Acute Care, High Conviction: Micro-Hospitals Filling the Gap Between Urgent Care and Overcrowded ERs with a Self-Funding Growth Engine—Initiating at Buy, $290 PT

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STOCK DATA	
Market Cap (mil)	$1,026.0
52-Week Range	$77.21–$193.07
3-Month ADTV	155,194
Shares Outstanding (mil)	6.9
Float (%)	67.3
Short Interest	1,115,541
Fiscal Year-End	December

FINANCIAL DATA			
Rev. (mil)	2025A	2026E	2027E
1Q	$211.8	$216.5A	$229.8
2Q	$244.0	$215.2	$235.6
3Q	$267.8	$220.0	$242.8
4Q	$141.7	$224.8	$249.3
FY	$875.3	$876.5	$957.4
EBITDA (mil)	2025A	2026E	2027E
1Q	$72.8	$57.6A	$61.1
2Q	$71.6	$54.4	$63.1
3Q	$98.5	$55.6	$65.5
4Q	$16.6	$57.9	$68.7
FY	$259.6	$225.4	$258.4
EPS	2025A	2026E	2027E
1Q	$3.62	$6.52A	$5.74
2Q	$(2.95)	$5.26	$5.89
3Q	$7.72	$5.35	$6.10
4Q	$1.48	$5.60	$6.41
FY	$10.48	$22.72	$24.14
P/E	14.2x	6.6x	6.2x

BALANCE SHEET DATA	
	1Q26
Cash & Equivalents	$210.6
Total Debt	$41.0
$ in millions.	

Summary and Recommendation

We are initiating coverage of Nutex Health Inc. (NUTX) with a Buy rating and $290 price target. NUTX operates a network of micro-hospitals, small but fully licensed acute-care facilities that pair a 24/7 emergency department with inpatient beds, in-house imaging, laboratory, and pharmacy services in roughly the footprint of a CVS. The model fills a widening gap in U.S. healthcare; urgent care clinics cannot treat genuinely acute conditions, while large hospital emergency rooms are increasingly overcrowded. By placing acute-capable facilities directly in fast-growing suburban and working-class communities, NUTX treats the chest pain, abdominal pain, and fractures that fall between those two extremes, admitting or stabilizing patients rather than turning them away. NUTX operates predominantly out of network, resolving underpaid claims through federal arbitration. Our thesis rests on a capital-light growth engine. Historically, NUTX's cash outlay to open a hospital was only $5M–$6M for equipment and working capital, with the $20M–$30M of land and construction carried by outside developers and physician partners. Under a newly board-approved model, NUTX funds the full project and then monetizes each stabilized facility through a sale-leaseback and recycles the proceeds into the next opening. Across an expected 3–5 openings per year, this converts a pipeline historically financed by outside developers and physician partners into a self-funding flywheel that adds units without straining a debt-light balance sheet ($166.4M net cash at 1Q26).

For 2026, we expect roughly flat revenue and lower adjusted EBITDA Y/Y, a function of 2024 arbitration claims collected in 2025 that do not recur, not of deteriorating economics. Beneath that reset, the Federal Independent Dispute Resolution (IDR) channel is becoming more efficient, and the Independent Practice Association (IPA) network is being built to funnel commercially insured volume into neighboring hospitals. We view NUTX's self-funding hospital pipeline and durable, increasingly efficient IDR reimbursement channel as supporting sustained top- and bottom-line growth beyond the 2026 reset.

Key Points

- **A deep identified de novo pipeline anchors multiyear unit growth.** NUTX targets three to five new hospitals per year from a pipeline of 13+ projects with visibility into 2029, including three openings in 2H26 (San Antonio, Jacksonville, and West Little Rock).
- **The IDR reimbursement channel is durable and becoming more efficient.** NUTX bills at hospital rates and resolves out-of-network claims through federal arbitration at 85%-plus win and 80%-plus collection rates. Courts have dismissed the lead insurer suits in consecutive rulings, and the May 2026 final rule cut the per-dispute fee from $115 to $15, doubled batching, and mandated eligibility coding, which should improve eligible-claim rates and cash conversion.
- **Micro-hospitals meet acute-care demand that the rest of the system misses.** NUTX places acute-capable facilities in dense suburban and working-class communities to treat mid-acuity emergencies (ESI levels 2-4: chest pain, abdominal pain, fractures, moderate trauma) for a largely commercially insured population. These patients are too severe for urgent care, which lacks the license, imaging, labs, and inpatient beds to treat them, while the nearest hospital ER is often distant and burdened with 6- to 9-hour waits. NUTX patients are seen in under 30 minutes, on average.
- **2026 is an optical reset, not a deterioration.** 2025 revenue (+82%) and adjusted EBITDA (+153%) were inflated by 2024-origin arbitration collected in 2025; we model 2026 roughly flat on revenue and lower on EBITDA as that catch-up rolls off. 2026 rebases the franchise to its clean run-rate; 2027 grows off it and anchors our $290 price target.

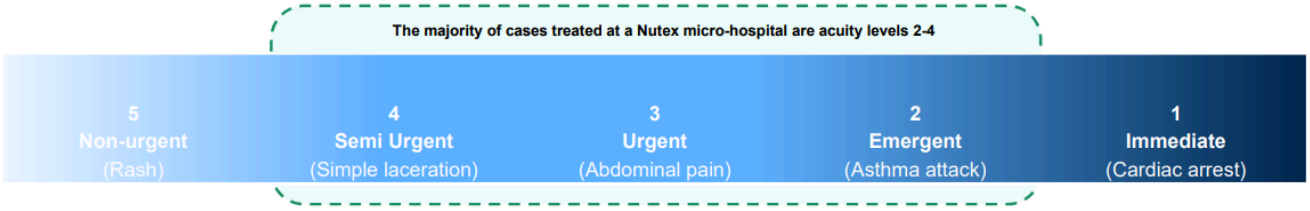
Business Overview

Nutex Health Inc. was founded in 2011 by Dr. Tom Vo, a board-certified emergency physician with 30 years of healthcare experience who also co-founded Neighbors Emergency Center (a freestanding ER model) in 2008 before departing in 2011. NUTX went public in April 2022 through a reverse merger with Clinigence, a population health technology company. Headquartered in Houston, Texas, NUTX operates as a physician-led, integrated healthcare delivery system through three reportable segments: hospital, population health management (PHM), and real estate. The hospital division represents approximately 95% of revenue and operates a national network of micro-hospitals, specialty hospitals, and hospital outpatient departments. As of early 2026, NUTX operates 27 facilities across 12 states (with the most recent opening in St. Louis, Missouri, in December 2025 and the Bayou City facility reopening in Humble, Texas, in January 2026). Importantly, NUTX operates predominantly as an out-of-network provider, and underpaid out-of-network claims are resolved through the Federal IDR process, which is central to the revenue model and detailed in a later section. The PHM division operates provider networks, including four independent practice associations (IPAs) in Los Angeles, Houston, Miami, and Phoenix, managing over 41,000 patients in risk-based arrangements through a contracted network of 300+ primary care physicians and 900+ specialists. The real estate segment owns and leases the land and buildings used by certain hospital entities through the company's property holding (PropCo) structure, a structure that is the subject of a deliberate shift in development and financing strategy, as discussed below.

The Micro-Hospital Model

A micro-hospital is a small, fully licensed hospital facility occupying approximately 15,000–30,000 square feet, roughly the footprint of a CVS or Walgreens location. Despite its compact size, each facility carries a full hospital license in its respective state and is equipped with the core capabilities of a traditional hospital: a 24/7 emergency department staffed by board-certified emergency physicians and emergency-trained nurses, in-house radiology (CT, X-ray, ultrasound, MRI) and laboratory services, a pharmacy, and inpatient beds for observation and admission. Typical configurations include 4–10 ER beds and 4–10 inpatient beds, with select newer facilities offering substantially more inpatient capacity.

NUTX Targets Mid-Acuity Patients



Source: Company presentation

The micro-hospital model occupies a distinct niche in the U.S. emergency care continuum. At the lower-acuity end, urgent care clinics, retail clinics (CVS MinuteClinic, Walmart Health), and primary care offices handle non-urgent visits. At the highest-acuity end, large traditional hospitals (often 300–500+ beds) serve critical and complex cases. NUTX positions itself in the middle, targeting semi-urgent, urgent, and emergent cases (ESI levels 2–4), conditions like chest pain, abdominal pain, fractures, moderate trauma, and headaches that are too acute for urgent care but often result in 6- to 9-hour waits at overcrowded large hospital ERs.

