508**	**$ (14,203)**	**$ 505,237**	**$ -**	**$ 40,264**	**$ (639)**	**$ (106,585)**	**$ 610,038**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,245,360**	**$ 2,381,936**	**$ 355,805**	**$ 2,420,383**	**$ -**	**$ 270,575**	**$ 76,965**	**$ 611,860**	**$ 12,043,592**

St. Elizabeth Health and Rehab
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6058	4325	1168	5798	0	504	209	987	19049
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6058	4325	1168	5798	0	504	209	987	19049

St. Catherine Healthcare
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,995,853	$ 512,942	$ 278,095	$ 6,494,819	$ -	$ 16,831	$ 205,486	$ 691,942	$ 12,195,968
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,995,853	$ 512,942	$ 278,095	$ 6,494,819	$ -	$ 16,831	$ 205,486	$ 691,942	$ 12,195,968
	Ancillary Services:									
105	Patient Supplies	$ 53,435	$ 7,600	$ -	$ 54,267	$ -	$ -	$ -	$ 3,891	$ 119,194
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,129,860	$ 119,025	$ 1,215	$ 1,381,230	$ -	$ 4,095	$ 765	$ 39,195	$ 2,675,385
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 992,160	$ 118,395	$ 1,350	$ 1,232,190	$ -	$ 4,050	$ -	$ 39,060	$ 2,387,205
130	Speech Pathology	$ 376,920	$ 23,310	$ 495	$ 68,895	$ -	$ 765	$ 135	$ 7,650	$ 478,170
135	Pharmacy	$ 570,986	$ 62,409	$ 1,583	$ 33,384	$ -	$ 4,358	$ 47	$ 41,852	$ 714,620
140	Laboratory	$ 59,896	$ 10,585	$ 1,282	$ 19,628	$ -	$ 241	$ 321	$ 1,720	$ 93,674
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 80,723	$ 22,065	$ -	$ 40,985	$ -	$ 571	$ -	$ 4,116	$ 148,459
170	Subtotal (Lines 105 through 155)	$ 3,263,981	$ 363,390	$ 5,925	$ 2,830,579	$ -	$ 14,080	$ 1,268	$ 137,484	$ 6,616,707
175	**Total Gross Revenue (Line 70 + 170)**	**$ 7,259,834**	**$ 876,332**	**$ 284,020**	**$ 9,325,398**	**$ -**	**$ 30,911**	**$ 206,754**	**$ 829,426**	**$ 18,812,675**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (10,660)	$ -	$ -	$ -	$ 660	$ 512	$ -	$ (9,488)
215	Contractual Adjustments - Medicare	$ (2,020,632)	$ 24,537	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,996,095)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 96,788	$ 2,541,629	$ -	$ -	$ -	$ -	$ 2,638,417
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 7,144	$ -	$ -	$ 7,144
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (70,171)	$ (70,171)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,020,632)**	**$ 13,877**	**$ 96,788**	**$ 2,541,629**	**$ -**	**$ 7,804**	**$ 512**	**$ (70,171)**	**$ 569,807**
250	**Net Patient Revenue (line 175 - 240)**	**$ 9,280,466**	**$ 862,455**	**$ 187,232**	**$ 6,783,769**	**$ -**	**$ 23,107**	**$ 206,242**	**$ 899,597**	**$ 18,242,868**

St. Catherine Healthcare
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	10842	1443	912	17775	0	46	573	1510	33101
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	10842	1443	912	17775	0	46	573	1510	33101

Summerfield
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,510,251	$ 677,779	$ 16,074	$ 1,968,171	$ -	$ 42,661	$ 45,040	$ 42,115	$ 7,302,091
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,510,251	$ 677,779	$ 16,074	$ 1,968,171	$ -	$ 42,661	$ 45,040	$ 42,115	$ 7,302,091
	Ancillary Services:									
105	Patient Supplies	$ -	$ 10,982	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,982
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 961,875	$ 153,765	$ -	$ 43,425	$ -	$ 8,415	$ 3,060	$ -	$ 1,170,540
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,104,525	$ 165,195	$ -	$ 48,195	$ -	$ 7,875	$ 4,545	$ -	$ 1,330,335
130	Speech Pathology	$ 204,075	$ 14,715	$ -	$ 6,930	$ -	$ -	$ -	$ -	$ 225,720
135	Pharmacy	$ 564,620	$ 96,409	$ 468	$ 9,636	$ -	$ 3,146	$ 1,343	$ -	$ 675,622
140	Laboratory	$ 29,224	$ 4,650	$ -	$ 4,140	$ -	$ 225	$ 73	$ -	$ 38,312
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 73,348	$ 14,304	$ 140	$ 5,055	$ -	$ 991	$ 454	$ -	$ 94,292
170	Subtotal (Lines 105 through 155)	$ 2,937,667	$ 460,020	$ 608	$ 117,381	$ -	$ 20,652	$ 9,475	$ -	$ 3,545,803
175	**Total Gross Revenue (Line 70 + 170)**	**$ 7,447,918**	**$ 1,137,799**	**$ 16,682**	**$ 2,085,552**	**$ -**	**$ 63,313**	**$ 54,515**	**$ 42,115**	**$ 10,847,894**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
215	Contractual Adjustments - Medicare	$ (5,531,529)	$ (434,054)	$ -	$ -	$ -	$ -	$ -	$ -	$ (5,965,583)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 1,256	$ (11,817)	$ -	$ -	$ -	$ -	$ (10,561)
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (6,319)	$ -	$ -	$ (6,319)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,649	$ 2,649
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (5,531,529)**	**$ (434,054)**	**$ 1,256**	**$ (11,817)**	**$ -**	**$ (6,319)**	**$ -**	**$ 2,649**	**$ (5,979,814)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 12,979,448**	**$ 1,571,853**	**$ 15,426**	**$ 2,097,369**	**$ -**	**$ 69,632**	**$ 54,515**	**$ 39,466**	**$ 16,827,708**

Summerfield
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	11099	1609	34	4884	0	185	93	106	18010
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	11099	1609	34	4884	0	185	93	106	18010

The Cove
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,268,450	$ 1,946,043	$ 344,803	$ 2,028,947	$ -	$ 266,362	$ 416,470	$ 12,750	$ 8,283,825
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,268,450	$ 1,946,043	$ 344,803	$ 2,028,947	$ -	$ 266,362	$ 416,470	$ 12,750	$ 8,283,825
	Ancillary Services:									
105	Patient Supplies	$ 44,929	$ 32,804	$ 4,985	$ 18,695	$ -	$ 4,887	$ 4,630	$ -	$ 110,930
110	Specialized Support Surfaces	$ 1,757	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,757
115	Physical Therapy	$ 765,810	$ 358,560	$ 2,250	$ 327,878	$ -	$ 54,630	$ 9,045	$ -	$ 1,518,173
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 888,615	$ 347,625	$ 2,205	$ 324,540	$ -	$ 54,090	$ 7,110	$ -	$ 1,624,185
130	Speech Pathology	$ 433,620	$ 70,830	$ -	$ 66,060	$ -	$ 12,105	$ -	$ -	$ 582,615
135	Pharmacy	$ 479,645	$ 301,257	$ 420	$ 8,365	$ -	$ 37,903	$ -	$ -	$ 827,589
140	Laboratory	$ 25,886	$ 21,293	$ -	$ 281	$ -	$ 2,758	$ -	$ -	$ 50,218
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 50,968	$ 48,669	$ -	$ 13,949	$ -	$ 5,510	$ (382)	$ -	$ 118,714
170	Subtotal (Lines 105 through 155)	$ 2,691,230	$ 1,181,038	$ 9,860	$ 759,768	$ -	$ 171,884	$ 20,403	$ -	$ 4,834,182
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,959,680**	**$ 3,127,081**	**$ 354,663**	**$ 2,788,715**	**$ -**	**$ 438,246**	**$ 436,873**	**$ 12,750**	**$ 13,118,007**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ -	$ -	$ -	$ -	$ (15,114)	$ (27,970)	$ -	$ (43,084)
215	Contractual Adjustments - Medicare	$ (722,527)	$ 501,349	$ -	$ -	$ -	$ -	$ -	$ -	$ (221,177)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 63,568	$ 726,913	$ -	$ -	$ -	$ -	$ 790,481
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 47,605	$ -	$ -	$ 47,605
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,865	$ 1,865
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (722,527)**	**$ 501,349**	**$ 63,568**	**$ 726,913**	**$ -**	**$ 32,491**	**$ (27,970)**	**$ 1,865**	**$ 575,689**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,682,207**	**$ 2,625,732**	**$ 291,095**	**$ 2,061,802**	**$ -**	**$ 405,755**	**$ 464,843**	**$ 10,885**	**$ 12,542,318**

