ENSIGN GROUP, INC
Form 10-Q
November 05, 2014
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended September 30, 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)

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 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
As of November 3, 2014, 22,478,506 shares of the registrant’s common stock were outstanding.

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2014
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Part I. Financial Information

Item 1. Financial Statements
THE ENSIGN GROUP, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except par values)
(Unaudited)

	September 30, 2014	December 31, 2013
Assets		
Current assets:		
Cash and cash equivalents	$39,206	$65,755
Restricted cash—current	6,652	—
Accounts receivable—less allowance for doubtful accounts of $19,452 and $16,540 at September 30, 2014 and December 31, 2013, respectively	120,647	111,370
Investments—current	5,883	5,511
Prepaid income taxes	5,078	9,915
Prepaid expenses and other current assets	8,432	9,213
Deferred tax asset—current	8,033	9,232
Total current assets	193,931	210,996
Property and equipment, net	127,448	479,770
Insurance subsidiary deposits and investments	18,170	16,888
Escrow deposits	600	1,000
Deferred tax asset	11,493	4,464
Restricted and other assets	8,449	9,804
Intangible assets, net	6,560	5,718
Goodwill	25,719	23,935
Other indefinite-lived intangibles	10,509	7,740
Total assets	$402,879	$760,315
Liabilities and equity		
Current liabilities:		
Accounts payable	$27,783	$23,793
Accrued wages and related liabilities	48,159	40,093
Accrued self-insurance liabilities—current	15,642	15,461
Other accrued liabilities	26,751	25,698
Current maturities of long-term debt	110	7,411
Total current liabilities	118,445	112,456
Long-term debt—less current maturities	3,307	251,895
Accrued self-insurance liabilities—less current portion	33,658	33,642
Fair value of interest rate swap	—	1,828
Deferred rent and other long-term liabilities	3,151	3,237
Total liabilities	158,561	403,058
Commitments and contingencies (Note 16)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 22,827 and 22,434 shares issued and outstanding at September 30, 2014, respectively, and 22,580 and 22,113 shares issued and outstanding at December 31, 2013, respectively	23	22

Additional paid-in capital	110,090	101,364
Retained earnings (Note 2)	136,043	257,502
Common stock in treasury, at cost, 202 and 237 shares at September 30, 2014 and December 31, 2013, respectively	(1,505)	(1,680)
Accumulated other comprehensive loss	—	(1,112)
Total Ensign Group, Inc. stockholders' equity	244,651	356,096
Non-controlling interest	(333)	1,161
Total equity	244,318	357,257
Total liabilities and equity	$402,879	$760,315

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(In thousands, except per share data)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Revenue	$260,841	$229,261	$750,537	$667,548
Expense:				
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	209,737	186,172	601,532	538,146
U.S. Government inquiry settlement (Note 16)	—	—	—	33,000
Facility rent—cost of services	18,176	3,404	30,008	10,056
General and administrative expense	12,956	10,601	44,370	28,321
Depreciation and amortization	4,677	8,795	21,343	25,198
Total expenses	245,546	208,972	697,253	634,721
Income from operations	15,295	20,289	53,284	32,827
Other income (expense):				
Interest expense	(407)	(3,181)	(12,490)	(9,441)
Interest income	142	141	435	363
Other expense, net	(265)	(3,040)	(12,055)	(9,078)
Income before provision for income taxes	15,030	17,249	41,229	23,749
Provision for income taxes	6,659	6,607	18,284	11,440
Income from continuing operations	8,371	10,642	22,945	12,309
Loss from discontinued operations, net of income tax benefit of $38 and $1,157 for the three and nine months ended September 30, 2013, respectively (Note 17)	—	(30)	—	(1,804)
Net income	8,371	10,612	22,945	10,505
Less: net (loss) income attributable to noncontrolling interests	(535)	148	(1,494)	(179)
Net income attributable to The Ensign Group, Inc.	$8,906	$10,464	$24,439	$10,684
Amounts attributable to The Ensign Group, Inc.:				
Income from continuing operations attributable to The Ensign Group, Inc.	$8,906	$10,494	$24,439	$12,488
Loss from discontinued operations, net of income tax	—	(30)	—	(1,804)
Net income attributable to The Ensign Group, Inc.	$8,906	$10,464	$24,439	$10,684
Net income per share:				
Basic:				
Income from continuing operations attributable to The Ensign Group, Inc.	$0.40	$0.48	$1.10	$0.57
Loss from discontinued operations	$—	$—	$—	$(0.08)
Net income attributable to The Ensign Group, Inc.	$0.40	$0.48	$1.10	$0.49
Diluted:				
Income from continuing operations attributable to The Ensign Group, Inc.	$0.38	$0.47	$1.06	$0.56
Loss from discontinued operations	$—	$—	$—	$(0.08)
Net income attributable to The Ensign Group, Inc.	$0.38	$0.47	$1.06	$0.48
Weighted average common shares outstanding:				
Basic	22,415	21,941	22,282	21,857
Diluted	23,186	22,409	23,014	22,316

Dividends per share	$0.070	$0.065	$0.210	$0.195

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(In thousands)
(Unaudited)

	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
Net income	$8,371	$10,612	$22,945	$10,505
Other comprehensive income, net of tax:				
Unrealized (gain) loss on interest rate swap, net of income tax expense (benefit) of ($78) for the nine months ended September 30, 2014, and $27 and ($332) for the three and nine months ended September 30, 2013, respectively.	—	(28)	89	531
Reclassification adjustment on termination of interest rate swap, net of income tax benefit of $638 for the nine months ended September 30, 2014.	—	—	1,023	—
Comprehensive income	8,371	10,584	24,057	11,036
Less: net (loss) income attributable to noncontrolling interests	(535)	148	(1,494)	(179)
Comprehensive income attributable to The Ensign Group, Inc.	$8,906	$10,436	$25,551	$11,215

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Nine Months Ended September 30 ,	
	2014	2013
Cash flows from operating activities:		
Net income	$22,945	$10,505
Adjustments to reconcile net income to net cash provided by operating activities:		
Loss from sale of discontinued operations (Note 17)	—	2,837
U.S. Government inquiry accrual (Note 16)	—	33,000
Depreciation and amortization	21,343	25,229
Amortization of deferred financing fees and debt discount	539	616
Deferred income taxes	(510)	(768)
Provision for doubtful accounts	9,271	8,505
Share-based compensation	3,813	2,932
Excess tax benefit from share-based compensation	(2,403)	(1,501)
Loss on extinguishment of debt	4,067	—
Loss on termination of interest rate swap	1,661	—
Gain on sale of equity method investment	—	(380)
Loss on disposition of property and equipment	14	1,164
Change in operating assets and liabilities		
Accounts receivable	(18,555)	(16,746)
Prepaid income taxes	4,811	(7,648)
Prepaid expenses and other current assets	853	987
Insurance subsidiary deposits and investments	(1,654)	14
Accounts payable	4,164	(2,950)
Accrued wages and related liabilities	6,271	(219)
Other accrued liabilities	8,580	1,241
Accrued self-insurance	1,562	552
Deferred rent liability	(85)	(260)
Net cash provided by operating activities	66,687	57,110
Cash flows from investing activities:		
Purchase of property and equipment	(42,125)	(21,884)
Cash payment for business acquisitions	(42,968)	(45,364)
Cash payment for asset acquisitions	(7,939)	—
Escrow deposits	(600)	(250)
Escrow deposits used to fund business acquisitions	1,000	4,635
Change in restricted cash	(6,652)	—
Cash proceeds on sale of urgent care franchising business, net of note receivable	—	3,610
Cash proceeds on sale of equity method investment	—	1,600
Cash proceeds from the sale of property and equipment	1	787
Restricted and other assets	(124)	(180)
Net cash used in investing activities	(99,407)	(57,046)
Cash flows from financing activities:		
Proceeds from issuance of debt (Note 14)	400,677	10,000
Payments on long-term debt	(301,171)	(5,383)
Issuance of treasury stock upon exercise of options	175	40