Target Markets and Location Strategy

NUTX situates its hospitals in high-density, high-traffic suburban and working-class communities away from existing major medical centers, targeting markets with limited access to timely emergency care. Site selection is rigorous and explicitly retail-oriented: The company favors highly visible locations near anchor retail (for example, near a Home Depot or Walmart) so that a new facility can compete for attention against incumbent hospital systems that may have served the area for decades. Management relies on local physician partnerships and on-the-ground market intelligence to identify locations with favorable supply/demand dynamics, communities where the nearest full-service ER may require extended travel or impose multi-hour waits.

27 Micro-Hospitals Across 12 States

Source: Company presentation

Capabilities and Level of Care

Each micro-hospital is equipped to handle the full spectrum of emergency presentations, from minor ailments to trauma cases, including gunshot wounds, stabbings, and major motor vehicle accidents. Management estimates that of every 100 patients who present to the ER, approximately 90 are treated and discharged, about 5 are admitted to the facility's own inpatient floor, and the remaining 5 are transferred to a higher-acuity facility for services not offered on site (such as surgery or intensive care). The company has been strategically increasing inpatient admissions and observation stays over time, as inpatient reimbursement is meaningfully higher than ER-only visits, lifting revenue per visit even where mature-hospital volume growth is modest.

Patient Mix and Commonly Treated Symptoms

Source: Company presentation

Clinical quality metrics have been strong and are a genuine source of referral volume. The company reports an average Google rating of 4.8 out of 5.0 across its markets (more than 2,400 patient reviews in 1Q26 alone), with many facilities at 4.9 to 5.0, reflecting minimal to no emergency room wait times and a high-touch, concierge-level experience. That differentiated patient experience, combined with physician alignment, supports physician retention rates, which management has cited at greater than 95%, and unusually low staff turnover relative to traditional hospital operators.

Revenue Model and Reimbursement

NUTX generates revenue primarily from emergency, inpatient, imaging, and laboratory services billed to commercial insurance carriers. Government payers (Medicare and Medicaid) represent less than 5% of the patient mix. The payer mix skews heavily commercial, with roughly half of commercial volume attributed to Blue Cross Blue Shield plans and the remainder spread across other national and regional carriers. Because NUTX facilities are licensed hospitals, they bill at hospital rates, the same reimbursement schedule as larger traditional hospital systems, while operating at a fraction of their cost. The company does not balance bill patients; out-of-network payment disputes are resolved through the Federal IDR process described in a later section.

Unit Economics

The cost to open a new micro-hospital has historically been approximately $5M to $6M, with roughly half allocated to medical equipment (CT, MRI, X-ray, laboratory equipment, stretchers, and beds) and the balance to working capital needed to fund operations from opening day through breakeven. Real estate is a separate and much larger cost, roughly $20M to $30M per facility, which historically NUTX did not fund directly. Management targets accrual breakeven within about 12 months and cash breakeven within roughly 12 to 15 months, with breakeven generally occurring around 12 to 20 patients per day. At maturity (near year two), a typical facility generates ~$30M of revenue and ~$10M of profitability, consistent with the company's historical 30%-plus margin profile as a private operator. Labor remains lean, at approximately 19% of net revenue in 1Q26, well below traditional hospital labor intensity, and medical supply costs are controlled through group purchasing organization (GPO) and vendor standardization efforts.

Turnkey De Novo Strategy

De Novo Facility Profile

Services / Staffing	■ Provide emergency, inpatient care, outpatient imaging, outpatient labs, minor procedures, etc. ■ ER Physician, RNs, Radiology Technologists, EMT with on-call Hospitalist on staff at all times
Size & Beds	■ ~20 – 30K sq ft ■ 4-10 in-patient beds; 6-10 emergency rooms
Site Selection and Evaluation	■ Target densely populated suburban and underserved markets (with a focus on populations covered by commercial payers) ■ Evaluate demographics, real estate costs, coverage and competitive landscape ■ Conduct regulatory and state / municipality research
Cost	■ Capex – around $5-6mm per facility to open ■ Cost of real estate – roughly $20-30mm per facility
Profitability	■ Typical facility is cash flow positive within ~12 months ■ Achieve breakeven at ~12-20 patients per day
Growth	■ Pipeline of in-development and early planning facilities; expect to build 3-5 facilities per year ■ Embedded growth of newly opened facilities to maturity supported by marketing and other business development ■ Expand service line offerings ■ Hub and spoke model including HOPDs

De Novo Rollout Timeline

Task	Timing
Identify Optimal Markets	> 18 months before entry
Evaluate Site Feasibility	12 - 18 months before entry
Build Sites	0 - 12 months leading to entry
Accelerated Market Growth and Expansion	Ongoing (once site is open)

Total time frame for opening a typical new facility is ~18 months

Source: Company presentation

Growth Strategy and Hospital Pipeline

NUTX's primary growth engine is de novo hospital development at a targeted pace of three to five openings per year. The company has 15-plus projects in its pipeline spanning 2026 through 2028, with three openings slated for 3Q26 and 4Q26 in San Antonio, Texas; Jacksonville, Florida; and West Little Rock, Arkansas—followed by roughly five projects each in 2027 and 2028, with 2029 sites already in early planning.

The de novo approach is a structural necessity rather than a preference: Micro-hospitals are a niche, purpose-built facility type that generally cannot be acquired off the shelf, so each must be developed from the ground up. Inbound demand is a recurring theme in management commentary; physicians and community leaders approach the company weekly seeking new facilities, which gives management latitude to be selective and prioritize the highest-return sites.

The New Hospital Ramp

Understanding the cadence of a single facility is central to modeling consolidated growth because newly opened hospitals dilute reported margins while they ramp, and the timing of openings drives near-term volume optics. A new facility carries a 24/7, 365-day cost structure that is effectively fixed from day one, while revenue builds gradually. Patient volume typically ramps from roughly five to seven visits per day in the first month or two toward nine to 10 and then 15 to 20 as the community becomes aware of the facility. Cash conversion lags volume meaningfully: The first commercial payment generally arrives more than 30 days after a visit is billed, and claims routed through arbitration take an additional four to six months. As a result, a new hospital usually burns cash through roughly its first two quarters, revenue accelerates in the third quarter, and cash inflows pick up materially in the fourth quarter and into the start of year two. Accrual breakeven is typically achieved within about 12 months and cash breakeven within roughly 12 to 15 months, with several recent openings reaching breakeven more quickly. By the end of year two, a facility is generally at its mature run-rate.

From Developer-Financed to Self-Funded: A Capital-Light Pivot

The most important strategic development for the growth algorithm is a change in how NUTX finances the real estate beneath its hospitals. Historically, real estate development was undertaken by third-party developers alongside local physician partners, who carried the construction risk and capital burden. NUTX then leased the completed facility under a long-term lease, with most leases reflected as finance leases on its balance sheet and physician partners frequently guaranteeing the underlying loans. That model made sense when NUTX was less profitable and capital constrained, but it diffused economics to outside developers, relied on external credit markets, and placed a financing burden on the physician partners on which the company depends.

In 2026, the board approved a shift to internalized development. NUTX will now invest the capital to develop and construct new facilities itself (roughly $20M to $30M of land and building per site, typically funded with a down payment plus a construction financing vehicle), carry the asset and associated mortgage on its balance sheet through construction and stabilization, and then monetize the stabilized facility through a sale-leaseback to a third-party owner such as a real estate investment trust (REIT). The company does not intend to hold these real estate assets long term. Proceeds from each sale-leaseback are to be recycled into the next wave of development so that after the first one to two years of seeding the model, management expects the pipeline to become substantially self-funding without recurring calls on external capital. Development cycles run roughly 18 to 24 months from start to opening, so the first fully self-financed facilities are expected to come on line around the end of 2027, with the more visible balance-sheet impact in 2028E; a portion of the 2027 class will still be externally financed during the transition.

