ENSIGN GROUP, INC
Form 10-K
February 09, 2015
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2014

o 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.)

27101 Puerta Real, Suite 450
Mission Viejo, CA 92691
(Address of Principal Executive Offices and Zip Code)
(949) 487-9500
(Registrant's Telephone Number, Including Area Code)
N/A
(Former Name, Former Address and Former Fiscal Year, If Changed Since Last Report)

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	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. x Yes o No
Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. o Yes x No
Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. x Yes o No
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted 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 and post such files). x Yes o No
Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, or a smaller reporting company. See the definitions of “large accelerated filer”, “accelerated filer” and “smaller reporting company” in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer o	Accelerated filer x	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company o

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). o Yes x No

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant, computed by reference to the closing price as of the last business day of the registrant's most recently completed second fiscal quarter, June 30, 2014, was approximately $623,416,000.

As of February 5, 2015, 22,616,050 shares of the registrant’s common stock 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 2015 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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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 negatives of these words. These statements are subject to the safe harbors created under the Securities Act of 1933 (Security Act) and the Securities Exchange Act of 1934 (Exchange Act). 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, 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 affiliated facilities, operating subsidiaries, the Service Center (defined below) and our wholly-owned captive insurance subsidiary (the Captive) are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of “we”, “us”, “our” and similar terms in this Annual Report is not meant to imply that any of our affiliated facilities, operating subsidiaries, the Service Center or the Captive are operated by the same entity.

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 operating subsidiaries through contractual relationships with such subsidiaries. In addition, our wholly-owned captive insurance subsidiary, which we refer to as the Captive, provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as for certain workers' compensation insurance liabilities.

We were incorporated in 1999 in Delaware. The Service Center address is 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691, 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.

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

Company Overview

We, through our operating subsidiaries, are a provider of skilled nursing, rehabilitative care services, home health, home care, hospice care, assisted living and urgent care services. As of December 31, 2014, we operated 136 facilities, twelve home health and eleven hospice operations, one home care business, one transitional care management company, fourteen urgent care centers and a mobile x-ray and diagnostic company, located in Arizona, California, Colorado, Idaho, Iowa, Oregon, Nebraska, Nevada, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of healthcare services, including skilled nursing, assisted living, home health and hospice, mobile ancillary, and urgent care services.

Our organizational structure is centered upon local leadership. We believe our organizational structure, which empowers leaders and staff at the local level, is unique within the healthcare services industry. Each of our operations is led by highly dedicated individuals who are responsible for key operational decisions at their operations. Leaders and staff are trained and motivated to pursue superior clinical outcomes, high patient and family satisfaction, operating efficiencies and financial performance at their operations.

We encourage and empower our leaders and staff to make their operation the “operation of choice” in the community it serves. This means that our leaders and staff are generally authorized 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 that particular community or market. We believe that our localized approach encourages prospective customers and referral sources to choose or recommend the operation. In addition, our leaders are enabled and motivated to share real-time operating data and otherwise benchmark clinical and operational performance against their peers in order to improve clinical care, enhance patient satisfaction and augment operational efficiencies, promoting the sharing of best practices.

We view healthcare services primarily as a local business, influenced by personal relationships and community reputation. We believe our success is largely dependent upon our ability to build strong relationships with key stakeholders from the local healthcare community, based upon a solid foundation of reliably superior care. Accordingly, our brand strategy is focused on encouraging the leaders and staff of each operation to focus on clinical excellence, and promote their operation independently within their local community.

Much of our historical growth can be attributed to 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. 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;

•constructing new facilities in existing and new markets, and

•strategically investing in and integrating other post-acute care healthcare businesses.

Company History

Our company was formed in 1999 with the goal of establishing a new level of quality care within the skilled nursing industry. 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 operating subsidiaries, and set a new industry standard for quality skilled nursing and rehabilitative care services.

We organize our operating subsidiaries into portfolio companies, which we believe has enabled us to maintain a local, field-driven organizational structure and 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 president. These presidents, who are experienced and proven leaders that 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.

On June 1, 2014, we completed the separation of our healthcare business and our real estate business into two separate and independent publicly traded companies through the distribution of all of the outstanding shares of common stock of CareTrust REIT, Inc. (CareTrust) to Ensign stockholders on a pro rata basis (the Spin-Off). Our stockholders received one share of CareTrust common stock for each share of our common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. Prior to the Spin-Off, we transferred 97 skilled nursing, assisted and independent living facilities to CareTrust. We continue to operate 94 of these facilities under multiple, long-term, triple-net leases with CareTrust.

Beginning in the fourth quarter of 2014, we realigned our operating segments to more closely correlate with our service offerings, which coincide with the way that we measure performance and allocate resources. We have two reportable operating segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted living facilities and is the largest portion of our business; and (2) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

We also report an “all other” category that includes revenue from our urgent care centers and a mobile x-ray and diagnostic company. Our urgent care centers and mobile x-ray and diagnostic businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. The expansion of our home health and hospice business led us to separate our home health and hospice businesses into distinct reportable segment in the fourth quarter of 2014. Previously, we had a single reportable segment, healthcare services, which included providing skilled nursing, assisted living, home health and hospice, urgent care and related ancillary services. We have presented 2013 and 2012 financial information in this Annual Report on a comparative basis to conform with the current year segment presentation. 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 7, Business Segments of the Notes to Consolidated Financial Statements.

Transitional, Skilled and Assisted Living Services Segment

Skilled Nursing Operations

As of December 31, 2014, our skilled nursing companies provided skilled nursing care at 121 operations, having 12,560 operational beds, in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Texas, Utah, Wisconsin and Washington. Through our skilled nursing operations, we provide short stay patients and long stay patients with a full range of medical, nursing, rehabilitative, pharmacy and routine services, including daily dietary, social and recreational services. We generate our revenue from Medicaid, private pay, managed care and Medicare payors. In the year ended December 31, 2014, approximately 42.5% and 28.9% of our skilled nursing revenue was derived from Medicaid and Medicare programs, respectively.

Assisted and Independent Living Operations

We complement our skilled nursing care business by providing assisted and independent living services at 32 operations, of which 17 are located on the same site location as our skilled nursing care operations. As of December 31, 2014, we had 2,165 units. Our assisted living companies located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Texas, Utah and Washington, provide residential accommodations, activities, meals, security, 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. We generate revenue at these units primarily from private pay sources, with a small portion earned from Medicaid or other state-specific programs. During the year ended December 31, 2014, approximately 98.8% of our assisted and independent living revenue was derived from private pay sources.

Home Health and Hospice Services Segment

Home Health

As of December 31, 2014, we provided home health care services in California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington. Our home health care services generally consist of providing some combination of the nursing, speech, occupational and physical therapists, medical social workers and certified home health aide services. Home health care is often a cost-effective solution for patients, and can also increase their quality of life and allow them to receive quality medical care in the comfort and convenience of a familiar setting. We derive the majority of our home health revenue from Medicare and managed care. During the year ended December 31, 2014, approximately 58.7% of our home health revenue were derived from Medicare.

Hospice

As of December 31, 2014, we provided hospice care services in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. Hospice services focus on the physical, spiritual and psychosocial needs of terminally ill individuals and their families, and consists primarily of palliative and clinical care, education and counseling. We derive the majority of our hospice revenue from Medicare reimbursement. During the year ended December 31, 2014, approximately 84.5% of our hospice revenue was derived from Medicare.

Other

In addition, as of December 31, 2014, we operated 14 urgent care clinics and held 80% of the membership interest of a mobile x-ray and diagnostic company. Our urgent care centers provide daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. Our diagnostic company is a leader in providing mobile diagnostic services, including digital x-ray, ultrasound, electrocardiograms, ankle-brachial index, and phlebotomy services to people in their homes or at long-term care facilities.

Growth

We have an established track record of successful acquisitions. Much of our historical growth can be attributed to 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 operating subsidiaries while limiting our acquisitions to strategically situated properties.

In the last few years, our acquisition activity accelerated, allowing us to add 35 facilities between January 1, 2012 and December 31, 2014. From January 1, 2008 through December 31, 2014, we acquired 76 facilities, which added 7,884 operational beds to our operating subsidiaries.

During the year ended December 31, 2014, we continued to expand our operations with the addition of fifteen stand-alone skilled nursing operations, three assisted living operations, three home health agencies, four hospice agencies, one home care business, one primary care group and one transitional care management company. We also opened seven urgent care centers during 2014. The following table summarizes our growth through December 31, 2014:

	December 31,											
	2005	2006	2007	2008	2009	2010	2011	2012	2013		2014	
Cumulative number of skilled nursing, assisted and independent living operations	46	57	61	63	77	82	102	108	119	(1)	136	(1)
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	5,585	6,667	7,105	7,324	8,948	9,539	11,702	12,198	13,204	(1)	14,725	(1)
Number of home health and hospice agencies	—	—	—	—	1	3	7	10	16		23	
Number of urgent care centers	—	—	—	—	—	—	—	3	7		14	

(1) Included in 2013 operational beds/units are operational beds/units of the three independent living facilities we transferred to CareTrust as part of the Spin-Off. Prior to the Spin-Off, the Company separated the healthcare operations from the independent living operations at two locations, resulting in two separate facilities and transferred the two separate facilities and one stand-alone independent facilities to CareTrust. Included in 2013 number of operations includes the one stand-alone independent facility transferred to CareTrust as part of the Spin-Off. 2014 operational beds/units and number of operations do not include the three independent living facilities.

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 facilities and establishing an operating platform for future growth. In addition, this program was expanded to broaden our reach to other lines of business closely related to the skilled nursing industry through our New Ventures program. For example, we entered into home health as part of this program. The New Ventures program encourages facility CEOs to evaluate service offerings with the goal of establishing an operating platform in new markets. 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.

Real Estate Investment Trust (REIT) Spin-Off. On June 1, 2014, we completed the separation of our healthcare business and our real estate business into two separate publicly traded companies through a tax-free distribution of all of the outstanding shares of common stock of CareTrust REIT, Inc. (CareTrust) to our stockholders on a pro rata basis (the Spin-Off). Our stockholders received one share of CareTrust common stock for each share of our common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. As a result of the Spin-Off, we lease back real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities from CareTrust on a triple-net basis (the Master Leases), under which we are responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

Immediately before the Spin-Off, on May 30, 2014, while CareTrust was a wholly-owned subsidiary, CareTrust raised $260.0 million of debt financing (The Bond). CareTrust also entered into the Fifth Amended and Restated Loan Agreement, with General Electric Capital Corporation (GECC), which consisted of an additional loan of $50.7 million to an aggregate principal amount of $99.0 million (the Ten Project Note). The Ten Project Note and The Bond were assumed by CareTrust in connection with the Separation and Distribution Agreement. CareTrust transferred $220.8 million to us, a portion of which we used to retire $208.6 million of long-term debt prior to maturity. The remaining portion was used to pay prepayment penalties

and other third party fees relating to the early retirement of outstanding debt. We also retained $8.2 million of the amount CareTrust transferred, which we used to pay regular quarterly dividend payments. See further details of the Spin-Off at Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust of Notes to Consolidated Financial Statements.

As a result of the early retirement of long-term debt, we incurred losses of $5.8 million consisting of $4.1 million in repayment penalties and the write-off of unamortized debt discount and deferred financing costs and $1.7 million of recognized loss due to the discontinuance of cash flow hedge accounting for the related interest-rate swap. We also entered into a new credit facility agreement (2014 Credit Facility) in an aggregate principal amount of $150.0 million with a lending consortium arranged by SunTrust effective May 30, 2014. We have and continue to expect to use the 2014 Credit Facility for working capital purposes, to fund acquisitions and for general corporate purposes. As of December 31, 2014, our subsidiaries had $65.0 million outstanding on the 2014 Credit Facility. See further details at Note 18, Debt of Notes to Consolidated Financial Statements.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of December 31, 2014:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	WI	Total
Cumulative number of skilled nursing and assisted living operations	46	16	26	12	7	8	6	3	5	5	2	136
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	4,806	2,446	3,146	1,360	587	739	477	304	366	356	138	14,725

In addition to the facility acquisitions above, in 2014, we acquired seven home health and hospice agencies. As of December 31, 2014, we provided home health and hospice services through our 23 operating subsidiaries in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington.

In the first quarter of 2014, we acquired a skilled nursing operation and a transitional care managing company in two states for an aggregate purchase price of $9.1 million. The acquisition of the skilled nursing operation added 196 operational skilled nursing beds to our operating subsidiaries. The acquisition of the transitional care managing company did not have an impact on the number of beds operated by our operating subsidiaries.

In the second quarter of 2014, we acquired three skilled nursing operations, one assisted living operation, one home health agency, one hospice agency and one primary care group in four states for an aggregate purchase price of $29.3 million. The acquisitions of the three skilled nursing and one assisted living operations added 368 and 144 operational skilled nursing beds and assisted living units, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and primary care group did not have an impact on the number of beds operated by our operating subsidiaries.

In addition, during the second quarter of 2014, we acquired the underlying assets of two skilled nursing operations in two states, which we previously operated under a long-term lease agreement, for an aggregate purchase price of approximately $7.5 million. These acquisitions did not have an impact on our operational bed count. We also entered into long-term lease agreements and assumed the operations of two skilled nursing facilities in two states. These transactions added 199 operational skilled nursing beds to our operating subsidiaries. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the leases.

During the third quarter of 2014, we acquired an assisted living operation, a hospice agency, a home health agency and a hospice license in three states for an aggregate purchase price of $8.3 million. We assumed an existing

HUD-insured loan as part of the transaction. We also entered into a long-term lease agreement and assumed the operations of one skilled nursing facility in one state. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the lease. The acquisition of the assisted living operation and the long-term lease of a skilled nursing operation added 135 and 67 operational assisted living units and skilled nursing beds, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and hospice license did not have an impact on the number of beds operated by our operating subsidiaries.

During the fourth quarter of 2014, we acquired eight skilled nursing operations, two assisted living operations, one home health agency, two hospice agencies and one private home care business in three states for an aggregate purchase price of $49.8 million. The acquisitions of skilled nursing and assisted living operations added 623 and 66 operational skilled nursing beds and assisted living units, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and private home care business did not have an impact on the number of beds operated by our operating subsidiaries.

Subsequent to the fourth quarter of 2014, we acquired five skilled nursing operations, two assisted living operations, two independent living operations, one home health agency and two urgent care clinics in three states for an aggregate purchase price of $38.6 million. The acquisition of the skilled nursing operations and assisted and independent living operations added 419 and 286 operational skilled nursing beds and assisted and independent living units, respectively, to our operating subsidiaries. The acquisitions of the home health agency and urgent care centers did not have an impact on the number of beds operated by our operating subsidiaries.

See further discussion of facility acquisitions in Note 8, Acquisitions in Notes to Consolidated Financial Statements.

Quality of Care Measures

In December 2008, the Centers for Medicare and Medicaid Services (CMS) introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each nursing home a rating of between one and five stars in various categories. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating. The prior operator's results will impact our rating until we have sufficient clinical measurements subsequent to the acquisition date. Generally we acquire facilities with a 1 or 2-Star rating. We believe compliance and quality outcomes are precursors to outstanding financial performance. The table below summarizes the improvements we have made in these quality measures since 2010:

	As of December 31,				
	2010	2011	2012	2013	2014
Cumulative number of facilities	82	102	108	119	136
4 and 5-Star Quality Rated facilities	21	38	45	60	77
Percentage of 4 and 5-Star Quality Rated facilities	25.6 %	37.3 %	41.7 %	50.4 %	56.6 %

Industry Trends

The skilled nursing 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 of patient care to lower cost settings. The skilled nursing 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 United States 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, inpatient rehabilitation facilities 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. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- 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 and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled

nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

- Accountable Care Organizations and Reimbursement Reform. A significant goal of federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization (ACO) models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing demonstration programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. On January 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018. Providers who respond successfully to these trends and are able to deliver quality care at lower cost are likely to benefit financially.

We believe the skilled nursing 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 seniors are looking for alternatives outside the family for their care.

Effects of Changing Prices

Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our skilled nursing operations under a prospective payment system (PPS) for certain inpatient covered services. Under the PPS, facilities are paid a predetermined amount per patient, per day, based on the anticipated costs of treating patients. The amount to be paid is determined by classifying each patient into a resource utilization group (RUG) category that is based upon each patient's acuity level. As of October 1, 2010, the RUG categories were expanded from 53 to 66 with the introduction of minimum data set (MDS) 3.0. Should future changes in skilled nursing facility payments reduce rates or increase the standards for reaching certain reimbursement levels, our Medicare revenues could be reduced and/or our costs to provide those services could increase, with a corresponding adverse impact on our financial condition or results of operations.

CMS Rulings. On July 31, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2.0% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA).

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimated that aggregate payments to skilled nursing facilities would increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase reflected a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% MFP as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. In its 2014 report to congress, the Medicare Payment Advisory Commission recommended eliminating the market basket update and reducing payments through the SNF prospective payments system.

On July 27, 2012, CMS announced a final rule updating Medicare skilled nursing facility PPS payments in fiscal year 2013. The update, a 1.8% or $670 million increase, reflected a 2.5% market basket increase, reduced by a 0.7% MFP adjustment mandated by the PPACA. This increase was offset by the 2% sequestration reduction, which became effective April 1, 2013.

On October 30, 2014, CMS announced payment changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the effects of the 2.1% home health payment update percentage and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor. CMS is also finalizing three changes to the face-to-face encounter requirements under the Affordable Care Act. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if each home health agency (HHA) claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services and c) clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care. This rule also established a minimum submission

threshold for the number of OASIS assessments that each HHA must submit under the Home Health Quality Reporting Program and the Home Health Conditions of Participant for speech language pathologist personnel.

On November 22, 2013, CMS issued its final ruling regarding Medicare payment rates for home health agencies effective January 1, 2014. As required by the PPACA, this rule included rebasing adjustments, with a four-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. Under the ruling, CMS projected that Medicare payments to home health agencies in calendar year 2014 would be reduced by 1.05%, or $200 million, reflecting the combined effects of the 2.3% increase in the home health national payment update percentage; offset by a 2.7% decrease due to rebasing adjustments to the national, standardized 60-day episode payment rate, mandated by the Affordable Care Act; and a 0.6% decrease due to the effects of Home Health Prospective Payment Systems Grouper refinements. This final rule also updated the home health wage index for calendar year 2014. The ruling also established home health quality reporting requirements for 2014 payment and subsequent years to specify that Medicaid responsibilities for home health surveys be explicitly recognized in the State Medicaid Plan, which is similar to the current regulations for surveys of skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

In November 2012, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2013. These final regulations implemented a net market basket increase of 1.3% consisting of a 2.3% market basket inflation increase, less a 1.0% adjustment mandated by the PPACA. In addition, CMS implemented a 1.3% reduction in case mix. CMS projected the impact of these changes would result in a less than 0.1% decrease in payments to home health agencies.

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS’ seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). The final rule also states that CMS will begin national implementation of the CAHPS Hospice Survey starting January 1, 2015. In the final rule, CMS requires providers to complete their hospice cap determination within 150 days after the cap period and remit any overpayments. If a hospice does not complete its cap determination in a timely fashion, its Medicare payments would be suspended until the cap determination is complete and received by the contractor. This is similar to the current practice for all other provider types that file cost reports with Medicare.

On August 2, 2013, CMS issued its final rule that updated fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices were projected to see an estimated 1.0% increase in their payments for fiscal year 2014. The hospice payment increase was the net result of a hospice payment update percentage of 1.7% (a 2.5% hospital market basket increase minus a 0.8% reduction mandated by law), offset by a 0.7% decrease in payments to hospices due to updated wage data and the fifth year of the CMS's seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). As finalized in this rule, CMS planned to update the hospice per diem rates for fiscal year 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years. The fiscal year 2014 hospice payment rates and wage index became effective on October 1, 2013.

In July 2012, CMS issued its final rule for hospice services for its 2013 fiscal year. These final regulations implemented a net market basket increase of 1.6% consisting of a 2.6% market basket inflation increase, less offsets to the standard payment conversion factor mandated by the PPACA of 0.7% to account for the effect of a productivity adjustment, and 0.3% as required by statute. CMS projected the impact of these changes would result in a 0.9% increase in payments to hospice providers.

On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014, which averted a 24% cut in Medicare payments to physicians and other Part B providers until March 31, 2015. In addition, this law maintains the 0.5% update for such services through December 31, 2014 and provides a 0.0% update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015. Among other things, this law provides the framework for implementation of a value-based purchasing program for skilled nursing facilities. Under this legislation HHS is required to develop by October 1, 2016 measures and performance standards regarding preventable hospital readmissions from skilled nursing facilities. Beginning October 1, 2018, HHS will withhold 2% of Medicare payments to all skilled nursing facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute creates a Commission on Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term care services and supports for individuals in need of such services and supports. Any implementation of recommendations from this commission may have an impact on coverage and payment for our services.