Cash retained by CareTrust at separation (Note 2)	(78,731)	—
Issuance of common stock upon exercise of options	2,510	2,694
Dividends paid	(4,753)	(2,874)
Excess tax benefit from share-based compensation	2,416	1,501
Prepayment penalties on early retirement of debt	(2,069)	—
Payments of deferred financing costs	(12,883)	(730)
Net cash provided by financing activities	6,171	5,248
Net (decrease) increase in cash and cash equivalents	(26,549)	5,312
Cash and cash equivalents beginning of period	65,755	40,685
Cash and cash equivalents end of period	$39,206	$45,997

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS - (Continued)
(In thousands)
(Unaudited)

	Nine Months Ended September 30 ,	
	2014	2013
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$13,102	$9,464
Income taxes	$14,690	$17,238
Non-cash financing and investing activity:		
Accrued capital expenditures	$1,520	$826
Note receivable on sale of urgent care franchising business	$—	$4,000
Debt assumed as part of business acquisition	$3,417	$—

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Dollars and shares in thousands, except per share data)
(Unaudited)

1. DESCRIPTION OF BUSINESS

The Company - The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. Subsidiaries and affiliates of the Company are operated by separate, independent entities, each of which has its own management, employees and assets. These subsidiaries and affiliates of Ensign provide skilled nursing and rehabilitative care services through the operation of 127 facilities, eleven home health and ten hospice operations, fourteen urgent care centers and a mobile x-ray and diagnostic company as of September 30, 2014, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah, Washington, and Wisconsin. The Company's operating subsidiaries, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted living, home health and hospice, mobile x-ray and diagnostic, and urgent care services. The Company's affiliated facilities have a collective capacity of approximately 14,000 operational skilled nursing, assisted living and independent living beds. As of September 30, 2014, the Company owned 9 of its 127 affiliated facilities and leased an additional 118 facilities through long-term lease arrangements, and had options to purchase two of those 118 facilities. As of December 31, 2013, the Company owned 96 of its 119 affiliated facilities and leased an additional 23 facilities through long-term lease arrangements, and had options to purchase two of those 23 facilities. See Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust, for the change in ownership profile.
One of the Company’s wholly-owned subsidiaries, referred to as the Service Center, provides 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. The Company also has a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to the Company’s operating subsidiaries for general and professional liability, as well as coverage for certain workers’ compensation insurance liabilities.
Like the Company’s affiliated facilities, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar verbiage i this quarterly report is not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by either The Ensign Group or the same entity.
Other Information — The accompanying condensed consolidated financial statements as of September 30, 2014 and for the three and nine months ended September 30, 2014 and 2013 (collectively, the Interim Financial Statements), are unaudited. Certain information and note disclosures normally included in annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company’s audited consolidated financial statements and notes thereto for the year ended December 31, 2013 which are included in the Company’s annual report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company’s financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

2. SPIN-OFF OF REAL ESTATE ASSETS THROUGH A REAL ESTATE INVESTMENT TRUST

On June 1, 2014, the Company completed the separation of its healthcare business and its 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 Ensign stockholders on a pro rata basis (the Spin-Off). Ensign stockholders received one share of CareTrust common stock for each share of Ensign common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. The Spin-Off was effective from and after June 1, 2014, with shares of CareTrust common stock distributed on June 2, 2014. CareTrust is listed on the NASDAQ Global Select Market (NASDAQ) and trades under the ticker symbol “CTRE.”

The Company received a private letter ruling from the Internal Revenue Service (IRS) substantially to the effect that the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes. The private letter ruling relies on certain facts, representations, assumptions and undertakings. The Company also received opinions from its advisors as to the satisfaction of certain requirements for the tax-free treatment of the Spin-Off, and an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014, CareTrust has been organized in conformity with the requirements for qualification

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as a real estate investment trust ("REIT") under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

Prior to the Spin-Off, the Company entered into a Separation and Distribution Agreement with CareTrust, setting forth the mechanics of the Spin-Off, certain organizational matters and other ongoing obligations of the Company and CareTrust. The Company and CareTrust or their respective subsidiaries, as applicable, also entered into a number of other agreements to govern the relationship between CareTrust and the Company after the Spin-Off.

Immediately before the Spin-Off, on May 30, 2014, while CareTrust was a wholly-owned subsidiary of the Company, CareTrust raised $260,000 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 $50,676 to an aggregate principal amount of $99,000 (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 $220,752 to the Company, a portion of which the Company used to retire $208,635 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. The amount retained by the Company of $8,219 was recorded as restricted cash, of which $6,400 is classified as current assets and $1,819 is classified as non-current assets as of June 1, 2014. The amount represents a portion of the proceeds received from CareTrust in connection with the Separation and Distribution Agreement that the Company intends to use to pay up to eight regular quarterly dividend payments. During the third quarter of 2014, the Company utilized $1,567 to pay the third quarter dividend payments. As of September 30, 2014, the Company has $6,652 of restricted cash remaining, which is classified as current assets as the Company intends to utilize all the remaining amount to make dividend payments within the next twelve months. The remaining cash of $78,731 that CareTrust retained on the Spin-Off date was transferred to CareTrust as part of the assets and liabilities contributed to CareTrust in connection with the Spin-Off.

As of March 31, 2014, the Company operated 120 affiliated facilities. Prior to the Spin-Off, the Company separated the healthcare operations from the independent living operations at two locations, resulting in a total of 122 affiliated facilities. The Company contributed to CareTrust the assets and liabilities associated with all of the 94 real property and three independent living facilities that CareTrust now operates that were previously owned by the Company. The results of the three independent living facilities that were transferred to CareTrust in connection with the Spin-Off were not material to the Company's three and nine months ended September 30, 2014 or 2013. The assets and liabilities were contributed to CareTrust based on their historical carrying values, which were as follows (in thousands):

Cash and cash equivalents	$78,731
Other current assets	34
Property and equipment, net	421,846
Deferred financing costs	11,088
Accounts payable and accrued expenses	(4,971)
Current deferred tax liability	(125)
Deferred tax liability	(5,925)
Current maturities of long-term debt	(2,342)
Long-term debt—less current maturities	(357,171)
Net contribution	$141,165

As a result of the Spin-Off, CareTrust owns all of the 94 real property and three independent living facilities that were transferred in connection with the Spin-Off. The Company leases the 94 real property from CareTrust under eight "triple-net" master lease agreements (collectively, the Master Leases). The Company continues to operate the affiliated skilled nursing, assisted living and independent living facilities that are leased from CareTrust pursuant to the Master Leases. The Master Leases consist of multiple leases, each with its own pool of properties that has varying maturities and diversity in property geography. Under each Master Lease, the Company's individual subsidiaries that operate those properties subject to such Master Lease are the tenants and CareTrust's individual subsidiaries that own the properties are the landlords. The Company guarantees the obligations of the tenants under the Master Leases. If a tenant defaults under a Master Lease with respect to any property, CareTrust is entitled to exercise remedies under such Master Lease as to all properties covered by such Master Lease as though all such properties were in default. In addition, each Master Lease with the tenant contains cross-default provisions that results in a default under all of the Master Leases if a default occurs under any Master Lease.

Commencing in the third year, the rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. Annual rent expense under the Master Lease will be approximately $56,000 during each of the first two years of the Master Leases. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties.