We view this pivot as the core of the growth thesis. It accomplishes three things at once: It secures a more reliable, cost-efficient pipeline under the company's own control; it converts each opening into a capital-recycling event that funds the next, materially reducing reliance on external credit and on physician-partner financing; and it keeps stabilized real estate off the balance sheet, preserving a debt-light posture ($207.3M cash and $24.3M net long-term debt at 1Q26) while still expanding the footprint at a three- to five-facility annual clip. When executed repeatedly, we expect the sale-leaseback to become a recurring source of cash even if any single transaction is nonrecurring in form. From a modeling standpoint, any gain on sale is likely to be treated as a one-time item and, in management's current thinking, excluded from adjusted EBITDA unless the cadence proves steady enough to be considered recurring; in either case, the cash is real and feeds the next opening. We separately note that the company is also pursuing a sale-leaseback of the existing PropCo portfolio to an institutional landlord, which would replace the related-party landlord structure and address a long-standing governance concern; the structure and timing of any such transaction are not yet finalized.

Organic Revenue Growth Levers

Beyond unit additions, NUTX has several levers within existing hospitals. The company has focused on increasing inpatient admissions and observation stays rather than on simply driving ER visit volume. Because inpatient reimbursement is materially higher than ER-only visits, this mix shift lifts revenue per visit even in mature hospitals with modest visit growth. We model mature, same-hospital organic growth at a conservative ~2% (some of the largest, most established facilities grow more slowly because of their size), with the newer-vintage facilities providing the bulk of top-line growth as they ramp. The company is also adding clinical service lines and specialists (including behavioral health, medical detox, outpatient imaging, outpatient procedures, and personal injury services) to treat more complex cases in-house rather than transferring them and is investing in AI and information technology tools for patient access, documentation, coding accuracy, and workforce productivity that likely represent additional efficiency levers.

Population Health and the IPA Funnel

The population health management division is small (roughly 5% of revenue, $8.9M in 1Q26, up about 14% Y/Y), but its strategic role is larger than its revenue line suggests. An IPA is a network of contracted, credentialed primary care physicians and specialists that contracts with payers and manages the total care of patients; NUTX's IPAs are risk-bearing organizations that assume partial or full risk and pay physicians via fee-for-service or capitation. NUTX does not operate these networks to build the largest possible IPA. It operates them to build a physician web around each hospital that ultimately feeds patient volume into the micro-hospital.

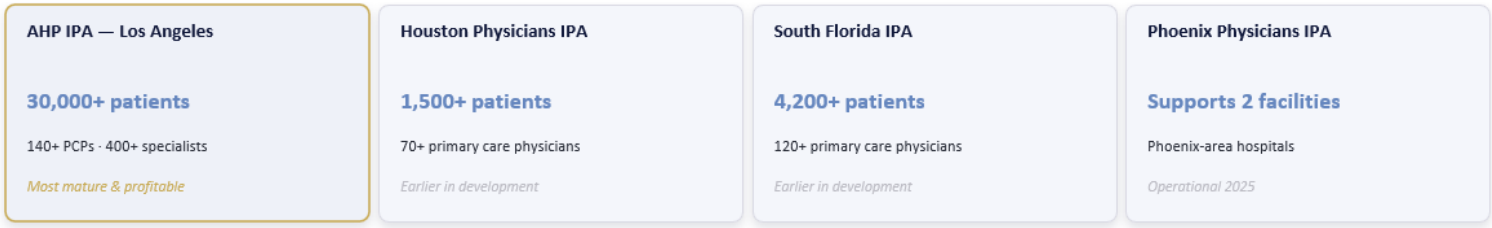
How the Funnel Works

NUTX offers participating physicians ownership in the IPA entities, seats on IPA boards and committees, staff privileges at NUTX hospitals so they can admit and follow their own patients, and incentives tied to quality metrics. In exchange, the company builds awareness of its hospitals among local community physicians and their patients. As physicians become aligned with and aware of the neighboring micro-hospital, they direct patients there: not only the IPA's own managed-care lives, but, as management has observed anecdotally, their broader panel of commercially insured PPO patients, who represent the most attractive reimbursement opportunities. The relationship is symbiotic: The IPA refers patients into the hospital, and the hospital refers patients back to IPA primary care physicians, creating a coordinated local care ecosystem and a self-reinforcing volume loop. For a business whose hospital economics turn on commercial volume, an aligned physician network sitting beside each facility is a high-leverage, low-cost source of incremental patients.

Current Footprint and Stand-Alone Profitability

NUTX operates four IPAs today. The Los Angeles network (AHP IPA) is the most mature and most profitable, with more than 30,000 patients, 140-plus primary care physicians, and 400-plus specialists. The Houston, South Florida, and Phoenix IPAs are earlier in their development; Houston serves more than 1,500 patients with 70-plus primary care physicians, South Florida serves more than 4,200 patients with 120-plus primary care physicians, and Phoenix works in conjunction with the company's two Phoenix-area facilities. Importantly, each of the established IPAs generated cash on a stand-alone basis in 2025, so the funnel strategy does not come at the expense of the segment's own economics.

Current IPA Footprint



Source: Company presentation and B Riley Research

IPA Growth Outlook

Management plans to launch one to three new IPAs per year, each sited deliberately to support a current or planned micro-hospital rather than to maximize covered lives in isolation. Three networks are currently in the process of being built, in Dallas, San Antonio, and St. Louis, all expected to come on line over the next two to three years and timed to complement hospitals that are open or planned in those markets. The company has also pointed to South Florida expansion (a planned Hallandale-area hospital and a West Palm Beach facility) to complement its existing South Florida network. The IPA pipeline is thinner than the hospital pipeline because attractive networks are less readily available, and IPAs typically take longer to ramp to profitability than hospitals. We therefore treat the segment as a strategic volume driver and a modest, lumpy revenue contributor rather than as a primary earnings engine, with its principal value being the incremental commercial volume it routes into the higher-margin hospital division. Over a multiyear horizon, surrounding a larger share of the 27-and-growing hospital base with aligned physician networks represents a meaningful, under-appreciated support to same-market hospital volume, in our opinion.

The No Surprises Act and the IDR Process

Background and Intent

The No Surprises Act (NSA) was enacted as part of the Consolidated Appropriations Act of 2021 and became effective on January 1, 2022. The legislation was designed to protect patients from "surprise" or "balance" medical bills, unexpected charges that arose when patients received emergency or certain non-emergency services from out-of-network providers, particularly if they were hospitalized in in-network facilities. Under the NSA, patients are responsible only for their in-network cost-sharing obligations (copays, deductibles, coinsurance), and providers are prohibited from billing patients for any balance beyond that amount. The NSA also established the IDR process as the mechanism for resolving payment disputes between out-of-network providers and insurers, with the patient removed entirely from the equation.

The Initial Impact: 2022–2023

For NUTX, the NSA's implementation was initially devastating. While management states that it had never engaged in surprise or balance billing practices, the act's vague early implementation language and regulations created an environment in which insurers aggressively reduced reimbursement to out-of-network providers. Revenue dropped approximately 35% from 2021 to 2022, with adjusted EBITDA collapsing from $145M in 2021 to just $12.6M in 2022 (–90% Y/Y). This occurred just as NUTX was becoming a public company through its April 2022 reverse merger with Clinigence, creating an extremely difficult first impression for public market investors.

Management's response during 2022–2023 included (1) aggressively increasing patient volume to offset per-visit revenue declines; (2) tightening billing, coding, and collection processes; (3) resubmitting underpaid claims with supporting documentation; (4) renegotiating payer contracts where possible; and (5) engaging with legislators and regulators to advocate for fairer implementation of the NSA. These efforts helped to stabilize the business, but the fundamental reimbursement issue persisted until the IDR process became operationally viable.

The IDR Turning Point: Mid-2024 to Present

The Federal IDR process, while authorized by the original NSA legislation, was not functionally operational and cost-effective until approximately mid-2024, after CMS had spent two years refining the portal, processes, and regulations. On July 1, 2024, NUTX engaged HaloMD, a specialized health technology firm, to assist with challenging underpaid out-of-network claims through the Federal IDR process and state-level surprise billing regulations. HaloMD manages the complex, tech-enabled submission process for arbitration claims, while NUTX retains in-house control over which claims to submit.

The IDR process works as follows: When a payer's initial payment is believed to be inadequate, the provider initiates an open negotiation period with the insurer. If unresolved, either party can submit the dispute to a certified independent dispute resolution entity (IDRE), an independent third-party arbitrator. The IDRE reviews evidence from both sides, including the qualifying payment amount (QPA, a proxy for the median in-network rate), patient acuity, provider training, market conditions, and complexity of service, and renders a binding payment determination. The losing party must pay within 30 days.