The Cove
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7663	4511	804	4777	0	607	939	30	19331
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7663	4511	804	4777	0	607	939	30	19331

The Grove SNF
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 908,600	$ 2,050,305	$ 256,478	$ 883,122	$ -	$ 190,271	$ 17,400	$ 228,550	$ 4,534,726
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 908,600	$ 2,050,305	$ 256,478	$ 883,122	$ -	$ 190,271	$ 17,400	$ 228,550	$ 4,534,726
	Ancillary Services:									
105	Patient Supplies	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 627,030	$ 549,225	$ 7,065	$ 173,925	$ -	$ 50,805	$ 17,145	$ -	$ 1,425,195
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 826,785	$ 541,350	$ 6,975	$ 176,310	$ -	$ 49,635	$ 3,465	$ -	$ 1,604,520
130	Speech Pathology	$ 163,260	$ 105,750	$ 900	$ 29,025	$ -	$ 4,995	$ 90	$ -	$ 304,020
135	Pharmacy	$ 319,326	$ 654,614	$ 1,422	$ 18,939	$ -	$ 105,567	$ -	$ 573	$ 1,100,442
140	Laboratory	$ 38,597	$ 118,580	$ 1,848	$ 8,689	$ -	$ 9,330	$ -	$ 451	$ 177,495
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 2,692	$ 22,910	$ 330	$ 1,948	$ -	$ 2,307	$ -	$ -	$ 30,186
170	Subtotal (Lines 105 through 155)	$ 1,977,690	$ 1,992,429	$ 18,539	$ 408,835	$ -	$ 222,639	$ 20,700	$ 1,025	$ 4,641,857
175	**Total Gross Revenue (Line 70 + 170)**	**$ 1,928,555**	**$ 4,042,734**	**$ 275,017**	**$ 1,291,957**	**$ -**	**$ 412,910**	**$ 38,100**	**$ 229,575**	**$ 9,176,583**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (150)	$ -	$ -	$ -	$ 41	$ -	$ -	$ (108)
215	Contractual Adjustments - Medicare	$ 358,502	$ 115,865	$ -	$ -	$ -	$ -	$ -	$ -	$ 474,367
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 68,732	$ 387,366	$ -	$ -	$ -	$ -	$ 456,098
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 133,344	$ -	$ -	$ 133,344
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 21,576	$ 21,576
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 358,502**	**$ 115,716**	**$ 68,732**	**$ 387,366**	**$ -**	**$ 133,385**	**$ -**	**$ 21,576**	**$ 1,085,277**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,117,831**	**$ 3,927,019**	**$ 206,285**	**$ 904,591**	**$ -**	**$ 279,524**	**$ 38,100**	**$ 207,999**	**$ 8,091,306**

The Grove SNF
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2583	5864	788	2471	0	580	42	653	12981
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	2583	5864	788	2471	0	580	42	653	12981

The Hills Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,751,900	$ 1,094,732	$ 689,284	$ 15,389,366	$ -	$ 511,818	$ 117,379	$ 804,950	$ 20,359,429
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,751,900	$ 1,094,732	$ 689,284	$ 15,389,366	$ -	$ 511,818	$ 117,379	$ 804,950	$ 20,359,429
	Ancillary Services:									
105	Patient Supplies	$ -	$ 849	$ -	$ 13,920	$ -	$ -	$ -	$ -	$ 14,769
110	Specialized Support Surfaces	$ -	$ -	$ -	$ 36,300	$ -	$ -	$ -	$ -	$ 36,300
115	Physical Therapy	$ 567,315	$ 209,745	$ 5,085	$ 1,708,608	$ -	$ 93,105	$ -	$ -	$ 2,583,858
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 526,185	$ 204,300	$ 5,670	$ 1,858,005	$ -	$ 90,810	$ -	$ -	$ 2,684,970
130	Speech Pathology	$ 362,880	$ 39,240	$ 2,655	$ 714,240	$ -	$ 13,725	$ -	$ -	$ 1,132,740
135	Pharmacy	$ 168,495	$ 114,409	$ 3,690	$ 170,054	$ -	$ 69,032	$ 60	$ 4,839	$ 530,579
140	Laboratory	$ 69,637	$ 60,606	$ 5,124	$ 140,955	$ -	$ 22,348	$ -	$ 533	$ 299,203
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 27,719	$ 42,313	$ -	$ 47,503	$ -	$ 11,523	$ 0	$ -	$ 129,059
170	Subtotal (Lines 105 through 155)	$ 1,722,232	$ 671,461	$ 22,223	$ 4,689,585	$ -	$ 300,544	$ 60	$ 5,372	$ 7,411,477
175	**Total Gross Revenue (Line 70 + 170)**	**$ 3,474,132**	**$ 1,766,194**	**$ 711,507**	**$ 20,078,951**	**$ -**	**$ 812,361**	**$ 117,439**	**$ 810,322**	**$ 27,770,906**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 33,116	$ -	$ -	$ -	$ 10,694	$ (26,120)	$ -	$ 17,691
215	Contractual Adjustments - Medicare	$ (415,438)	$ 135,249	$ -	$ -	$ -	$ -	$ -	$ -	$ (280,189)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 117,679	$ 4,558,232	$ -	$ -	$ -	$ -	$ 4,675,911
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 139,333	$ -	$ -	$ 139,333
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 199,263	$ 199,263
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (415,438)**	**$ 168,365**	**$ 117,679**	**$ 4,558,232**	**$ -**	**$ 150,027**	**$ (26,120)**	**$ 199,263**	**$ 4,752,009**
250	**Net Patient Revenue (line 175 - 240)**	**$ 3,889,570**	**$ 1,597,828**	**$ 593,828**	**$ 15,520,719**	**$ -**	**$ 662,334**	**$ 143,559**	**$ 611,060**	**$ 23,018,898**

The Hills Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	4556	2883	2123	45493	0	1442	392	2177	59066
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	4556	2883	2123	45493	0	1442	392	2177	59066

The Orchard
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,490,000	$ 2,735,050	$ 816,770	$ 10,922,330	$ -	$ 28,850	$ 418,000	$ 531,200	$ 17,942,200
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,490,000	$ 2,735,050	$ 816,770	$ 10,922,330	$ -	$ 28,850	$ 418,000	$ 531,200	$ 17,942,200
	Ancillary Services:									
105	Patient Supplies	$ 14,452	$ 25,235	$ -	$ 1,363	$ -	$ 113	$ -	$ -	$ 41,163
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 698,310	$ 939,825	$ 3,060	$ 1,554,750	$ -	$ 8,010	$ 2,205	$ -	$ 3,206,160
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 825,030	$ 789,705	$ 3,645	$ 1,293,660	$ -	$ 7,470	$ 2,160	$ -	$ 2,921,670
130	Speech Pathology	$ 287,055	$ 120,690	$ 90	$ 251,145	$ -	$ 450	$ -	$ -	$ 659,430
135	Pharmacy	$ 237,229	$ 248,570	$ -	$ 1,957	$ -	$ 5,120	$ -	$ -	$ 492,877
140	Laboratory	$ 17,151	$ 42,162	$ -	$ -	$ -	$ 197	$ -	$ -	$ 59,510
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 37,293	$ 200,329	$ -	$ 20,236	$ -	$ 468	$ -	$ -	$ 258,326
170	Subtotal (Lines 105 through 155)	$ 2,116,520	$ 2,366,517	$ 6,795	$ 3,123,111	$ -	$ 21,829	$ 4,365	$ -	$ 7,639,136
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,606,520**	**$ 5,101,567**	**$ 823,565**	**$ 14,045,441**	**$ -**	**$ 50,679**	**$ 422,365**	**$ 531,200**	**$ 25,581,336**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 2,468	$ -	$ -	$ -	$ -	$ 180	$ -	$ 2,648
215	Contractual Adjustments - Medicare	$ (1,666,847)	$ 60,110	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,606,737)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 100,345	$ 2,347,765	$ -	$ -	$ -	$ -	$ 2,448,111
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 14,929	$ -	$ -	$ 14,929
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,347	$ 30,347
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,666,847)**	**$ 62,577**	**$ 100,345**	**$ 2,347,765**	**$ -**	**$ 14,929**	**$ 180**	**$ 30,347**	**$ 889,296**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,273,367**	**$ 5,038,990**	**$ 723,220**	**$ 11,697,676**	**$ -**	**$ 35,750**	**$ 422,185**	**$ 500,853**	**$ 24,692,040**