Each Master Lease has a term ranging from 12 to 19 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If the Company elects to renew the term of a Master Lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the Master Lease. The extension of the term of any of the Master Leases will be subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and being continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases will be subject to termination prior to the expiration of the then current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases.

The Company does not have the ability to terminate the obligations under a Master Lease prior to its expiration without CareTrust's consent. If a Master Lease is terminated prior to its expiration other than with CareTrust's consent, the Company may be liable for damages and incur charges such as continued payment of rent through the end of the lease term and maintenance and repair costs for the leased property.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. As of September 30, 2014, we were in compliance with the Master Leases covenants.

The Company and CareTrust also entered into an Opportunities Agreement, which grants CareTrust the right to match any offer from a third party to finance the acquisition or development of any healthcare or senior-living facility by the Company or any of its affiliates for a period of one year following the Spin-Off. In addition, this agreement requires CareTrust to provide the Company, subject to certain exceptions, a right to either purchase and operate, or lease and operate, the affiliated facilities included in any portfolio of five or fewer healthcare or senior living facilities presented to the Company during the first year following the Spin-Off; provided that the portfolio is not subject to an existing lease with an operator or manager that has a remaining term of more than one year, and is not presented to the Company by or on behalf of another operator seeking lease or other financing. If the Company elects to lease and operate such a property or portfolio, the lease would be on substantially the same terms as the Master Leases.

As the Spin-Off was completed in the second quarter of 2014, the Company did not incur transaction costs for the three months ended September 30, 2014. The Company incurred transaction costs of $8,871 for nine months ended September 30, 2014 associated with the Spin-Off, which are included in general and administrative expenses within the condensed consolidated statements of income. During the three and nine months ended September 30, 2013, the Company incurred transaction costs of $1,648 and $1,857, respectively, related to the Spin-Off.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States of America. The Company is the sole member or shareholder of various consolidated limited liability companies and corporations; each established to operate various acquired skilled nursing and assisted living facilities, home health and hospice operations, urgent care centers and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interest within the equity section of its consolidated balance sheets. The Company presents the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interest in its consolidated statements of income.

The consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest and the accounts of any variable interest entities (VIEs) where the Company is subject to a majority of the risk of loss from the VIE's activities, or entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impact" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. The Company's relationship with variable interest entities was not material at September 30, 2014.

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On March 25, 2013, the Company agreed to terms to sell Doctors Express (DRX), a national urgent care franchise system. The asset sale was effective on April 15, 2013. The results of operations for DRX have been classified as discontinued operations for all periods presented (see Note 17, Discontinued Operations) in the accompanying Interim Financial Statements. In addition, the results of operations of DRX and the loss or impairment related to this divestiture have been classified as discontinued operations in the accompanying condensed consolidated statements of operations for all periods presented.

Estimates and Assumptions — The preparation of Interim Financial Statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company’s Interim Financial Statements relate to revenue, allowance for doubtful accounts, intangible assets and goodwill, impairment of long-lived assets, general and professional liability, worker’s compensation, and healthcare claims included in accrued self-insurance liabilities, and income taxes. Actual results could differ from those estimates.

Business Segments — The Company has a single reportable segment — long-term care services, which includes providing skilled nursing, assisted living, home health and hospice, urgent care and related ancillary services. The Company’s single reportable segment is made up of several individual operating segments grouped together principally based on their geographical locations within the United States. Based on the similar economic and other characteristics of each of the operating segments, management believes the Company meets the criteria for aggregating its operating segments into a single reportable segment.

Fair Value of Financial Instruments —The Company’s financial instruments consist principally of cash and cash equivalents, debt security investments, accounts receivable, insurance subsidiary deposits, accounts payable and borrowings. The Company believes all of the financial instruments’ recorded values approximate fair values because of their nature or respective short durations.

Revenue Recognition — The Company recognizes 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. The Company's revenue is derived primarily from providing healthcare services to residents and is recognized on the date services are provided at amounts billable to the individual. For 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 the Medicare and Medicaid programs accounted for 70.3% and 70.6% of the Company’s revenue for the three and nine months ended September 30, 2014, respectively, and 71.2% and 72.2% for the three and nine months ended September 30, 2013, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company’s revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare 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. The Company recorded retroactive adjustments to revenue which were not material to the Company's consolidated revenue for the three and nine months ended September 30, 2014 and 2013.

The Company’s service specific revenue recognition policies are as follows:

Skilled Nursing Revenue

The Company’s revenue is derived primarily from providing long-term healthcare services to residents and is recognized on the date services are provided at amounts billable to individual residents. For residents 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. The Company records revenue from private pay patients, at the agreed-upon rate, 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 the Company 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.

The Company makes 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, the Company believes 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, the Company also recognizes 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. Thereby, estimating revenue and recognizing it on a daily basis.

Non-Medicare Revenue

Episodic Based Revenue - The Company recognizes revenue in a similar manner as it recognizes 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 the Company delivers. The Company makes 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, the Company monitors its provider numbers and estimates amounts due back to Medicare if a cap has been exceeded. The Company records these adjustments as a reduction to revenue and increases 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.

In evaluating the collectability of accounts receivable, the Company considers 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 the recent collection experience of the Company. In order to determine the appropriate reserve rate percentages which ultimately establish the allowance, the Company analyzes historical cash collection patterns by payor and by state. The percentages applied to the aged receivable balances are based on the Company's historical experience and time limits, if any, for managed care, Medicare, Medicaid and other payors. The Company periodically refines its estimates of the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances.

Property and Equipment — Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 57 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Impairment of Long-Lived Assets — The Company reviews the carrying value of long-lived assets that are held and used in the Company's operating subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiaries to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has not identified any asset impairment during the three and nine months ended September 30, 2014 or 2013.

Intangible Assets and Goodwill — Definite-lived intangible assets consist primarily of favorable leases, lease acquisition costs, patient base, facility trade names and customer relationships. Favorable leases and lease acquisition costs are amortized over the life of the lease of the facility, typically ranging from ten to 20 years. Patient base is amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date. Trade names at affiliated facilities are amortized over 30 years and customer relationships are amortized over a period up to 20 years.

The Company's indefinite-lived intangible assets consist of trade names and home health and hospice Medicare licenses. The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. The Company defines reporting units as the individual operating subsidiaries. The Company performs its annual test for impairment during the fourth quarter of each year. See further discussion at Note 10, Goodwill and Other Indefinite-Lived Intangible Assets.

Self-Insurance — The Company is 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 the Company. For claims made after January 1, 2013, the combined self-insured retention was $500 per claim, subject to an additional one-time deductible of $1,000 for California affiliated facilities and a separate, one-time, deductible of $750 for non-California facilities. For all affiliated facilities, except those located in Colorado, the third-party coverage above these limits was $1,000 per occurrence, $3,000 per facility, with a $5,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1,000 per occurrence and $3,000 per facility for skilled nursing facilities, which is independent of the aforementioned blanket aggregate applicable to its other 120 affiliated facilities.

The self-insured retention and deductible limits for general and professional liability and California workers' compensation are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying condensed 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. The Company's 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. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. Accrued general liability and professional malpractice liabilities on an undiscounted basis, net of anticipated insurance recoveries, were $29,133 and $29,204 as of September 30, 2014 and December 31, 2013, respectively.