NUTX's IDR results have been strong. The company consistently submits 50% to 60% of hospital claims to the IDR process, wins legal determinations on more than 85% of those claims, and collects more than 80% of award value on wins, a collection rate that has improved over time. Public CMS IDR data indicate that providers nationally have prevailed on the large majority of determinations, with median winning offers well above the relevant in-network benchmarks; for NUTX-tagged line items, public data have implied award multiples on the order of several times QPA. We address the durability of these outcomes directly in the bear-case section. Normalized revenue per visit since the arbitration program began in mid-2024 has settled in a roughly $4,000 to $4,200 range, which we treat as the steady-state anchor for forward modeling rather than the elevated 2025 optics produced by prior-period catch-up.

How the IDR Process Works

At its core, the dispute is about price, and the two sides anchor far apart. NUTX's position, per management, is not that it should collect more than comparable hospitals but that it should be paid in line with what in-network peers receive for the same service in the same market: comparable reimbursement for comparable care. The insurer anchors instead to the qualifying payment amount (QPA), which becomes the gravitational center of the negotiation and arbitration that follow.

The QPA is the insurer's calculation of the median contracted in-network rate for a given service and geographic market, originally benchmarked to January 31, 2019, and trended forward by the Consumer Price Index for All Urban Consumers. Two features drive the conflict. First, the insurer computes it, using its own contracted rates and methodology, with limited provider visibility into the inputs. Second, providers argue that it systematically understates prevailing commercial rates because insurers can fold in artificially low or "ghost" contracts (rates with providers that do not actually furnish the service in that market) that pull down the median. NUTX therefore enters each dispute with an offer anchored to in-network peer rates that sits well above both the insurer's initial payment and its QPA-based offer, and the arbitration data bear out that providers, NUTX included, generally prevail at levels well above the QPA.

The May 2026 Operations Final Rule: A Tailwind for Disciplined Filers

The trajectory of the Federal IDR process is increasingly constructive for high-volume, high-success providers such as NUTX. The May 2026 IDR Operations Final Rule confirms that arbitration has moved beyond its contested formative phase, during which Texas Medical Association litigation and repeated portal suspensions raised questions about the system's durability, and into a phase of administrative institutionalization that establishes the channel as a permanent feature of out-of-network reimbursement. CMS has signaled an intent to complete the buildout by 2028, which would provide a multiyear window of regulatory stability.

Four changes stand out. First, the CMS administrative fee falls from $115 to $15 per party per dispute, a sharp reduction that lowers the cost of starting each dispute (the $115 fee was a modest component of total arbitration cost, typically a few percentage points). Second, batching expands to as many as 50 line items per dispute from 25, allowing more efficient submission of similar claims, though not every claim batches, and grouping still depends on matching service codes across comparable cases. Third, and in our view most consequential for filing discipline, insurers are now required to include remittance advice and claim adjustment reason codes on their explanations of benefits that identify eligibility; previously, roughly three-quarters of remittances lacked the codes needed to determine eligibility cleanly, and NUTX's historical ineligibility rate (approximately 8%) already ran well below an industry average near 19%. Better up-front eligibility data should reduce wasted submissions and improve the quality of what gets filed, a clear tailwind for a disciplined filer. Fourth, CMS is establishing a centralized electronic portal to replace today's email-based communication, materially streamlining negotiations and case tracking.

For NUTX, these reforms reduce per-dispute friction, allow a larger share of underpaid claims to be pursued cost-effectively, and most importantly improve eligible-claim rates and the conversion of favorable determinations into collected cash. We also expect these reforms to intensify pressure on payers over time. As the process becomes faster, cheaper, and more predictable for providers who consistently prevail, the recurring cost of losing arbitration strengthens the rationale for payers to bring high-win-rate operators such as NUTX in-network on negotiated terms. Management is actively evaluating in-network contracts, assessing each against its IDR outcomes, and reports modestly better payer offers; the pace of any such migration will vary by payer, but the direction of both regulatory and commercial incentives increasingly favors providers at NUTX's scale. We keep this in-network migration in the bull column rather than treating it as a risk: In-network conversion at fair rates would likely trade some potential upside for greater recurring stability, a favorable exchange for the franchise, in our opinion.

On the legislative front, a bipartisan group has separately advanced the No Surprises Act Enforcement Act (the Murphy bill), which would raise penalties on insurers for non-payment and enhance enforcement and reporting. If enacted, we would view it as a positive catalyst for participating providers, but the bills remain early in committee, and we treat enactment as a potential upside tail rather than a base-case driver. A separate proposal under discussion would extend a loser-pays principle to the CMS administrative fee (the arbitration fee is already recoverable by the winning party); even if adopted, the dramatically lower $15 fee makes that change far less punitive than it would have been previously, and a broader loser-pays-all regime would likely require congressional action.

Revenue Recognition and Cash Collection

NUTX accrues IDR revenue conservatively, booking revenue at roughly its observed collection rate (more than 80%) of the legal determination rather than 100% of the award; as collections improve, this accrual rate can be adjusted upward. At the same time, the company records 100% of anticipated arbitration costs. This asymmetry (full cost accrual against collection-based revenue accrual) mechanically inflates the reported arbitration cost ratio in any single period: In 1Q26, the load ran near 35% of arbitration revenue versus a steady-state expectation of 24% to 26%, which management attributes to period mix and expects to normalize over the balance of the year as realization catches up. Cash collection has been robust (net cash from operating activities of $248.1M in 2025 and $75.5M in 1Q26, up 48% Y/Y), and accounts receivables stood at $339.6M at 1Q26, reflecting the timing lag inherent in the IDR determination and collection cycle. We expect the lower fees and faster, portal-based processing under the final rule to improve the receivables conversion cycle as the platform scales.

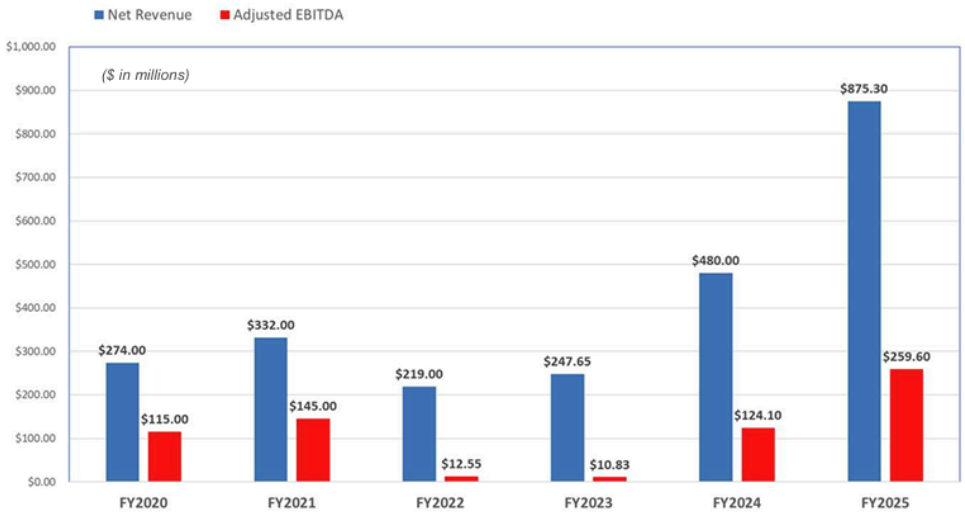
Short Seller Reports and the Bear Case

NUTX was the subject of short-seller reports in 2025 that drove meaningful share price volatility. The substantive concern relevant to our thesis is the one bearing on the revenue model: that the company's IDR-driven reimbursement is unsustainable and that the wave of insurer litigation against its arbitration vendor, HaloMD, threatens that revenue stream. The subsequent legal record has, to date, resolved that concern in providers' favor.