Should future changes in PPS include further reduced rates or increased standards for reaching certain reimbursement levels, our Medicare revenues derived from our affiliated skilled nursing facilities (including rehabilitation therapy services provided at our affiliated skilled nursing facilities) could be reduced, with a corresponding adverse impact on our financial condition or results of operations.

On February 22, 2012, the President signed into law H.R. 3630, which among other things, delayed a cut in physician and Part B services. In establishing the funding for the law, payments to nursing facilities for patients' unpaid Medicare A co-insurance was reduced. The Deficit Reduction Act of 2005 had previously limited reimbursement of bad debt to 70% on privately responsibility co-insurance. However, under H.R. 3630, this reimbursement will be reduced to 65%.

Further, prior to the introduction of H.R. 3630, we were reimbursed for 100% of bad debt related to dual-eligible Medicare patients' co-insurance. H.R. 3630 will phase down the dual-eligible reimbursement over three years. Effective October 1, 2012, Medicare dual-eligible co-insurance reimbursement decreased from 100% to 88%, with further rates reductions to 77% and 65% as of October 1, 2013 and 2014, respectively. Any reductions in Medicare or Medicaid reimbursement could materially adversely affect our profitability.

Medicare Part B Therapy Cap. Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The Deficit Reduction Act of 2005 (DRA) added Sec. 1833(g)(5) of the Social Security Act and directed CMS to develop a process that allows exceptions for Medicare beneficiaries to therapy caps when continued therapy is deemed medically necessary.

The therapy cap exception has been reauthorized in a number of subsequent laws, most recently in the Protecting Access to Medicare Act of 2014, which extends the cap and exception process through March 31, 2015. That statute implements a two-tiered exception process, with an automatic exception process and a manual medical review exception process. The automatic exception process applies for patients who reach a $1,920 threshold. The manual medical review exception process applies at the $3,700 threshold. Every claim exceeding threshold after April 1, 2014 is subject to Manual Medical Review (MMR). The Texas and California ‘Pre-Payment’ MMR has been discontinued at this point in time. All states continued to be subject to post payment review when exceeding $3,700 Speech/Part time combined and $3,700 overtime alone. All threshold exceptions over $3,700 are subject to review. It was expected that the MMR Pre-Payment Review would be reinstated in August 2014. However, due to the continued delay in awarding new Recovery Auditor contracts, the CMS initiated contract modifications to the current Recovery Auditor contracts to allow the Recovery Auditors to restart some reviews. Most reviews will be done on an automated basis, but a limited number will be complex reviews of topics selected by CMS. While the RAC Contractors have begun to reinstate some reviews, the Part B ‘Pre-Payment’ MMR Pause continues at this time.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond March 31, 2015, which could also have an adverse effect on our revenue after that date.

In addition, the Multiple Procedure Payment Reduction (MPPR) was increased from a 25% to 50% reduction applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies 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. The change from 25% of the practice expense to a 50% reduction went into effect for Medicare Part B services provided on or after April 1, 2013.

Medicare Coverage Settlement Agreement. A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved

on January 24, 2013, which tasked CMS with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve. At the conclusion of the CMS education campaign, the members of the class will have the opportunity for re-review of their claims, and a two- or three-year monitoring period will commence. Implementation of the provisions of this settlement agreement could favorably impact Medicare coverage reimbursement for our services.

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates, see Item 1A. Risk Factors -

Risks Related to Our Business and Industry - “Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare,” “Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending,” “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” and “Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements." 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.

Payor Sources

We derive revenue primarily from the Medicaid and Medicare programs, private pay patients and managed care payors. 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 quality mix, which is the percentage of non-Medicaid revenue from each of our facilities, 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.

Medicaid. Medicaid is a state-administered program financed by state funds and matching federal funds. Medicaid programs are 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 financially needy persons aged 65 and older. 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 the largest source of funding for nursing home facilities.

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. The prospective payment for each beneficiary is based upon the medical condition of and care needed by the beneficiary. Medicare 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.

Managed Care and Private Insurance. Managed care patients consist of individuals who are insured by a third-party entity, typically a senior HMO plan, or who are Medicare beneficiaries who have assigned their Medicare benefits to a senior HMO plan. Another type of insurance, long-term care insurance, is also becoming more widely 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.

Billing and Reimbursement. Our revenue from government payors, including Medicare and state Medicaid agencies, is subject to retroactive adjustments in the form of claimed overpayments and underpayments based on rate adjustments, audits or asserted billing and reimbursement errors. We believe billing and reimbursement errors, disagreements, overpayments and underpayments are common in our industry, and we are regularly engaged with government payors and their contractors in reviews, audits and appeals of our claims for reimbursement due to the subjectivity inherent in the processes related to patient diagnosis and care, recordkeeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors or disagreements those subjectivities can produce.

We take seriously our responsibility to act appropriately under applicable laws and regulations, including Medicare and Medicaid billing and reimbursement laws and regulations. Accordingly, we employ accounting, reimbursement and compliance specialists who train, mentor and assist our clerical, clinical and rehabilitation staffs in the preparation of claims and supporting documentation, regularly monitor billing and reimbursement practices within our operating subsidiaries, and assist with the appeal of overpayment and recoupment claims generated by governmental, Medicare contractors and other auditors and reviewers. In addition, due to the potentially serious consequences that could arise from any impropriety in our billing and

reimbursement processes, we investigate allegations of impropriety or irregularity relative thereto, and sometimes do so with the aid of outside auditors (other than our independent registered public accounting firm), attorneys and other professionals.

Whether information about our billing and reimbursement processes is obtained from external sources or activities such as Medicare and Medicaid audits or probe reviews, internal investigations, or our regular day-to-day monitoring and training activities, we collect and utilize such information to improve our billing and reimbursement functions and the various processes related thereto. While, like other operators in our industry, we experience billing and reimbursement errors, disagreements and other effects of the inherent subjectivities in reimbursement processes on a regular basis, we believe that we are in substantial compliance with applicable Medicare and Medicaid reimbursement requirements. We continually strive to improve the efficiency and accuracy of all of our operational and business functions, including our billing and reimbursement processes.

The following table sets forth our total revenue by payor source generated by each of our reportable segments and our "all other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Year Ended December 31, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$352,874	$5,245	$—	$358,119	34.9	%
Medicare	274,723	38,421	—	313,144	30.5	
Medicaid-skilled	51,157	—	—	51,157	5.0	
Subtotal	678,754	43,666	—	722,420	70.4	
Managed care	138,215	7,581	—	145,796	14.2	
Private and other	133,349	3,269	22,572 (1)	159,190	15.4	
Total revenue	$950,318	$54,516	$22,572	$1,027,406	100.0	%

(1) Private and other payors from our "all other" category includes revenue from urgent care centers and other ancillary businesses.

	Year Ended December 31, 2013					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$320,580	$3,223	$—	$323,803	35.8	%
Medicare	264,223	28,694	—	292,917	32.4	
Medicaid-skilled	36,085	—	—	36,085	4.0	
Subtotal	620,888	31,917	—	652,805	72.2	%
Managed care	112,669	5,499	—	118,168	13.1	
Private and other	119,722	2,346	11,515 (1)	133,583	14.7	
Total revenue	$853,279	$39,762	$11,515	$904,556	100.0	%

(1) Private and other payors from our "all other" category includes revenue from urgent care centers and other ancillary businesses.

	Year Ended December 31, 2012					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue	%
Medicaid	$301,051	$995	$—	$302,046	36.7	%
Medicare	261,745	16,833	—	278,578	33.8	
Medicaid-skilled	25,418	—	—	25,418	3.1	
Subtotal	588,214	17,828	—	606,042	73.6	
Managed care	102,737	3,531	—	106,268	12.9	
Private and other	108,702	1,927	216	(1) 110,845	13.5	
Total revenue	$799,653	$23,286	$216	$823,155	100.0	%

(1) Private and other payors from our "all other" category includes revenue from urgent care centers and other ancillary businesses.

Payor Sources as a Percentage of Skilled Nursing Services. We use both our skilled mix and quality mix as measures of the quality of reimbursements we receive at our skilled nursing operations over various periods. The following table sets forth our percentage of skilled nursing patient days by payor source:

	Year Ended December 31,					
	2014		2013		2012	
Percentage of Skilled Nursing Days:						
Medicare	14.2	%	14.8	%	15.3	%
Managed care	9.7		8.9		9.0	
Other skilled	3.7		2.7		1.6	
Skilled mix	27.6		26.4		25.9	
Private and other payors	13.1		13.7		13.2	
Quality mix	40.7		40.1		39.1	
Medicaid	59.3		59.9		60.9	
Total skilled nursing	100.0	%	100.0	%	100.0	%

Reimbursement for Specific Services

Reimbursement for Skilled Nursing Services. Skilled nursing facility revenue is primarily derived from Medicaid, private pay, managed care and Medicare 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.

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 assisted 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 Assisted Living Services. Assisted living facility revenue is primarily derived from private pay patients at rates we establish based upon the services we provide and market conditions in the area of operation. In addition, Medicaid or other state-specific programs in some states where we operate supplement payments for board and care services provided in assisted living facilities.

Reimbursement for Hospice Services. Hospice revenues are primarily derived from Medicare. We receive one of four predetermined daily or hourly rates based on the level of care we furnish to the beneficiary. These rates are subject to annual adjustments based on inflation and geographic wage considerations.

We are subject to two limitations on Medicare payments for hospice services. First, if inpatient days of care provided to patients at a hospice exceed 20% of the total days of hospice care provided for an annual period beginning on November 1st, then payment for days in excess of this limit are paid at the routine home care rate.

Second, overall payments made by Medicare to us on a per hospice program basis are also subject to a cap amount calculated by the Medicare fiscal intermediary at the end of the hospice cap period. The Medicare revenue paid to a hospice program from November 1 to October 31 may not exceed the annual aggregate cap amounts. For cap years ending on or after October 31, 2012, and all subsequent cap years, the hospice aggregate cap is calculated using the proportional method. Under the proportional method, the hospice shall include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that were spent in that hospice in that cap year, using the best data available at the time of the calculation. The whole and fractional shares of Medicare beneficiaries' time in a given cap year are then summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year. The hospice's total Medicare beneficiaries in a given cap year is multiplied by the Medicare per beneficiary cap amount, resulting in that hospice's aggregate cap, which is the allowable amount of total Medicare payments that hospice can receive for that cap year. If a hospice exceeds its aggregate cap, then the hospice must repay the excess back to Medicare. The Medicare cap amount is reduced proportionately for patients who transferred in and out of our hospice services.

Reimbursement for Home Health Services. We derive substantially all of the revenue from our home health business from Medicare and managed care sources. Our home health care services generally consist of providing some combination of the services of registered nurses, speech, occupational and physical therapists, medical social workers and certified home health aides. Home health care is often a cost-effective solution for patients, and can also increase their quality of life and allow them to receive quality medical care in the comfort and convenience of a familiar setting.

Competition

The skilled nursing 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. We also compete with inpatient rehabilitation facilities and long-term acute care hospitals. 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 skilled nursing industry are:

- ability to attract and to retain qualified management and caregivers;
- reputation and commitment to quality;
- attractiveness and location of facilities;
- the expertise and commitment of the facility 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.

There are few barriers to entry in the home health and hospice business in jurisdictions that do not require certificates of need or permits of approval. Our primary competition in these jurisdictions comes from local privately and publicly-owned and hospital-owned health care providers. We compete based on the availability of personnel, the quality of services, expertise of visiting staff, and, in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations that finance acquisitions and capital expenditures on a tax-exempt basis and charity-funded programs that may have strong ties to their local medical communities and receive charitable contributions that are unavailable to us.

Our other services, such as assisted 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 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 operating subsidiaries' employees are among the best in their respective industry. We believe each of our operating 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 lead our operating 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,” 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 company-wide commitment to ongoing education, training and professional development. 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 on a monthly basis. Training and educational topics include leadership development, our values, updates on Medicaid and Medicare billing requirements, updates on new regulations or legislation, emerging healthcare service alternatives and other relevant clinical, business and industry specific coursework. Additionally, we 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 a Service Center 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 centralized 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-facility-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 highly operations driven. 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, 2014, we have acquired 136 facilities with 14,725 operational beds, including 1,901 assisted living beds and 264 independent living units, through both long-term leases and purchases. We believe our experience in acquiring these facilities 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 facilities to our unique organizational culture and operating systems, which enables us to acquire facilities with limited disruption to patients, residents and facility operating staff, while significantly improving quality of care. We also intend to consider the construction of new facilities as we determine that market conditions justify the cost of new construction in some of our markets.

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 reputation for quality, 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 and 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 facility 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 facility 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 facility 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 automated software and touch-screen interface systems in each facility 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 operating subsidiaries. We generally have between five and 20 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 facility Chief Executive Officer Program, which facilitates the continued development of these talented business leaders into outstanding facility CEOs, through regular peer review, our Ensign University and on-the-job training.

In addition, our Chief Operating Officer Program recruits and trains highly-qualified Directors of Nursing to lead the clinical programs in our skilled nursing facilities. Working together with their facility CEO and/or administrator, other key facility 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 therapy 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 and therapy patients to our facilities 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 facilities. 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 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. Therefore, consolidated occupancy will vary significantly based on these factors. Our average occupancy rates for the years ended December 31, 2014, 2013 and 2012 were 78.0%, 77.5% and 79.0%, respectively.

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.

We also have achieved incremental occupancy and revenue growth by creating or expanding outpatient therapy programs in existing facilities. Physical, occupational and speech therapy services account for a significant portion of revenue in most of our skilled nursing facilities. By expanding therapy programs to provide outpatient 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 Operations and Expand Existing Operations. A key element of our growth strategy includes the acquisition of new and existing facilities from third parties, the expansion and upgrade of current operations, and the construction of new 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 or by partnering with a construction company to build out new facilities. In addition, we have targeted facilities that we believed were performing and operations that were underperforming, and 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 90 facilities that we acquired from 2001 through 2014, the aggregate EBITDAR (defined below) as a percentage of revenue improved from 11.3% during the first full three months of operations to 14.1% during the thirteenth through fifteenth months of operations.

Constructing New Facilities in Existing and New markets. Another key element to our growth strategy includes constructing new skilled nursing and assisted living facilities in new and existing markets. We plan to target geographies that we believe to be under served or where the demand exists for new high-end healthcare facilities that will offer a wide array of hospitality-oriented amenities, activities and services. In addition, lowering the average age of our facilities will allow us to manage the cost of renovating and maintaining our facilities. In the near term, we have entered into several build-to-suit leases with Mainstreet Property Group in the states of Texas, Kansas and Colorado and expect to open our first newly-constructed operations in the second quarter of 2015. We also expect to work together with Mainstreet to select additional locations in the future. In addition, we also have plans underway to construct some small replacement facilities and are looking to develop additional relationships with other developers.

Strategically Investing In and Integrating Other Post-Acute Care Healthcare Businesses. Another important element to our growth strategy includes acquiring new and existing home health, hospice and other post-acute care healthcare businesses. Since 2010, we have steadily expanded our home health and hospice businesses through the acquisition of smaller third-party providers. Our strategy is to provide a more seamless experience to manage the transition of care throughout the post-acute continuum. Our objective is to simultaneously improve patient outcomes and reduce costs to payers, ACOs and hospital systems. We believe that the same principles that have guided our skilled nursing and assisted living operations are transferable to these businesses, including reliance on experienced local leaders at the community level to focus on integrating these operations into the continuum of care services we provide. Between 2010 and February 2015, we have acquired eleven hospice agencies, thirteen home health agencies, one home care business and one transitional care management company, and we are well positioned for continued growth in these and other healthcare businesses.

Labor

The operation of our skilled nursing and assisted living facilities, home health and hospice operations and urgent care centers requires a large number of highly skilled healthcare professionals and support staff. At December 31, 2014, we had approximately 13,229 full-time equivalent employees who were employed by our Service Center and our operating subsidiaries. For the year ended December 31, 2014, 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 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.

Government Regulation

The regulatory environment within the skilled nursing industry continues to intensify in the amount and type of laws and regulations affecting it. In addition to this changing regulatory environment, federal, state and local officials are increasingly focusing their efforts on the enforcement of these laws. In order to operate our businesses we must comply with federal, state and local laws relating to licensure, delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate-setting, billing and reimbursement, building codes and environmental protection. Additionally, we must also adhere to anti-kickback laws, physician referral laws, and safety and health standards set by the Occupational Safety and Health Administration (OSHA). Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

Our operating subsidiaries are also subject to various regulations and licensing requirements promulgated by state and local health and social service agencies and other regulatory authorities. Requirements vary from state to state and these requirements can affect, among other things, personnel education and training, patient and personnel records, services, staffing levels, monitoring of patient wellness, patient furnishings, housekeeping services, dietary requirements, emergency plans and procedures, certification and licensing of staff prior to beginning employment, and patient rights. These laws and regulations could limit our ability to expand into new markets and to expand our services and facilities in existing markets.

State Regulations. On March 24, 2011, the governor of California signed Assembly Bill 97 (AB 97), the budget trailer bill on health, into law. AB 97 outlines significant cuts to state health and human services programs. Specifically, the law reduced provider payments by 10% for physicians, pharmacies, clinics, medical transportation, certain hospitals, home health, and nursing facilities. AB X1 19 Long Term Care was subsequently approved by the governor on June 28, 2011. Federal approval was obtained on October 27, 2011. AB X1 19 limited the 10% payment reduction to skilled-nursing providers to 14 months for the services provided on June 1, 2011 through July 31, 2012. The 10% reduction in provider payments was repaid by December 31, 2012.

Federal Health Care Reform. On October 6, 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014. This legislation requires post-acute care providers, such as skilled nursing facilities, hospices, and home health providers, to report standardized patient assessment data, data on quality measures, and data on resource use and other measures, and directs HHS to provide feedback reports to providers and arrange for public reporting of provider performance on the reported data. Post-acute care providers that do not report such data will have their Medicare payments reduced.

CMS also recently announced two proposed post-acute care provider initiatives. First, CMS proposes to expand and strengthen the Five Star Quality Rating System for nursing homes to improve consumer information about quality measures at individual nursing homes. In addition, CMS announced proposals to adopt new standards that home health agencies must comply with in order to participate in the Medicare program, including the strengthening of patient rights and communication requirements that focus on patient well-being.

On August 2, 2011, the President signed into law the Budget Control Act of 2011 (Budget Control Act), which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act created a Congressional Joint

Select Committee on Deficit Reduction (the Committee) that was tasked with proposing additional deficit reduction of at least $1.5 trillion over ten years. As the Committee was unable to achieve its targeted savings, this regulation triggered automatic reductions in discretionary and mandatory spending, or budget sequestration, starting in 2013, including reductions of not more than 2% to payments to Medicare providers. The Budget Control Act also requires Congress to vote on an amendment to the Constitution that would require a balanced budget.

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) or the Affordable Care Act into law, which contained several sweeping changes to America's health insurance system. Among other reforms contained in PPACA, many Medicare providers received reductions in their market basket updates. Unlike for some other Medicare providers, PPACA made no reduction to the market basket update for skilled nursing facilities in fiscal years 2010 or 2011. However, under PPACA, the skilled nursing facility market basket update became subject to a full productivity adjustment beginning in fiscal year 2012. In addition, PPACA enacted several reforms with respect to skilled nursing facilities and hospice organizations, including payment measures to realize significant savings of federal and state funds by deterring and prosecuting fraud and abuse in both the Medicare and Medicaid programs.

While many of the provisions of PPACA have not taken effect, or are subject to further refinement through the promulgation of regulations, some key provisions of PPACA are:

- Enhanced CMPs. PPACA included expanded civil monetary penalty (CMP) provisions applicable to all Medicare and Medicaid providers. PPACA provided for the imposition of CMPs of up to $50,000 and, in some cases, treble damages, for actions relating to alleged false statements to the federal government.

- Nursing Home Transparency Requirements. In addition to expanded CMP provisions, PPACA imposed substantial and onerous new transparency requirements for Medicare-participating nursing facilities. CMS has not yet promulgated final regulations to implement these provisions.

- Face-to-Face Encounter Requirements. PPACA imposed new patient face-to-face encounter requirements on home health agencies and hospices to establish a patient's ongoing eligibility for Medicare home health services or hospice services, as applicable. To comply, a certifying physician or other designated health care professional must conduct and properly document the face-to-face encounters with the Medicare beneficiary within a specified timeframe, and failure of the face-to-face encounter to occur and be properly documented during the applicable timeframe could render the patient's care ineligible for reimbursement under Medicare.

- Suspension of Payments During Pending Fraud Investigations. PPACA also provided the federal government with expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud. Section 6402 of the PPACA provides that Medicare and Medicaid payments may be suspended pending a "credible investigation of fraud," unless the Secretary of Health and Human Services determined that good cause exists not to suspend payments. "Credible investigation of fraud" is undefined, although the Secretary must consult with the Office of the Inspector General (OIG) in determining whether a credible investigation of fraud exists. This suspension authority created a new mechanism for the federal government to suspend both Medicare and Medicaid payments for allegations of fraud, independent of whether a state exercised its authority to suspend Medicaid payments pending a fraud investigation. To the extent the Secretary applied this suspension of payments provision to one or more of our affiliated facilities for allegations of fraud, such a suspension could adversely affect our revenue, cash flow, financial condition and results of operations. OIG promulgated regulations making these provisions effective as of March 25, 2011.