The Company's operating subsidiaries are self-insured for workers' compensation liability in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $500 for each claim. In Texas, the operating subsidiaries have elected non-subscriber status for workers' compensation claims and, effective February 1, 2011, the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 for each claim. The Company's operating subsidiaries in other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $350 for each claim. In Washington, the operating subsidiaries' coverage is financed through premiums paid by the employers and employees. The claims and pay benefits are managed through an insurance state pool. In California and Texas, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers'

compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $14,700 and $13,883 as of September 30, 2014 and December 31, 2013, respectively.
In addition, the Company has recorded an asset and equal liability of $1,916 and $3,280 at September 30, 2014 and December 31, 2013, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis.
The Company provides self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 for each covered person with an aggregate individual stop loss deductible of $75. The Company’s accrued liability

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under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $3,551 and $2,736 at September 30, 2014 and December 31, 2013, respectively.
The Company believes that adequate provision has been made in the Interim Financial Statements for liabilities that may arise out of patient care, workers' compensation, healthcare benefits and related services provided to date. The amount of the Company's reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires the Company to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and the Company's assumptions about emerging trends, the Company, with the assistance of an independent actuary, develops information about the size of ultimate claims based on the Company's historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damage awards with respect to unpaid claims. The self-insured liabilities are based upon estimates, and while management believes that the estimates of loss are reasonable, the ultimate liability may be in excess of or less than the recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that the Company could experience changes in estimated losses that could be material to net income. If the Company's actual liability exceeds its estimates of loss, its future earnings, cash flows and financial condition would be adversely affected.

Income Taxes —Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The Company generally expects to fully utilize its deferred tax assets; however, when necessary, the Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized.

For interim reporting purposes, the provision for income taxes is determined based on the estimated annual effective income tax rate applied to pre-tax income, adjusted for certain discrete items occurring during the period. In determining the effective income tax rate for interim financial statements, the Company must consider expected annual income, permanent differences between financial reporting and tax recognition of income or expense and other factors. When the Company takes uncertain income tax positions that do not meet the recognition criteria, it records 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, the Company 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 for interim periods, or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

Noncontrolling Interest — The noncontrolling interest in a subsidiary is initially recognized at estimated fair value on the acquisition date and is presented within total equity in the Company's condensed consolidated balance sheets. The Company presents the noncontrolling interest and the amount of consolidated net income attributable to The Ensign Group, Inc. in its condensed consolidated statements of income and net income per share is calculated based on net income attributable to The Ensign Group, Inc.'s stockholders. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

Stock-Based Compensation — The Company measures and recognizes compensation expense for all share-based payment awards made to employees and directors including employee stock options based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the fair value of all stock options and restricted stock awards issued, the amount of which is contingent upon the number of future grants and other variables.

Derivatives and Hedging Activities — Previously, the Company had an interest-rate swap contract in place. Effective May 30, 2014, the Company de-designated its interest rate swap contract that historically qualified for cash flow hedge accounting. This was due to the termination of the interest rate swap agreement related to the early retirement of the Senior Credit Facility. As a result, the loss previously recorded in accumulated other comprehensive loss related to the interest rate swap was recognized in interest expense in the Condensed Consolidated Statements of Income during the second quarter of 2014. There was no outstanding interest rate swap contract as of September 30, 2014.

The Company has historically evaluated variable and fixed interest rate risk exposure on a routine basis and to the extent the Company believes that it is appropriate, it will offset most of its variable risk exposure by entering into interest-rate swap agreements. It is the Company's policy to only utilize derivative instruments for hedging purposes (i.e. not for speculation). The Company formally designates its interest rate swap agreements as hedges and documents all relationships between hedging instruments and hedged items. The Company formally assesses effectiveness of its hedging relationships, both at the hedge inception and on an ongoing basis, then measures and records ineffectiveness. The Company would discontinue hedge accounting prospectively (i) if it is determined that the derivative is no longer effective in offsetting change in the cash flows of a hedged item, (ii) when the derivative expires or is sold, terminated or exercised, (iii) if it is no longer probable that the forecasted transaction will occur, or (iv) if management determines that designation of the derivative as a hedge instrument is no longer appropriate.

Accumulated Other Comprehensive Loss and Total Comprehensive Income — Accumulated other comprehensive loss refers to revenue, expenses, gains, and losses that are recorded as an element of stockholders’ equity but are excluded from net income. The Company’s other comprehensive loss consists of net deferred gains and losses on certain derivative instruments accounted for as cash flow hedges. The Company recognized a loss of $1,023, net of taxes of $638, to interest expense from accumulated other comprehensive loss during the nine months ended September 30, 2014 related to the termination of the interest rate swap agreement. There was no gain or loss recognized in the Condensed Consolidated Statements of Income during the three months ended September 30, 2014 as the interest rate swap was terminated in the second quarter of 2014. As of September 30, 2014, accumulated other comprehensive losses were $0, in stockholders' equity. As of December 31, 2013, accumulated other comprehensive losses were $1,828, net of tax of $716, or $1,112.

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

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 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 the Company's fiscal year 2015, with early adoption permitted. The Company does not expect the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

In May 2014, the FASB and IASB 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 the Company's fiscal year 2017. Early adoption is not permitted. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's 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 the Company's fiscal year 2016, with early adoption permitted. The Company does not expect the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

4. COMPUTATION OF NET INCOME PER COMMON SHARE

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

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

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THE ENSIGN GROUP, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Numerator:				
Income from continuing operations	$8,371	$10,642	$22,945	$12,309
Less: net (loss) income attributable to noncontrolling interests	(535)	148	(1,494)	(179)
Income from continuing operations attributable to The Ensign Group, Inc.	8,906	10,494	24,439	12,488
Loss from discontinued operations, net of income tax	—	(30)	—	(1,804)
Net income attributable to The Ensign Group, Inc.	$8,906	$10,464	$24,439	$10,684
Denominator:				
Weighted average shares outstanding for basic net income per share	22,415	21,941	22,282	21,857
Basic net income (loss) per common share:				
Income from continuing operations attributable to The Ensign Group, Inc.	$0.40	$0.48	$1.10	$0.57
Loss from discontinued operations	$—	$—	$—	$(0.08)
Net income attributable to The Ensign Group, Inc.	$0.40	$0.48	$1.10	$0.49

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Numerator:				
Income from continuing operations	$8,371	$10,642	$22,945	$12,309
Less: net (loss) income attributable to noncontrolling interests	(535)	148	(1,494)	(179)
Income from continuing operations attributable to The Ensign Group, Inc.	8,906	10,494	24,439	12,488
Loss from discontinued operations, net of income tax	—	(30)	—	(1,804)
Net income attributable to The Ensign Group, Inc.	$8,906	$10,464	$24,439	$10,684
Denominator:				
Weighted average common shares outstanding	22,415	21,941	22,282	21,857
Plus: incremental shares from assumed conversion [1]	771	468	732	459
Adjusted weighted average common shares outstanding	23,186	22,409	23,014	22,316
Diluted net income (loss) per common share:				
Income from continuing operations attributable to The Ensign Group, Inc.	$0.38	$0.47	$1.06	$0.56
Loss from discontinued operations	$—	$—	$—	$(0.08)
Net income attributable to The Ensign Group, Inc.	$0.38	$0.47	$1.06	$0.48

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 693 and 508 for the three and nine months ended September 30, 2014 and 249 and 402 for the three and nine months ended September 30, 2013, respectively. As discussed in Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust and Note 15, Options and Awards effective with the Spin-Off

transaction, the holders of the Company's stock options on the date of record received stock options consistent with a conversion ratio that was necessary to maintain the pre spin-off intrinsic value of the options. The stock option terms and conditions are based on the existing terms in the the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan). In order to preserve the aggregate intrinsic value of the Company's stock options held by such persons, the exercise prices of such awards were adjusted by using the proportion of the CareTrust when issued closing stock price to the total Company closing stock prices on the distribution date. The number of options outstanding were increased by a conversion rate of 1.83 as a result of the Spin-Off.

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5. FAIR VALUE MEASUREMENTS
Fair value measurements are based on a three-tier hierarchy that prioritizes the inputs used to measure fair value. These tiers include: Level 1, defined as observable inputs such as quoted market prices in active markets; Level 2, defined as inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly; and Level 3, defined as observable inputs for which little or no market data exists, therefore requiring an entity to develop its own assumptions.