Federal courts have dismissed the lead insurer cases on the merits in a string of consecutive rulings, including the Central District of California's April 9, 2026, dismissal of the Anthem case and the Eastern District of Texas's May 27, 2026, dismissal of *BCBS Texas v. HaloMD*, both with prejudice, alongside companion dismissals in the Middle District of Florida and the Eastern District of Pennsylvania. The common holding is that the No Surprises Act forecloses collateral judicial attacks on IDR eligibility and award determinations. Because the finality of IDR awards is statutory, the credible reform vector is administrative rulemaking rather than the courts, and rulemaking to date, including the May 2026 operations rule, has been neutral to favorable. The matter is not fully closed: The lead insurer has appealed the California dismissal to the Ninth Circuit, and at least one insurer suit remains pending, but the template now strongly favors the defense.

The structure of NUTX's arbitration program also keeps the company a step removed from this litigation. NUTX has not been named as a defendant in any of the insurer suits, each of which targets HaloMD and, in some jurisdictions, affiliated provider groups rather than the hospital operators whose claims were submitted. Because NUTX engages HaloMD as its IDR vendor while retaining in-house control over which claims to submit, the vendor stands as the operational and legal counterparty to the payers, so insurers seeking to attack the arbitration strategy must direct their claims at HaloMD and not at NUTX directly. We do not characterize the buffer as absolute because HaloMD-affiliated providers have been named as co-defendants in at least one case, and NUTX retains economic exposure to the vendor's continued operation, but to date, the structure has kept the company outside the payer litigation, and the underlying legal theories have failed on the merits regardless of which party was named.

NUTX Sustained Positive Adjusted EBITDA Through the Worst of the NSA Transition



Source: Company presentation

Even under a severe adverse scenario for IDR economics, the company's own history creates a downside boundary, in our view. As shown above, NUTX sustained positive adjusted EBITDA through 2022 and 2023, during the depth of the surprise billing disruption and a period that predated a functioning IDR process. Today's platform is larger and operationally more mature, with rebuilt coding, billing, and collection processes and a broader hospital base, which implies a higher profitability floor than the trough that the company already cleared. We do not minimize the revenue concentration, but the relevant question for franchise value is, in our opinion, the ex-IDR floor, and that floor sits above where it was in the last downturn.

Financial Analysis

Full-Year 2025 Results

NUTX reported 2025 revenue of $875.3M, up 82.4% Y/Y from $479.9M, with net income attributable to NUTX of $70.8M (diluted EPS of $10.48) including $117.0M of non-cash stock-based compensation expense, and adjusted EBITDA of $259.6M, up 152.6% from $102.8M. Net cash from operating activities was $248.1M. The year's results were materially elevated by IDR collections recognized during 2025 that related to claims originating in 2024, a catch-up dynamic as the arbitration program scaled; this is the central reason why 2025 is not a clean run-rate base. Fourth-quarter revenue of $151.7M was depressed by a roughly $55M one-time reconciliation that swept approximately 18,950 cumulative ineligible claims spanning roughly 18 months into a single quarter; stripping that item out, underlying 4Q activity was broadly consistent with the rest of the year. Management has been explicit that investors should view 2025 as a full-year story rather than extrapolate the noisy fourth quarter.

First-Quarter 2026 Results

First-quarter 2026 total revenue was $216.5M, up 2.2% Y/Y, with hospital division revenue of $207.6M (up 1.8%) and PHM revenue of $8.9M (up roughly 14%). Same-hospital revenue rose just 0.2% and same-hospital visits 0.6%, while total hospital visits increased 3.1% to 49,742; management attributed the muted comparison to a milder flu season versus 1Q25 and to two of three recent openings coming on line in late December 2025 and one in January 2026, all still ramping. Net income attributable to NUTX was $46.8M (diluted EPS of $6.52) versus $21.2M a year earlier. Adjusted EBITDA was $57.6M, down 21% from $72.8M, driven by the timing of IDR cost recognition: The arbitration cost load ran near 35% of arbitration revenue in the quarter (against a 24% to 26% steady state) because the company records 100% of anticipated costs while accruing revenue at its collection rate. Operating income was essentially flat at $81.3M. The balance sheet strengthened, with cash of $207.3M (up from $185.6M at year-end 2025), long-term debt of $24.3M (down from $29.2M at year-end 2025), and total debt of $41.1M. The company completed its inaugural $25M buyback (retiring approximately 119,000 shares) and initiated a second $25M program during the quarter.

Outlook: A Flat-Revenue, Lower-EBITDA Reset in 2026

We expect 2026 to be a transition year on the optics. We forecast revenue to be roughly flat against 2025 and adjusted EBITDA to decline Y/Y. Both reflect the same cause: The 2024-origin arbitration collections that inflated 2025 do not recur, and reimbursement economics have stabilized since the third and early fourth quarters of 2025, so a Y/Y comparison can look like it moves slightly backward even as the underlying business is healthy. GAAP net income and diluted EPS move sharply the other way, with EPS roughly doubling, but this too is a normalization rather than an operational inflection: 2025 GAAP earnings were artificially depressed by an abnormal $117M of noncash stock-based compensation (driven by share-price appreciation and physician facility earnouts), and that charge falls to well under $10M in 2026 as the earnouts substantially conclude. We therefore caution against reading the EPS jump as a fundamental step-change; it primarily reflects the SBC distortion clearing, and adjusted EBITDA remains the cleaner read on the year because it is neutral to that swing. Underneath the reset, newer-vintage hospitals continue to ramp, mature same-hospital growth continues in the low single digits, and the cost structure is increasingly repeatable, supporting a return toward the company's historical margin profile as the fleet seasons. We view 2026 as the trough year for the Y/Y growth optics and 2027 and beyond as a reacceleration driven primarily by unit additions and margin expansion rather than by further IDR step-ups.

Peer Group Analysis

No pure-play public comparable exists for an out-of-network micro-hospital operator, so we construct our peer group from facility-based healthcare services companies. We believe the companies below represent NUTX's peer group.

NUTX Comp Table

($M, except price and per share items)				Sales		EBITDA		EPS		Sales Growth		EBITDA Growth		EBITDA Margin		EV/EBITDA		P/E	
Ticker	Company Name	Price	Enterprise Value	2026E	2027E	2026E	2027E	2026E	2027E	2026E	2027E	2026E	2027E	2026E	2027E	2026E	2027E	2026E	2027E
	Peer Group																		
RDNT	RadNet, Inc.	58.16	5,961	2,492	2,770	356	417	0.52	0.94	22%	11%	18%	17%	14%	15%	16.8x	14.3x		
HCA	HCA Healthcare Inc	387.76	136,668	78,561	82,276	15,938	16,734	30.22	33.18	4%	5%	2%	5%	20%	20%	8.6x	8.2x	12.8x	11.7x
ACHC	Acadia Healthcare Company, Inc.	24.96	4,779	3,409	3,614	599	641	1.51	1.75	3%	6%		7%	18%	18%	8.0x	7.5x	16.6x	14.3x
ARDT	Ardent Health, Inc.	9.40	3,009	6,542	6,841	509	534	1.12	1.28	3%	5%		5%	8%	8%	5.9x	5.6x	8.4x	7.3x
SEM	Select Medical Holdings Corporation	16.57	5,020	5,695	5,941	524	560	1.22	1.34	4%	4%	6%	7%	9%	9%	9.6x	9.0x	13.6x	12.4x
EHC	Encompass Health Corporation	102.25	12,875	6,422	6,944	1,370	1,477	6.01	6.54	8%	8%	8%	8%	21%	21%	9.4x	8.7x	17.0x	15.6x
BTSG	BrightSpring Health Services, Inc.	67.61	16,774	15,064	17,114	815	949	1.69	2.12	17%	14%	32%	17%	5%	6%				
	Min									3%	4%	2%	5%	5%	6%	5.9x	5.6x	8.4x	7.3x
	Mean									9%	8%	13%	9%	14%	14%	9.7x	8.9x	13.7x	12.3x
	Median									4%	6%	8%	7%	14%	15%	9.0x	8.4x	13.6x	12.4x
	Max									22%	14%	32%	17%	21%	21%	16.8x	14.3x	17.0x	15.6x
NUTX	Nutex Health Inc	147.54	890	876	957	225	258	22.72	24.14	0%	9%	-13%	15%	26%	27%	3.9x	3.4x	6.5x	6.1x

Source: FactSet, company filings, and B. Riley Securities Research

Valuation

Our $290 price target is based on a 7.7x EV/EBITDA multiple or 12.0x P/E multiple applied to our 2027 EBITDA and EPS estimates of $258.4M and $24.14, respectively. NUTX screens with above-average sales growth, EBITDA growth, and margins relative to its peer group, which trades at an average of 8.8x EV/EBITDA and 12.3x P/E on 2027 estimates. We continue to ascribe a slight discount to peers given the limited investor familiarity with the Federal IDR process and NUTX's less conventional revenue model than its contracted in-network peers.