- Overpayment Reporting and Repayment; Expanded False Claims Act Liability. PPACA also enacted several important changes that expand potential liability under the federal False Claims Act. PPACA provided that overpayments related to services provided to both Medicare and Medicaid beneficiaries must be reported and returned

to the applicable payor within the later of sixty days of identification of the overpayment, or the date the corresponding cost report (if applicable) is due.

- Skilled Nursing Facility Value-Based Purchasing Program. PPACA required the U.S. Department of Health and Human Services (HHS) to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities. The value-based purchasing program would provide payment incentives for Medicare-participating skilled nursing facilities to improve the quality of care provided to Medicare beneficiaries. Among the most relevant factors in HHS' plans to implement value-based purchasing for skilled nursing facilities is the current Nursing Home Value-Based Purchasing Demonstration Project, which concluded in December 2012. HHS provided Congress with an outline of plans to implement a value-based purchasing program.

Voluntary Pilot Program — Bundled Payments. To support the policies of making all providers responsible during an episode of care and rewarding value over volume, HHS will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 to 90 days following discharge. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. Payment arrangements among providers participating in the bundled payment must navigate regulatory compliance under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law and the related waivers. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.

Accountable Care Organizations. PPACA authorized CMS to enter into contracts with ACOs, which are entities of providers and suppliers organized to deliver services to Medicare beneficiaries and eligible to receive a share of any cost savings the entity can achieve by delivering services to those beneficiaries at a cost below a set baseline and with sufficient quality of care. CMS recently finalized regulations to implement the ACO initiative. The widespread adoption of ACO payment methodologies in the Medicare program, and in other programs and payors, could impact our operations and reimbursement for our services.

On June 28, 2012 the United States Supreme Court ruled that the enactment of PPACA did not violate the Constitution of the United States. This ruling permits the implementation of most of the provisions of PPACA to proceed. The provisions of PPACA discussed above are only examples of federal health reform provisions that we believe may have a material impact on the long-term care industry and on our business. However, the foregoing discussion is not intended to constitute, nor does it constitute, an exhaustive review and discussion of PPACA. It is possible that these and other provisions of PPACA may be interpreted, clarified, or applied to our affiliated facilities or operating subsidiaries in a way that could have a material adverse impact on the results of operations.

Regulations Regarding Our Facilities. Governmental and other authorities periodically inspect our facilities to assess our compliance with various standards. The intensified regulatory and enforcement environment continues to impact healthcare providers, as these providers respond to periodic surveys and other inspections by governmental authorities and act on any noncompliance identified in the inspection process. Unannounced surveys or inspections generally occur at least annually, and also following a government agency's receipt of a complaint about a facility. We must pass these inspections to maintain our licensure under state law, to obtain or maintain certification under the Medicare and Medicaid programs, to continue participation in the Veterans Administration (VA) program at some facilities, and to comply with our provider contracts with managed care clients at many facilities. From time to time, we, like others in the healthcare industry, may receive notices from federal and state regulatory agencies alleging that we failed to comply with applicable standards. These notices may require us to take corrective action, may impose civil monetary penalties for noncompliance, and may threaten or impose other operating restrictions on skilled nursing facilities such as admission holds, provisional skilled nursing license or increased staffing requirements. If our facilities fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, we could lose our certification as a Medicare or Medicaid provider, or lose our state licenses to operate the facilities.

Regulations Protecting Against Fraud. 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 Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Balanced Budget Act of 1997 (BBA) expanded the penalties for healthcare fraud. Additionally, in connection with our involvement with federal healthcare reimbursement programs, the government or those acting on its behalf may bring an action under the False Claims Act (FCA), alleging that a

healthcare provider has defrauded the government. These claimants may seek treble damages for false claims and payment of additional civil monetary penalties. The FCA allows a private individual with knowledge of fraud to bring a claim on behalf of the federal government and earn a percentage of the federal government's recovery. Due to these "whistleblower" incentives, suits have become more frequent. Many states also have a false claim prohibition that mirrors or tracks the federal FCA.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by 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 a FCA violation can occur without any affirmative fraudulent action

or statement, as long as it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, there is no need for an employment relationship in order to qualify for protection against retaliation for whistleblowing.
On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute lengthened the retrospective time period for which CMS can recover overpayments from health care providers, from three years following the year in which payment was made, to five years following the year in which payment was made.

Regulations Regarding Financial Arrangements. We are also subject to federal and state laws that regulate financial arrangement by healthcare providers, such as the federal and state anti-kickback laws, the Stark laws, and various state referral laws. The federal anti-kickback laws and similar state laws make it unlawful for any person to pay, receive, offer, or solicit any benefit, directly or indirectly, for the referral or recommendation for products or services which are eligible for payment under federal healthcare programs, including Medicare and Medicaid. For the purposes of the anti-kickback law, a “federal healthcare program” includes Medicare and Medicaid programs and any other plan or program that provides health benefits which are funded directly, in whole or in part, by the United States government.

The arrangements prohibited under these anti-kickback laws can involve nursing homes, hospitals, physicians and other healthcare providers, plans, suppliers and non-healthcare providers. These laws have been interpreted very broadly to include a number of practices and relationships between healthcare providers and sources of patient referral. The scope of prohibited payments is very broad, including anything of value, whether offered directly or indirectly, in cash or in kind. Federal “safe harbor” regulations describe certain arrangements that will not be deemed to constitute violations of the anti-kickback law. Arrangements that do not comply with all of the strict requirements of a safe harbor are not necessarily illegal, but, due to the broad language of the statute, failure to comply with a safe harbor may increase the potential that a government agency or whistleblower will seek to investigate or challenge the arrangement. The safe harbors are narrow and do not cover a wide range of economic relationships.

Violations of the federal anti-kickback laws can result in criminal penalties of up to $25,000 and five years imprisonment. Violations of the anti-kickback laws can also result in civil monetary penalties of up to $50,000 and an assessment of up to three times the total amount of remuneration offered, paid, solicited, or received. Violation of the anti-kickback laws may also result in an individual's or organization's exclusion from future participation in Medicare, Medicaid and other state and federal healthcare programs. Exclusion of us or any of our key employees from the Medicare or Medicaid program could have a material adverse impact on our operations and financial condition.

In addition to these regulations, we may face adverse consequences if we violate the federal Stark laws related to certain Medicare physician referrals. The Stark laws prohibit a physician from referring Medicare patients for certain designated health services where the physician has an ownership interest in or compensation arrangement with the provider of the services, with limited exceptions. Also, any services furnished pursuant to a prohibited referral are not eligible for payment by the Medicare programs, and the provider is prohibited from billing any third party for such services. The Stark laws provide for the imposition of a civil monetary penalty of $15,000 per prohibited claim, and up to $100,000 for knowingly entering into certain prohibited cross-referral schemes, and potential exclusion from Medicare for any person who presents or causes to be presented a bill or claim the person knows or should know is submitted in violation of the Stark laws. Such designated health services include physical therapy services; occupational therapy services; radiology services, including CT, MRI and ultrasound; durable medical equipment and services; radiation therapy services and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics and prosthetic devices and supplies; home health services; outpatient prescription drugs; inpatient and outpatient hospital services; clinical laboratory services; and diagnostic and therapeutic nuclear medical services.

Regulations Regarding Patient Record Confidentiality. We are also subject to laws and regulations enacted to protect the confidentiality of patient health information. For example, the U.S. Department of Health and Human Services has issued rules pursuant to HIPAA, which relate to the privacy of certain patient information. These rules govern our use and disclosure of protected health information. We have established policies and procedures to comply with HIPAA privacy and security requirements at these facilities. We believe that we are in compliance with all current HIPAA laws and regulations.

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. In some respects, the application of federal and state antitrust laws to healthcare is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, healthcare providers and insurance and managed care organizations may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by

a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

Environmental Matters

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.

Available Information

We are subject to the reporting requirements under 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 report 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 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 http://www.ensigngroup.net, electronic copies of our annual report 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. Information contained in our website is not deemed to be a part of this Annual Report.

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Item 1A. Risk Factors

Set forth below are certain risk factors that could harm our business, results of operations and financial condition. 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

Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare.

We derived 39.9% and 39.8% of our revenue from the Medicaid program for the years ended December 31, 2014 and 2013, respectively. We derived 30.5% and 32.4%, of our revenue from the Medicare program for the years ended December 31, 2014 and 2013, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our patients.

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting base rates or basis of payment, retroactive rate adjustments, annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to Medicare beneficiaries, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates and frequency at which these programs reimburse us for our services. For example, the Medicaid Integrity Contractor (MIC) program is increasing the scrutiny placed on Medicaid payments, and could result in recoupments of alleged overpayments in an effort to rein in Medicaid spending. Recent budget proposals and legislation at both the federal and state levels have called for cuts in reimbursement for health care providers participating in the Medicare and Medicaid programs. Enactment and implementation of measures to reduce or delay reimbursement could result in substantial reductions in our revenue and profitability. Payors may disallow our requests for reimbursement based on 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 reasonably 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.

In addition, on October 1, 2010, the next generation of the Minimum Data Set (MDS) 3.0 was implemented, creating significant changes in the methodology for calculating the resource utilization group (RUG) category under Medicare Part A, most notably eliminating Section T. Because therapy does not necessarily begin upon admission, MDS 2.0 and the RUGS-III system included a provision to capture therapy services that are scheduled to occur but have not yet been provided in order to calculate a RUG level that better reflects the level of care the recipient would actually receive. This is eliminated with MDS 3.0, which creates a new category of assessment called the Medicare Short Stay Assessment. This assessment provides for calculation of a rehabilitation RUG for patients discharged on or before day eight who received less than five days of therapy.

On July 31, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2.0% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA).

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimated that aggregate payments to skilled nursing facilities would increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase reflects a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% MFP adjustment as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. For fiscal year 2012 (most recent available fiscal year), the projected market basket percentage change exceeded the actual market basket percentage change by 0.51%.

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On July 27, 2012, CMS announced a final rule updating Medicare skilled nursing facility PPS payments in fiscal year 2013. The update, a 1.8% or $670 million increase, reflected a 2.5% market basket increase, reduced by a 0.7% multi-factor productivity (MFP) adjustment mandated by the Patient Protection and Affordable Care Act (PPACA). This increase will be offset by the 2% sequestration reduction, discussed below, which became effective April 1, 2013.

On October 30, 2014, CMS announced payment changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the effects of the 2.1% home health payment update percentage and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor. CMS is also finalizing three changes to the face-to-face encounter requirements under the Affordable Care Act. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if a home health agency (HHA) claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services and c) clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care. This rule also established a minimum submission threshold for the number of OASIS assessments that each HHA must submit under the Home Health Quality Reporting Program and the Home Health Conditions of Participant for speech language pathologist personnel.

On November 22, 2013, CMS issued its final ruling regarding Medicare payment rates for home health agencies effective January 1, 2014. As required by the PPACA, this rule included rebasing adjustments, with a four-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. Under the ruling, CMS projected that Medicare payments to home health agencies in calendar year 2014 would be reduced by 1.05%, or $200 million, reflecting the combined effects of the 2.3% increase in the home health national payment update percentage; a 2.7% decrease due to rebasing adjustments to the national, standardized 60-day episode payment rate, mandated by the Affordable Care Act; and a 0.6% decrease due to the effects of HH PPS Grouper refinements. This final rule also updated the home health wage index for calendar year 2014. The ruling also established home health quality reporting requirements for 2014 payment and subsequent years to specify that Medicaid responsibilities for home health surveys be explicitly recognized in the State Medicaid Plan, which is similar to the current regulations for surveys of skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

In November 2012, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2013. These final regulations implemented a net market basket increase of 1.3% consisting of a 2.3% market basket inflation increase, less a 1.0% adjustment mandated by the PPACA. In addition, CMS implemented a 1.3% reduction in case mix. CMS projected the impact of these changes would result in a less than 0.1% decrease in payments to home health agencies.

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS’ seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). The final rule also states that CMS will begin national implementation of the CAHPS Hospice Survey starting January 1, 2015. In the final rule, CMS requires providers to complete their hospice cap determination within 150 days after the cap period and remit any overpayments. If a hospice does not complete its cap determination in a timely fashion, its Medicare payments

would be suspended until the cap determination is complete and received by the contractor. This is similar to the current practice for all other provider types that file cost reports with Medicare.

On August 2, 2013, CMS issued its final rule that updated fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices were projected to see an estimated 1.0% ($160 million) increase in their payments for fiscal year 2014. The hospice payment increase was the net result of a hospice payment update percentage of 1.7% (a 2.5% hospital market basket increase minus a 0.8% reduction mandated by law), and a 0.7% decrease in payments to hospices due to updated wage data and the fifth year of the CMS's seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). As finalized in this rule, CMS will update the hospice per diem rates for fiscal year 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years. The fiscal year 2014 hospice payment rates and wage index became effective on October 1, 2013.

In July 2012, CMS issued its final rule for hospice services for its 2013 fiscal year. These final regulations implemented a net market basket increase of 1.6% consisting of a 2.6% market basket inflation increase, less offsets to the standard payment

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conversion factor mandated by the PPACA of 0.7% to account for the effect of a productivity adjustment, and 0.3% as required by statute. CMS projected the impact of these changes would result in a 0.9% increase in payments to hospice providers.

On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute delays significant cuts in Medicare rates for physician services until December 31, 2013. The statute also created a Commission on Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term care services and supports for individuals in need of such services and supports. Any implementation of recommendations from this commission may have an impact on coverage and payment for our services.

Should future changes in PPS, similar to those described above, include further reduced rates or increased standards for reaching certain reimbursement levels, our Medicare revenues derived from our affiliated skilled nursing facilities (including rehabilitation therapy services provided at our affiliated skilled nursing facilities) could be reduced, with a corresponding adverse impact on our financial condition or results of operations.

On October 6, 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014. This legislation requires post-acute care providers, such as skilled nursing facilities, hospices, and home health providers, to report standardized patient assessment data, data on quality measures, and data on resource use and other measures, and directs HHS to provide feedback reports to providers and arrange for public reporting of provider performance on the reported data. Post-acute care providers that do not report such data will have their Medicare payments reduced.

On February 22, 2012, the President signed into law H.R. 3630, which among other things, delayed a cut in physician and Part B services. In establishing the funding for the law, payments to nursing facilities for patients' unpaid Medicare A co-insurance was reduced. The Deficit Reduction Act of 2005 had previously limited reimbursement of bad debt to 70% on privately responsibility co-insurance. However, under H.R. 3630, this reimbursement will be reduced to 65%.

Further, prior to the introduction of H.R. 3630, we were reimbursed for 100% of bad debt related to dual-eligible Medicare patients' co-insurance. H.R. 3630 will phase down the dual-eligible reimbursement over three years. Effective October 1, 2012, Medicare dual-eligible co-insurance reimbursement decreased from 100% to 88%, with further reductions to 77% and 65% as of October 1, 2013 and 2014, respectively. Any reductions in Medicare or Medicaid reimbursement could materially adversely affect our profitability.

Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending.

Medicaid, which is largely administered by the states, is a significant payor for our skilled nursing services. Rapidly increasing Medicaid spending, combined with slow state revenue growth, has led many states to institute measures aimed at controlling spending growth. For example, in February 2009, the California legislature approved a new budget to help relieve a $42 billion budget deficit. The budget package was signed after months of negotiation, during which time California's governor declared a fiscal state of emergency in California. The new budget implemented spending cuts in several areas, including Medi-Cal spending. Further, California initially had extended its cost-based Medi-Cal long-term care reimbursement system enacted through Assembly Bill 1629 (A.B.1629) through the 2009-2010 and 2010-2011 rate years with a growth rate of up to five percent for both years. However, due to California's severe budget crisis, in July 2009, the State passed a budget-balancing proposal that eliminated this five percent growth cap by amending the current statute to provide that, for the 2009-2010 and 2010-2011 rate years, the weighted average Medi-Cal reimbursement rate paid to long-term care facilities shall not exceed the weighted average Medi-Cal reimbursement rate for the 2008-2009 rate year. In addition, the budget proposal increased the amounts that California nursing facilities will pay to Medi-Cal in quality assurance fees for the 2009-2010 and 2010-2011 rate years by including Medicare revenue in the calculation of the quality assurance fee that nursing facilities pay under A.B. 1629. Although overall reimbursement from Medi-Cal remained stable, individual facility rates varied.

California's Governor signed the budget trailer into law in October 2010. Despite its enactment, these changes in reimbursement to long-term care facilities were to be implemented retroactively to the beginning of the calendar quarter in which California submitted its request for federal approval of CMS. In January, 2011, the California Governor proposed a budget for 2011-2012 which proposes to reduce Medi-Cal provider payments by 10%, including payments to long-term care facilities.

On March 24, 2011, the governor of California signed Assembly Bill 97 (AB 97), the budget trailer bill on health, into law. AB 97 outlines significant cuts to state health and human services programs. Specifically, the law reduced provider payments by 10% for physicians, pharmacies, clinics, medical transportation, certain hospitals, home health, and nursing facilities. AB X1 19 Long Term Care was subsequently approved by the governor on June 28, 2011. Federal approval was obtained on October

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27, 2011. AB X1 19 limited the 10% payment reduction to skilled-nursing providers to 14 months for the services provided on June 1, 2011 through July 31, 2012. The 10% reduction in provider payments was repaid on or before December 31, 2012.

California's Governor released a 2014-2015 budget that includes $1.2 billion in additional Medi-Cal funding. This proposal, however, would not eliminate retroactive rate cuts for hospital-based skilled nursing facilities.

Because state legislatures control the amount of state funding for Medicaid programs, cuts or delays in approval of such funding by legislatures could reduce the amount of, or cause a delay in, payment from Medicaid to skilled nursing facilities. Since a significant portion of our revenue is generated from our skilled nursing operating subsidiaries in California, these budget reductions, if approved, could adversely affect our net patient service revenue and profitability. We expect continuing cost containment pressures on Medicaid outlays for skilled nursing facilities, and any such decline could adversely affect our financial condition and results of operations.

To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements such as provider taxes. Under provider tax arrangements, states collect taxes or fees from healthcare providers and then return the revenue to these providers as Medicaid expenditures. Congress, however, has placed restrictions on states' use of provider tax and donation programs as a source of state matching funds. Under the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, the federal medical assistance percentage available to a state was reduced by the total amount of healthcare related taxes that the state imposed, unless certain requirements are met. The federal medical assistance percentage is not reduced if the state taxes are broad-based and not applied specifically to Medicaid reimbursed services. In addition, the healthcare providers receiving Medicaid reimbursement must be at risk for the amount of tax assessed and must not be guaranteed to receive reimbursement through the applicable state Medicaid program for the tax assessed. Lower Medicaid reimbursement rates would adversely affect our revenue, financial condition and results of operations.

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.

Skilled nursing facilities are required to perform consolidated billing for certain items and services furnished to patients and residents. The consolidated billing requirement essentially confers on the skilled nursing facility itself the Medicare billing responsibility for the entire package of care that its patients receive in these situations. The BBA also affected skilled nursing facility payments by requiring that post-hospitalization skilled nursing services be "bundled" into the hospital's Diagnostic Related Group (DRG) payment in certain circumstances. Where this rule applies, the hospital and the skilled nursing facility must, in effect, divide the payment which otherwise would have been paid to the hospital alone for the patient's treatment, and no additional funds are paid by Medicare for skilled nursing care of the patient. At present, this provision applies to a limited number of DRGs, but already is apparently having a negative effect on skilled nursing facility utilization and payments, either because hospitals are finding it difficult to place patients in skilled nursing facilities which will not be paid as before or because hospitals are reluctant to discharge the patients to skilled nursing facilities and lose part of their payment. This bundling requirement could be extended to more DRGs in the future, which would accentuate the negative impact on skilled nursing facility utilization and payments. 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.

Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements.

PPACA and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) include sweeping changes to how health care is paid for and furnished in the United States.

PPACA, as modified by the Reconciliation Act, is projected to expand access to Medicaid for approximately 11 to 13 million additional people each year between 2015 - 2024. It also reduces the projected growth of Medicare by $106 billion by 2020 by tying payments to providers more closely to quality outcomes. It also imposes new obligations on skilled nursing facilities, requiring them to disclose information regarding ownership, expenditures and certain other information. This information is disclosed on a website for comparison by members of the public.