The following table summarizes the financial assets and liabilities measured at fair value on a recurring basis as of September 30, 2014 and December 31, 2013:

	September 30, 2014			December 31, 2013		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$39,206	—	—	$65,755	—	—
Fair value of interest rate swap	—	$—	—	—	$1,828	—

Our non-financial assets, which include long-lived assets, including goodwill, intangible assets and property and equipment, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, we assess our long-lived assets for impairment. When impairment has occurred, such long-lived assets are written down to fair value. See Note 3, Summary of Significant Accounting Policies for further discussion of our significant accounting policies.

Debt Security Investments - Held to Maturity

At September 30, 2014 and December 31, 2013, the Company had approximately $24,053 and $22,399, respectively, in debt security investments which were classified as held to maturity and carried at amortized cost. The carrying value of the debt securities approximates fair value. The Company has the intent and ability to hold these debt securities to maturity. Further, at September 30, 2014, the debt security investments are held in AA-, A- and BBB- rated debt securities.

Interest Rate Swap Agreement

In connection with the Senior Credit Facility with a six-bank lending consortium arranged by SunTrust and Wells Fargo (the Senior Credit Facility), in July 2011, the Company entered into an interest rate swap agreement in accordance with Company policy to reduce risk from volatility in the income statement due to changes in the LIBOR interest rate. The swap agreement, with a notional amount of $75,000, amortized concurrently with the related term loan portion of the Senior Credit Facility, was five years in length and set to mature on July 15, 2016. The interest rate swap has been designated as a cash flow hedge and, as such, changes in fair value are reported in other comprehensive income in accordance with hedge accounting. Under the terms of this swap agreement, the net effect of the hedge was to record swap interest expense at a fixed rate of approximately 4.3%, exclusive of fees. Net interest paid under the swap was $0 and $423 for the three and nine months ended September 30, 2014 and $269 and $783 for the three and nine months ended September 30, 2013, respectively.

Effective May 30, 2014, the Company de-designated its interest rate swap contract that historically qualified for cash flow hedge accounting. This was due to the termination of the interest rate swap agreement related to the early retirement of the Senior Credit Facility. As a result, the Company recognized a loss of $1,023, net of income tax benefit of $638, to interest expense from accumulated other comprehensive loss during the second quarter of 2014. See Note 14, Debt for additional information.

There was no outstanding interest rate swap contract as of September 30, 2014. There were no gains or losses due to the discontinuance of cash flow hedge treatment during the three and nine months ended September 30, 2013.

6. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and nine months ended September 30, 2014 and 2013 is summarized in the following tables:

	Three Months Ended September 30,					
	2014			2013		
	Revenue	% of Revenue		Revenue	% of Revenue	
Medicaid	$91,707	35.2	%	$81,802	35.7	%
Medicare	78,056	29.9		72,138	31.5	
Medicaid — skilled	13,614	5.2		9,204	4.0	
Total Medicaid and Medicare	183,377	70.3		163,144	71.2	
Managed care	36,562	14.0		30,886	13.5	
Private and other payors[(1)]	40,902	15.7		35,231	15.3	
Revenue	$260,841	100.0	%	$229,261	100.0	%

	Nine Months Ended September 30,					
	2014			2013		
	Revenue	% of Revenue		Revenue	% of Revenue	
Medicaid	$260,986	34.8	%	$237,301	35.5	%
Medicare	231,860	30.9		218,214	32.7	
Medicaid — skilled	36,575	4.9		26,616	4.0	
Total Medicaid and Medicare	529,421	70.6		482,131	72.2	
Managed care	105,316	14.0		87,446	13.1	
Private and other payors[(1)]	115,800	15.4		97,971	14.7	
Revenue	$750,537	100.0	%	$667,548	100.0	%

(1) Private and other payors includes revenue from urgent care centers and other ancillary services.

Accounts receivable as of September 30, 2014 and December 31, 2013 is summarized in the following table:

	September 30, 2014		December 31, 2013	
Medicaid	$42,829		$38,068	
Managed care	35,311		30,911	
Medicare	32,720		34,562	
Private and other payors	29,239		24,369	
	140,099		127,910	
Less: allowance for doubtful accounts	(19,452	)	(16,540	)
Accounts receivable	$120,647		$111,370	

7. ACQUISITIONS

The Company’s acquisition strategy is to purchase or lease operating subsidiaries that are complementary to the Company’s current affiliated facilities, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company’s operating subsidiaries are included in the accompanying Interim 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. Where the Company enters into facility lease agreements, the Company typically does not pay any material amount to the prior facility operator nor does the Company acquire any assets or assume any liabilities, other than rights and obligations under the lease and operations transfer agreement, as part of the transaction. Some leases include options to purchase the affiliated facilities. As a result, from time to time, the Company will acquire affiliated facilities that the Company has been operating under third-party leases.

During the nine months ended September 30, 2014, the Company acquired four stand-alone skilled nursing facilities, two assisted living facilities, two home health agencies, two hospice agencies, one primary care group and one transitional care management company. The aggregate purchase price of the twelve business acquisitions was approximately $46,385, of which $42,968 was paid in cash and the assumption of an existing HUD-insured loan of $3,417. The Company also entered into a separate operations transfer agreement with the prior operator as part of each transaction. The details of the operating subsidiaries acquired during the three and nine months ended September 30, 2014 are as follows:

- On March 1, 2014, the Company acquired a skilled nursing facility in Arizona for approximately $9,108, which was paid in cash. The acquisition added 196 operational skilled nursing beds operated by the Company's operating subsidiaries.
- On March 3, 2014, the Company acquired a transitional care management company in Idaho for $40, which was paid in cash. The Company recorded $31 of goodwill as a part of this transaction. This acquisition did not have an impact on the number of beds operated by the Company's operating subsidiaries.
- On April 1, 2014 the Company acquired a home health and hospice agency in Idaho and a primary care group in Washington in two separate transactions, for an aggregate purchase price of approximately $1,350 , which was paid in cash. The Company recorded $360 of goodwill as a part of the primary care group acquisition. These acquisitions did not impact the number of beds operated by the Company's operating subsidiaries.
- On May 1, 2014, the Company acquired a skilled nursing facility in Arizona for approximately $10,127, which was paid in cash. This acquisition added 230 operational skilled nursing beds operated by the Company's operating subsidiaries.
- On May 3, 2014, the Company acquired an assisted living facility in California and the underlying assets of a skilled nursing facility which the Company previously operated under a long-term lease agreement for an aggregate purchase price of approximately $16,012, which was paid in cash. The assisted living facility acquisition added 144 operational assisted living units operated by the Company's operating subsidiaries. The skilled nursing facility acquisition did not have an impact on the number of beds operated by the Company's operating subsidiaries.
- On May 7, 2014, the Company purchased the underlying assets of one skilled nursing facility in Utah which it previously operated under a long-term lease agreement for approximately $4,812, which was paid in cash.
- On June 1, 2014, the Company entered into long-term lease agreements and assumed the operations of one skilled nursing facility in Washington and one skilled nursing facility in Colorado. These acquisitions added 199 operational skilled nursing beds operated by the Company's operating subsidiaries. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the leases.
- In a separate transaction, on June 1, 2014, the Company acquired two skilled nursing facilities in Wisconsin for an aggregate purchase price of approximately $4,507, which was paid in cash. The acquisition added 138 operational skilled nursing beds operated by the Company's operating subsidiaries.
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On July 1, 2014, the Company entered into a long-term lease agreement and assumed the operations of one skilled nursing facility in Washington. The acquisition added 67 operational skilled nursing beds operated by the Company's operating subsidiaries. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the lease.