Price Target Calculation

PT Calculation (EV/EBITDA Methodology)	
EV/EBITDA Multiple	**7.7x**
2027 EBITDA Estimate	$258.4
Implied EV	$1,976.5
Cash	$210.6
Debt	$41.0
Implied Equity Value	$2,146.2
Fully Diluted Share Count	7.4
PT	**$290**

PT Calculation (P/E)	
PE Ratio	**12.0x**
FY27 EPS Estimate	$24.14
Implied Share Price	**$290**

Current Price	147.54
Potential Upside	97%

Current Price	$147.54
Potential Upside	97%

$ in millions except per share data.

Source: B. Riley Securities Research

Management Team and Board of Directors[1]

Thomas T. Vo, M.D., chief executive officer, and chairman of the board of Nutex Health Inc. Dr. Vo was appointed CEO on April 1, 2022, and elected chairman effective the same date. Dr. Vo founded Nutex Health's affiliated entities and has served as an executive officer of those affiliates since 2010. He was a founder and original partner of Neighbors Emergency Center from 2008 to 2011. From 2008 onward, Dr. Vo has been involved in the opening of more than 40 freestanding emergency departments and micro-hospitals. He previously practiced emergency medicine in Houston, Texas, for over 20 years. Dr. Vo holds a B.S. in life sciences from Kent State University, an M.D. from Northeast Ohio University's College of Medicine, and an M.B.A. (2004) from Rice University.

Warren Hosseinion, M.D., president and director of Nutex Health Inc. and nonexecutive chairman of Cardio Diagnostics Holdings, Inc. Dr. Hosseinion has served as president and a director of Nutex since April 2022. From February 2021 to April 2022, he was CEO of Clinigence Holdings, Inc. (Nutex's predecessor public entity). From April 2019 to April 2022, he was CEO and chairman of Clinigence Holdings, Inc. Dr. Hosseinion co-founded ApolloMed Hospitalists in 2001. He is a co-founder of Apollo Medical Holdings, Inc., where he served on the board from July 2008 to March 2019, as CEO from July 2008 to December 2017, and as co-CEO from December 2017 to March 2019. He has served as nonexecutive chairman of Cardio Diagnostics Holdings, Inc. since October 2022. He holds a B.S. in biology from the University of San Francisco, an M.S. in physiology and biophysics from Georgetown University Graduate School of Arts and Sciences, and an M.D. from Georgetown University School of Medicine. He completed his internal medicine residency at the Los Angeles County–USC Medical Center.

Jon C Bates, CPA, chief financial officer. Mr. Bates was appointed CFO effective June 30, 2022. From 2006 to June 2022, he was vice president of accounting/corporate controller at U.S. Physical Therapy, Inc. He previously served as CFO and chief accounting officer of Commerciant, L.P., chief accounting officer/corporate controller of National Alarm Technologies LLC, assistant corporate controller at American Residential Services, Inc., and senior auditor at Arthur Andersen LLP. Mr. Bates is a certified public accountant and holds a B.B.A. from the University of Texas at Austin and an M.B.A. from the University of Houston.

Wesley Bamburg, FACHE, chief operating officer. Mr. Bamburg was appointed COO effective October 13, 2025. From July 2024 until his appointment, he served as COO of HCA Houston Healthcare North Cypress. From 2019 to 2024, he was COO of HCA Houston Healthcare Medical Center. He joined HCA Healthcare in 2013 as vice president of payor contracting & alignment for the Gulf Coast division. He holds a B.S. in healthcare administration from Southwestern Oklahoma State University and an M.B.A. from Oklahoma City University. Mr. Bamburg is board-certified in healthcare management and a Fellow of the American College of Healthcare Executives (FACHE).

Michael Chang, M.D., chief medical officer. Dr. Chang was appointed CMO effective April 1, 2022. He founded Tyvan LLC, a medical billing company, in 2012 and served as its principal until it became a wholly owned subsidiary of the company through the April 2022 merger. With Dr. Vo, he co-founded Neighbors Emergency Center in 2008 and served as executive director of practice management and chairman of the board. He is founder and medical director of Hope Restored, a medical detox and rehabilitation program operated within SE Texas Hospital, a Nutex subsidiary. In 2018, he founded Synergy Wellness.

Pamela W. Montgomery, J.D., LL.M., RN, chief legal officer (healthcare) and secretary. Ms. Montgomery was appointed chief legal officer (healthcare) effective April 1, 2022. She began her career as a nurse at Texas Children's Hospital and St. Luke's Hospital in the Texas Medical Center before moving into law, practicing for a decade as a sole practitioner in family, corporate, personal injury, and medical malpractice law and then for a decade as a supervising shareholder at a Houston defense firm, where she represented physicians and healthcare facilities in malpractice, contract, real estate, and regulatory matters. She has also served as an adjunct professor at the Texas Woman's University School of Nursing. She holds a B.S.N. from the University of Texas, an M.S.N. from Texas Woman's University, a J.D. from South Texas College of Law, and an LL.M. in Health Law from the University of Houston Law Center.

Elisa Luqman, J.D., chief legal officer (SEC) and secretary. Ms. Luqman was appointed chief legal officer (SEC) effective April 1, 2022. From October 2019 she served as chief financial officer and general counsel of Clinigence Holdings (NUTX's predecessor public entity), overseeing its accounting and SEC filings, and she previously served as CFO and general counsel of iGambit Inc. from 2009, responsible for its SEC and FINRA filings and public company compliance through the 2019 reverse merger with Clinigence. Earlier, she co-founded Big Vault Storage Technologies (acquired by Digi-Data Corporation in 2006) and served as COO and later general counsel of Digi-Data's Vault Services Division. She holds a B.A., a J.D., and an M.B.A. in finance from Hofstra University and is a member of the New York and New Jersey bars.

[1] *Source: Company reports*

Cheryl Grenas, RN, director of Nutex Health Inc. and chief nursing officer of Behavioral Hospital of Bellaire. Ms. Grenas has served as a director since April 1, 2022. Since March 2018, she has served as chief nursing officer at Behavioral Hospital of Bellaire. From July 2017 to March 2018, she was a consultant to freestanding emergency departments in the Houston area. From August 2015 to July 2017, she was regional facility director at Neighbors Emergency Center. Ms. Grenas served 20 years in the U.S. Navy, retiring at the rank of Lieutenant Commander, with deployments supporting Operation Iraqi Freedom (2005) and Operation Enduring Freedom (2011). She holds a B.S.N. and an MSN from Prairie View A&M University.

Michael L Reed, MPH, director of Nutex Health Inc. Mr. Reed has served as a director since April 1, 2022. Since January 2018, he has been an independent consultant in emergency medicine, hospitalist medicine, hospital operations, risk-based payor contracts, value-based care, and physician practice operations. From January 2019 to January 2020, he was senior vice president, business development and strategic partnerships at The Oncology Institute. From April 2018 to December 2018, he was CEO of Turtle Peak Customer Service, LLC. He has served as senior advisor to NueHealth, LLC since August 2017. From July 2009 to October 2013, he was president and CEO of Team Health Hospital Medicine, a division of TeamHealth (acquired by Blackstone in 2017). From December 2001 to November 2004, he was COO of Pinnacle Health System. He holds a B.S. in health services management from California State University and an MPH from UCLA.

Scott J. Saunders, MPPM, director of Nutex Health Inc. and managing director and head of healthcare advisory services at Farlie Turner Gilbert & Co., LLC. Mr. Saunders has served as a director since April 11, 2024. Since 2006, he has served as managing director and head of healthcare advisory services at Farlie Turner Gilbert & Co., LLC, a middle-market investment bank in Fort Lauderdale, Florida. He has advised middle-market companies since 1992, primarily in healthcare, as well as in media and communications, business services, industrial, and consumer products. He has been a guest lecturer at the University of Florida, Florida International University, and the University of Miami. He holds a B.A. from Wesleyan University and an MPPM (now designated M.B.A.) from the Yale University School of Management.