To address potential fraud and abuse in federal health care programs, including Medicare and Medicaid, PPACA includes provider screening and enhanced oversight periods for new providers and suppliers, as well as enhanced penalties for submitting false claims. It also provides funding for enhanced anti-fraud activities. The new law imposes enrollment moratoria in elevated risk areas by requiring providers and suppliers to establish compliance programs. PPACA also provides the federal government with expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud. Section 6402 of the PPACA provides that Medicare and Medicaid payments may be suspended pending a “credible investigation of fraud,” unless the Secretary of Health and Human Services determines that good cause exists not to suspend payments. To the extent the Secretary

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applies this suspension of payments provision to one of our affiliated facilities for allegations of fraud, such a suspension could adversely affect our results of operations.

Under PPACA, the U.S. Department of Health and Human Services (HHS) will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care. The bundled payment will cover the costs of acute care inpatient services; physicians' services delivered in and outside of an acute care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services; inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. As with Medicare's shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.

PPACA attempts to improve the health care delivery system through incentives to enhance quality, improve beneficiary outcomes and increase value of care. One of these key delivery system reforms is the encouragement of Accountable Care Organizations (ACOs). ACOs will facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Participating ACOs that meet specified quality performance standards will be eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount. Quality performance standards will include measures in such categories as clinical processes and outcomes of care, patient experience and utilization of services.

In addition, PPACA required HHS to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities. HHS delivered a report to Congress outlining its plans for implementing this value-based purchasing program. The value-based purchasing program would provide payment incentives for Medicare-participating skilled nursing facilities to improve the quality of care provided to Medicare beneficiaries. Among the most relevant factors in HHS' plans to implement value-based purchasing for skilled nursing facilities is the current Nursing Home Value-Based Purchasing Demonstration Project, which concluded in 2012. HHS provided Congress with an outline of plans to implement a value-based purchasing program, and any permanent value-based purchasing program for skilled nursing facilities will be implemented after that evaluation.

On June 28, 2012 the United States Supreme Court ruled that the enactment of PPACA did not violate the Constitution of the United States. This ruling permits the implementation of most of the provisions of PPACA to proceed. The provisions of PPACA discussed above are only examples of federal health reform provisions that we believe may have a material impact on the long-term care industry and on our business. However, the foregoing discussion is not intended to constitute, nor does it constitute, an exhaustive review and discussion of PPACA. It is possible that these and other provisions of PPACA may be interpreted, clarified, or applied to our affiliated facilities or operating subsidiaries in a way that could have a material adverse impact on the results of operations.

On April 1, 2014, the President signed into law the Protecting Access to Medicare Act of 2014 which, among other things, provides the framework for implementation of a value-based purchasing program for skilled nursing facilities. Under this legislation HHS is required to develop by October 1, 2016 measures and performance standards regarding preventable hospital readmissions from skilled nursing facilities. Beginning October 1, 2018, HHS will withhold 2%

of Medicare payments to all skilled nursing facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

We cannot predict what effect these changes 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 and adversely affect our business.

The Affordable Care Act and its implementation could impact our business.

In addition, the Affordable Care Act could result in sweeping changes to the existing U.S. system for the delivery and financing of health care. The details for implementation of many of the requirements under the Affordable Care Act will depend on the promulgation of regulations by a number of federal government agencies, including the HHS. It is impossible to predict

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the outcome of these changes, what many of the final requirements of the Health Reform Law will be, and the net effect of those requirements on us. As such, we cannot predict the impact of the Affordable Care Act on our business, operations or financial performance.

A significant goal of Federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals at lower cost. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. Providers who respond successfully to these trends and are able to deliver quality care at lower cost are likely to benefit financially.

The Affordable Care Act and the programs implemented by the law may reduce reimbursements for our services and may impact the demand for the Company’s products. In addition, various healthcare programs and regulations may be ultimately implemented at the federal or state level. Failure to respond successfully to these trends could negatively impact our business, results of operations and/or financial condition.

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, Certified Nurse Assistants (CNAs) and therapists. Our success also depends upon our ability to retain and attract skilled management personnel who are responsible for the day-to-day operations of each of our affiliated facilities. 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 that is directly responsible for day-to-day care of the patients and marketing and community outreach programs. Other key positions supporting each facility may include individuals responsible for physical, occupational and speech therapy, food service and maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

We operate one or more affiliated skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Texas, Utah, Washington, and Wisconsin. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities operating in that state. 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. In addition, 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. Deficiencies (depending on the level) may also result in the suspension of patient admissions and/or the termination of Medicaid participation, or the suspension, revocation or nonrenewal of the skilled nursing facility's license. If the federal or state governments were to issue regulations which 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.

Increased competition for or a shortage of nurses or other trained personnel, or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge to the patients of our operating subsidiaries. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility.

An increase in costs associated with, or a shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

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 these programs and applicable laws and regulations. We are also subject to audits under various government programs, including Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC), Program Safeguard Contractors (PSC) and Medicaid Integrity Contributors (MIC) programs, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare programs. Private pay sources also reserve the right to conduct audits. We believe that billing and reimbursement

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errors and disagreements are common in our industry. 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 and other sanctions on us;
- 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 various markets.

In 2004, one of our Medicare fiscal intermediaries began to conduct selected reviews of claims previously submitted by and paid to some of our affiliated facilities. While we have always been subject to post-payment audits and reviews, more intensive "probe reviews" appear to be a permanent procedure with our fiscal intermediary. Although some of these probe reviews identified patient miscoding, documentation deficiencies and other errors in our recordkeeping and Medicare billing, these errors resulted in no Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments. As of December 31, 2014, we had one facility under probe review.

If the government or court were to conclude that such errors and deficiencies constituted criminal violations, or were to conclude that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or if it 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/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we and/or some of the key personnel of our operating subsidiaries could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare. In any event, it is likely that a governmental investigation alone, regardless of its outcome, would divert material time, resources and attention 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.

In some cases, probe reviews can also result in a facility being temporarily placed on prepayment review of reimbursement claims, requiring additional documentation and adding steps and time to the reimbursement process for the affected facility. Failure to meet claim filing and documentation requirements during the prepayment review could subject a facility to an even more intensive "targeted review," where a corrective action plan addressing perceived deficiencies must be prepared by the facility and approved by the fiscal intermediary. During a targeted review, additional claims are reviewed pre-payment to ensure that the prescribed corrective actions are being followed. Failure to make corrections or to otherwise meet the claim documentation and submission requirements could eventually result in Medicare decertification. None of our operating subsidiaries are currently on prepayment review, although some may be placed on prepayment review in the future. We have no operating subsidiaries that are currently undergoing targeted review.

Public and government calls for increased survey and enforcement efforts toward long-term care facilities 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 has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to identify multi-facility providers with patterns of noncompliance. In addition, the Department of Health and Human Services has adopted a rule that requires CMS to charge user fees to healthcare facilities cited during regular certification, recertification or substantiated complaint surveys for deficiencies, which require a revisit to assure that corrections have been made. 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.

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other

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enforcement actions. The diversion of these resources, including our management team, clinical and compliance staff, and others take away from the time and energy that these individuals could otherwise spend on routine operations. As noted, 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. The focus of these deficiency reports tends to vary from year to year. 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, which could result in the imposition of fines, imposition of a provisional or conditional license, 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. We currently have no affiliated facilities operating under provisional licenses which were the result of inspection deficiencies.

Furthermore, in some states, citations in one facility impact other facilities in the state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew 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. If state or federal regulators were to determine, formally or otherwise, that one facility's regulatory history ought to impact another of our existing or prospective facilities, this could also increase costs, result in increased scrutiny by state and federal survey agencies, and even impact our expansion plans. Therefore, our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations as a whole.

When a facility is found to be deficient under state licensing and Medicaid and Medicare standards, sanctions may be threatened or imposed such as denial of payment for new Medicaid and Medicare admissions, civil monetary penalties, focused state and federal oversight and even loss of eligibility for Medicaid and Medicare participation or state licensure. 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 return, 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. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients' care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance. In the past, some of our affiliated facilities have been in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of the revenue associated with the Medicare and Medicaid patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, these sanctions, entailing various remedies up to and including decertification, would further negatively affect our financial condition and results of operations. From time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements.

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 nine months, 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, are not generally 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 (including us, historically) 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 we acquire them and that develop new deficiencies after we acquire them 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 quality of care problems through the special focus facility initiative. A facility's administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility's compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility “graduates” from the program once it demonstrates significant improvements in quality of care that are continued over time.

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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 affiliated facilities. We have had several affiliated facilities placed on special focus facility status, due largely or entirely to their respective regulatory histories prior to our acquisition of the operating subsidiaries, and have successfully graduated four affiliated facilities from the program to date. CMS currently has included one of our affiliated facilities on its special focus facilities listing. To date, this affiliated facility has passed both surveys. The successful completion of two surveys are required for a special focus facility to graduate from the program. Other affiliated facilities may be identified for such status in the future.

Annual caps that limit the amounts that can be paid for outpatient therapy services rendered to any Medicare beneficiary may reduce our future revenue and profitability or cause us to incur losses.

Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The BBA requires a combined cap for physical therapy and speech-language pathology and a separate cap for occupational therapy.

The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006 for patients with certain conditions or multiple complexities whose therapy services are reimbursed under Medicare Part B. A significant portion of the patients in our affiliated skilled nursing facilities and patients served by our rehabilitation therapy programs whose therapy is reimbursed under Medicare Part B have qualified for the exceptions to these reimbursement caps. DRA added Sec. 1833(g)(5) of the Social Security Act and directed them to develop a process that allows exceptions for Medicare beneficiaries to therapy caps when continued therapy is deemed medically necessary.

The therapy cap exception has been reauthorized in a number of subsequent laws, most recently in the Protecting Access to Medicare Act of 2014, which extends the cap and exception process through March 31, 2015. That statute implements a two-tiered exception process, with an automatic exception process and a manual medical review exception process. The automatic exception process applies for patients who reach a $1,920 threshold. The manual medical review exception process applies at the $3,700 threshold.

In addition, the Multiple Procedure Payment Reduction (MPPR) was increased from a 25% to 50% reduction applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies 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. The change from 25% of the practice expense to a 50% reduction went into effect for Medicare Part B services provided on or after April 1, 2013.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond March 31, 2015, which could also have an adverse effect on our revenue after that date.

Our hospice operating subsidiaries are subject to annual Medicare caps calculated by Medicare. If such caps were to be exceeded by any of our hospice providers, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

With respect to our hospice operating subsidiaries, overall payments made by Medicare to each provider number are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare

fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we are required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We are subject to extensive and complex federal and state government laws and regulations which could change at any time and increase our cost of doing business and subject us to enforcement actions.

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:

- facility and professional licensure, certificates of need, permits and other government approvals;

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- adequacy and quality of healthcare services;
- qualifications of healthcare and support personnel;
- quality of medical equipment;
- 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;
- certification of additional facilities by the Medicare program; and
- payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to frequent change. We believe that such regulations may increase in the future and we cannot predict the ultimate content, timing or impact on us of any healthcare reform legislation. Changes in existing laws or regulations, or the enactment of new laws or regulations, could negatively impact our business. If we fail to comply with these applicable laws and regulations, 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.

We are subject to federal and state laws, such as the federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, and the federal “Stark” laws, that govern financial and other arrangements among healthcare providers, their owners, vendors and referral sources, and that are intended to prevent healthcare fraud and abuse. Among other things, these laws prohibit kickbacks, bribes and rebates, as well as other direct and indirect payments or fee-splitting arrangements that are designed to induce the referral of patients to a particular provider for medical products or services payable by any federal healthcare program, and prohibit presenting a false or misleading claim for payment under a federal or state program. They also prohibit some physician self-referrals. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. Changes in these laws could increase our cost of doing business. 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 corporate integrity, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties. For example, in April 2013, we announced that we reached a tentative settlement with the Department of Justice (DOJ) regarding their investigation related to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. As part of the settlement, we entered into a Corporate Integrity Agreement with the Office of Inspector General-HHS. Failure to comply with the terms of the Corporate Integrity Agreement could result in substantial civil or criminal penalties and being excluded from government health care programs, which could adversely affect our financial condition and results of operations.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by FERA, health care providers face significant penalties for known 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 a FCA violation can occur without any affirmative fraudulent action or statement, as long as it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also

contractors and agents. Thus, there is no need for an employment relationship in order to qualify for protection against retaliation for whistleblowing.

We are also required to comply with state and federal laws governing the transmission, privacy and security of health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to comply with certain standards for the use of individually identifiable health information within our company, and the disclosure and electronic transmission of such information to third parties, such as payors, business associates and patients. These include standards for common electronic healthcare transactions and information, such as claim submission, plan eligibility determination, payment information submission and the use of electronic signatures; unique identifiers for providers, employers and health plans; and the security and privacy of individually identifiable health information. In addition, some states have enacted comparable or, in some cases, more stringent

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privacy and security laws. If we fail to comply with these state and federal laws, we could be subject to criminal penalties and civil sanctions and be forced to modify our policies and procedures.

On January 25, 2013 the Department of Health and Human Services promulgated new HIPAA privacy, security, and enforcement regulations, which increase significantly the penalties and enforcement practices of the Department regarding HIPAA violations. In addition, any breach of individually identifiable health information can result in obligations under HIPAA and state laws to notify patients, federal and state agencies, and in some cases media outlets, regarding the breach incident. Breach incidents and violations of HIPAA or state privacy and security laws could subject us to significant penalties, and could have a significant impact on our business. The new HIPAA regulations are effective as of March 26, 2013, and compliance was required by September 23, 2013.

Our failure to obtain or renew required regulatory approvals or licenses or to comply with applicable regulatory requirements, the suspension or revocation of our licenses or our disqualification from participation in federal and state reimbursement programs, or the imposition of other harsh enforcement sanctions could increase our cost of doing business and expose us to potential sanctions. Furthermore, if we were to lose licenses or certifications for any of our affiliated facilities as a result of regulatory action or otherwise, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness and lease obligations.

Increased civil and criminal enforcement efforts of government agencies against skilled nursing facilities could harm our business, and could preclude us from participating in federal healthcare programs.

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, skilled nursing facilities. The focus of these investigations includes, among other things:

- cost reporting and billing practices;
- quality of care;
- financial relationships with referral sources; and
- medical necessity of services provided.

If any of our affiliated facilities 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 affiliated facilities could harm our reputation for quality care and lead to a reduction in the patient referrals of our operating subsidiaries and ultimately a reduction in occupancy at these facilities. Also, responding to enforcement efforts would divert material time, resources and attention 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.

Federal law provides that practitioners, providers and related persons may not participate in most federal healthcare programs, including the Medicaid and Medicare programs, if the individual or entity has been convicted of a criminal offense related to the delivery of a product or service under these programs or if the individual or entity has been convicted under state or federal law of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a healthcare product or service. Other individuals or entities may be, but are not required to be, excluded from such programs under certain circumstances, including, but not limited to, the following:

- medical necessity of services provided;

- conviction related to fraud;
- conviction relating to obstruction of an investigation;
- conviction relating to a controlled substance;
- licensure revocation or suspension;
- exclusion or suspension from state or other federal healthcare programs;

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- filing claims for excessive charges or unnecessary services or failure to furnish medically necessary services;

- ownership or control of an entity by an individual who has been excluded from the Medicaid or Medicare programs, against whom a civil monetary penalty related to the Medicaid or Medicare programs has been assessed or who has been convicted of a criminal offense under federal healthcare programs; and

- the transfer of ownership or control interest in an entity to an immediate family or household member in anticipation of, or following, a conviction, assessment or exclusion from the Medicare or Medicaid programs.

The OIG, among other priorities, is responsible for identifying and eliminating fraud, abuse and waste in certain federal healthcare programs. The OIG has implemented a nationwide program of audits, inspections and investigations and from time to time issues “fraud alerts” to segments of the healthcare industry on particular practices that are vulnerable to abuse. The fraud alerts inform healthcare providers of potentially abusive practices or transactions that are subject to criminal activity and reportable to the OIG. An increasing level of resources has been devoted to the investigation of allegations of fraud and abuse in the Medicaid and Medicare programs, and federal and state regulatory authorities are taking an increasingly strict view of the requirements imposed on healthcare providers by the Social Security Act and Medicaid and Medicare programs. Although we have created a corporate compliance program that we believe is consistent with the OIG guidelines, the OIG may modify its guidelines or interpret its guidelines in a manner inconsistent with our interpretation or the OIG may ultimately determine that our corporate compliance program is insufficient.

In some circumstances, if one facility is convicted of abusive or fraudulent behavior, then other facilities under common control or ownership may be decertified from participating in Medicaid or Medicare programs. Federal regulations prohibit any corporation or facility from participating in federal contracts if it or its principals have been barred, suspended or declared ineligible from participating in federal contracts. In addition, some state regulations provide that all facilities under common control or ownership licensed within a state may be de-licensed if one or more of the facilities are de-licensed. If any of our affiliated facilities were decertified or excluded from participating in Medicaid or Medicare programs, our revenue would be adversely affected.

The Office of the Inspector General or other organizations may choose to more closely scrutinize the billing practices of for-profit skilled nursing facilities, 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.

In December 2010, the OIG released a report entitled “Questionable Billing by Skilled Nursing Facilities.” The report examined the billing practices of skilled nursing facilities based on Medicare Part A claims from 2006 to 2008 and found, among other things, that for-profit skilled nursing facilities were more likely to bill for higher paying therapy RUGs, particularly in the ultra high therapy categories, than government and not-for-profit operators. It also found that for-profit skilled nursing facilities showed a higher incidence of patients using RUGs with higher activities of daily living (ADL) scores, and had a “long” average length of stay among Part A beneficiaries, compared to their government and not-for-profit counterparts. The OIG recommended that CMS vigilantly monitor overall payments to skilled nursing facilities, adjust RUG rates annually, change the method for determining how much therapy is needed to ensure appropriate payments and conduct additional reviews for skilled nursing operators that exceed certain thresholds for higher paying therapy RUGs. CMS concurred with and agreed to take action on three of the four recommendations, declining only to change the methodology for assessing a patient's therapy needs. The OIG issued a separate memorandum to CMS listing 384 specific facilities that the OIG had identified as being in the top one percent for use of ultra high therapy, RUGs with high ADL scores, or “long” average lengths of stay, and CMS agreed to forward the list to the appropriate fiscal intermediaries or other contractors for follow up. Although we believe our therapy assessment and billing practices are consistent with applicable law and CMS requirements, we cannot predict

the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. Two of our affiliated facilities have been listed on the report. Our business model, like those of some other for-profit operators, is based in part on seeking out higher-acuity patients whom we believe are generally more profitable, and over time our overall patient mix has consistently shifted to higher-acuity and higher-RUGs patients in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording ADL 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, as well as other government agencies, unions, advocacy groups and others who seek to pursue their own mandates and agendas. In its fiscal year 2014 work plan, OIG specifically stated that it will continue to study and report on questionable Part A and Part B billing practices amongst skilled nursing facilities. Efforts by officials and others to make or advocate for any increase in regulatory monitoring and oversight, adversely change RUG rates, revise methodologies for assessing and treating patients, or conduct more frequent or intense reviews of our treatment and billing practices, could reduce our reimbursement, increase our costs of doing business and otherwise adversely affect our business, financial condition and results of operations.

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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 skilled nursing facilities, to obtain prior approval, known as a certificate of need, for:

- the purchase, construction or expansion of healthcare facilities;
- capital expenditures exceeding a prescribed amount; or
- changes in services or bed capacity.

In addition, other states that do not require certificates of need have effectively barred the expansion of existing facilities and the development of new ones by placing partial or complete moratoria on the number of new Medicaid beds they will certify in certain areas or in the entire state. 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 the acquisition of a facility being operated by a non-profit organization requires the approval of the state Attorney General.

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, 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.

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

Our operating subsidiaries are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act which governs such matters as minimum wages, overtime and other working conditions, the Americans with Disabilities Act (ADA) and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission (EEOC), regulations of the Office of Civil Rights, regulations of state Attorneys General, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Because labor represents such a large portion of our operating costs, changes in federal and state employment-related laws and regulations could increase our cost of doing business.

The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our affiliated facilities are required to comply with the ADA. The ADA has separate compliance requirements for “public accommodations” and “commercial properties,” but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if

implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law. While we are insured for these types of claims, we could experience damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

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

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In addition, we are required to operate our affiliated facilities in compliance with applicable fire and safety regulations, building codes and other land use regulations and food licensing or certification requirements as they may be adopted by governmental agencies and bodies from time to time. Like other healthcare facilities, our affiliated skilled nursing facilities 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.

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 affiliated facilities as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of the patients of our operating subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, 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 because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. For the year ended December 31, 2014, 70.4% of our revenue was provided by government payors that reimburse us at predetermined rates. 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 operating 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. Among other initiatives, these payors attempt to control healthcare costs by 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, we may lose patients if we choose not to renew our contracts with these insurers at lower rates.

Compliance with state and federal employment, immigration, licensing and other laws could increase our cost of doing business.

We have hired personnel, including skilled nurses and therapists, from outside the United States. If immigration laws are changed, or if new and more restrictive government regulations proposed by the Department of Homeland Security are enacted, our access to qualified and skilled personnel may be limited.