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- On July 1, 2014, the Company acquired a hospice agency in Colorado for approximately $1,866, which was paid in cash. The Company recorded $1,392 and $467 of goodwill and other indefinite-lived intangible assets, respectively, as part of this transaction. This acquisition did not have an impact on the number of beds operated by the Company's operating subsidiaries.
- On August 1, 2014, the Company acquired a home health agency in California for approximately $1,277 which was paid in cash. The Company recorded $1,277 of other indefinite-lived intangible assets as part of this transaction. This acquisition did not impact the number of beds operated by the Company's operating subsidiaries.
- On August 21, 2014, the Company acquired a hospice license in Arizona for approximately $425, which was paid in cash. The Company recorded $425 of other indefinite-lived intangible assets as part of this transaction. This acquisition did not impact the number of beds operated by the Company's operating subsidiaries.
- On September 24, 2014, the Company acquired an assisted living facility in Arizona for approximately $4,800, which was purchased with a combination of cash and the assumption of an existing HUD-insured loan. This acquisition added 135 operational assisted living units operated by the Company's operating subsidiaries.

The table below presents the allocation of the purchase price for the operations acquired in business combinations during the nine months ended September 30, 2014 and 2013:

	September 30,	
	2014	2013
Land	$8,814	$9,312
Building and improvements	30,988	26,593
Equipment, furniture, and fixtures	1,550	1,386
Assembled occupancy	545	724
Definite-lived intangible assets	360	—
Goodwill	1,784	3,197
Other indefinite-lived intangible assets	2,344	4,152
	$46,385	$45,364

The Company’s acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return on invested capital. The operating subsidiaries acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operating subsidiaries, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not a meaningful, representation of the Company’s current operating results or indicative of the integration potential of its newly acquired operating subsidiaries. The businesses acquired during the three and nine months ended September 30, 2014 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the September 30, 2014 condensed consolidated balance sheet of the Company, and the operating results have been included in the condensed consolidated statements of operations of the Company since the dates the Company gained effective control.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

8. PROPERTY AND EQUIPMENT

Property and equipment consist of the following:

	September 30, 2014	December 31, 2013
Land	$17,490	$79,679
Buildings and improvements	45,663	379,021
Equipment	74,956	97,984
Furniture and fixtures	6,193	8,851
Leasehold improvements	44,659	44,123
Construction in progress	211	2,081
	189,172	611,739
Less: accumulated depreciation	(61,724)	(131,969)
Property and equipment, net	$127,448	$479,770

See Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust for the impact of the Spin-Off on property and equipment and Note 7, Acquisitions for information on acquisitions during the nine months ended September 30, 2014.

9. INTANGIBLE ASSETS — Net

Intangible Assets	Weighted Average Life (Years)	September 30, 2014 Gross Carrying Amount	Accumulated Amortization	Net	December 31, 2013 Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	15.5	$684	$(622)	$62	$684	$(589)	$95
Favorable lease	15.0	2,210	(618)	1,592	1,596	(532)	1,064
Assembled occupancy	0.5	3,524	(3,325)	199	2,979	(2,948)	31
Facility trade name	30.0	733	(214)	519	733	(195)	538
Customer relationships	20.0	4,570	(382)	4,188	4,200	(210)	3,990
Total		$11,721	$(5,161)	$6,560	$10,192	$(4,474)	$5,718

Amortization expense was $282 and $688 for the three and nine months ended September 30, 2014 and $356 and $863 for the three and nine months ended September 30, 2013, respectively. Of the $688 in amortization expense incurred during the nine months ended September 30, 2014, approximately $379 related to the amortization of patient base intangible assets at recently acquired facilities, which is typically amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date.

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

Year	Amount
2014 (remainder)	$236
2015	482
2016	386
2017	386
2018	386
2019	386

Thereafter	4,298
	$6,560

10. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The Company performs its annual goodwill impairment analysis during the fourth quarter of each year for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment. The Company tests for impairment by comparing the net assets of each reporting unit to their respective fair values. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. In the event a unit's net assets exceed its fair value, an implied fair value of goodwill must be determined by assigning the unit's fair value to each asset and liability of the unit. The excess of the fair value of the reporting unit over the amounts assigned to its assets and liabilities is the implied fair value of goodwill. An impairment loss is measured by the difference between the goodwill carrying value and the implied fair value.

The following table represents activity in goodwill as of and for the nine months ended September 30, 2014:

	Goodwill
January 1, 2014	$23,935
Impairments	—
Additions	1,784
September 30, 2014	$25,719

As of September 30, 2014, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes. See further discussion of goodwill acquired at Note 7, Acquisitions.

Other indefinite-lived intangible assets consists of the following:

	September 30, 2014	December 31, 2013
Trade name	$1,055	$1,033
Home health and hospice Medicare license	9,454	6,707
	$10,509	$7,740

11. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	September 30, 2014	December 31, 2013
Note receivable	$2,076	$2,000
Debt issuance costs, net	2,759	2,801
Long-term insurance losses recoverable asset	1,916	3,280
Deposits with landlords	900	872
Capital improvement reserves with landlords and lenders	726	706
Other long-term assets	72	145
Restricted and other assets	$8,449	$9,804

Included in restricted and other assets as of September 30, 2014, are anticipated insurance recoveries related to the Company's general and professional liability claims that are recorded on a gross rather than net basis in accordance with an Accounting Standards Update issued by the FASB, capitalized debt issuance costs and notes receivable.

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12. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	September 30, 2014	December 31, 2013
Quality assurance fee	$4,536	$3,933
Resident refunds payable	6,272	5,238
Deferred revenue	3,635	4,633
Cash held in trust for residents	1,832	1,780
Resident deposits	1,585	1,680
Dividends payable	1,584	1,564
Property taxes	4,069	2,894
Other	3,238	3,976
Other accrued liabilities	$26,751	$25,698

Quality assurance fee represents amounts payable to California, Arizona, Utah, Idaho, Washington, Colorado, Iowa, and Nebraska in respect of a mandated fee based on resident days. Resident refunds payable includes amounts due to residents for overpayments and duplicate payments. Deferred revenue occurs when the Company receives payments in advance of services provided. Cash held in trust for residents reflects monies received from, or on behalf of, residents. Maintaining a trust account for residents is a regulatory requirement and, while the trust assets offset the liabilities, the Company assumes a fiduciary responsibility for these funds. The cash balance related to this liability is included in other current assets in the accompanying condensed consolidated balance sheets.

13. INCOME TAXES

For the nine months ended September 30, 2014 and the year ended December 31, 2013, the Company incurred $6,899 and $3,884, respectively, of third-party costs in connection with the Spin-Off. The Company has determined that $8,820 of the third-party costs directly facilitating the Spin-Off are permanently non-deductible for tax purposes and has reflected this determination in its calculation of the estimated annual effective tax rate. The Company's net tax benefit for the deductible portion of these costs is approximately $770.

See Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust, for the changes to the Company's balance sheet as a result of the Spin-Off on the portions of the Company's consolidated deferred tax assets and liabilities that no longer pertain to the Company.

The Company recorded total pre-tax charges related to the settlement with the U.S. Department of Justice (DOJ) and related expenses of $33,000 during the nine months ended September 30, 2013. The Company recorded estimated tax benefits of $10,373 during the nine months ended September 30, 2013. See Note 16, Commitments and Contingencies.