The Orchard
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	7089	8080	3164	34282	0	66	1294	1751	55726
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	7089	8080	3164	34282	0	66	1294	1751	55726

Ukiah
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 884,820	$ 258,320	$ 166,124	$ 4,343,525	$ -	$ 23,875	$ 236,670	$ 40,710	$ 5,954,044
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 884,820	$ 258,320	$ 166,124	$ 4,343,525	$ -	$ 23,875	$ 236,670	$ 40,710	$ 5,954,044
	Ancillary Services:									
105	Patient Supplies	$ 82,780	$ 15,640	$ 6,148	$ 199,056	$ -	$ 819	$ -	$ 312	$ 304,754
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 283,320	$ 142,470	$ -	$ 577,710	$ -	$ 7,335	$ -	$ -	$ 1,010,835
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 246,825	$ 84,105	$ -	$ 283,455	$ -	$ 4,320	$ -	$ -	$ 618,705
130	Speech Pathology	$ 58,725	$ 14,805	$ 360	$ 25,650	$ -	$ -	$ -	$ -	$ 99,540
135	Pharmacy	$ 354,083	$ 71,456	$ 1,249	$ 3,064	$ -	$ 15,935	$ -	$ -	$ 445,787
140	Laboratory	$ 103,336	$ 46,627	$ 985	$ -	$ -	$ 1,100	$ -	$ -	$ 152,048
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 7,620	$ 2,423	$ -	$ 34,367	$ -	$ 440	$ -	$ -	$ 44,850
170	Subtotal (Lines 105 through 155)	$ 1,136,689	$ 377,527	$ 8,742	$ 1,123,301	$ -	$ 29,949	$ -	$ 312	$ 2,676,520
175	**Total Gross Revenue (Line 70 + 170)**	**$ 2,021,509**	**$ 635,847**	**$ 174,866**	**$ 5,466,826**	**$ -**	**$ 53,824**	**$ 236,670**	**$ 41,022**	**$ 8,630,564**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (211)	$ -	$ -	$ -	$ -	$ -	$ -	$ (211)
215	Contractual Adjustments - Medicare	$ (186,342)	$ 60,950	$ -	$ -	$ -	$ -	$ -	$ -	$ (125,393)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ (11,031)	$ 551,792	$ -	$ -	$ -	$ -	$ 540,762
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 3,404	$ -	$ -	$ 3,404
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,328	$ 2,328
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (186,342)**	**$ 60,739**	**$ (11,031)**	**$ 551,792**	**$ -**	**$ 3,404**	**$ -**	**$ 2,328**	**$ 420,890**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,207,823**	**$ 575,108**	**$ 185,896**	**$ 4,915,034**	**$ -**	**$ 50,420**	**$ 236,670**	**$ 38,693**	**$ 8,209,674**

Ukiah
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2562	739	421	12386	0	63	748	118	17037
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	2562	739	421	12386	0	63	748	118	17037

Upland
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,711,050	$ 3,768,596	$ 725,236	$ 10,555,714	$ -	$ 530,104	$ 177,600	$ 438,793	$ 17,907,093
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ 674,200	$ 710,000	$ 388,049	$ 3,420,018	$ -	$ 130,350	$ 102,383	$ 740,664	$ 6,165,664
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,385,250	$ 4,478,596	$ 1,113,285	$ 13,975,732	$ -	$ 660,454	$ 279,983	$ 1,179,457	$ 24,072,757
	Ancillary Services:									
105	Patient Supplies	$ 54,402	$ 60,872	$ 16,878	$ 173,572	$ -	$ 11,886	$ 8,264	$ 12,696	$ 338,570
110	Specialized Support Surfaces	$ -	$ -	$ -	$ 5,044	$ -	$ -	$ -	$ -	$ 5,044
115	Physical Therapy	$ 508,815	$ 1,370,475	$ 4,320	$ 518,445	$ -	$ 160,020	$ 450	$ 77,850	$ 2,640,375
120	Respiratory Therapy	$ 221,985	$ 203,625	$ 122,175	$ 922,815	$ -	$ 39,645	$ -	$ 83,835	$ 1,594,080
125	Occupational Therapy	$ 616,050	$ 1,353,780	$ 3,645	$ 458,145	$ -	$ 161,190	$ 450	$ 77,805	$ 2,671,065
130	Speech Pathology	$ 233,280	$ 201,555	$ -	$ 95,985	$ -	$ 35,595	$ -	$ 13,455	$ 579,870
135	Pharmacy	$ 554,642	$ 554,885	$ 5,836	$ 92,416	$ -	$ 156,053	$ -	$ 93,691	$ 1,457,522
140	Laboratory	$ 42,516	$ 35,664	$ 12,779	$ 55,431	$ -	$ 6,149	$ 633	$ 4,389	$ 157,561
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 53,630	$ 303,269	$ 3,300	$ 5,480	$ -	$ 35,284	$ -	$ 2,633	$ 403,596
170	Subtotal (Lines 105 through 155)	$ 2,285,320	$ 4,084,125	$ 168,933	$ 2,327,333	$ -	$ 605,823	$ 9,797	$ 366,353	$ 9,847,684
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,670,570**	**$ 8,562,721**	**$ 1,282,218**	**$ 16,303,065**	**$ -**	**$ 1,266,277**	**$ 289,780**	**$ 1,545,810**	**$ 33,920,440**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 1,460	$ -	$ -	$ -	$ (43,134)	$ (2,100)	$ -	$ (43,774)
215	Contractual Adjustments - Medicare	$ (1,629,534)	$ (651,202)	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,280,735)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 151,860	$ 1,191,548	$ -	$ -	$ -	$ -	$ 1,343,408
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (58,333)	$ -	$ -	$ (58,333)
225	Contractual Adjustments - Other	$ -	$ -	$ 1,307	$ -	$ -	$ -	$ -	$ 201,617	$ 202,924
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,629,534)**	**$ (649,742)**	**$ 153,166**	**$ 1,191,548**	**$ -**	**$ (101,466)**	**$ (2,100)**	**$ 201,617**	**$ (836,511)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,300,104**	**$ 9,212,463**	**$ 1,129,052**	**$ 15,111,517**	**$ -**	**$ 1,367,743**	**$ 291,880**	**$ 1,344,193**	**$ 34,756,951**

Upland
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	5689	12297	2722	33821	0	1572	536	1147	57784
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	1238	1184	889	7305	0	400	242	519	11777
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6927	13481	3611	41126	0	1972	778	1666	69561