Frank E. Jaumot, CPA, director of Nutex Health Inc. and director of accounting and auditing at Ahearn Jasco & Company, P.A. Mr. Jaumot has served as a director since July 14, 2025. Since 1991, he has served as director of accounting and auditing at the certified public accounting firm Ahearn, Jasco & Company, P.A., where he is a shareholder. From 1979 to 1991, he was with Deloitte & Touche LLP. He served as a director of Bimini Capital Management, Inc. from 2009 through November 2025 and as a director of MasTec, Inc. from September 2004 to May 2016, including as audit committee chair from 2007 to 2016. He served on the boards and as audit committee chair of Vapor Corp. from 2014 to 2015 and Protective Products of America, Inc. from 2009 to 2010. The NUTX board has determined Mr. Jaumot is an “audit committee financial expert” under SEC rules. Mr. Jaumot is a certified public accountant licensed in Ohio (1981) and Florida (1985). He holds a B.S. in accounting (cum laude) from Marquette University.

Kelvin Spears, M.D., director of Nutex Health Inc. and physician partner, chief medical director & emergency department director at Alexandria Emergency Hospital. Dr. Spears has served as a director since April 1, 2024. Since 2017, he has served as physician partner, chief medical director, and emergency department director at Alexandria Emergency Hospital in Alexandria, Louisiana. He also serves as EMS medical director for the Alexandria Fire Department, Pineville Fire Department, Cotile Fire Department, Central Louisiana Bureau EMS, Kisatchie Forest/U.S. Forest Service, and Rapides Parish School. From 2014 to 2017, he was emergency department director at CHRISTUS St. Frances Cabrini Hospital in Alexandria, Louisiana. Dr. Spears is board certified in emergency medicine by the American Board of Emergency Medicine and a Fellow of the American College of Emergency Physicians. He holds a B.S. in chemistry from Dillard University and an M.D. from Meharry Medical College and completed an emergency medicine residency and a critical care fellowship at Charles R. Drew University of Medicine and Science in Los Angeles.

Income Statement—Nutex Health Inc. (NUTX)

Nutex Health Inc. (NUTX)

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Income Statement ($ Millions)	2023A	2024A	2025A	1Q26A	2Q26E	3Q26E	4Q26E	2026E	1Q27E	2Q27E	3Q27E	4Q27E	2027E
Revenue	**247.6**	**479.9**	**875.3**	**216.5**	**215.2**	**220.0**	**224.8**	**876.5**	**229.8**	**235.6**	**242.8**	**249.3**	**957.4**
growth y/y	12.9%	93.8%	82.4%	2.2%	(11.8%)	(17.9%)	48.2%	0.1%	6.2%	9.5%	10.3%	10.9%	9.2%
Operating costs and expenses													
Payroll	108.4	117.5	158.1	41.4	42.0	43.5	45.0	171.8	50.6	51.8	53.4	54.8	210.6
Contract services	42.3	100.8	190.3	60.5	60.3	61.6	62.9	245.3	66.6	68.3	70.4	72.3	277.7
Medical supplies	14.2	15.3	17.2	4.0	4.3	4.4	4.5	17.2	4.6	4.7	4.9	5.0	19.1
Depreciation and amortization	17.6	19.0	20.5	5.5	5.4	5.5	5.6	22.0	5.7	5.9	6.1	6.2	23.9
Other	30.4	31.1	44.8	13.3	12.9	13.2	13.5	52.9	13.8	14.1	14.6	15.0	57.4
Total operating costs and expenses	212.9	283.7	431.0	124.8	124.8	128.2	131.5	509.2	141.3	144.9	149.3	153.3	588.8
Gross Profit	**34.8**	**196.3**	**444.3**	**91.7**	**90.4**	**91.9**	**93.3**	**367.3**	**88.5**	**90.7**	**93.5**	**96.0**	**368.6**
Corporate and other costs													
Stock-based compensation	2.8	16.6	117.0	(3.9)	3.2	3.3	3.4	6.0	3.4	3.5	3.6	3.7	14.4
Impairment of assets	29.1	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment of goodwill	1.1	3.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
General and administrative	33.2	41.9	51.7	14.4	14.4	14.7	15.1	58.6	15.2	15.5	16.0	16.5	63.2
Total corporate and other costs	66.5	65.6	168.7	10.5	17.6	18.0	18.4	64.6	18.6	19.1	19.7	20.2	77.6
Income (Loss) from Operations	**(31.8)**	**130.7**	**275.6**	**81.3**	**72.7**	**73.8**	**74.8**	**302.7**	**69.9**	**71.6**	**73.8**	**75.8**	**291.1**
Interest expense, net	16.3	19.9	22.2	4.7	4.5	4.5	4.3	18.0	4.0	4.0	4.0	4.0	16.0
Gain on warranty liability	0.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other (income) expense	0.4	(0.7)	8.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pre-Tax Income	(48.5)	109.8	244.8	76.6	68.2	69.3	70.5	284.7	73.9	75.6	77.8	79.8	307.1
Income Taxes	(5.1)	15.0	64.4	13.8	12.3	12.5	12.7	51.3	14.8	15.1	15.6	16.0	61.4
Net Income	**(43.4)**	**94.8**	**180.4**	**62.8**	**55.9**	**56.8**	**57.9**	**233.4**	**59.1**	**60.5**	**62.2**	**63.8**	**245.6**
Net income (loss) attributable to noncontrolling interests	2.4	42.7	109.6	16.0	18.0	18.0	17.0	69.0	17.0	17.0	17.0	16.0	67.0
Net income (loss) attributable to Nutex Health Inc.	**(45.8)**	**52.1**	**70.8**	**46.8**	**37.9**	**38.8**	**40.9**	**164.5**	**42.1**	**43.5**	**45.2**	**47.8**	**178.6**
EPS - Basic	(10.39)	10.23	11.13	6.70	5.40	5.49	5.75	23.33	5.89	6.05	6.26	6.58	24.78
EPS - Diluted	**(10.39)**	**9.69**	**10.48**	**6.52**	**5.26**	**5.35**	**5.60**	**22.72**	**5.74**	**5.89**	**6.10**	**6.41**	**24.14**
Shares Outstanding - Basic (M)	4.408	5.091	6.361	6.990	7.030	7.070	7.110	7.050	7.150	7.190	7.230	7.270	7.210
Shares Outstanding - Diluted (M)	**4.408**	**5.492**	**6.756**	**7.179**	**7.219**	**7.259**	**7.299**	**7.239**	**7.339**	**7.379**	**7.419**	**7.459**	**7.399**

Adjusted EBITDA													
Net Income	(45.8)	52.1	70.8	46.8	37.9	38.8	40.9	164.5	42.1	43.5	45.2	47.8	178.6
Interest	16.3	19.9	22.2	4.7	4.5	4.5	4.3	18.0	4.0	4.0	4.0	4.0	16.0
Tax	(5.1)	15.0	64.4	13.8	12.3	12.5	12.7	51.3	14.8	15.1	15.6	16.0	61.4
Depreciation and amortization	17.6	19.0	20.5	5.5	5.4	5.5	5.6	22.0	5.7	5.9	6.1	6.2	23.9
Allocation to noncontrolling interests	(5.5)	(7.2)	(9.4)	(2.5)	(2.5)	(2.5)	(2.5)	(9.9)	(2.4)	(2.5)	(2.5)	(2.6)	(10.0)
EBITDA	(22.5)	98.8	168.6	68.3	57.6	58.8	61.0	245.8	64.2	66.0	68.4	71.4	270.0
Stock-based compensation	2.8	16.6	117.0	(3.9)	3.2	3.3	3.4	6.0	3.4	3.5	3.6	3.7	14.4
Finance lease paybacks	0.0	(21.3)	(26.0)	(6.8)	(6.5)	(6.5)	(6.5)	(26.3)	(6.5)	(6.5)	(6.5)	(6.5)	(26.0)
Facility closing costs	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Acquisition costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Loss on warranty liability	0.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment of assets	29.1	3.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Impairment of goodwill	1.1	3.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
								0.0					0.0
Adjusted EBITDA	**10.8**	**102.8**	**259.6**	**57.6**	**54.4**	**55.6**	**57.9**	**225.4**	**61.1**	**63.1**	**65.5**	**68.7**	**258.4**
Adjusted EBITDA margin	4.4%	21.4%	29.7%	26.6%	25.3%	25.3%	25.7%	25.7%	26.6%	26.8%	27.0%	27.6%	27.0%