We operate in at least one state that requires us to verify employment eligibility using procedures and standards that exceed those required under federal Form I-9 and the statutes and regulations related thereto. Proposed federal regulations would extend similar requirements to all of the states in which our affiliated facilities operate. To the extent that such proposed regulations or similar measures become effective, and we are required by state or federal authorities to verify work authorization or legal residence for current and prospective employees beyond existing Form I-9 requirements and other statutes and regulations currently in effect, it may make it more difficult for us to recruit, hire and/or retain qualified employees, may increase our risk of non-compliance with state and federal employment, immigration, licensing and other laws and regulations and could increase our cost of doing business.

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 operating subsidiaries and the services we provide. We and others in our industry are subject to a large and increasing number of claims and lawsuits, including professional liability claims, alleging that our services have resulted in personal injury, elder abuse, wrongful death or other related claims. The defense of these lawsuits has in the past, and may in the future, result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards. Plaintiffs tend to sue every healthcare provider who may have been involved in the patient's care and, accordingly, we respond to multiple lawsuits and claims every year.

In addition, plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers and other long-term care companies, and have employed a wide variety of advertising and publicity strategies. Among other things, these strategies include establishing their own Internet websites, paying for premium advertising space on other websites, paying Internet search engines to optimize their plaintiff solicitation advertising so that it appears in advantageous positions on Internet search results, including results from searches for our company and affiliated facilities, using newspaper, magazine and television ads targeted at customers of the healthcare industry generally, as well as at

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customers of specific providers, including us. From time to time, law firms claiming to specialize in long-term care litigation have named us, our affiliated facilities and other specific healthcare providers and facilities in their advertising and solicitation materials. These advertising and solicitation activities could result in more claims and litigation, which could increase our liability exposure and legal expenses, divert the time and attention of the personnel of our operating subsidiaries from day-to-day business operations, and materially and adversely affect our financial condition and results of operations. Furthermore, to the extent the frequency and/or severity of losses from such claims and suits increases, our liability insurance premiums could increase and/or available insurance coverage levels could decline, which could materially and adversely affect our financial condition and results of operations. Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and we are routinely subjected to varying types of claims. One particular type of suit arises from alleged violations of state-established minimum staffing requirements for skilled nursing facilities. Failure to meet these requirements can, among other things, jeopardize a facility's compliance with conditions of participation under certain state and federal healthcare programs; it may also subject the facility to a notice of deficiency, a citation, civil monetary penalty, or litigation. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements, and have become more prevalent in the wake of a previous substantial jury award against one of our competitors. We expect the plaintiff's bar to continue to be aggressive in their pursuit of these staffing and similar claims.

A class action staffing suit was previously filed against us in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act at certain of our California affiliated facilities. In 2007, we settled this class action suit, and the settlement was approved by the affected class and the Court. We have been defending a second such staffing class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, were approximately $6.5 million, of which, approximately $1.5 million and $2.6 million of this amount was recorded in the fiscal year ended December 31, 2013 and 2012, respectively, with the balance having been expensed in prior periods. We believe that the settlement will not have a material ongoing adverse effect on our business, financial condition or 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 an increase in the number of wage and hour class action claims filed in several of the jurisdictions where we are present. Allegations typically include claimed 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 or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could have a material adverse effect to our business, financial condition, results of operations and cash flows. In addition, we contract with a variety of landlords, lenders, vendors, suppliers, consultants and other individuals and businesses. These contracts typically contain covenants and default provisions. If the other party to one or more of our contracts were to allege that we have violated the contract terms, we could be subject to civil liabilities which could have a material adverse effect on our financial condition and results of operations.

Were litigation to be instituted against one or more of our subsidiaries, a successful 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.

On February 26, 2009, Congress reintroduced the Fairness in Nursing Home Arbitration Act of 2009. After failing to be enacted into law in the 110th Congress in 2008, the Fairness in Nursing Home Arbitration Act of 2009 was introduced in the 111th Congress and referred to the House and Senate judiciary committees in March 2009. The 111th Congress did not pass the bill and therefore has been cleared from the present agenda. This bill was reintroduced in the 112th Congress as the Fairness in Nursing Home Arbitration Act of 2012, and was referred to the

House Judiciary committee. If enacted, this bill 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. We 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. 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 U.S. Department of Justice has conducted an investigation into the billing and reimbursement processes of some of our operating subsidiaries, which could adversely affect our operations and financial condition.

In October 2013, we entered into a settlement agreement (the Settlement Agreement) with the DOJ pertaining to an investigation of certain of our operating subsidiaries. Pursuant to the settlement agreement, we made a single lump-sum remittance

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to the government in the amount of $48.0 million in October 2013. We have denied engaging in any illegal conduct, and have agreed to the settlement amount without any admission of wrongdoing in order to resolve the allegations and to avoid the uncertainty and expense of protracted litigation.

In connection with the settlement and effective as of October 1, 2013, we entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. The CIA acknowledges the existence of our current compliance program, which is in accord with the Office of the Inspector General (OIG)'s guidance related to an effective compliance program, and requires that we continue during the term of the CIA to maintain said compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. We are also required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that we have committed a crime or has engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by Federal health care programs. We are also required to retain an Independent Review Organization (IRO) to review certain clinical documentation annually for the term of the CIA.

Our participation in federal healthcare programs is not currently affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in federal healthcare programs and/or subject to prosecution.

If any additional litigation were to proceed in the future, and we are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal 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 and/or other arrangement with the government.

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

As an operator of healthcare facilities, we have a program to help us comply 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, government manuals 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 operating 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, for example, 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, and would continue to do so in the future, initiated internal inquiries into possible recordkeeping and related irregularities at our affiliated skilled nursing facilities, 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 also identified and, at the conclusion of such investigations, assisted in implementing, targeted improvements in the assessment and recordkeeping practices to make them consistent with the existing standards and policies applicable to our affiliated skilled nursing facilities in these areas. 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 would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

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

To date, our revenue growth has been significantly driven 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, the purchase price of the facilities, 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 historically acquired a few facilities, either because they were included in larger, indivisible groups of facilities or under other circumstances, which were or have proven to be non-strategic or less desirable, and we may consider disposing of such facilities or exchanging them for facilities which are more desirable. To the extent we dispose of such a facility without simultaneously acquiring a facility in exchange, our revenues might decrease.

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

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

During the year ended December 31, 2014, we continued to expand our operations with the addition of fifteen stand-alone skilled nursing operations, three stand-alone assisted living operations, three home health agencies, four hospice agencies, one home care business, one primary care group and one transitional care management company, with a total of 1,453 operational skilled nursing beds and 333 operational assisted living units. During the year ended December 31, 2013, we acquired seven stand-alone skilled nursing operations, three stand-alone assisted living operations, three home health operations, three hospice operations and one urgent care center with a total of 652 operational skilled nursing beds and 281 operational assisted living units. 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 facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such facilities 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 facility 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 facilities, against whom we may have little or no recourse. Many facilities we have historically acquired were

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underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved operating subsidiaries and patient care at affiliated facilities that we have acquired, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant facilities into 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, facilities that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable. For example, in July of 2006 we acquired a facility that had a history of intermittent noncompliance. Although the affiliated facility had already been surveyed once by the local state survey agency after being acquired by us, and that survey would have met the heightened requirements of the special focus facility program, based upon the facility's compliance history prior to our acquisition, in January 2008, state officials nevertheless recommended to CMS that the facility be placed on special focus facility status. In addition, in October of 2006, we acquired a facility which had a history of intermittent non-compliance. This affiliated facility was surveyed by the local state survey agency during the third quarter of 2008 and passed the heightened survey requirements of the special focus facility program. Both affiliated facilities have successfully graduated from the Centers for Medicare and Medicaid Services' Special Focus program. As of December 31, 2014, we had one affiliated facility on special focus facility status. To date, this affiliated facility has passed both surveys. The successful completion of two surveys are required for a special focus facility to graduate from the program. Other affiliated facilities may be identified for such status in the future.

In addition, we might encounter unanticipated difficulties and expenditures relating to any of the acquired facilities, including contingent liabilities. For example, when we acquire a facility, we generally assume the facility's existing Medicare provider number for purposes of billing Medicare for services. If CMS later determined that the prior owner of the facility had received overpayments from Medicare for the period of time during which it operated the facility, or had incurred fines in connection with the operation of the facility, CMS could hold us liable for repayment of the overpayments or fines. If the prior operator is defunct or otherwise unable to reimburse us, we may be unable to recover these funds. We may be unable to improve every facility that we acquire. In addition, operation of these facilities 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. 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.

Termination of our patient admission agreements and the resulting vacancies in our affiliated facilities could cause revenue at our affiliated facilities to decline.

Most state regulations governing skilled nursing and assisted living facilities require written patient admission agreements with each patient. Several of these regulations also require that each patient have the right to terminate the patient agreement for any reason and without prior notice. Consistent with these regulations, all of our skilled nursing patient agreements allow patients to terminate their agreements without notice, and all of our assisted living resident agreements allow patients to terminate their agreements upon thirty days' notice. Patients and residents terminate their agreements from time to time for a variety of reasons, causing some fluctuations in our overall occupancy as patients and residents are admitted and discharged in normal course. If an unusual number of patients or residents elected to terminate their agreements within a short time, occupancy levels at our affiliated facilities could decline. As a result, beds may be unoccupied for a period of time, which would have a negative impact on our revenue, financial condition and results of operations.

We face significant competition from other healthcare providers and may not be successful in attracting patients and residents to our affiliated facilities.

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The skilled nursing, assisted living, home health and hospice fields are highly competitive, and we expect that these fields may become increasingly competitive in the future. Our affiliated skilled nursing facilities compete primarily on a local and regional basis with many long-term care providers, from national and regional multi-facility providers that have substantially greater financial resources to small providers who operate a single nursing facility. We also compete with other skilled nursing and assisted living facilities, and with inpatient rehabilitation facilities, long-term acute care hospitals, home healthcare and other similar services and care alternatives. Increased competition could limit our ability to attract and retain patients, attract and retain skilled personnel, maintain or increase private pay and managed care rates or expand our business.

We may not be successful in attracting patients to our operating subsidiaries, particularly Medicare, managed care, and private pay patients who generally come to us at higher reimbursement rates. Some of our competitors have greater financial and other resources than us, 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 do and may thereby attract current or potential patients. Other competitors may have lower expenses or other competitive advantages, and, therefore, present significant price competition for managed care and private pay patients. In addition, some of our competitors operate on a not-for-profit basis or as charitable organizations and have the ability to finance capital expenditures on a tax-exempt basis or through the receipt of charitable contributions, neither of which are available to us.

If we do not achieve and maintain competitive quality of care ratings from CMS and private organizations engaged in similar monitoring activities, or if the frequency of CMS surveys and enforcement sanctions increases, our business may be negatively affected.

CMS, as well as certain private organizations engaged in similar monitoring activities, provides comparative data available to the public on its web site, rating every skilled nursing facility operating in each state based upon quality-of-care indicators. These quality-of-care indicators include such measures as percentages of patients with infections, bedsores and unplanned weight loss. In addition, CMS has undertaken an initiative to increase Medicaid and Medicare survey and enforcement activities, to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to require state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified. We have found a correlation between negative Medicaid and Medicare surveys and the incidence of professional liability litigation. From time to time, we experience a higher than normal number of negative survey findings in some of our affiliated facilities.

In December 2008, CMS introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each nursing home a rating of between one and five stars in various categories. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating. The prior operator's results will impact our rating until we have sufficient clinical measurements subsequent to the acquisition date. If we are unable to achieve quality of care ratings that are comparable or superior to those of our competitors, our ability to attract and retain patients could be adversely affected.
CMS also recently announced two proposed post-acute care provider initiatives. First, CMS proposes to expand and strengthen the Five Star Quality Rating System for nursing homes to improve consumer information about quality measures at individual nursing homes. In addition, CMS announced proposals to adopt new standards that home health agencies must comply with in order to participate in the Medicare program, including the strengthening of patient rights and communication requirements that focus on patient well-being.

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 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 tighten underwriting standards applicable to us or our industry; or

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- insurers or reinsurers are unable or unwilling to insure us or the industry at historical premiums and coverage levels.

If any of these potential circumstances were to occur, our insurance carriers may require us to significantly increase our self-insured retention levels or pay substantially higher premiums for the same or reduced coverage for insurance, including workers compensation, property and casualty, automobile, employment practices liability, directors and officers liability, employee healthcare and general and professional liability coverages.

In some states, the law prohibits or limits insurance coverage for the risk of punitive damages arising from professional liability and general liability claims or litigation. Coverage for punitive damages is also excluded under some insurance policies. As a result, we may be liable for punitive damage awards in these states that either are not covered or are in excess of our insurance policy limits. Claims against us, regardless of their merit or eventual outcome, also could inhibit our ability to attract patients or expand our business, and could require our management to devote time to matters unrelated to the day-to-day operation of our business.

With few exceptions, workers' compensation and employee health insurance costs have also increased markedly in recent years. To partially offset these increases, we have increased the amounts of our self-insured retention (SIR) and deductibles in connection with general and professional liability claims. We also have implemented a self-insurance program for workers compensation in all states, except Washington and Texas, and elected non-subscriber status for workers' compensation in Texas. In Washington, the insurance coverage is financed through premiums paid by the employers and employees. 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 have maintained general and professional liability insurance since 2002 and workers' compensation insurance since 2005 through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our self-insurance reimbursements (SIR) 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 SIR 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.

In May 2006, we began self-insuring 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 affiliated facilities could leave us vulnerable to an economic downturn, regulatory changes or acts of nature in those areas.

Our affiliated facilities 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, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since approximately 30% of our affiliated facilities are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as fires, earthquakes or mudslides.

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In addition, our affiliated facilities in Iowa, Nebraska and Texas are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, tornadoes and flooding. These acts of nature may cause disruption to us, the employees of our operating subsidiaries and our affiliated facilities, which could have an adverse impact on the patients of our operating subsidiaries and our business. In order to provide care for the patients of our operating subsidiaries, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our affiliated facilities, and the availability of employees to provide services at our affiliated facilities. If the delivery of goods or the ability of employees to reach our affiliated facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our affiliated facilities and our business. Furthermore, the impact, or impending threat, of a natural disaster may require that we evacuate one or more facilities, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters and similar events is inherently uncertain. Such events could harm the patients and employees of our operating subsidiaries, severely damage or destroy one or more of our affiliated facilities, 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 operating subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staffs at our affiliated facilities that have been approached to unionize have uniformly rejected union organizing efforts. If employees decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

The unwillingness on the part of both our management and staff to accede to union demands for “neutrality” and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union actively prosecuted a negative retaliatory publicity action, also known as a “corporate campaign,” against us and filed, promoted or participated in multiple legal actions against us. The union's campaign asserted, among other allegations, poor treatment of patients, inferior medical services provided by the employees of our operating subsidiaries, poor treatment of the employees of our operating subsidiaries, and health code violations by us. In addition, the union has publicly mischaracterized actions taken by the DHS against us and our affiliated facilities. In numerous cases, the union's allegations created the false impression that violations and other events that occurred at facilities prior to our acquisition of those facilities were caused by us. Since a large component of our business involves acquiring underperforming and distressed facilities, and improving the quality of operations at these facilities, we may have been associated with the past poor performance of these facilities. To the extent this union or another elects to directly or indirectly prosecute a corporate campaign against us or any of our affiliated facilities, our business could be negatively affected.

The Service Employees International Union has issued in the past, and may again issue in the future, public statements alleging that we or other for-profit skilled nursing operators have engaged in unfair, questionable or illegal practices in various areas, including staffing, patient care, patient evaluation and treatment, billing and other areas and activities related to the industry and our operating subsidiaries. We continue to anticipate similar criticisms, charges and other negative publicity from such sources on a regular basis, particularly in the current political environment and following the recent December 2010 OIG report entitled “Questionable Billing by Skilled Nursing Facilities," described above in " The Office of the Inspector General or other organizations may choose to more closely scrutinize the billing practices of for-profit skilled nursing facilities, 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." Two of our affiliated facilities have been listed on the report. Such reports provide unions and their allies with additional opportunities to make negative statements about, and to encourage regulators to seek investigatory and enforcement actions against, the industry in general and non-union operators like us specifically. Although we believe that our operations and business practices substantially conform to applicable laws and regulations, we cannot predict the extent to which we might be subject to adverse publicity or calls for increased regulatory scrutiny from union and union ally sources, or what effect, if any, such negative publicity would have on us, but to the extent they are successful, our revenue may be reduced, our costs may be increased and our profitability and business could be adversely affected.

This union has also attempted to pressure hospitals, doctors, insurers and other healthcare providers and professionals to cease doing business with or referring patients to us. If this union or another union is successful in convincing the patients of our operating subsidiaries, their families or our referral sources to reduce or cease doing business with us, our revenue may be reduced and our profitability could be adversely affected. Additionally, if we are unable to attract and retain qualified staff due to negative public relations efforts by this or other union organizations, our quality of service and our revenue and profits could decline. Our strategy for responding to union allegations involves clear public disclosure of the union's identity, activities and agenda, and rebuttals to its negative campaign.

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Our ability to respond to unions, however, may be limited by some state laws, which purport to make it illegal for any recipient of state funds to promote or deter union organizing. For example, such a state law passed by the California Legislature was successfully challenged on the grounds that it was preempted by the National Labor Relations Act, only to have the challenge overturned by the Ninth Circuit in 2006 before being ultimately upheld by the United States Supreme Court in 2008. In addition, proposed legislation making it more difficult for employees and their supervisors to educate co-workers and oppose unionization, such as the proposed Employee Free Choice Act which would allow organizing on a single “card check” and without a secret ballot and similar changes to federal law, regulation and labor practice being advocated by unions and considered by Congress and the National Labor Relations Board, could make it more difficult to maintain union-free workplaces in our affiliated facilities. If proponents of these and similar laws are successful in facilitating unionization procedures or hindering employer responses thereto, our ability to oppose unionization efforts could be hindered, and our business could be negatively affected.

Because we lease substantially all of our affiliated facilities, we could experience risks associated with leased property, including risks relating to lease termination, lease extensions and special charges, which could adversely affect our business, financial position or results of operations.

As of December 31, 2014, we leased 125 of our 136 affiliated facilities. 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 number of reasons, including, subject to applicable cure periods, 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.

In addition, if some of our leased affiliated facilities should prove to be unprofitable, we could remain obligated for lease payments and other obligations under the leases even if we decided to withdraw from those locations. We could incur special charges relating to the closing of such facilities including lease termination costs, impairment charges and other special charges that would reduce our net income and could adversely affect our business, financial condition and results of operations.

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

In May 2014, we paid in full all outstanding borrowings under the Senior Credit Facility, bonds and mortgage notes and transferred remaining outstanding borrowings under the Ten Project Notes and promissory notes to CareTrust in connection with the Spin-Off. We also entered into the 2014 Credit Facility in May 2014 with a lending consortium arranged by SunTrust (the 2014 Credit Facility) in an aggregate amount of $150.0 million. As of December 31, 2014, our operating subsidiaries had $65.0 million outstanding under the 2014 Credit Facility.

On September 24, 2014, we assumed an existing HUD-insured loan with Red Mortgage Capital, LLC of approximately $3.4 million in connection with our acquisition of the assisted living facility in Arizona. The term of the mortgage loan is for twenty five years, with monthly principal and interest payments. As of December 31, 2014, our operating subsidiary had $3.4 million outstanding, of which $0.1 million is classified as short-term and the remaining $3.3 million is classified as long-term. The balance of the loan is due on October 1, 2037.

In addition, we had $1.1 billion of future operating lease obligations as of December 31, 2014. We intend to continue financing our affiliated facilities 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 facilities 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

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advances under existing credit facilities 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 notes, 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 operating subsidiaries, many of which are beyond our control. If we are unable to generate sufficient cash flow from operations in the future to service our debt or to make lease payments on our 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.

If we decide to expand our presence in the assisted living, home health, hospice or urgent care industries, we would become subject to risks in a market in which we have limited experience.

The majority of our affiliated facilities have historically been skilled nursing facilities. If we decide to expand our presence in the assisted living, home health, hospice and urgent care industries or other relevant healthcare service, our existing overall business model would change and we would become subject to risks in a market in which we have limited experience. Although assisted living operating subsidiaries generally have lower costs and higher margins than skilled nursing, they typically generate lower overall revenue than skilled nursing operating subsidiaries. In addition, assisted living and urgent care revenue is derived primarily from private payors as opposed to government reimbursement. In most states, skilled nursing, assisted living, home health, hospice and urgent care are regulated by different agencies, and we have less experience with the agencies that regulate assisted living, home health, hospice and urgent care. In general, we believe that assisted living is a more competitive industry than skilled nursing. If we decided to expand our presence in the assisted living, home health, hospice and urgent care industries, we might have

to adjust part 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 physicians, hospitals and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our affiliated facilities. Our referral sources are not obligated to refer business to us and may refer business to other healthcare providers. We believe many of our referral sources refer business to us as a result of the quality of our patient care and our efforts to establish and build a relationship with our referral sources. If we lose, or fail to maintain, existing relationships with our referral resources, fail to develop new relationships, or if we are perceived by our referral sources as not providing high quality patient care, our occupancy rate and the quality of our patient mix could suffer. 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.