Valley of the Moon Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 1,315,800	$ 641,268	$ 443,907	$ 5,163,093	$ -	$ 25,200	$ 3,742	$ 1,467,900	$ 9,060,910
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 1,315,800	$ 641,268	$ 443,907	$ 5,163,093	$ -	$ 25,200	$ 3,742	$ 1,467,900	$ 9,060,910
	Ancillary Services:									
105	Patient Supplies	$ -	$ 1,926	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,926
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 129,690	$ 63,675	$ -	$ 101,475	$ -	$ 1,980	$ 45	$ -	$ 296,865
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 187,290	$ 46,980	$ -	$ 71,910	$ -	$ 2,385	$ 315	$ -	$ 308,880
130	Speech Pathology	$ 38,295	$ 10,665	$ -	$ 3,375	$ -	$ -	$ 270	$ -	$ 52,605
135	Pharmacy	$ 51,829	$ 20,279	$ 19	$ 3,220	$ -	$ 676	$ -	$ 1,186	$ 77,210
140	Laboratory	$ 702	$ 141	$ 32	$ 893	$ -	$ 163	$ -	$ 170	$ 2,101
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 706	$ 9,186	$ -	$ 10,687	$ -	$ -	$ -	$ -	$ 20,579
170	Subtotal (Lines 105 through 155)	$ 408,512	$ 152,852	$ 52	$ 191,560	$ -	$ 5,204	$ 630	$ 1,356	$ 760,166
175	**Total Gross Revenue (Line 70 + 170)**	**$ 1,724,312**	**$ 794,119**	**$ 443,959**	**$ 5,354,653**	**$ -**	**$ 30,404**	**$ 4,372**	**$ 1,469,256**	**$ 9,821,075**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (7,412)	$ -	$ -	$ -	$ 9,350	$ 24,300	$ -	$ 26,238
215	Contractual Adjustments - Medicare	$ 196,490	$ 134,248	$ -	$ -	$ -	$ -	$ -	$ -	$ 330,738
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 118,009	$ 1,239,961	$ -	$ -	$ -	$ -	$ 1,357,969
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (14,588)	$ -	$ -	$ (14,588)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 345,709	$ 345,709
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ 196,490**	**$ 126,836**	**$ 118,009**	**$ 1,239,961**	**$ -**	**$ (5,238)**	**$ 24,300**	**$ 345,709**	**$ 2,046,066**
250	**Net Patient Revenue (line 175 - 240)**	**$ 1,527,822**	**$ 667,284**	**$ 325,950**	**$ 4,114,693**	**$ -**	**$ 35,642**	**$ (19,928)**	**$ 1,123,547**	**$ 7,775,009**

Valley of the Moon Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total	
5	Skilled Nursing	1403	566	474	5614	0	26	1	1593	9677	
10	Intermediate Care										
15	Mentally Disordered										
20	Developmentally Disabled										
25	Sub-Acute	0	0	0	0	0	0	0	0	0	
30	Sub-Acute Pediatric										
35	Transitional Inpatient Care										
40	Hospice Inpatient Care										
45	Other Routine										
70	Subtotal	1403	566	474	5614	0	26	1	1593	9677	

Victoria CM
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 4,127,600	$ 3,117,512	$ 570,476	$ 4,093,130	$ -	$ 89,578	$ 470,500	$ 86,100	$ 12,554,895
10	Intermediate Care	$ -	$ -	$ -	$ 88,100	$ -	$ -	$ -	$ -	$ 88,100
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 4,127,600	$ 3,117,512	$ 570,476	$ 4,181,230	$ -	$ 89,578	$ 470,500	$ 86,100	$ 12,642,995
	Ancillary Services:									
105	Patient Supplies	$ 59,793	$ 32,412	$ 7,429	$ 51,963	$ -	$ 850	$ -	$ 1,328	$ 153,774
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 782,820	$ 668,430	$ 2,880	$ 1,058,265	$ -	$ 31,860	$ 12,960	$ -	$ 2,557,215
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 950,130	$ 636,525	$ 2,250	$ 1,068,615	$ -	$ 22,275	$ 1,845	$ -	$ 2,681,640
130	Speech Pathology	$ 164,295	$ 64,575	$ -	$ 273,600	$ -	$ 2,070	$ 2,205	$ -	$ 506,745
135	Pharmacy	$ 343,433	$ 239,023	$ -	$ 1,676	$ -	$ 13,479	$ -	$ -	$ 597,612
140	Laboratory	$ 40,164	$ 55,838	$ 3,705	$ 11,409	$ -	$ 1,444	$ -	$ 121	$ 112,679
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 36,518	$ 87,521	$ 100	$ 27,171	$ -	$ 2,662	$ -	$ -	$ 153,972
170	Subtotal (Lines 105 through 155)	$ 2,377,153	$ 1,784,323	$ 16,364	$ 2,492,698	$ -	$ 74,640	$ 17,010	$ 1,449	$ 6,763,637
175	**Total Gross Revenue (Line 70 + 170)**	**$ 6,465,918**	**$ 4,901,835**	**$ 586,839**	**$ 6,673,928**	**$ -**	**$ 164,218**	**$ 487,510**	**$ 87,549**	**$ 19,406,632**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 1,994	$ -	$ -	$ -	$ 5,236	$ (18,135)	$ -	$ (10,905)
215	Contractual Adjustments - Medicare	$ (269,002)	$ 710,002	$ -	$ -	$ -	$ -	$ -	$ -	$ 441,000
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 210,289	$ 2,257,182	$ -	$ -	$ -	$ -	$ 2,467,471
222	Contractual Adjustments - Commercial Coverage	$ 76	$ -	$ -	$ -	$ -	$ 54,870	$ -	$ -	$ 54,947
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ 71,328	$ -	$ -	$ -	$ 29,224	$ 100,552
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (268,926)**	**$ 711,996**	**$ 210,289**	**$ 2,328,510**	**$ -**	**$ 60,106**	**$ (18,135)**	**$ 29,224**	**$ 3,053,064**
250	**Net Patient Revenue (line 175 - 240)**	**$ 6,755,373**	**$ 4,189,839**	**$ 376,550**	**$ 4,345,419**	**$ -**	**$ 104,112**	**$ 505,645**	**$ 58,325**	**$ 16,353,568**

Victoria CM
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	8110	6504	1496	9899	0	237	977	185	27408
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	8110	6504	1496	9899	0	237	977	185	27408

Victoria Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 950,250	$ 2,819,891	$ 787,803	$ 7,992,297	$ -	$ 387,159	$ 100,100	$ 1,271,900	$ 14,309,400
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 950,250	$ 2,819,891	$ 787,803	$ 7,992,297	$ -	$ 387,159	$ 100,100	$ 1,271,900	$ 14,309,400
	Ancillary Services:									
105	Patient Supplies	$ 12,024	$ 41,236	$ 5,408	$ 79,721	$ -	$ 4,182	$ 48	$ 8,252	$ 150,871
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 249,525	$ 780,480	$ -	$ 520,380	$ -	$ 98,370	$ 1,305	$ -	$ 1,650,060
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 300,870	$ 710,775	$ -	$ 368,325	$ -	$ 88,335	$ 585	$ -	$ 1,468,890
130	Speech Pathology	$ 281,475	$ 253,440	$ -	$ 302,715	$ -	$ 29,520	$ 630	$ -	$ 867,780
135	Pharmacy	$ 141,434	$ 670,947	$ 10,395	$ 200,665	$ -	$ 77,557	$ -	$ 7,920	$ 1,108,918
140	Laboratory	$ 28,080	$ -	$ -	$ 1,170	$ -	$ -	$ -	$ -	$ 29,250
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 17,663	$ 76,627	$ 480	$ 46,160	$ -	$ 9,761	$ -	$ -	$ 150,692
170	Subtotal (Lines 105 through 155)	$ 1,031,071	$ 2,533,506	$ 16,283	$ 1,519,137	$ -	$ 307,726	$ 2,568	$ 16,172	$ 5,426,461
175	**Total Gross Revenue (Line 70 + 170)**	**$ 1,981,321**	**$ 5,353,397**	**$ 804,085**	**$ 9,511,434**	**$ -**	**$ 694,884**	**$ 102,668**	**$ 1,288,072**	**$ 19,735,861**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 6,923	$ -	$ -	$ -	$ (198)	$ (10,850)	$ -	$ (4,125)
215	Contractual Adjustments - Medicare	$ (309,505)	$ (516,049)	$ -	$ -	$ -	$ -	$ -	$ -	$ (825,554)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 115,720	$ 877,026	$ -	$ -	$ -	$ -	$ 992,746
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (103,917)	$ -	$ -	$ (103,917)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 149,537	$ 149,537
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (309,505)**	**$ (509,126)**	**$ 115,720**	**$ 877,026**	**$ -**	**$ (104,114)**	**$ (10,850)**	**$ 149,537**	**$ 208,687**
250	**Net Patient Revenue (line 175 - 240)**	**$ 2,290,826**	**$ 5,862,523**	**$ 688,366**	**$ 8,634,408**	**$ -**	**$ 798,999**	**$ 113,518**	**$ 1,138,535**	**$ 19,527,174**

Victoria Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	2688	8033	2449	22654	0	1140	286	3634	40884
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	2688	8033	2449	22654	0	1140	286	3634	40884