During the third quarter of 2014, the IRS sent notification to the Company that the 2012 tax return will be examined. During the first quarter of 2012, the State of California initiated an examination of the Company's income tax returns for the 2008 and 2009 income tax years. The state examination was primarily focused on the Captive and the treatment of related insurance matters. California has verbally indicated it does not intend to propose any adjustments. The Company is not currently under examination by any other major income tax jurisdiction. During 2014, the statutes of limitations will lapse on the Company's 2010 Federal tax year and certain 2009 and 2010 state tax years. The Company does not believe the Federal or state statute lapses, the Federal or California examinations, or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the three and nine months ended September 30, 2014 or 2013.

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14. DEBT

Long-term debt consists of the following:

	September 30, 2014	December 31, 2013
Promissory note with RBS, principal and interest payable monthly and continuing through March 2019, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	$—	$20,347
Mortgage note, principal, and interest payable monthly and continuing through October 2037, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	3,417	—
Senior Credit Facility with SunTrust and Wells Fargo, principal and interest payable quarterly, balance due at February 1, 2018, secured by substantially all of the Company's personal property.	—	144,325
Ten Project Note with GECC, principal and interest payable monthly; interest is fixed, balance due June 2016, collateralized by deeds of trust on real property, assignment of rents, security agreements and fixture financing statements.	—	48,864
Promissory note with RBS, principal and interest payable monthly and continuing through January 2018, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	—	32,122
Promissory notes, principal, and interest payable monthly and continuing through October 2019, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	—	8,919
Mortgage note, principal, and interest payable monthly and continuing through February 2027, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	—	5,429
	3,417	260,006
Less current maturities	(110)	(7,411)
Less debt discount	—	(700)
	$3,307	$251,895

2014 Credit Facility with a Lending Consortium Arranged by SunTrust (the 2014 Credit Facility)

On May 30, 2014, the Company entered into the 2014 Credit Facility in an aggregate principal amount of $150,000 from a syndicate of banks and other financial institutions. Under the 2014 Credit Facility, the Company may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $75,000. The interest rates applicable to loans under the 2014 Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 1.25% to 2.25% per annum or LIBOR plus a margin ranging from 2.25% to 3.25% per annum, based on the debt to Consolidated EBITDA ratio of the Company and its subsidiaries as defined in the agreement. In addition, the Company will pay a commitment fee on the unused portion of the commitments under the 2014 Credit Facility that will range from 0.30% to 0.50% per annum, depending on the debt to Consolidated EBITDA ratio of the Company and its subsidiaries. Loans made under the 2014 Credit Facility are not subject to interim amortization. The Company is not required to repay any loans under the 2014 Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the 2014 Credit Facility. The Company is permitted to prepay all or any portion of the loans under the 2014 Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders. In connection with the 2014 Credit Facility, the Company incurred financing costs of approximately $2,013, which were deferred and are being amortized over the term of the 2014 Credit Facility. As of September 30, 2014, there were no borrowings outstanding under the 2014

Credit Facility.

The 2014 Credit Facility is guaranteed, jointly and severally, by certain of the Company's wholly owned subsidiaries. The 2014 Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the 2014 Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum debt to consolidated EBITDA ratio, and a minimum interest/rent coverage ratio. The majority of lenders can require that the Company and its subsidiaries mortgage certain of their real property assets to secure the 2014 Credit Facility if an event of default occurs, the debt to consolidated EBITDA ratio is above 2.50:1.00 for two consecutive fiscal quarters, or the Company's

liquidity is equal or less than 10% of the Aggregate Revolving Commitment Amount as defined in the agreement for ten consecutive business days, provided that such mortgages will no longer be required if the event of default is cured, the debt to consolidated EBITDA ratio is below 2.50:1.00 for two consecutive fiscal quarters, or the Company's liquidity is above 10% of the Aggregate
Revolving Commitment Amount as defined in the agreement for ninety consecutive days, as applicable. As of September 30, 2014, the Company is in compliance with all loan covenants.

Mortgage Loan with Red Mortgage Capital, LLC

On September 24, 2014, the Company acquired an assisted living facility in Arizona. The acquisition was purchased with a combination of cash and the assumption of an existing mortgage loan with Red Mortgage Capital, LLC of approximately $3,417. The mortgage loan is insured with the U.S. Department of Housing and Urban Development (HUD), which subjects the facility to HUD oversight and periodic inspections. The mortgage loan bears interest at the rate of 2.55% per annum. Amounts borrowed under the mortgage loan may be prepaid starting after the second anniversary of the note subject to prepayment fees of 9.0% of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% a year for years three through 11 of the loan. There is no repayment penalty after year 11. The term of the mortgage loan is for 25 years, with monthly principal and interest payments commencing on September 12, 2012 and the balance due on October 1, 2037. The mortgage loan was secured by the real property comprising the facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

CareTrust Indebtedness

Immediately before the Spin-Off on May 30, 2014, while CareTrust was a wholly-owned subsidiary of the Company, CareTrust raised $260,000 of debt financing, which was part of the net assets contributed to CareTrust as part of the Spin-Off. See Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust.

Senior Credit Facility with a Lending Consortium Arranged by SunTrust and Wells Fargo (the Senior Credit Facility)
On July 15, 2011, the Company entered into the Senior Credit Facility in an aggregate principal amount of up to $150,000 comprised of a $75,000 revolving credit facility and a $75,000 term loan advanced in one drawing on July 15, 2011. Borrowings under the term loan portion of the Senior Credit Facility amortize in equal quarterly installments commencing on September 30, 2011, in an aggregate annual amount equal to 5.0% per annum of the original principal amount. Amounts borrowed pursuant to the Senior Credit Facility were guaranteed by certain of the Company's wholly-owned subsidiaries and secured by substantially all of their personal property. To reduce the risk related to interest rate fluctuations, the Company, on behalf of the subsidiaries, entered into an interest rate swap agreement to effectively fix the interest rate on the term loan portion of the Senior Credit Facility. See further details of the interest rate swap at Note 5, Fair Value Measurements.

On May 30, 2014, the Senior Credit Facility outstanding was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.
Promissory Note with RBS Asset Finance, Inc.

On February 17, 2012, two of the Company's real estate holding subsidiaries as Borrowers executed a promissory note in favor of RBS Asset Finance, Inc. (RBS) as Lender for an aggregate of $21,525 (the 2012 RBS Loan). The 2012 RBS Loan was secured by Commercial Deed of Trust, Security Agreement, Assignment of Leases and Rents and Fixture Filings on the properties owned by the Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2012 RBS Loan had a fixed interest rate of 4.75%.

On May 30, 2014, the RBS Loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

Promissory Note with RBS Asset Finance, Inc.

On December 31, 2010, four of the Company's real estate holding subsidiaries executed a promissory note with RBS as Lender for an aggregate of $35,000 (RBS Loan). The RBS Loan was secured by Commercial Deeds of Trust, Security Agreements, Assignment of Leases and Rents and Fixture Fillings on the four properties and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The RBS Loan had a fixed interest rate of 6.04%.

On May 30, 2014, the RBS Loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of the Company's independent real estate holding subsidiaries jointly entered into The Ten Project Note with GECC, which consisted of an approximately $55,700 multiple-advance term loan. The Ten Project Note was secured by the real and personal property comprising the ten facilities owned by these subsidiaries.

On May 30, 2014, the Company entered into the Fifth Amended and Restated Loan Agreement, with GECC, which consisted of an additional loan of $50,676 to an aggregate principal amount of $99,000. The Ten Project Note matures in May 2017 and are currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries. The initial term loan of $55,700 was funded in advances, with each advance bearing interest at a separate rate. The interest rates range from 6.95% to
7.50% per annum. The additional loan of $50,676 bears interest at a floating rate equal to the three month LIBOR plus 3.35%, reset monthly and subject to a LIBOR floor of 0.50%, with monthly principal and interest payments based on a 25 years amortization.

On May 30, 2014, the Ten Project Note was assumed by CareTrust in connection with the Spin-Off.