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Our systems are subject to security breaches and other cybersecurity incidents.

We may experience cyber attacks, and as a result, unauthorized parties may obtain access to our computer systems and networks. Such cyber attacks could result in the misappropriation of our proprietary information and technology or interrupt our business. The reliability and security of our information technology infrastructure is critical to our business. To the extent that any disruptions or security breaches result in significant loss or damage to our data, or inappropriate disclosure of significant proprietary information, it could require notice to state and federal agencies of such a breach, cause damage to our reputation and affect our relationships with our patients, may result in civil and/or criminal fines and penalties or related class action litigation, any of which could have a material adverse effect on our business, results of operations and financial condition.

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

Our ability to maintain and enhance our affiliated facilities 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 affiliated facilities and equipment. We are sometimes more aggressive than our competitors in capital spending to address issues that arise in connection with aging and obsolete facilities and equipment. 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. 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.

Financial markets experienced significant disruptions from 2008 through 2010. These disruptions impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. As a result of these market conditions, the cost and availability of credit has been and may continue to be adversely affected by illiquid credit markets and wider credit spreads. Concern about the stability of the markets has led many lenders and institutional investors to reduce, and in some cases, cease to provide credit to borrowers.

Further, 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, credit and financial market conditions, 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, unless and until the current U.S. and global political, credit and financial market crisis has

been sufficiently resolved, it may be 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.

Though we anticipate that the cash amounts generated internally, together with amounts available under the revolving credit facility portion of the 2014 Credit Facility, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available or available on terms favorable 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. For example,

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in January 2009, the State of California announced expected cash shortages in February which impacted payments to Medi-Cal providers from late March through April. Medi-Cal had also delayed the release of the reimbursement rates which were announced in January 2010. These rate increases were put in place on a retrospective basis, effective August 1, 2009.

Further, on March 24, 2011, the governor of California signed Assembly Bill 97 (AB 97), the budget trailer bill on health, into law. AB 97 outlines significant cuts to state health and human services programs. Specifically, the law reduced provider payments by 10% for physicians, pharmacies, clinics, medical transportation, certain hospitals, home health, and nursing facilities. AB X1 19 Long Term Care was subsequently approved by the governor on June 28, 2011. Federal approval was obtained on October 27, 2011. AB X1 19 limited the 10% payment reduction to skilled-nursing providers to 14 months for the services provided on June 1, 2011 through July 31, 2012. The 10% reduction in provider payments was repaid by December 31, 2012. There can be no assurance that similar delays or reductions in our payment cycle of provider payments will not lead to material adverse consequences in the future.

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

One of our affiliated facilities is currently subject to regulatory agreements with the Department of Housing and Urban Development (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. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection. The re-inspection occurred in the fourth quarter of 2009 and the facility passed its HUD re-inspection. 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. This facility was transferred to CareTrust as part of the Spin-Off.

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 operating 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 affiliated facilities generate infectious or other hazardous medical waste due to the illness or physical condition of the patients. Each of our affiliated facilities 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 for operating subsidiaries for which we are responsible 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 affiliated 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 potential 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 asbestos-containing materials, or the failure to properly dispose of or remediate such materials, also may adversely affect our ability to attract and retain patients and staff, to borrow when using such property as collateral or to make improvements to such property.

The presence of mold, lead-based paint, underground storage tanks, contaminants in drinking water, radon and/or other substances at any of the affiliated facilities we lease, own or may acquire 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. Furthermore, in some circumstances, areas affected by mold may be unusable for periods of time for repairs,

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and even after successful remediation, the known prior presence of extensive mold could adversely affect the ability of a facility to retain or attract patients and staff and could adversely affect a facility's market value and ultimately could lead to the temporary or permanent closure of the facility.

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.

In addition, because environmental laws vary from state to state, expansion of our operating subsidiaries to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our affiliated 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 affiliated facilities is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the 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 operating subsidiaries to provide us with the funds necessary to meet our financial obligations. Liabilities of any one or more of our subsidiaries could be imposed upon us or our other subsidiaries.

We are a holding company with no direct operating assets, employees or revenues. Each of our affiliated facilities 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 shareholders, agreements of those subsidiaries, the terms of our financing arrangements and the terms of any future financing arrangements of our subsidiaries.

Changes in federal and state income tax laws and regulations could adversely affect our provision for income taxes and estimated income tax liabilities.

We are subject to both state and federal income taxes. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in tax laws and regulations, changes in our interpretations of tax laws, including pending tax law changes. In addition, in certain cases more than one state in which we operate has indicated an intent to attempt to tax the same assets and activities, which could result in double taxation if successful. Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.
We are subject to the continuous examination of our income tax returns by the Internal Revenue Service and other local, state and foreign tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. The outcomes from these continuous examinations could adversely affect our provision for income taxes and estimated income tax liabilities.

If the Spin-Off were to fail to qualify as a tax-free transaction for U.S. federal income tax purposes, we could be subject to significant tax liabilities and, in certain circumstances, we could be required to indemnify CareTrust for material taxes pursuant to indemnification obligations under the Tax Matters Agreement that we entered into with CareTrust.

We received a private letter ruling from the Internal Revenue Services (IRS), which provides substantially to the effect that, on the basis of certain facts presented and representations and assumptions set forth in the request submitted to the IRS, the Spin-Off will qualify as tax-free under Sections 368(a)(1)(D) and 355 of the Internal Revenue Code (the IRS Ruling). The IRS Ruling does not address certain requirements for tax-free treatment of the Spin-Off under Section 355 of the Code, and we received tax opinions from our tax advisor and counsel, substantially to the effect that, with respect to such requirements on which the IRS will not rule, such requirements have been satisfied. The IRS Ruling, and the tax opinions that we received from our tax advisor

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and counsel, rely on, among other things, certain facts, representations, assumptions and undertakings, including those relating to the past and future conduct of our and CareTrust's businesses, and the IRS Ruling and the tax opinions would not be valid if such facts, representations, assumptions and undertakings were incorrect in any material respect. Notwithstanding the IRS Ruling and the tax opinions, the IRS could determine the Spin-Off should be treated as a taxable transaction for U.S. federal income tax purposes if it determines any of the facts, representations, assumptions or undertakings that were included in the request for the IRS Ruling are false or have been violated or if it disagrees with the conclusions in the opinions that are not covered by the IRS Ruling.

If the Spin-Off ultimately is determined to be taxable, we would recognize taxable gain in an amount equal to the excess, if any, of the fair market value of the shares of CareTrust common stock held by us on the distribution date over our tax basis in such shares. Such taxable gain and resulting tax liability would be substantial.

In addition, under the terms of the Tax Matters Agreement that we entered into with CareTrust in connection with the Spin-Off, we generally are responsible for any taxes imposed on CareTrust that arise from the failure of the Spin-Off to qualify as tax-free for U.S. federal income tax purposes, within the meaning of Sections 368(a)(1)(D) and 355 of the Code, to the extent such failure to qualify is attributable to certain actions, events or transactions relating to our stock, assets or business, or a breach of the relevant representations or any covenants made by us in the Tax Matters Agreement, the materials submitted to the IRS in connection with the request for the IRS Ruling or the representation letter provided in connection with the tax opinion relating to the Spin-Off. Our indemnification obligations to CareTrust and its subsidiaries, officers and directors are not limited by any maximum amount. If we are required to indemnify CareTrust under the circumstance set forth in the Tax Matters Agreement, we may be subject to substantial tax liabilities.

In connection with the Spin-Off, CareTrust will indemnify us and we will indemnify CareTrust for certain liabilities. There can be no assurance that the indemnities from CareTrust will be sufficient to insure us against the full amount of such liabilities, or that CareTrust's ability to satisfy its indemnification obligation will not be impaired in the future.

Pursuant to the Separation and Distribution Agreement that we entered into with CareTrust in connection with the Spin-Off, the Tax Matters Agreement and other agreements we entered into in connection with the Spin-Off, CareTrust agreed to indemnify us for certain liabilities, and we agreed to indemnify CareTrust for certain liabilities. However, third parties might seek to hold us responsible for liabilities that CareTrust agreed to retain under these agreements, and there can be no assurance that CareTrust will be able to fully satisfy its indemnification obligations under these agreements. Moreover, even if we ultimately succeed in recovering from CareTrust any amounts for which we are held liable to a third party, we may be temporarily required to bear these losses while seeking recovery from CareTrust. In addition, indemnities that we may be required to provide to CareTrust could be significant and could adversely affect our business.

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 our beds, 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. In addition, the revolving credit facility portion of the Senior Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement. The failure to pay or maintain dividends could adversely affect our stock price.

The market price and trading volume of our common stock may be volatile, which could result in rapid and substantial losses for our stockholders.

The market price of our common stock may be highly volatile and could be subject to wide fluctuations. In addition, the trading volume in our common stock may fluctuate and cause significant price variations to occur. We cannot assure you that the market price of our common stock will not fluctuate or decline significantly in the future. On some occasions in the past, when the market price of a stock has been volatile, holders of that stock have instituted securities class action litigation against the company that issued the stock. If any of our stockholders brought a lawsuit against us due to volatility in the market price of our common stock, we could incur substantial costs defending or settling the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business.

Future offerings of debt or equity securities by us may adversely affect the market price of our common stock.

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In the future, we may attempt to increase our capital resources by offering debt or additional equity securities, including commercial paper, medium-term notes, senior or subordinated notes, preferred shares or shares of our common stock. Upon liquidation, holders of our debt securities and preferred shares, and lenders with respect to other borrowings, would receive a distribution of our available assets prior to any distribution to the holders of our common stock. Additional equity offerings may dilute the economic and voting rights of our existing stockholders or reduce the market price of our common stock, or both. Because our decision to issue securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our common stock bear the risk of our future offerings reducing the market price of our common stock and diluting their shareholdings in us. We also intend to continue to actively pursue acquisitions of facilities and may issue shares of stock in connection with these acquisitions.

Any shares issued in connection with our acquisitions, the exercise of outstanding stock options or otherwise would dilute the holdings of the investors who purchase our shares.

Failure to maintain effective internal controls in accordance with Section 404 of the Sarbanes-Oxley Act could result in a restatement of our financial statements, cause investors to lose confidence in our financial statements and our company and have a material adverse effect on our business and stock price.

We produce our consolidated financial statements in accordance with the requirements of GAAP. Effective internal controls are necessary for us to provide reliable financial reports to help mitigate the risk of fraud and to operate successfully as a publicly traded company. As a public company, we are required to document and test our internal control procedures in order to satisfy the requirements of Section 404 of the Sarbanes-Oxley Act of 2002, or Section 404, which requires annual management assessments of the effectiveness of our internal controls over financial reporting.

Testing and maintaining internal controls can divert our management's attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not be able or willing to issue an unqualified report if we conclude that our internal controls over financial reporting are not effective. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified report as required by Section 404, investors could lose confidence in our reported financial information and our company, which could result in a decline in the market price of our common stock, and cause us to fail to meet our reporting obligations in the future, which in turn could impact our ability to raise additional financing if needed in the future.

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;

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- 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.

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Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Service Center. We currently lease 29,829 square feet of office space in Mission Viejo, California for our Service Center pursuant to a lease that expires in August 2019. We have two options to extend our lease term at this location for an additional five-year term for each option.

Facilities. As of December 31, 2014, we operated 136 affiliated facilities in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Texas, Utah, Wisconsin and Washington, with the operational capacity to serve approximately 14,725 patients. Of the 136 facilities that we operated, we owned eleven facilities and leased 125 facilities pursuant to operating leases, three of which contain purchase options that provide us with the right to purchase or agreements to purchase the facility in the future. We currently do not manage any facilities for third parties, except on a short-term basis pending receipt of new operating licenses by our operating subsidiaries.

The following table provides summary information regarding the number of operational beds at our skilled nursing and assisted and independent living facilities at December 31, 2014:

State	Leased without a Purchase Option	Purchase Agreement or Leased with a Purchase Option	Owned	Total Operational Beds
Arizona	1,885	—	561	2,446
California	3,873	508	425	4,806
Colorado	587	—	—	587
Idaho	477	—	—	477
Iowa	356	—	—	356
Nevada	304	—	—	304
Nebraska	366	—	—	366
Texas	3,146	—	—	3,146
Utah	1,252	—	108	1,360
Washington	739	—	—	739
Wisconsin	—	—	138	138
Total	12,985	508	1,232	14,725
Skilled nursing	11,235	438	887	12,560
Assisted living	1,498	70	333	1,901
Independent living	252	—	12	264
Total	12,985	508	1,232	14,725

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Home health and hospice agencies. As of December 31, 2014, we had 23 home health and hospice operating subsidiaries in Arizona, California, Colorado, Idaho, Iowa, Texas, Utah, and Washington.

The following table provides summary information regarding the locations of our home health and hospice care agencies at December 31, 2014:

State	Home Health Services	Hospice Services
Arizona	—	1
California[1]	2	2
Colorado[1]	1	1
Idaho[1]	2	2
Iowa	1	—
Texas[1]	1	2
Oregon	1	—
Utah[1]	2	2
Washington[1]	2	1
Total	12	11

(1) Including a home health and a hospice agency that are located in the same location

In addition, as of December 31, 2014, we had fourteen urgent care centers, which are all in Washington, at December 31, 2014.

Item 3. Legal Proceedings

Regulatory Matters — Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from certain governmental programs. We believe that we are in compliance in all material respects with all applicable laws and regulations.

Cost-Containment Measures — 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.

Income Tax Examinations — During the third quarter of 2014, we received a notification from the IRS that our 2012 tax return will be examined. During the first quarter of 2012, the State of California initiated an examination of our income tax returns for the 2008 and 2009 income tax years. The examination was primarily focused on the Captive and the treatment of related insurance matters. The examination was closed with no adjustments. See Note 15, Income Taxes of Notes to Consolidated Financial Statements.

Indemnities — From time to time, we enter into certain types of 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, (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 employees, under which we may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. 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 — The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents served by our operating subsidiaries. We, our operating subsidiaries, and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

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In addition to the potential lawsuits and claims described above, we are also subject to potential lawsuits under the Federal False Claims Act and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. 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. Some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. As such, we could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which it does business.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the Federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by 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 a FCA violation can occur without any affirmative fraudulent action or statement, as long as it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, there is generally no need for an employment relationship 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, and we are routinely subjected to varying types of claims. One particular type of suit arises from alleged violations of state-established minimum staffing requirements for skilled nursing facilities. Failure to meet these requirements can, among other things, jeopardize a facility's compliance with conditions of participation under certain state and federal healthcare programs; it may also subject the facility to a notice of deficiency, a citation, civil monetary penalty, or litigation. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements, and have become more prevalent in the wake of a previous substantial jury award against one of our competitors. We expect the plaintiff's bar to continue to be aggressive in their pursuit of these staffing and similar claims.

A class action staffing suit was previously filed against us and certain of our California subsidiaries in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act. In 2007, we settled this class action suit, and the settlement was approved by the affected class and the Court. We have been defending a second such staffing class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, were approximately $6.5 million, of which, approximately $1.5 million and $2.6 million of this amount was recorded during the year ended December 31, 2013 and 2012, respectively, with the balance having been expensed in prior periods. We believe that the settlement will not have a material ongoing adverse effect on our business, financial condition or results of operations.

Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect our business, financial condition, results of operations and cash flows.

We and our affiliates subsidiaries have been, and continue to be, subject to claims and legal actions that arise in the ordinary course of business, including potential claims related to patient care and treatment as well as employment related claims. We do not believe that the ultimate resolution of these actions will have a material adverse effect on our business, cash flows, financial condition or results of operations. A significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, could materially adversely affect our business, financial condition, results of operations and cash flows.

We cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and we, our affiliates and subsidiaries are subjected to, alleged to be liable for, or agrees to a settlement of, claims or obligations under Federal Medicare statutes, the Federal False Claims Act, or similar State and Federal statutes and related regulations, our business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.

Medicare Revenue Recoupments — We are subject to reviews relating to Medicare services, billings and potential overpayments. The Company had one operation subject to probe review during the year ended December 31, 2014. We anticipate

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that these probe reviews will increase in frequency in the future. Further, we currently have no affiliated facilities on prepayment review; however, others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. We have no affiliated facilities that are currently undergoing targeted review.

U.S. Government Inquiry — In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. We recorded an initial estimated liability in the amount of $15.0 million in the fourth quarter of 2012 for the resolution of claims connected to the investigation based on the facts available at the time. In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of $33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to $48.0 million (the Reserve Amount).

In October 2013, we completed and executed a settlement agreement (the Settlement Agreement) with the DOJ and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. Pursuant to the Settlement Agreement, we made a single lump-sum remittance to the government in the amount of $48.0 million in October 2013. We have denied engaging in any illegal conduct, and have agreed to the settlement amount without any admission of wrongdoing in order to resolve the allegations and to avoid the uncertainty and expense of protracted litigation.

In connection with the settlement and effective as of October 1, 2013, we entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. The CIA acknowledges the existence of our current compliance program, which is in accord with the Office of the Inspector General (OIG)’s guidance related to an effective compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other federal health care programs. We are also required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that we have committed a crime or have engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by federal health care programs. We are also required to retain an Independent Review Organization (IRO) to review certain clinical documentation annually for the term of the CIA.

Participation in federal healthcare programs by us is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in federal healthcare programs and/or subject to prosecution.

Item 4. Mine Safety Disclosures

None.

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PART II.

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

Market Information

Our common stock has been traded under the symbol “ENSG” on the NASDAQ Global Select Market since our initial public offering on November 8, 2007. Prior to that time, there was no public market for our common stock. The following table shows the high and low sale prices for the common stock as reported by the NASDAQ Global Select Market for the periods indicated:

	High	Low
Fiscal 2013		
First Quarter	$33.70	$27.54
Second Quarter	$38.08	$31.57
Third Quarter	$42.26	$35.24
Fourth Quarter	$46.39	$39.60
Fiscal 2014		
First Quarter	$45.48	$38.20
Second Quarter(1)	$47.78	$26.02
Third Quarter	$36.16	$28.00
Fourth Quarter	$46.08	$33.17

(1) Stock prices on and before June 1, 2014 include the value of the CareTrust business, which was spun off on that date. The prices after that date reflect only the business of Ensign after the Spin-Off. The stock price on the distribution date, which was June 1, 2014, was adjusted by using the proportion of the CareTrust when-issued closing stock price to the total Company closing stock price on such date.

During fiscal 2014, we declared aggregate cash dividends of $0.29 per share of common stock, for a total of approximately $6.4 million. As of February 3, 2015, there were approximately 216 holders of record of our common stock.

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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 this 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 an investment of $100 (and the reinvestment of any dividends thereafter) on December 31, 2009 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 a Peer Group

*$100 invested on 12/31/09 in stock in index, including reinvestment of dividends.
Fiscal year ending December 31.

	December 31,					
	2009	2010	2011	2012	2013	2014
The Ensign Group, Inc.	$100.00	$163.62	$162.62	$181.83	$298.68	$522.55
NASDAQ Market Index	$100.00	$118.02	$117.04	$137.47	$192.62	$221.02
Peer Group	$100.00	$141.66	$116.47	$139.75	$173.77	$245.95

The current composition of the Skilled Nursing Facilities Peer Group 1, SIC Code 8051 is as follows:

AdCare Health Systems, Inc., Diversicare Healthcare Services, Five Star Quality Care, Inc., National Healthcare Corporation, Skilled Healthcare Group, Inc., and The Ensign Group, Inc.

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Dividend Policy

The following table summarizes common stock dividends declared to shareholders during the two most recent fiscal years:

	Dividend per Share	Aggregate Dividend Declared (in thousands)
2013		
First Quarter	$0.065	$1,437
Second Quarter	$0.065	$1,438
Third Quarter	$0.065	$1,443
Fourth Quarter	$0.070	$1,564
2014		
First Quarter	$0.070	$1,570
Second Quarter	$0.070	$1,580
Third Quarter	$0.070	$1,584
Fourth Quarter	$0.075	$1,707

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. From 2002 to 2014, we paid aggregate annual dividends equal to approximately 5% to 18% of our net income, after adjusting for the charge related to the U.S. Government inquiry settlement of $33.0 million and $15.0 million in fiscal years ended December 31, 2013 and 2012, respectively. However, future dividends will continue to be at the discretion of our board of directors, and we may or may not continue to pay dividends at such rate. We expect that the payment of dividends will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, legal restrictions on the payment of dividends and other factors the Board of Directors deems relevant. A portion of the proceeds received from CareTrust in connection with the Spin-Off will be used to pay dividend payments. See Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust in the to Consolidated Financial Statements for additional information.