Victoria Ventura
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 5,079,100	$ 2,923,352	$ 949,756	$ 16,713,555	$ -	$ 44,263	$ 256,749	$ 899,925	$ 26,866,700
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 5,079,100	$ 2,923,352	$ 949,756	$ 16,713,555	$ -	$ 44,263	$ 256,749	$ 899,925	$ 26,866,700
	Ancillary Services:									
105	Patient Supplies	$ 12,153	$ 20,961	$ 1,116	$ 12,434	$ -	$ -	$ -	$ 8	$ 46,672
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 987,030	$ 639,900	$ 3,780	$ 658,080	$ -	$ 21,015	$ 270	$ -	$ 2,310,075
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 1,506,555	$ 593,550	$ 3,060	$ 812,475	$ -	$ 10,575	$ -	$ -	$ 2,926,215
130	Speech Pathology	$ 598,590	$ 167,850	$ 1,530	$ 179,325	$ -	$ 675	$ -	$ -	$ 947,970
135	Pharmacy	$ 498,809	$ 206,691	$ 7,844	$ 63,782	$ -	$ 6,197	$ 240	$ 1,209	$ 784,771
140	Laboratory	$ 113,799	$ 87,510	$ 1,297	$ 21,791	$ -	$ 922	$ -	$ 104	$ 225,423
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 2,638	$ 3,054	$ -	$ 61,056	$ -	$ 120	$ -	$ -	$ 66,868
170	Subtotal (Lines 105 through 155)	$ 3,719,573	$ 1,719,516	$ 18,627	$ 1,808,944	$ -	$ 39,504	$ 510	$ 1,321	$ 7,307,994
175	**Total Gross Revenue (Line 70 + 170)**	**$ 8,629,653**	**$ 4,642,868**	**$ 968,382**	**$ 18,522,499**	**$ -**	**$ 83,767**	**$ 257,259**	**$ 901,246**	**$ 34,174,694**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 5,820	$ -	$ -	$ -	$ -	$ 39,127	$ -	$ 44,947
215	Contractual Adjustments - Medicare	$ (1,530,007)	$ (303,170)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,833,177)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 278,284	$ 4,260,493	$ -	$ -	$ -	$ -	$ 4,538,777
222	Contractual Adjustments - Commercial Coverage	$ 3,835	$ -	$ -	$ -	$ -	$ 6,169	$ -	$ -	$ 10,004
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 212,278	$ 212,278
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,526,172)**	**$ (297,349)**	**$ 278,284**	**$ 4,260,493**	**$ -**	**$ 6,169**	**$ 39,127**	**$ 212,278**	**$ 2,972,830**
250	**Net Patient Revenue (line 175 - 240)**	**$ 10,256,806**	**$ 4,940,217**	**$ 690,099**	**$ 14,262,006**	**$ -**	**$ 77,598**	**$ 218,132**	**$ 688,968**	**$ 31,201,864**

Victoria Ventura
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	11788	7308	2675	41025	0	114	553	2245	65708
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	11788	7308	2675	41025	0	114	553	2245	65708

Villa Maria Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,156,680	$ 688,246	$ 368,592	$ 6,180,892	$ -	$ 17,980	$ 179,150	$ 184,195	$ 10,775,735
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,156,680	$ 688,246	$ 368,592	$ 6,180,892	$ -	$ 17,980	$ 179,150	$ 184,195	$ 10,775,735
	Ancillary Services:									
105	Patient Supplies	$ -	$ 1,814	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,814
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 837,270	$ 132,660	$ -	$ 495,676	$ -	$ 2,835	$ -	$ -	$ 1,468,441
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 850,680	$ 138,870	$ -	$ 684,090	$ -	$ 3,240	$ -	$ -	$ 1,676,880
130	Speech Pathology	$ 769,635	$ 79,290	$ -	$ 157,455	$ -	$ 1,755	$ -	$ -	$ 1,008,135
135	Pharmacy	$ 369,782	$ 83,553	$ -	$ 5,016	$ -	$ 2,766	$ -	$ -	$ 461,118
140	Laboratory	$ 9,768	$ 1,988	$ -	$ -	$ -	$ 101	$ -	$ -	$ 11,856
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 18,255	$ 3,069	$ -	$ 20,265	$ -	$ -	$ -	$ -	$ 41,589
170	Subtotal (Lines 105 through 155)	$ 2,855,389	$ 441,244	$ -	$ 1,362,503	$ -	$ 10,697	$ -	$ -	$ 4,669,833
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,595,369**	**$ 1,129,490**	**$ 368,592**	**$ 7,543,395**	**$ -**	**$ 28,677**	**$ 179,150**	**$ 184,195**	**$ 15,445,568**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 1,936	$ -	$ -	$ -	$ -	$ 3,780	$ -	$ 5,716
215	Contractual Adjustments - Medicare	$ (1,530,092)	$ 18,479	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,511,613)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 79,590	$ 1,250,079	$ -	$ -	$ (1,861)	$ -	$ 1,327,808
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 9,027	$ -	$ -	$ 9,027
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 45,725	$ 45,725
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,530,092)**	**$ 20,415**	**$ 79,590**	**$ 1,250,079**	**$ -**	**$ 9,027**	**$ 1,919**	**$ 45,725**	**$ (123,337)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 7,351,013**	**$ 1,109,075**	**$ 289,003**	**$ 6,293,315**	**$ -**	**$ 19,650**	**$ 177,231**	**$ 138,470**	**$ 15,568,905**

Villa Maria Post Acute
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	8048	1755	1446	16116	0	46	91	468	27970
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	8048	1755	1446	16116	0	46	91	468	27970

Vista Knoll
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 2,187,330	$ 5,321,947	$ 720,327	$ 8,397,863	$ -	$ 153,379	$ 155,760	$ 538,518	$ 17,475,124
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 2,187,330	$ 5,321,947	$ 720,327	$ 8,397,863	$ -	$ 153,379	$ 155,760	$ 538,518	$ 17,475,124
	Ancillary Services:									
105	Patient Supplies	$ 58,646	$ 42,210	$ 3,124	$ 51,195	$ -	$ 2,972	$ 1,615	$ 20,837	$ 180,599
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 1,016,685	$ 532,170	$ 90	$ 941,490	$ -	$ 43,875	$ 3,285	$ 18,495	$ 2,556,090
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 746,010	$ 508,410	$ 180	$ 764,370	$ -	$ 40,185	$ -	$ 18,675	$ 2,077,830
130	Speech Pathology	$ 574,830	$ 191,880	$ 1,485	$ 560,340	$ -	$ 13,140	$ -	$ 11,925	$ 1,353,600
135	Pharmacy	$ 165,454	$ 153,651	$ 1,086	$ 1,641	$ -	$ 16,240	$ -	$ 28,517	$ 366,589
140	Laboratory	$ 15,525	$ 495	$ 172	$ 309	$ -	$ -	$ -	$ 54	$ 16,555
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 25,940	$ 33,685	$ 1,264	$ 24,040	$ -	$ 2,471	$ -	$ 513	$ 87,913
170	Subtotal (Lines 105 through 155)	$ 2,603,091	$ 1,462,501	$ 7,400	$ 2,343,385	$ -	$ 118,883	$ 4,900	$ 99,016	$ 6,639,176
175	**Total Gross Revenue (Line 70 + 170)**	**$ 4,169,061**	**$ 6,784,448**	**$ 727,727**	**$ 10,741,248**	**$ -**	**$ 272,262**	**$ 157,375**	**$ 637,534**	**$ 24,114,300**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ 9,821	$ -	$ -	$ -	$ 750	$ (870)	$ -	$ 9,701
215	Contractual Adjustments - Medicare	$ (1,209,968)	$ (276,074)	$ -	$ -	$ -	$ -	$ -	$ -	$ (1,486,042)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 161,225	$ 1,743,325	$ -	$ -	$ -	$ -	$ 1,904,550
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ (43,202)	$ -	$ -	$ (43,202)
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (664,523)	$ (664,523)
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (1,209,968)**	**$ (266,253)**	**$ 161,225**	**$ 1,743,325**	**$ -**	**$ (42,452)**	**$ (870)**	**$ (664,523)**	**$ (279,517)**
250	**Net Patient Revenue (line 175 - 240)**	**$ 5,686,472**	**$ 7,050,701**	**$ 566,502**	**$ 8,997,923**	**$ -**	**$ 314,714**	**$ 158,245**	**$ 1,302,058**	**$ 24,393,817**

Vista Knoll
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	6636	5297	2457	24652	0	437	449	2450	42378
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	6636	5297	2457	24652	0	437	449	2450	42378