Proprietary to B. Riley Securities June 25, 2026

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Source: Company reports and B. Riley Securities Research

Balance Sheet—Nutex Health Inc. (NUTX)

Nutex Health Inc. (NUTX)													Anderson Schock (646) 885-5430 aschock@brileysecurities.com
Balance Sheet ($Millions)	**2023A**	**2024A**	**2025A**	**1Q26A**	**2Q26E**	**3Q26E**	**4Q26E**	**2026E**	**1Q27E**	**2Q27E**	**3Q27E**	**4Q27E**	**2027E**
Assets													
Cash & Cash Equivalents	22.0	40.6	185.6	207.3	245.1	280.8	317.5	317.5	339.3	362.6	387.6	414.1	414.1
Restricted cash	0.0	0.0	0.3	3.3	2.7	2.1	1.5	1.5	1.6	1.8	1.9	2.0	2.0
Restricted short-term investments	0.0	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Accounts receivable	58.6	232.4	319.4	339.6	342.9	346.2	349.4	349.4	355.7	361.9	368.2	374.4	374.4
Accounts receivable - related parties	4.2	3.6	6.0	6.3	7.9	9.4	11.0	11.0	11.7	12.5	13.2	14.0	14.0
Inventories	3.4	2.9	2.9	4.7	4.7	4.8	4.9	4.9	5.4	5.9	6.4	6.9	6.9
Income tax receivable	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Prepaid expenses and other current assets	2.7	10.0	24.7	18.4	21.5	24.6	27.7	27.7	28.4	29.2	29.9	30.7	30.7
Total Current Assets	**$90.8**	**$292.5**	**$538.8**	**$579.6**	**$624.8**	**$667.9**	**$711.9**	**$711.9**	**$742.2**	**$773.8**	**$807.1**	**$842.1**	**$842.1**
Property and equipment, net	81.4	77.9	94.6	94.9	98.2	101.4	104.6	104.6	127.3	150.1	172.8	195.6	195.6
Operating lease right-of-use	11.9	27.9	27.0	26.6	25.0	23.5	22.0	22.0	20.7	19.5	18.2	17.0	17.0
Financings lease right-of-use	176.1	218.9	222.4	220.7	217.9	215.1	212.4	212.4	209.4	206.4	203.4	200.4	200.4
Intangible assets	20.5	15.5	21.2	20.9	20.7	20.5	20.2	20.2	20.0	19.7	19.5	19.2	19.2
Goodwill	17.1	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9	13.9
Deferred tax assets	0.0	8.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other assets	0.4	0.7	0.7	0.7	0.8	1.0	1.2	1.2	1.3	1.4	1.5	1.7	1.7
Total Non-Current Assets	**$307.4**	**$362.8**	**$379.7**	**$377.7**	**$376.5**	**$375.4**	**$374.2**	**$374.2**	**$392.6**	**$411.0**	**$429.4**	**$447.7**	**$447.7**
Total Assets	**$398.2**	**$655.3**	**$918.5**	**$957.3**	**$1,001.3**	**$1,043.2**	**$1,086.1**	**$1,086.1**	**$1,134.8**	**$1,184.7**	**$1,236.5**	**$1,289.8**	**$1,289.8**
Liabilities & Shareholders' Equity													
Accounts Payable	18.9	9.6	45.9	46.5	49.6	52.7	55.9	55.9	57.9	59.9	61.9	63.9	63.9
Accounts Payable - related parties	6.4	0.8	3.1	3.9	4.3	4.7	5.1	5.1	5.4	5.6	5.9	6.1	6.1
Lines of credit	3.4	3.6	0.7	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Current portion of long-term debt	10.8	14.4	13.3	16.7	15.5	14.2	13.0	13.0	13.0	13.0	13.0	13.0	13.0
Operating lease liabilities	1.6	2.1	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2
Financing lease liabilities	4.3	7.7	7.1	7.4	7.3	7.2	7.1	7.1	7.1	7.1	7.1	7.1	7.1
Accrued arbitration expenses	0.0	47.7	49.7	56.8	52.8	48.8	44.7	44.7	44.7	44.7	44.7	44.7	44.7
Accrued income tax expense	0.0	26.5	0.9	15.6	12.4	9.1	5.9	5.9	6.6	7.4	8.1	8.9	8.9
Accrued stock-based compensation	0.0	16.4	8.3	2.7	4.6	6.4	8.3	8.3	9.8	11.3	12.8	14.3	14.3
Accrued expenses and other current liabilities	13.0	25.4	26.8	32.5	35.6	38.7	41.8	41.8	44.3	46.8	49.3	51.8	51.8
Total Current Liabilities	**$58.3**	**$154.2**	**$157.9**	**$184.4**	**$184.2**	**$184.0**	**$183.8**	**$183.8**	**$190.8**	**$197.8**	**$204.8**	**$211.8**	**$211.8**
Long-term debt	26.3	22.5	29.2	24.3	22.6	20.9	19.2	19.2	16.7	14.2	11.7	9.2	9.2
Non-current operating lease liabilities	15.5	30.6	30.0	29.6	28.8	27.9	27.0	27.0	26.3	25.5	24.8	24.0	24.0
Non-current financing lease liabilities	213.9	259.5	268.9	268.8	268.8	268.9	268.9	268.9	268.9	268.9	268.9	268.9	268.9
Deferred tax liabilities	5.1	0.0	9.1	8.2	7.8	7.5	7.1	7.1	6.6	6.1	5.6	5.1	5.1
Total Non-Current Liabilities	**$260.8**	**$312.6**	**$337.2**	**$330.8**	**$327.9**	**$325.1**	**$322.2**	**$322.2**	**$318.4**	**$314.7**	**$310.9**	**$307.2**	**$307.2**
Total Liabilities	**$319.1**	**$466.8**	**$495.1**	**$515.3**	**$512.2**	**$509.1**	**$506.0**	**$506.0**	**$509.3**	**$512.5**	**$515.8**	**$519.0**	**$519.0**
Shareholders' Equity	79.1	188.5	423.4	442.1	489.2	534.1	580.1	580.1	625.5	672.2	720.7	770.8	770.8
Total Liabilities & Shareholders' Equity	**$398.2**	**$655.3**	**$918.5**	**$957.3**	**$1,001.3**	**$1,043.2**	**$1,086.1**	**$1,086.1**	**$1,134.8**	**$1,184.7**	**$1,236.5**	**$1,289.8**	**$1,289.8**

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Valuation

We base our $290 price target on a 7.7x EV/EBITDA multiple or 12.0x P/E multiple applied to our 2027 EBITDA and EPS estimates of $258.4M and $24.14, respectively. We believe this multiple is appropriate given NUTX's above-average sales and EBITDA growth and margin profile for 2027, with peers trading at an average of 8.8x EV/EBITDA and 12.2x P/E on 2027 estimates.

Risks

Reimbursement and regulatory risk. The model depends on out-of-network reimbursement set through the Federal IDR process; adverse CMS rulemaking on eligibility, batching, or QPA methodology (the most credible disruption vector, in our view) could compress award levels, win rates, or the share of claims eligible for arbitration, and win rates and award multiples could normalize lower over time.

Litigation risk. Although NUTX is not a named defendant and the lead insurer suits against HaloMD have been dismissed, an adverse Ninth Circuit ruling or new litigation could pressure the arbitration channel or the company's vendor relationship.

Revenue concentration and visibility. A large share of profitability is tied to arbitration-derived reimbursement, which is structurally lumpy; quarterly results can be volatile and difficult to forecast, as the 2025-to-2026 reset illustrates.

Execution and financing risk. The capital-light thesis assumes NUTX can develop facilities on time and on budget and execute sale-leasebacks on attractive terms. Delays, cost overruns, weaker REIT market conditions, or higher financing costs would slow the capital recycling flywheel and pressure the balance sheet during the transition.

Governance and key person risk. The existing PropCo structure involves related-party leases (the contemplated institutional sale-leaseback would address this but is not finalized), and leadership and founder influence are concentrated in CEO Dr. Tom Vo.

*Closing price of last trading day immediately prior to the date of this publication unless otherwise indicated.

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(1) As of midnight on the business day immediately prior to the date of this publication.

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