The 2014 Credit Facility restricts our subsidiaries' and our ability to pay dividends to stockholders in excess of 20% of consolidated net income, or at all if we receive notice that we are in default under the facility. In addition, we are a holding company with no direct operating assets, employees or revenues. As a result, we are dependent upon distributions from our independent operating subsidiaries to generate the funds necessary to meet our financial obligations and pay dividends. It is possible that in certain quarters, we may pay dividends that exceed our net income for such period as calculated in accordance with U.S. GAAP.

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Item 6. Selected Financial Data

The following selected consolidated financial data for the periods indicated have been derived from our consolidated financial statements. The financial data set forth below should be read in connection with Part II, Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations and with our consolidated financial statements and related notes thereto:

	Year Ended December 31,				
	2014	2013	2012	2011	2010
	(In thousands, except per share data)				
Revenue	$1,027,406	$904,556	$823,155	$758,277	$649,532
Expense:					
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	822,669	725,989	656,424	600,804	516,668
Charge related to U.S. Government inquiry	—	33,000	15,000	—	—
Facility rent - cost of services	48,488	13,613	13,281	13,725	14,478
General and administrative expense	56,895	40,103	31,819	29,766	26,099
Depreciation and amortization	26,430	33,909	28,358	23,286	16,633
Total expenses	954,482	846,614	744,882	667,581	573,878
Income from operations	72,924	57,942	78,273	90,696	75,654
Other income (expense):					
Interest expense	(12,976)	(12,787)	(12,229)	(13,778)	(9,123)
Interest income	594	506	255	249	248
Other expense, net	(12,382)	(12,281)	(11,974)	(13,529)	(8,875)
Income before provision for income taxes	60,542	45,661	66,299	77,167	66,779
Provision for income taxes	26,801	20,003	25,134	29,492	26,253
Income from continuing operations	33,741	25,658	41,165	47,675	40,526
Loss from discontinued operations	—	(1,804)	(1,357)	—	—
Net income	$33,741	$23,854	$39,808	$47,675	$40,526
Less: net loss attributable to noncontrolling interests	(2,209)	(186)	(783)	—	—
Net income attributable to The Ensign Group, Inc.	$35,950	$24,040	$40,591	$47,675	$40,526
Amounts attributable to The Ensign Group, Inc.:					
Income from continuing operations attributable to The Ensign Group, Inc.	$35,950	$25,844	$41,948	$47,675	$40,526
Loss from discontinued operations, net of income tax	—	(1,804)	(1,357)	—	—
Net income attributable to The Ensign Group, Inc.	$35,950	$24,040	$40,591	$47,675	$40,526
Net income per share[1]:					
Basic:					
Income from continuing operations attributable to The Ensign Group, Inc.	$1.61	$1.18	$1.96	$2.27	$1.95
Loss from discontinued operations [2]	—	(0.08)	(0.07)	—	—
Net income attributable to The Ensign Group, Inc.	$1.61	$1.10	$1.89	$2.27	$1.95
Diluted:					
Income from continuing operations attributable to The Ensign Group, Inc.	$1.56	$1.16	$1.91	$2.21	$1.92
Loss from discontinued operations [2]		(0.09)	(0.06)	—	—
Net income attributable to The Ensign Group, Inc.	$1.56	$1.07	$1.85	$2.21	$1.92
Weighted average common shares outstanding:					
Basic	22,341	21,900	21,429	20,967	20,744

Diluted	23,095	22,364	21,942	21,583	21,159

(1) See Note 4 of Notes to Consolidated Financial Statements.
(2) See Note 22 of Notes to Consolidated Financial Statements.

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	December 31,				
	2014	2013	2012	2011	2010
	(In thousands, except per share data)				
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$50,408	$65,755	$40,685	$29,584	$72,088
Working capital	83,209	98,540	46,252	40,252	76,642
Total assets	493,916	716,315	690,862	596,339	479,892
Long-term debt, less current maturities	68,279	251,895	200,505	181,556	139,451
Equity	257,803	357,257	327,884	277,485	228,203
Cash dividends declared per common share	$0.29	$0.27	$0.25	$0.23	$0.21

	Year Ended December 31,		
	2014	2013	2012
	(In thousands)		
Other Non-GAAP Financial Data:			
EBITDA[1]	$101,563	$92,037	$107,414
Adjusted EBITDA[1][2]	112,829	136,741	131,427
EBITDAR[1]	150,051	105,650	120,695
Adjusted EBITDAR[1][2]	159,376	149,345	143,848

(1) EBITDA, EBITDAR, Adjusted EBITDA and Adjusted EBITDAR are supplemental non-GAAP financial measures. Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Exchange Act define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income from continuing operations, adjusted for net losses attributable to noncontrolling interest, before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude facility rent—cost of services. 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 EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR are useful to investors and other external users of our financial statements in evaluating our operating performance because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall operating performance of companies in our industry without regard to items such as interest expense, net 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 EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR:

- 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 evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We typically use EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR to compare the operating performance of each operation. EBITDA and EBITDAR are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, and, with respect to EBITDAR, facility rent — cost of services, which may vary from period-to-period depending upon various factors, including the method used to finance facilities, the amount of debt that we have incurred, whether a facility is owned or leased, the

date of acquisition of a facility or business, and the tax law of

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the state in which a business unit operates. As a result, we believe that the use of EBITDA and EBITDAR provide a meaningful and consistent comparison of our business between periods by eliminating certain items required by GAAP.

We also establish compensation programs and bonuses for our leaders that are partially based upon the achievement of Adjusted EBITDAR targets.

Despite the importance of these measures in analyzing our underlying business, designing incentive compensation and for our goal setting, EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR are non-GAAP financial measures that have no standardized meaning defined by GAAP. Therefore, our EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR 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 net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- 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 EBITDA and EBITDAR 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. For information about our financial results as reported in accordance with GAAP, see our consolidated financial statements and related notes included elsewhere in this document.

(2) Adjusted EBITDA is EBITDA adjusted for non-core business items, which for the reported periods includes, to the extent applicable:

- charge related to the U.S. Government inquiry;
- expenses incurred in connection with the Company's spin-off of CareTrust;
- legal costs incurred in connection with the U.S. Government inquiry;
- settlement of a class action lawsuit;
- impairment charges
  - results at our newly opened urgent care centers (including the portion related to the non-controlling interest);
- results at our newly constructed skilled nursing facility;
- results at three independent living facilities transferred to CareTrust as part of the Spin-Off transaction;
- acquisition-related costs;
- costs incurred to recognize income tax credits; and
- rent related to our newly opened urgent care centers, one newly constructed skilled nursing facility and three independent living facilities transferred to CareTrust.

Adjusted EBITDAR is EBITDAR adjusted for the above noted non-core business items.

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

	Year Ended December 31,				
	2014	2013	2012	2011	2010
	(In thousands)				
Consolidated statements of income data:					
Net income	$33,741	$23,854	$39,808	$47,675	$40,526
Less: net loss attributable to noncontrolling interests	(2,209)	(186)	(783)	—	—
Loss from discontinued operations	—	1,804	1,357	—	—
Interest expense, net	12,382	12,281	11,974	13,529	8,875
Provision for income taxes	26,801	20,003	25,134	29,492	26,253
Depreciation and amortization	26,430	33,909	28,358	23,286	16,633
EBITDA	$101,563	$92,037	$107,414	$113,982	$92,287
Facility rent—cost of services	48,488	13,613	13,281	13,725	14,478
EBITDAR	$150,051	$105,650	$120,695	$127,707	$106,765
EBITDA	$101,563	$92,037	$107,414	$113,982	$92,287
Charge related to the U.S. Government inquiry(a)	—	33,000	15,000	—	—
Expenses related to the Spin-Off(b)	9,026	4,050	—	—	—
Legal costs(c)	—	1,098	1,945	—	—
Settlement of class action lawsuit(d)	—	1,524	2,596	1,544	—
Impairment of goodwill and other indefinite-lived intangibles(e)	—	490	2,225	—	185
Urgent care center (earnings) losses(f)	(389)	1,844	546	—	—
Earnings at three operations transferred to REIT(g)	(122)	—	—	—	—
Loss at skilled nursing facility not at full operation(h)	—	1,256	—	—	—
Acquisition related costs(i)	672	288	250	452	150
Costs incurred to recognize income tax credits(j)	138	145	591	—	—
Rent related to items(f), (g), and (h) above(k)	1,941	1,009	860	—	—
Adjusted EBITDA	$112,829	$136,741	$131,427	$115,978	$92,622
Facility rent—cost of services	48,488	13,613	13,281	13,725	14,478
Less: rent related to items(f), (g) and (h) above(k)	(1,941)	(1,009)	(860)	—	—
Adjusted EBITDAR	$159,376	$149,345	$143,848	$129,703	$107,100

(a) Charges related to our resolution of any claims connected to the DOJ settlement.

(b) Expenses incurred in connection with the Spin-Off.

(c) Legal costs incurred in connection with the settlement of the investigation into the billing and reimbursement processes of some of our subsidiaries conducted by the DOJ.

(d) Settlement of a class action lawsuit regarding minimum staffing requirements in the State of California.

(e) Impairment charges to goodwill for a skilled nursing facility in Utah during the year ended December 31, 2013 and a decline in the estimated fair value of redeemable noncontrolling interest of our urgent care franchising business during the year ended December 31, 2012.

(f) Operating results at newly opened urgent care centers. This amount excluded rent, depreciation, interest and income taxes. The results also excluded the net loss attributable to the variable interest entity associated with our urgent care business of approximately $2.2 million.

(g) Results at three independent living facilities which were transferred to CareTrust as part of the Spin-Off, excluding rent, depreciation, interest and income taxes.

(h)

Losses incurred through the second quarter of 2013 at one newly constructed skilled nursing facility which began operations during the first quarter of 2013, excluding rent, depreciation, interest and income taxes.

(i) Costs incurred to acquire an operation which are not capitalizable.

(j) Costs incurred to recognize income tax credits which contributed to a decrease in effective tax rate.

(k) Rent related to newly opened urgent care centers, one newly constructed skilled nursing facility which began operations during the first quarter of 2013, and the three independent living facilities which were transferred to CareTrust as part of the Spin-Off, not included in items (f), (g) and (h) above.

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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. 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. See Part I. Item 1A. Risk Factors and Cautionary Note Regarding Forward-Looking Statements.

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 136 facilities, twelve home health and eleven hospice operations, one home care business, one transitional care management company, fourteen urgent care centers and a mobile x-ray and diagnostic company as of December 31, 2014, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the service of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted living, home health and hospice, mobile ancillary, and urgent care services. As of December 31, 2014, we owned eleven of our 136 affiliated facilities and operated an additional 125 facilities under long-term lease arrangements, and had options to purchase three of those 125 facilities.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of December 31, 2014:

	Owned		Leased (with a Purchase Option)		Leased (without a Purchase Option)		Total	
Number of facilities	11		3		122		136	
Percentage of total	8.1	%	2.2	%	89.7	%	100.0	%
Operational skilled nursing, assisted living and independent living beds	1,232		508		12,985		14,725	
Percentage of total	8.4	%	3.4	%	88.2	%	100.0	%

We are a holding company with no direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly-owned subsidiaries, 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 operating subsidiaries through contractual relationships with such subsidiaries. We also have a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as coverage for certain workers' compensation insurance liabilities. 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.

Real Estate Investment Trust (REIT) Spin-Off. On June 1, 2014, we completed the separation of our healthcare business and our real estate business into two publicly traded companies through a tax-free distribution of all of the outstanding shares of common stock of CareTrust REIT, Inc. (CareTrust) to our stockholders on a pro rata basis (the Spin-Off). Our stockholders received one share of CareTrust common stock for each share of our common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. As a result of the Spin-Off, we lease back real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities from CareTrust on a triple-net basis (the Master Leases), under which we are responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

Immediately before the Spin-Off, on May 30, 2014, while CareTrust was a wholly-owned subsidiary, CareTrust raised $260.0 million of debt financing (The Bond). CareTrust also entered into the Fifth Amended and Restated Loan Agreement, with General Electric Capital Corporation (GECC), which consisted of an additional loan of $50.7 million to an aggregate principal amount of $99.0 million (the Ten Project Note). The Ten Project Note and The Bond were assumed by CareTrust in connection with the Separation and Distribution Agreement. CareTrust transferred $220.8 million to us, a portion of which we used to retire $208.6 million of long-term debt prior to maturity. The remaining portion was used to pay prepayment penalties and other third party fees relating to the early retirement of outstanding debt. We also retained $8.2 million of the amount CareTrust transferred, which we intend to use to pay up to eight regular quarterly dividend payments. See further details of the Spin-Off at Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust of Notes to Consolidated Financial Statements.

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As a result of the early retirement of long-term debt, we incurred losses of $5.8 million consisting of $4.1 million in repayment penalties and the write-off of unamortized debt discount and deferred financing costs and $1.7 million of recognized loss due to the discontinuance of cash flow hedge accounting for the related interest-rate swap. We also entered into a new credit facility agreement (the 2014 Credit Facility) agreement in an aggregate principal amount of $150.0 million with a lending consortium arranged by SunTrust Bank (SunTrust) effective May 30, 2014. We have and continue to expect to use the 2014 Credit Facility for working capital purposes, to fund acquisitions and for general corporate purposes. As of December 31, 2014, our subsidiaries had $65.0 million outstanding under the 2014 Credit Facility. See further details at Note 18, Debt of Notes to Consolidated Financial Statements.

Corporate Integrity Agreement — In connection with the settlement with the U.S. Department of Justice and effective as of October 1, 2013 (the Settlement Agreement), we entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. The CIA acknowledges the existence of our current compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other federal health care programs. Our participation in federal healthcare programs is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in federal healthcare programs and/or subject to prosecution. See further details of the CIA at Note 20, Commitments and Contingencies of Notes to Consolidated Financial Statements.

Acquisition History

The following table sets forth the location of our affiliated facilities and the number of operational beds located at our facilities as of December 31, 2014:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	WI	Total
Cumulative number of skilled nursing and assisted living operations	46	16	26	12	7	8	6	3	5	5	2	136
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	4,806	2,446	3,146	1,360	587	739	477	304	366	356	138	14,725

In addition to the operation acquisitions above, in 2014, we acquired seven home health and hospice agencies. As of December 31, 2014, we provided home health and hospice services through our 23 operating subsidiaries in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington.

In the first quarter of 2014, we acquired a skilled nursing operation and a transitional care managing company in two states for an aggregate purchase price of $9.1 million. The acquisition of the skilled nursing operation added 196 operational skilled nursing beds to our operating subsidiaries. The acquisition of the transitional care managing company did not have an impact on the number of beds operated by our operating subsidiaries.

In the second quarter of 2014, we acquired three skilled nursing operations, one assisted living operation, one home health agency, one hospice agency and one primary care group in four states for an aggregate purchase price of $29.3 million. The acquisitions of the three skilled nursing and one assisted living operations added 368 and 144 operational skilled nursing beds and assisted living units, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and primary care group did not have an impact on the number of beds operated by our operating subsidiaries.

In addition, during the second quarter of 2014, we acquired the underlying assets of two skilled nursing operations in two states, which we previously operated under a long-term lease agreement, for an aggregate purchase price of approximately $7.5 million. These acquisitions did not have an impact on our operational bed count. We also entered into long-term lease agreements and assumed the operations of two skilled nursing facilities in two states. These transactions added 199 operational skilled nursing beds to our operating subsidiaries. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the leases. During the third quarter of 2014, we acquired an assisted living operation, a hospice agency, a home health agency and a hospice license in four states for an aggregate purchase price of $8.3 million. We assumed an existing HUD-insured loan as part of the transaction. We also entered into a long-term lease agreement and assumed the operations of one skilled nursing facility in

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one state. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the lease. The acquisition of the assisted living operation and the long-term lease of a skilled nursing operation added 135 and 67 operational assisted living units and skilled nursing beds, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and hospice license did not have an impact on the number of beds operated by our operating subsidiaries.

During the fourth quarter of 2014, we acquired eight skilled nursing operations, two assisted living operations, one home health agency, two hospice agencies and one private home care business in three states for an aggregate purchase price of $49.8 million. The acquisitions of skilled nursing and assisted living facilities added 623 and 66 operational skilled nursing beds and assisted living units, respectively, to our operating subsidiaries. The acquisitions of the home health and hospice agencies and private home care business did not have an impact on the number of beds operated by our operating subsidiaries.

Subsequent to the fourth quarter of 2014, we acquired five skilled nursing operations, two assisted living operations, two independent living operations, one home health agency and two urgent care clinics in three states for an aggregate purchase price of $38.6 million. The acquisition of the skilled nursing operations and assisted and independent living operations added 419 and 286 operational skilled nursing beds and assisted and independent living units, respectively, to our operating subsidiaries. The acquisitions of the home health agency and urgent care centers did not have an impact on the number of beds operated by our operating subsidiaries.

See further discussion of facility acquisitions in Note 8, Acquisitions in Notes to Consolidated Financial Statements.

Key Performance Indicators

We manage our fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. These indicators and their definitions include the following:

Transitional, Skilled and Assisted Living 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 that 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 assisted living services.
- Skilled mix. The amount of our skilled revenue as a percentage of our total routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving services at the skilled nursing facilities divided by the total number of days patients (less days from assisted living services) from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Quality mix. The amount of routine non-Medicaid revenue as a percentage of our total routine revenue. Quality mix (in days) represents the number of days our non-Medicaid patients are receiving services at the skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Average daily rates. The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period.
- Occupancy percentage (operational beds). The total number of patients occupying a bed in a skilled nursing, assisted living or independent living 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, assisted living and independent living facilities that we own or operate and the total number of operational beds associated with these facilities.

Skilled and Quality 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.

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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 and quality mix from our skilled nursing services for the periods indicated as a percentage of our total routine revenue (less revenue from assisted living services) and as a percentage of total patient days (less days from assisted living services):

	Year ended December 31,		
	2014	2013	2012
Skilled Mix:			
Days	27.6 %	26.4 %	25.9 %
Revenue	50.8 %	50.0 %	50.0 %
Quality Mix:			
Days	40.7 %	40.1 %	39.1 %
Revenue	59.9 %	59.5 %	59.5 %

Occupancy. We define occupancy derived from our transitional, skilled and assisted services as the ratio of actual patient days (one patient day equals one resident 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 licensed and independent living beds in a skilled nursing, assisted living or independent living 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 the periods indicated:

	Year ended December 31,		
	2014	2013	2012
Occupancy:			
Operational beds at end of period	14,725	13,204	12,198
Available patient days	5,029,738	4,710,768	4,371,034
Actual patient days	3,921,758	3,648,651	3,452,598
Occupancy percentage (based on operational beds)	78.0 %	77.5 %	79.0 %

Home Health and Hospice

- Medicare episodic admissions. The total number of episodic admissions derived from patients who are receiving care under Medicare reimbursement programs.
- Average Medicare revenue per completed episode. The average amount of revenue for each completed 60-day episode generated from patients who are receiving care under Medicare reimbursement programs.
- Average daily census. The average number of patients who are receiving hospice care as a percentage of total number of patient days.

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Segments

Beginning in the fourth quarter of 2014, we realigned our operating segments to more closely correlate with our service offerings, which coincide with the way that we measure performance and allocate resources. We have two reportable segments: (1) transitional, skilled and assisted living services, which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of our business; and (2) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

We also report an “all other” category that includes revenue from our urgent care centers and a mobile x-ray and diagnostic company. Our urgent care centers and mobile x-ray and diagnostic businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. The expansion of our home health and hospice business led us to separate our home health and hospice businesses into a distinct reportable segment in the fourth quarter of 2014. Previously, we had a single reportable segment, healthcare services, which included providing skilled nursing, assisted living, home health and hospice, urgent care and related ancillary services. We have presented 2013 and 2012 financial information on a comparative basis to conform with the current year segment presentation.

Revenue Sources

The following table sets forth our total revenue by payor source generated by each of our reportable segments and our "All Other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Year ended December 31, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$352,874	$5,245	$—	$358,119	34.9	%
Medicare	274,723	38,421	—	313,144	30.5	
Medicaid-skilled	51,157	—	—	51,157	5.0	
Subtotal	678,754	43,666	—	722,420	70.4	
Managed care	138,215	7,581	—	145,796	14.2	
Private and other	133,349	3,269	22,572 (1)	159,190	15.4	
Total revenue	$950,318	$54,516	$22,572	$1,027,406	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers and other ancillary businesses.

	Year ended December 31, 2013					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$320,580	$3,223	$—	$323,803	35.8	%
Medicare	264,223	28,694	—	292,917	32.4	
Medicaid-skilled	36,085	—	—	36,085	4.0	
Subtotal	620,888	31,917	—	652,805	72.2	
Managed care	112,669	5,499	—	118,168	13.1	
Private and other	119,722	2,346	11,515 (1)	133,583	14.7	
Total revenue	$853,279	$39,762	$11,515	$904,556	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers and other ancillary businesses.