Whittier Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Revenues

Line No	GROSS REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
	Routine Services:									
5	Skilled Nursing Care	$ 3,054,660	$ 2,209,234	$ 495,774	$ 10,285,081	$ -	$ 112,651	$ 396,884	$ 754,201	$ 17,308,485
10	Intermediate Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
15	Mentally Disordered Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
20	Developmentally Disabled Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25	Sub-Acute Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
30	Sub-Acute Care - Pediatric	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
35	Transitional Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
40	Hospice Inpatient Care	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
45	Other Routine Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
70	Subtotal (Lines 5 through 45)	$ 3,054,660	$ 2,209,234	$ 495,774	$ 10,285,081	$ -	$ 112,651	$ 396,884	$ 754,201	$ 17,308,485
	Ancillary Services:									
105	Patient Supplies	$ 60,822	$ 69,095	$ 2,872	$ 34,449	$ -	$ 2,532	$ 1,646	$ -	$ 171,417
110	Specialized Support Surfaces	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115	Physical Therapy	$ 876,285	$ 525,555	$ 5,445	$ 1,615,410	$ -	$ 26,145	$ 1,215	$ -	$ 3,050,055
120	Respiratory Therapy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125	Occupational Therapy	$ 890,775	$ 536,535	$ 6,345	$ 1,569,150	$ -	$ 27,540	$ 1,260	$ -	$ 3,031,605
130	Speech Pathology	$ 721,305	$ 263,250	$ 2,340	$ 408,285	$ -	$ 9,360	$ 675	$ -	$ 1,405,215
135	Pharmacy	$ 310,447	$ 362,016	$ 7,302	$ 38,089	$ -	$ 17,803	$ 374	$ -	$ 736,032
140	Laboratory	$ 25,725	$ 56,580	$ 814	$ 14,256	$ -	$ 2,098	$ 36	$ 108	$ 99,617
145	Home Health Services	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
155	Other Ancillary Services	$ 52,348	$ 129,300	$ 1,698	$ 74,661	$ -	$ 2,445	$ -	$ 499	$ 260,951
170	Subtotal (Lines 105 through 155)	$ 2,937,707	$ 1,942,332	$ 26,816	$ 3,754,300	$ -	$ 87,923	$ 5,206	$ 607	$ 8,754,892
175	**Total Gross Revenue (Line 70 + 170)**	**$ 5,992,367**	**$ 4,151,566**	**$ 522,590**	**$ 14,039,381**	**$ -**	**$ 200,574**	**$ 402,090**	**$ 754,808**	**$ 26,063,377**

Line No	DEDUCTIONS FROM REVENUE	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
205	Charity Adjustments	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
210	Administrative Adjustments	$ -	$ (33,640)	$ -	$ -	$ -	$ 26,884	$ (7,947)	$ -	$ (14,703)
215	Contractual Adjustments - Medicare	$ (2,662,067)	$ 443,974	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,218,093)
220	Contractual Adjustments - Medi-Cal	$ -	$ -	$ 69,422	$ 2,995,082	$ -	$ -	$ (0)	$ -	$ 3,064,504
222	Contractual Adjustments - Commercial Coverage	$ -	$ -	$ -	$ -	$ -	$ 6,787	$ (675)	$ -	$ 6,112
225	Contractual Adjustments - Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 87,902	$ 87,902
230	Other Deductions from Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
240	**Total Deductions from Revenue**	**$ (2,662,067)**	**$ 410,335**	**$ 69,422**	**$ 2,995,082**	**$ -**	**$ 33,671**	**$ (8,622)**	**$ 87,902**	**$ 925,723**
250	**Net Patient Revenue (line 175 - 240)**	**$ 8,654,434**	**$ 3,741,231**	**$ 453,168**	**$ 11,044,299**	**$ -**	**$ 166,903**	**$ 410,712**	**$ 666,905**	**$ 25,137,654**

Whittier Hills
Statement of Patient Revenues and Census by Payer
California Skilled Nursing Facility Operations
For Year ended December 31, 2024

Statement of Patient Census

Line No	Patient Census Days	Medicare FFS	Medicare Managed Care	Medi-Cal FFS	Medi-Cal Managed Care	Commercial FFS	Commercial Managed Care	Self Pay	Other	Total
5	Skilled Nursing	9402	7311	2180	33401	0	398	1279	2422	56393
10	Intermediate Care									
15	Mentally Disordered									
20	Developmentally Disabled									
25	Sub-Acute	0	0	0	0	0	0	0	0	0
30	Sub-Acute Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine									
70	Subtotal	9402	7311	2180	33401	0	398	1279	2422	56393

Organization Chart: West Star Healthcare LLC

The Ensign Group, Inc. - 33-0861263

100% sole shareholder in Flagstone Healthcare South LLC

(The Ensign Group, Inc. does not manage, operate or control Flagstone Healthcare South LLC)

Flagstone Healthcare South LLC - 55-0913892

100% sole shareholder in West Star Healthcare LLC

(Flagstone Healthcare South LLC does not manage, operate or control West Star Healthcare LLC)

West Star Healthcare LLC 99-4906952

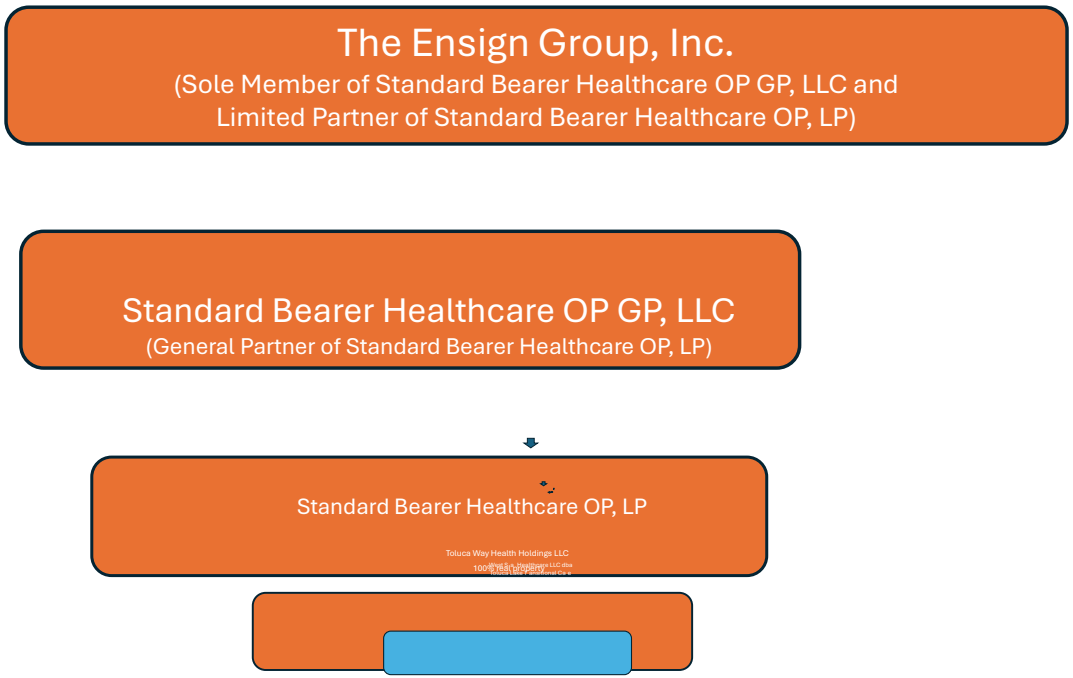
10425 Magnolia Boulevard, North Hollywood, CA 91601-4109

100% responsible for the management of

Providence St. Elizabeth Health Care Center

Adam Willits, Manager 0% ownership; Alicia Gamero, President 0% ownership;

Soon Burnam, Secretary 0% ownership; Ami Sato, Treasurer 0% ownership


The Ensign Group, Inc.
(Sole Member of Standard Bearer Healthcare OP GP, LLC and
Limited Partner of Standard Bearer Healthcare OP, LP)
Standard Bearer Healthcare OP GP, LLC
(General Partner of Standard Bearer Healthcare OP, LP)
Standard Bearer Healthcare OP, LP

OPERATING AGREEMENT

OF

FLAGSTONE HEALTHCARE SOUTH LLC

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OPERATING AGREEMENT

OF

FLAGSTONE HEALTHCARE SOUTH LLC

THIS OPERATING AGREEMENT is between FLAGSTONE HEALTHCARE SOUTH LLC, a Nevada limited liability company (the "Company") and THE ENSIGN GROUP, INC., a Delaware corporation (the "Member").