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	Year ended December 31, 2012					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$301,051	$995	$—	$302,046	36.7	%
Medicare	261,745	16,833	—	278,578	33.8	
Medicaid-skilled	25,418	—	—	25,418	3.1	
Subtotal	588,214	17,828	—	606,042	73.6	
Managed care	102,737	3,531	—	106,268	12.9	
Private and other	108,702	1,927	216	(1) 110,845	13.5	
Total revenue	$799,653	$23,286	$216	$823,155	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers and other ancillary businesses.

Transitional, Skilled and Assisted Living Services

Skilled Nursing Operations. Within our skilled nursing operations, we generate our revenue from Medicaid, private pay, managed care and Medicare payors. We believe that our skilled mix, which we define as the number of days our Medicare, managed care, or other skilled patients are receiving services at our skilled nursing operations divided by the total number of patient days (less days from assisted living services) from all payor sources are receiving services at our skilled nursing facilities for any given period (less days from assisted living services), 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 and managed care payors, for whom we receive higher reimbursement rates.

Assisted and Independent Living Operations. Within our assisted and independent living operations, we generate revenue primarily from private pay sources, with a small portion earned from Medicaid or other state-specific programs.

Home Health and Hospice Services

Home Health. We provided home health care in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington as of December 31, 2014. We derive the majority of our revenue from our home health business from Medicare and managed care. The payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The home health prospective payment system (PPS) provides home health agencies with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin. There are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary’s health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits was fewer than five; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (c) a payment adjustment based upon the level of therapy services required; (d) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes in the base episode payments established by the Medicare program; (f) adjustments to the base episode payments for case mix and geographic wages; and (g) recoveries of overpayments.

Hospice. As of December 31, 2014, we provided hospice care in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. We derive substantially all of the revenue from our hospice business from Medicare reimbursement. The estimated payment rates are daily rates for each of the levels of care we deliver. 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. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimates amounts due back to Medicare if a cap has been exceeded.

Other

In addition, as of December 31, 2014, we operated fourteen urgent care clinics, which are all in Washington. Our urgent care centers provide daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. As of December 31, 2014, we held 80% of the membership interest of a mobile

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x-ray and diagnostic company. The diagnostic company is a leader in providing mobile diagnostic services, including digital x-ray, ultrasound, electrocardiograms, ankle-brachial index, and phlebotomy services to people in their homes or at long-term care facilities. 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 facility rent and depreciation and amortization shown separately). Our cost of services represents the costs of operating our affiliated 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 and other general cost of services with respect to our operations.

Facility Rent - Cost of Services. Facility rent - cost of services consists solely of base minimum rent amounts payable under lease agreements to third-party owners of the facilities that we operate but do not own and does not include taxes, insurance, impounds, capital reserves or other charges payable under the applicable lease agreements.

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, stock-based compensation and rent for our Service Center office.

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 57 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 Policies

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. On an ongoing basis we review our judgments and estimates, including but not limited to those related to doubtful accounts, income taxes, stock compensation, intangible assets and loss contingencies. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty, and actual results could differ materially from the amounts reported. The following summarizes our critical accounting

policies, defined as those policies that we believe: (a) are the most important to the portrayal of our financial condition and results of operations; and (b) require management's most subjective or complex judgments, often as a result of the need to make estimates about the effects of matters that are inherently uncertain.

Revenue Recognition

We recognize revenue when the following four conditions have been met: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii) the price is fixed or determinable; and (iv) collection is reasonably assured. Our 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. For patients under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts on a per patient, daily basis.

Revenue from Medicare and Medicaid programs account for 70.4%, 72.2% and 73.6% of our revenue for the years ended December 31, 2014, 2013 and 2012, respectively. We record revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. Our revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare

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industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. We recorded adjustments upon settlement to revenue which were not material to our consolidated revenue for the years ended December 31, 2014, 2013 and 2012.

Our service specific revenue recognition policies are as follows:

Skilled Nursing, Assisted and Independent Living Revenue

Our revenue is derived primarily from providing long-term healthcare services to patients and is recognized on the date services are provided at amounts billable to individual patients. 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 rate on a per patient, daily basis or as services are performed.

Home Health Revenue

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if patient care was unusually costly; (b) a low utilization payment adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or we received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare Program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments.

We make adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Therefore, we believe that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. As such, we estimate revenue and recognize it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on visits performed.

Non-Medicare Revenue

Episodic Based Revenue — We recognize revenue in a similar manner as we recognize Medicare revenue for episodic-based rates that are paid by other insurance carriers, including Medicare Advantage programs; however, these rates can vary based upon the negotiated terms.

Non-episodic Based Revenue — Revenue is recorded on an accrual basis based upon the date of service at amounts equal to its established or estimated per-visit rates, as applicable.

Hospice Revenue

Revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily rates for each of the levels of care we deliver. We make adjustments to revenue for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimated amounts due back to Medicare if a cap has been exceeded. We record these adjustments as a reduction to revenue and increases to other accrued liabilities.

Accounts Receivable and Allowance for Doubtful Accounts

Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources. Estimated provisions for doubtful accounts are recorded to the extent it is probable that a portion or all of a particular account will not be collected.

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In evaluating the collectability of accounts receivable, we consider a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type and the status of ongoing disputes with third-party payors. On an annual basis, the historical collection percentages are reviewed by payor and by state and are updated to reflect our recent collection experience. In order to determine the appropriate reserve rate percentages which ultimately establish the allowance, we analyze historical cash collection patterns by payor and by state. The percentages applied to the aged receivable balances are based on our historical experience and time limits, if any, for managed care, Medicare, Medicaid and other payors. We periodically refine our estimates of the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances.

Self-Insurance

We are partially self-insured for general and professional liability 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 occurrence, per location and on an aggregate basis for us. For claims made after January 1, 2013, the combined self-insured retention was $0.5 million per claim, subject to an additional one-time deductible of $1.0 million for California affiliated facilities and a separate, one-time, deductible of $0.8 million for non-California facilities. For all affiliated facilities, except those located in Colorado, the third-party coverage above these limits was $1.0 million per claim, $3.0 million per facility, with a $5.0 million blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1.0 million per claim and $3.0 million per facility for skilled nursing facilities, which is independent of the aforementioned blanket aggregate applicable to our other 129 affiliated facilities.

The self-insured retention and deductible limits for general and professional liability and workers' compensation for all states except Texas and Washington are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying consolidated balance sheets. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. 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. We evaluate the estimates for claim loss exposure on a quarterly basis.

Our operating subsidiaries are self-insured for workers’ compensation liability for all states, except Texas and Washington. To protect ourselves against loss exposure in California with this policy, we have purchased individual specific excess insurance coverage that insures individual claims that exceed $0.5 million per occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers’ compensation claims, and we maintain individual stop-loss coverage for individual claims that exceed $0.8 million per occurrence. As of July 1, 2014, our operating subsidiaries in other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $0.4 million per occurrence. In Washington, the operating subsidiaries' coverage is financed through premiums paid by the employers and employees. The claims and pay benefits are managed through a state insurance pool. Outside of California, Texas, and Washington, we have purchased insurance coverage that insures individual claims that exceed $0.4 million per accident. In all states, except Washington, we accrue 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. We use actuarial valuations to estimate the liability based on historical experience and industry information.

We self-fund medical (including prescription drugs) and dental healthcare benefits to the majority of our affiliated subsidiaries' employees. We are fully liable for all financial and legal aspects of these benefit plans. To protect ourselves against loss exposure with this policy, we have purchased individual stop-loss insurance coverage that insures individual claims that exceed $0.3 million for each covered person with an additional one-time aggregate individual stop loss deductible of $0.1 million.

We believe 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 our reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This 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, with the assistance of 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 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 we could experience changes in estimated losses that could be material to our results of operations. If our actual liability exceeds our estimates of loss, our results of operations, cash flows and financial condition could be materially adversely affected.

Leases and Leasehold Improvements

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At the inception of each lease, we perform an evaluation to determine whether the lease should be classified as an operating or capital lease. We record rent expense for operating leases that contain scheduled rent increases 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 we are given control of the leased premises through the end of the lease term. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements, as well as the period over which we record straight-line rent expense.

Business Combinations

Our acquisition strategy is to purchase or lease operating subsidiaries that are complementary to our current affiliated facilities, accretive to our business or otherwise advance our strategy. The results of all of our operating subsidiaries are included in the accompanying Financial Statements subsequent to the date of acquisition. Acquisitions are typically paid for in cash and are accounted for using the acquisition method of accounting. We account for business combinations using the purchase method of accounting and, accordingly, the assets and liabilities of the acquired entities are recorded at their estimated fair values at the acquisition date. Goodwill represents the excess of the purchase price over the fair value of net assets, including the amount assigned to identifiable intangible assets. Given the time it takes to obtain pertinent information to finalize the acquired company's balance sheet, the initial fair value might not be finalized at the time of the reported period. Accordingly, it is not uncommon for the initial estimates to be subsequently revised.

In accounting for business combinations, we are required to record the assets and liabilities of the acquired business at fair value. In developing estimates of fair values for long-lived assets, we utilize a variety of factors including market data, cash flows, growth rates, and replacement costs. Determining the fair value for specifically identified intangible assets involves significant judgment, estimates and projections related to the valuation to be applied to intangible assets such as favorable leases, customer relationships, Medicare licenses, and trade names. The subjective nature of management's assumptions increases the risk associated with estimates surrounding the projected performance of the acquired entity. Additionally, as we amortize finite-lived acquired intangible assets over time, the purchase accounting allocation directly impacts the amortization expense recorded on the financial statements.

Income Taxes

Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of our assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. We generally expect to fully utilize our deferred tax assets; however, when necessary, we record a valuation allowance to reduce our net deferred tax assets to the amount that is more likely than not to be realized.

When we take uncertain income tax positions that do not meet the recognition criteria, we record a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, we must consider the potential outcomes from a review of the positions by the taxing authorities.
In determining the need for a valuation allowance, the annual income tax rate, or the need for and magnitude of liabilities for uncertain tax positions, we make 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 our estimates and assumptions, actual results could differ.

Recent Accounting Pronouncements

Except for rules and interpretive releases of the SEC under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) Accounting Standards Codification™ (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. We have reviewed the FASB issued Accounting Standards Update (ASU) accounting pronouncements and interpretations thereof that have effectiveness dates during the periods reported and in future periods. For any new pronouncements announced, we consider whether the new pronouncements could alter previous generally accepted accounting principles and determine whether any new or modified principles will have a material impact on our reported financial position or operations in the near term. The applicability of any standard is subject to the formal review of our financial management and certain standards are under consideration.

In April 2014, the FASB issued an accounting standards update that raises the threshold for disposals to qualify as discontinued operations and allows companies to have significant continuing involvement with and continuing cash flows from or to the

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discontinued operation. It also requires additional disclosures for discontinued operations and new disclosures for individually material disposal transactions that do not meet the definition of a discontinued operation. This guidance will be effective for fiscal years beginning after December 15, 2014, which will be our fiscal year 2015, with early adoption permitted. We do not expect the adoption of the guidance will have a material impact on our consolidated financial statements.

In May 2014, the FASB and International Accounting Standards Board issued their final standard on revenue from contracts with customers that outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. The new standard supersedes most current revenue recognition guidance, including industry-specific guidance. This guidance will be effective for fiscal years beginning after December 15, 2016, which will be our fiscal year 2017. Early adoption is not permitted. We are currently assessing whether the adoption of the guidance will have a material impact on our consolidated financial statements.

In August 2014, the FASB issued its final standard on going concerns, which requires management to perform interim and annual assessments of an entity's ability to continue as a going concern within one year of the date the financial statements are issued. It also requires additional disclosures if an entity's conditions or events raise substantial doubt about the entity's ability to continue as a going concern. This guidance applies to all entities and is effective for annual periods ending after December 15, 2016, which will be our fiscal year 2016, with early adoption permitted. We do not expect the adoption of the guidance will have a material impact on our consolidated financial statements.

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Results of Operations

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

	Year Ended December 31,		
	2014	2013	2012
Revenue	100.0 %	100.0 %	100.0 %
Expenses:			
Cost of services (exclusive of facility rent, general and administrative expense and depreciation and amortization shown separately below)	80.1	80.3	79.7
U.S. Government inquiry settlement	—	3.6	1.8
Facility rent—cost of services	4.7	1.5	1.6
General and administrative expense	5.5	4.4	3.9
Depreciation and amortization	2.6	3.8	3.4
Total expenses	92.9	93.6	90.4
Income from operations	7.1	6.4	9.6
Other income (expense):			
Interest expense	(1.3)	(1.4)	(1.5)
Interest income	—	—	—
Other expense, net	(1.3)	(1.4)	(1.5)
Income before provision for income taxes	5.8	5.0	8.1
Provision for income taxes	2.6	2.2	3.1
Income from continuing operations	3.2	2.8	5.0
Loss from discontinued operations	—	(0.2)	(0.2)
Net income	3.2	2.6	4.8
Less: net loss attributable to the noncontrolling interests	(0.2)	(0.1)	(0.1)
Net income attributable to The Ensign Group, Inc.	3.4 %	2.7 %	4.9 %

Year Ended December 31, 2014 Compared to the Year Ended December 31, 2013

The comparison of results of operations between 2014 and 2013 was impacted significantly by the following items:

- In the second quarter of 2014, we completed the Spin-Off transaction of our real estate business. As a result, we incurred approximately $9.0 million of transaction costs associated with the Spin-Off in 2014, which are included in general and administrative expenses within the consolidated statements of income. See Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust of Notes to Consolidated Financial Statements for additional information. We also recorded additional Spin-Off related costs of approximately $5.8 million, consisting of $4.1 million in repayment penalties and the write-off of unamortized debt discount and deferred financing costs upon retirement of outstanding debt in connection with the Spin-Off and $1.7 million of recognized loss due to the discontinuance of cash flow hedge accounting for the related interest-rate swap. See Note 18, Debt of Notes to Consolidated Financial Statements for additional information. In addition, as part of the transaction, we transferred real properties and entered into new lease agreements with CareTrust, which resulted in additional rent expense of $32.7 million during the year ended 2014 and a reduction in depreciation expense. In 2013, we incurred $4.1 million of transaction costs associated with the Spin-Off.

- Our 2013 results are impacted by an accrual of $33.0 million for the settlement to resolve the U.S. Department of Justice (DOJ) investigation during the first quarter of 2013. In addition, we incurred charges of $2.6 million in settlement charges and legal costs in 2013 associated with a class action lawsuit. See Note 20, Commitments and Contingencies of the Notes to Consolidated Financial Statements for additional information. We did not record

settlement charges related to the DOJ investigation in 2014.

- During 2013, we recorded a $0.5 million goodwill impairment charge on one facility as a result of the facility experiencing a significant reduction in admissions due to extensive renovations, which occurred over a year, resulting in declines in

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related forecasted cash flows, resulting in the impairment to goodwill. There was no impairment charge to goodwill in 2014.

Revenue

Total consolidated revenue increased $122.9 million, or 13.6% , to $1.0 billion for the year ended December 31, 2014 from $904.6 million for the year ended December 31, 2013.

	Years Ended December 31,					
	2014			2013		
	Revenue Dollars	Revenue Percentage		Revenue Dollars	Revenue Percentage	
Transitional, skilled and assisted living services:						
Skilled nursing facilities	$901,470	87.7	%	$812,348	89.8	%
Assisted and independent living facilities	48,848	4.8		40,931	4.5	
Total transitional, skilled and assisted living services	950,318	92.5		853,279	94.3	
Home health and hospice services:						
Home health	29,577	2.9		21,978	2.4	
Hospice	24,939	2.4		17,784	2.0	
Total home health and hospice services	54,516	5.3		39,762	4.4	
All other (1)	22,572	2.2		11,515	1.3	
Total revenue	$1,027,406	100.0	%	$904,556	100.0	%

(1) Includes revenue from services provided at our urgent care clinics and a mobile x-ray and diagnostic company.

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Transitional, Skilled and Assisted Living Services

	Year Ended December 31, 2014		2013		Change	% Change	
	(Dollars in thousands)						
Total Facility Results:							
Skilled nursing revenue	$901,470		$812,348		$89,122	11.0	%
Assisted and independent living revenue	48,848		40,931		7,917	19.3	%
Total transitional, skilled and assisted living revenue	$950,318		$853,279		$97,039	11.4	%
Number of facilities at period end	136		119		17	14.3	%
Actual patient days	3,921,758		3,648,651		273,107	7.5	%
Occupancy percentage — Operational beds	78.0	%	77.5	%		0.5	%
Skilled mix by nursing days	27.6	%	26.4	%		1.2	%
Skilled mix by nursing revenue	50.8	%	50.0	%		0.8	%

	Year Ended December 31, 2014		2013		Change	% Change	
	(Dollars in thousands)						
Same Facility Results(1):							
Skilled nursing revenue	$724,422		$688,184		$36,238	5.3	%
Assisted and independent living revenue	17,456		16,493		963	5.8	%
Total transitional, skilled and assisted living revenue	$741,878		$704,677		$37,201	5.3	%
Number of facilities at period end	82		82		—	—	%
Actual patient days	2,832,584		2,784,664		47,920	1.7	%
Occupancy percentage — Operational beds	81.9	%	80.4	%		1.5	%
Skilled mix by nursing days	29.3	%	27.9	%		1.4	%
Skilled mix by nursing revenue	52.4	%	51.4	%		1.0	%

	Year Ended December 31, 2014		2013		Change	% Change	
	(Dollars in thousands)						
Transitioning Facility Results(2):							
Skilled nursing revenue	$99,326		$96,454		$2,872	3.0	%
Assisted and independent living revenue	18,171		16,467		1,704	10.3	%
Total transitional, skilled and assisted living revenue	$117,497		$112,921		$4,576	4.1	%
Number of facilities at period end	25		25		—	—	%
Actual patient days	634,772		619,161		15,611	2.5	%
Occupancy percentage — Operational beds	71.3	%	69.6	%		1.7	%
Skilled mix by nursing days	19.8	%	19.5	%		0.3	%
Skilled mix by nursing revenue	41.5	%	40.7	%		0.8	%

	Year Ended December 31, 2014	2013	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Skilled nursing revenue	$77,722	$27,710	$50,012	NM
Assisted and independent living revenue	11,974	4,512	7,462	NM
Total transitional, skilled and assisted living revenue	$89,696	$32,222	$57,474	NM
Number of facilities at period end	29	11	18	NM

Actual patient days	426,386		171,861		254,525	NM
Occupancy percentage — Operational beds	66.5	%	66.2	%		NM
Skilled mix by nursing days	24.4	%	20.5	%		NM
Skilled mix by nursing revenue	47.0	%	46.6	%		NM

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	Year Ended December 31,			
	2014	2013	Change	% Change
	(Dollars in thousands)			
Transferred to CareTrust(4):				
Skilled nursing revenue	$—	$—	$—	NM
Assisted and independent living revenue	1,247	3,459	(2,212)	NM
Total transitional, skilled and assisted living revenue	$1,247	$3,459	$(2,212)	NM
Actual patient days	28,016	72,965		NM
Occupancy percentage — Operational beds	70.3 %	75.7 %		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2011.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2011 to December 31, 2012.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2013.

(4) Transferred to CareTrust results represent the results at three independent living facilities which were transferred to CareTrust as part of the Spin-Off on June 1, 2014. These results were excluded from Same Facility and Transitioning Facility for the year ended December 31, 2014 and 2013 for comparison purposes.

Revenue. Transitional, skilled and assisted living revenue increased $97.0 million, or 11.4%, to $950.3 million for the year ended December 31, 2014 compared to $853.3 million for the year ended December 31, 2013. Of the $97.0 million increase, Medicare and managed care revenue increased $36.0 million, or 9.6%, Medicaid custodial revenue increased $32.3 million, or 10.1%, private and other revenue increased $13.6 million, or 11.4%, and Medicaid skilled revenue increased $15.1 million, or 41.8%. Transitional, skilled and assisted living revenue generated by Recently Acquired Facilities increased by approximately $57.5 million. Since January 1, 2013, we have acquired 29 facilities in eight states.

Transitional, skilled and assisted living revenue generated by Same Facilities increased $37.2 million, or 5.3%, for the year ended December 31, 2014 as compared to the year ended December 31, 2013. This increase was primarily due to an increase in managed care revenue of $12.3 million, or 12.0%, which is primarily attributable to an increase in managed care days of 7.4% during the year ended December 31, 2014 compared to the year ended December 31, 2013. Medicare days remained consistent with the year ended December 31, 2013. Managed care revenue per patient day and Medicare revenue per patient day increased by 3.6% and 0.7%, respectively, during the year ended December 31, 2014 as compared to the year ended December 31, 2013.

Transitional, skilled and assisted living revenue at Transitioning Facilities increased $4.6 million, or 4.1% for the year ended December 31, 2014 as compared to the year ended December 31, 2013. This increase was primarily due to an increase in managed care revenue of $2.3 million, or 45.5%, which is primarily attributable to an increase in managed care days of 43.5% during the year ended December 31, 2014 compared to the year ended December 3