RECITALS

THE ENSIGN GROUP, INC., a Delaware corporation, is the Company's sole Member. The parties intend by this Agreement to define their rights and obligations with respect to the Company's governance and financial affairs and to adopt regulations and procedures for the conduct of the Company's activities. Accordingly, with the intention of being legally bound, they agree as follows:

ARTICLE 1: DEFINITIONS.

1.01 Scope. For purposes of this Agreement, unless the language or context clearly indicates that a different meaning is intended, capitalized terms have the meanings specified in this Article.

1.02 Defined Terms.

(a) "Act" means the Nevada Limited Liability Company Act and any successor statute, as amended from time to time.

(b) "Agreement" means this agreement, including any amendments.

(c) "Articles" means the Articles of Organization filed with the Secretary of State of the State of Nevada in connection with the conversion of the Company to a limited liability company, including any amendments.

(d) "Available Funds" means the Company's gross cash receipts from operations, less the sum of: (1) payments of principal, interest, charges and fees pertaining to the Company's indebtedness; (2) expenditures incurred incident to the usual conduct of the Company's business; and (3) amounts reserved to meet the reasonable needs of the Company's business.

(e) "Company" means FLAGSTONE HEALTHCARE SOUTH LLC and any successor limited liability company.

(f) "Contribution" means anything of value that the Member contributes to the Company as a prerequisite for or in connection with membership, including any combination of cash, property, services rendered, a promissory note or any other obligation to contribute cash or property or render services.

(g) "Distribution" means the Company's direct or indirect transfer of money or other property with respect to the Member's Membership Interest.

(h) "Effective Date," with respect to this Agreement, means the date on which the Company's existence as a limited liability company begins, as prescribed by the Act.

(i) "Effective Time," with respect to this Agreement, means September 25, 2019 at 11:55 p.m. (Eastern time).

(j) "Fiscal Year" means the calendar year.

(k) "Manager" means Barry Port.

(l) "Member" means THE ENSIGN GROUP, INC., a Delaware corporation, whose principal place of business is located at 29222 Rancho Viejo Road, Suite 127, San Juan Capistrano, California 926751.

(m) "Membership Interest" means the Member's interest in the Company, consisting of the Member's rights to the Company's Profit, to receive Distributions, to participate in the Company's governance, to approve the Company's acts and to receive information pertaining to the Company's affairs.

(n) "Person" means a natural person or an entity.

(o) "Profit," as to a positive amount, and "Loss," as to a negative amount, mean, for a Fiscal Year, the Company's income or loss for the Fiscal Year, as determined in accordance with accounting principles appropriate to the Company's method of accounting and consistently applied.

ARTICLE 2: THE COMPANY.

2.01 Formation. The Company was converted to a limited liability company by the filing of Articles of Conversion with the Secretary of State of the State of Nevada pursuant to the provisions of the Act, effective as of the Effective Time. The conversion of the Company to a limited liability company under the Act, the Articles of Conversion, the Articles, the filing of the Articles of Conversion and the Articles, and all actions taken by any person who executed or filed the Articles of Conversion or the Articles on behalf of the Company are hereby adopted, ratified and confirmed as acts of and on behalf of the Company, including without limitation, any actions taken by the organizer indicated in the Articles.

2.02 Status. The Company is a Nevada limited liability company organized under the Act.

2.03 Name. The Company's name is FLAGSTONE HEALTHCARE SOUTH LLC.

2.04 Term. The Company's existence as a limited liability company commenced as of the Effective Date and shall continue until terminated under this Agreement.

2.05 Purpose. The Company's purpose is to engage in any lawful act or activity for which a limited liability company may be organized under the Act.

2.06 Principal Place of Business. The Company's principal place of business is located at 29222 Rancho Viejo Road, Suite 127, San Juan Capistrano, California 92675.

2.07 Resident Agent and Registered Office. The Company's registered agent in Nevada is National Registered Agents, Inc. of NV, located at 311 S. Division St., Carson City, Nevada 89703.

2.08 Liability of the Member. All debts, obligations and liabilities of the Company, whether arising in contract, tort or otherwise, shall be solely the debts, obligations and liabilities of the Company, and the Member shall not be obligated personally for any such debt, obligation or liability of the Company solely by reason of being a member.

ARTICLE 3: MANAGEMENT.

3.01 Management.

(a) Scope. The Member hereby designates the Manager to be the "manager of the Company and have full power, authority and discretion to manage and direct the Company's business, affairs and properties, including, without limitation, the specific powers referred to in Article 3.01(b).

(b) Specific Powers. The Manager is authorized on the Company's behalf to make all decisions as to (i) the sale, lease or other disposition of the Company's assets; (ii) the purchase or other acquisition of other assets of all kinds; (iii) the management of all or any part of the Company's assets and business; (iv) the borrowing of money and the granting of security interests in the Company's assets (including loans from the Member); (v) the repayment, refinancing or extension of any mortgage affecting the Company's assets; (vi) the compromise or release of any of the Company's claims or debts; (vii) the payment of pensions and the establishment of pension plans, pension trusts, profit sharing plans, and benefit and incentive plans for the Member and the Company's employees; (viii) the making of donations to the public welfare or for religious, charitable, scientific, literary or education purposes; (ix) the purchase of insurance on the life of any employee of the Member or the Company; (x) the participation in partnerships, joint ventures or other associations of any kind with any Person or Persons; and (xi) the making of all elections available to the Company under any federal or state tax law or regulations.

(c) Officers. The Manager may, from time to time as it deems advisable, appoint officers of the Company and assign titles (including, without limitation, President, Vice President, Secretary, and Treasurer) to any such person. The Manager may delegate to such officers such power and authority as the Manager deems advisable, including the power, acting individually or jointly, to represent and bind the Company in all matters, in accordance with the scope of their respective duties. Each officer shall hold office until his successor is designated by the Manager or until his earlier death, resignation or removal. Any officer may resign at any time upon written notice to the Manager. Any officer may be removed by the Manager with or without cause at any time. A vacancy in any office occurring because of death, resignation,

removal or otherwise, may, but need not, be filled by the Manager. The initial officers of the Company are as follows:

Adam Willits	President
Soon Burnam	Treasurer
Craig Fitch	Secretary

(d) Binding Effect. The act of the Manager will bind the Company, and no Person dealing with the Company shall have any obligation to inquire into the power or authority of the Manager to act on the Company's behalf.

3.02 Fiduciary Duties.

(a) Exculpation. Notwithstanding any other provisions of this Agreement, whether express or implied, or any obligation or duty at law or in equity, neither the Member, the Manager, nor any of their respective officers, directors, stockholders, partners, members, managers, employees, affiliates, representatives or agents of the Member, nor any officer, employee, representative or agent of the Company (individually, a "Covered Person" and, collectively, the "Covered Persons") shall be liable to the Company or any other person for any act or omission (in relation to the Company, its property or the conduct of its business or affairs, this Agreement, any related document or any transaction contemplated hereby or thereby) taken or omitted by a Covered Person in good faith reliance on the provisions of this Agreement, provided such act or omission does not constitute willful misconduct, gross negligence, or a knowing violation of law.

(b) Limitation of Liability. This Agreement is not intended to, and does not, create or impose any fiduciary duty on any Covered Person. Furthermore, the Member, the Manager and the Company hereby waive any and all fiduciary duties that, absent such waiver, may be implied by applicable law, and in doing so, acknowledge and agree that the duties and obligations of each Covered Person to each other and to the Company are only as expressly set forth in this Agreement. The provisions of this Agreement, to the extent that they restrict the duties and liabilities of a Covered Person otherwise existing at law or in equity, are agreed by the Member and the Manager to replace such other duties and liabilities of such Covered Person. To the extent that, at law or in equity, any Covered Person has duties and liabilities related thereto to the Company or to any other Covered Person, a Covered Person acting under this Agreement shall not be liable to the Company or to any other Covered Person for such Covered Person's good faith reliance on the provisions of this Agreement.

(c) Justifiable Reliance. A Covered Person shall be fully protected in relying in good faith upon the records of the Company and upon such information, opinions, reports or statements (including financial statements and information, opinions, reports or statements as to the value or amount of the assets, liabilities, Profit or Loss of the Company or any facts pertinent to the existence and amount of assets from which Distributions might properly be paid) of the following Persons or groups: (i) one or more officers or employees of the Company; (ii) any attorney, independent accountant, appraiser or other expert or professional employed or engaged by or on behalf of the Company; or (iii) any other Person selected in good faith by or on behalf

of the Company, in each case, as to matters that such relying Person reasonably believes to be within such other Person's professional or expert competence.

3.03 Compensation. The Company may compensate the Manager for services rendered to or on behalf of the Company. The Company will reimburse the Manager for reasonable expenses properly incurred on the Company's behalf.

3.04 Indemnification. To the fullest extent permitted by the Act, the Company shall indemnify and hold harmless each Covered Person from and against any and all losses, claims, demands, liabilities, expenses, judgments, fines, settlements and other amounts arising from any and all claims, demands, actions, suits or proceedings, civil, criminal, administrative or investigative ("Claims"), in which the Covered Person may be involved, or threatened to be involved, as a party or otherwise, by reason of the fact that he, she or it is a Covered Person or which relates to or arises out of the Company or its property, business or affairs. A Covered Person shall not be entitled to indemnification under this Article 3.04 with respect to (i) any Claim with respect to which such Covered Person has engaged in willful misconduct, gross negligence, or a knowing violation of law or (ii) any Claim initiated by such Covered Person unless such Claim (A) was brought to enforce such Covered Person's rights to indemnification hereunder or (B) was authorized or consented to by the Manager. Expenses incurred in defending any Claim by (y) the Manager or any officer, director, stockholder, partner, member, manager, or affiliate of the Manager shall be paid by the Company and (z) any other Covered Person may be paid by the Company, but only upon the prior written approval of the Member in its sole and absolute discretion, upon such terms and conditions, if any, as the Manager deems appropriate, in each case, in advance of the final disposition of such Claim upon receipt by the Company of an undertaking by or on behalf of such Covered Person to repay such amount if it shall be ultimately determined that such Covered Person is not entitled to be indemnified by the Company as authorized by this Article 3.04.

3.05 Amendments. Any repeal or modification of this Article 3 by the Member shall not adversely affect any rights of such Covered Person pursuant to this Article 3, including the right to indemnification and to the advancement of expenses of a Covered Person, existing at the time of such repeal or modification with respect to any acts or omissions occurring prior to such repeal or modification.

ARTICLE 4: FINANCE.

4.01 Contributions.

(a) Member. The Member has previously made a contribution to the Company.

(b) Additional Contributions. The Member at any time may but is not required to make additional Contributions of cash and property to the Company.

(c) Contributions Not Interest Bearing. The Member is not entitled to interest or other compensation with respect to any cash or property the Member contributed to the Company.

4.02 Distributions.

(a) Available Funds. The Company will distribute its Available Funds to the Member in such amounts and at such times as the Member may determine.

(b) Limitation. The Company will make no Distribution unless, after the Distribution is made, the Company's assets are in excess of its liabilities.

ARTICLE 5: RECORDS AND ACCOUNTING.

5.01 Maintenance of Records.

(a) Required Records. The Company will maintain at its principal place of business such books, records and other materials as are reasonably necessary to document and account for its activities, including, without limitation, those required to be maintained by the Act.

(b) Member Access. The Member and the Member's authorized representative will have reasonable access to and may inspect and copy all books, records and other materials pertaining to the Company or its activities.

5.02 Accounting Method. The Company will account for its financial transactions using a method of accounting determined by the Member.

5.03 Reports. The Company will complete and file any periodic reports required by the Act or other applicable law.

ARTICLE 6: DISSOLUTION.

6.01 Dissolution.

(a) Events of Dissolution. The Company will dissolve upon the first to occur of:

(1) the effectiveness of a determination by the Member that such dissolution shall occur;

(2) any event that makes the Company ineligible to conduct its activities as a limited liability company under the Act; or

(3) any event or circumstance that makes it unlawful or impossible for the Company to carry on its business.

(b) Exclusivity of Events. Unless specifically referred to in this Article 6.01, no event, including an event of dissolution prescribed by the Act, will result in the Company's dissolution.

6.02 Effect of Dissolution.

(a) Appointment of Liquidator. Upon the Company's dissolution, the Member will appoint a liquidator, who may but need not be the Member. The liquidator will wind up and liquidate the Company in an orderly, prudent and expeditious manner in accordance with this Article 6.02.

(b) Final Accounting. The liquidator will make proper accountings (1) to the end of the month in which the event of dissolution occurred; and (2) to the date on which the Company is finally and completely liquidated.

(c) Duties and Authority of Liquidator. The liquidator will make adequate provisions for the discharge of all of the Company's debts, obligations and liabilities. The liquidator may sell, encumber or retain for distribution in kind any of the Company's assets.

(d) Final Distribution. The liquidator will distribute any assets remaining after the discharge or accommodation of the Company's debts, obligations and liabilities to the Member.

(e) Required Filings. The liquidator will file with the Secretary of State of the State of Nevada such statements, certificates and other instruments, and take such other actions, as are reasonably necessary or appropriate to effectuate and confirm the cessation of the Company's existence.

ARTICLE 7: GENERAL PROVISIONS.

7.01 Amendments.

(a) Required Amendments. The Company and the Member will execute and file any amendment to the Articles required by the Act. If any such amendment results in inconsistencies between the Articles and this Agreement, this Agreement will be considered to have been amended in the specifics necessary to eliminate the inconsistencies.

(b) Other Amendments. The Company and the Member may amend this Agreement at any time in any respect that is consistent with the Articles and the Act.

7.02 Nominee. Title to the Company's assets may be held in the name of the Company or any nominee (including the Member so acting), as the Company determines. The Company's agreement with any nominee may contain provisions indemnifying the nominee for costs or damages incurred as a result of the nominee's service to the Company.

7.03 Resolution of Inconsistencies. If there are inconsistencies between this Agreement and the Articles, the Articles will control. If there are inconsistencies between this Agreement and the Act, this Agreement will control, except to the extent the inconsistencies relate to provisions of the Act that the Member cannot alter by agreement.

7.04 Additional Instruments. The Member will execute and deliver any document or statement necessary to give effect to the terms of this Agreement or to comply with any law, rule or regulation governing the Company's formation and activities.

7.05 Computation of Time. In computing any period of time under this Agreement, the day of the act or event from which the specified period begins to run is not included. The last day of the period is included, unless it is a Saturday, Sunday or legal holiday, in which case the period will run until the end of the next day that is not a Saturday, Sunday or legal holiday.

7.06 Entire Agreement. This Agreement and the Articles comprise the entire agreement among the parties with respect to the Company. This Agreement and the Articles supersede any prior agreements or understandings with respect to the Company. Any representation, statement or condition not contained in this Agreement or the Articles has no force or effect.

7.07 Waiver. No right under this Agreement may be waived, except by an instrument in writing signed by the party sought to be charged with the waiver.

7.08 General Construction Principles. Words in any gender are deemed to include the other genders. The singular is deemed to include the plural and vice versa. The headings and underlined paragraph titles are for guidance only and have no significance in the interpretation of this Agreement.

7.09 Binding Effect. This agreement is binding on and will inure to the benefit of the Company, the Member and their respective distributees, successors and assigns.

7.10 Governing Law. Nevada law governs the construction and application of the terms of this Agreement.

7.11 Tax. Unless otherwise determined by the Member, the Company shall be a disregarded entity for U.S. federal income tax purposes (as well as for any analogous state or local tax purposes), and the Member and the Company shall timely make any and all necessary elections and filings for the Company to be treated as a disregarded entity for U.S. federal income tax purposes (as well as for any analogous state or local tax purposes).

[INTENTIONALLY LEFT BLANK]

SIGNED on the respective dates set forth below, to be effective as of the Effective Time.

COMPANY:

FLAGSTONE HEALTHCARE SOUTH LLC,
a Nevada limited liability company

By: _____
Soon Burnam
Treasurer

Dated: September 25, 2019

MEMBER:

THE ENSIGN GROUP, INC., a Delaware corporation

By: _____
Chad Keetch
Executive Vice President and Secretary

Dated: September 25, 2019