Promissory Notes with Johnson Land Enterprises, Inc.

On October 1, 2009, four subsidiaries of The Ensign Group, Inc. entered into four separate promissory notes with Johnson Land Enterprises, LLC, for an aggregate of $10,000, as a part of the Company’s acquisition of three skilled nursing facilities in Utah.

On May 30, 2014, the Company repaid the majority of the four promissory notes with a portion of the proceeds received from CareTrust in connection with the Separation and Distribution Agreement. The remaining $615 was assumed by CareTrust in connection with the Spin-Off.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with HUD, which subjects the Company's Southland facility to HUD oversight and periodic inspections. The mortgage loan was secured by the real property comprising the Southland Care Center facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

On May 30, 2014, the mortgage loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

In connection with the debt retirements, the Company incurred losses of $5,728 consisting of $4,067 in repayment penalties and the write off of unamortized debt discount and deferred financing costs and $1,661 of recognized loss due to the discontinuance of cash flow hedge accounting for the related interest-rate swap, which are included in interest expense within the condensed consolidated statements of income. The charges and loss were recognized in the second quarter of 2014.

Based on Level 2, the carrying value of the Company's long-term debt is considered to approximate the fair value of such debt for all periods presented based upon the interest rates that the Company believes it can currently obtain for similar debt.

15. OPTIONS AND AWARDS

Stock-based compensation expense consists of share-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company’s condensed consolidated statements of income for the three and nine months ended September 30, 2014 and 2013 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Plan, the 2005 Plan and the 2007 Plan, all of which have been approved by the stockholders. The total number of shares available under all of the Company’s stock incentive plans was 1,239 as of September 30, 2014.

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Effective with the Spin-Off transaction (see Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust, for further information), all holders of the Company's restricted stock awards on the May 22, 2014 date of record for the spin-off received CareTrust restricted stock awards consistent with the distribution ratio, with terms and conditions substantially similar to the terms and conditions applicable to the Company's restricted stock awards. Also, effective with the Spin-Off transaction, the holders of the Company's stock options on the date of record received stock options consistent with a conversion ratio that was necessary to maintain the pre spin-off intrinsic value of the options. The stock options terms and conditions are based on the preexisting terms in the 2001 Plan, 2005 Plan and 2007 Plan, including nondiscretionary antidilution provisions. In order to preserve the aggregate intrinsic value of the Company's stock options held by such persons, the exercise prices of such awards were adjusted by using the proportion of the CareTrust when issued closing stock price to the total Company closing stock prices on the distribution date. All of these adjustments were designed to equalize the fair value of each award before and after Spin-Off. These adjustments were accounted for as modifications to the original awards. A comparison of the fair value of the modified awards with the fair value of the original awards immediately before the modification did not yield incremental value. Accordingly, the Company did not record any incremental compensation expense as a result of the modifications to the awards on the Spin-Off date.

The Company's future share-based compensation expense will not be significantly impacted by the equity award adjustments that occurred as a result of the Spin-Off. Deferred compensation costs as of the date of the Spin-Off reflected the unamortized balance of the original grant date fair value of the equity awards held by the employees of the Company's operating subsidiaries (regardless of whether those awards are linked to the Company's stock or CareTrust's stock).

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for all share-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time. The Company granted 1,003 options and 20 restricted stock awards from the 2007 Plan during the nine months ended September 30, 2014.

The Company used the following assumptions for stock options granted during the three months ended September 30, 2014 and 2013:

Grant Year	Options Granted	Weighted Average Risk-Free Rate		Expected Life	Weighted Average Volatility		Weighted Average Dividend Yield	
2014	72	1.91	%	6.5 years	55	%	0.64	%
2013	62	1.87	%	6.5 years	55	%	0.93	%

The Company used the following assumptions for stock options granted during the nine months ended September 30, 2014 and 2013:

Grant Year	Options Granted	Weighted Average Risk-Free Rate				Expected Life	Weighted Average Volatility		Weighted Average Dividend Yield	
2014	1,003	1.80	%-	1.91	%	6.5 years	55	%	0.64	%
2013	337	1.18	%-	1.87	%	6.5 years	55	%	0.93	%

For the nine months ended September 30, 2014 and 2013, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2014	1,003	$25.03	$12.85
2013	337	$18.09	$8.93

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The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended September 30, 2014 and 2013 and therefore, the intrinsic value was $0 at date of grant.

As discussed above and in Note 2, Spin-Off of Real Estate Assets through a Real Estate Investment Trust, the weighted average exercise prices shown in the table above for the nine months ended September 30, 2014 were reduced as a result of the Spin-Off. The number of options outstanding shown in the table below for the nine months ended September 30, 2014 were increased as a result of the Spin-Off.

The following table represents the employee stock option activity during the nine months ended September 30, 2014:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2014	2,290	$11.30	1.249	$7.76
Granted	1,003	25.03		
Forfeited	(35)	14.86		
Exercised	(265)	10.11		
September 30, 2014	2,993	$15.98	1,194	$8.57

The following summary information reflects stock options outstanding, vested and related details as of September 30, 2014:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2005	2.72 - 3.14	30	*	1	30
2006	3.85 - 4.09	140	732	2	140
2008	5.12 - 8.11	350	1,070	4	350
2009	8.12 - 9.11	446	1,924	5	382
2010	9.53 - 9.91	114	551	6	72
2011	11.79 - 15.98	137	926	7	58
2012	13.12 - 15.91	369	2,720	8	110
2013	15.96 - 22.98	406	3,955	9	52
2014	21.09 - 33.40	1,001	12,869	10	—
Total		2,993	$ 24,747		1,194

* The Company will not recognize the Black-Scholes fair value for awards granted prior to January 1, 2006 unless such awards are modified.

The Company granted 14 and 20 restricted stock awards during the three and nine months ended September 30, 2014, respectively. The Company granted 13 and 73 restricted stock awards during the three and nine months ended September 30, 2013, respectively. All awards were granted at an exercise price of $0 and generally vest over five years.

A summary of the status of the Company's nonvested restricted stock awards as of September 30, 2014, and changes during the nine-month period ended September 30, 2014 is presented below:

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	Nonvested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2014	230	$28.68
Granted	20	35.04
Vested	(50)	26.35
Forfeited	(10)	30.36
Nonvested at September 30, 2014	190	$29.85

As a result of the Spin-Off, holders of outstanding restricted stock awards received an additional share of restricted stock unit award in CareTrust common stock at the Spin-Off so that the intrinsic value of these awards were equivalent to those that existed immediately prior to the Spin-Off. The weighted average grant date fair value shown in the table above did not change as a result of the Spin-Off. The number of nonvested restricted awards shown in the table above did not change as a result of the Spin-Off.

In addition, during the three and nine months ended September 30, 2014, the Company granted 2 and 5 automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards ranged from $30.75 to $44.71 based on the market price on the grant date.

Total share-based compensation expense recognized for the three and nine months ended September 30, 2014 and 2013 was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Share-based compensation expense related to stock options	$938	$538	$2,292	$1,617
Share-based compensation expense related to restricted stock awards	404	357	1,221	1,000
Share-based compensation expense related to stock awards	88	93	300	700
Total	$1,430	$988	$3,813	$3,317

In future periods, the Company expects to recognize approximately $17,369 and $4,959 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of September 30, 2014. Future share-based compensation expense will be recognized over 4.2 and 3.1 weighted average years for unvested options and restricted stock awards, respectively. There were 1,787 unvested and outstanding options at September 30, 2014, of which 1,532 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at September 30, 2014 was 7.0 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of September 30, 2014 and December 31, 2013 is as follows:

Options	September 30, 2014	December 31, 2013
Outstanding	$53,494	$29,431
Vested	30,124	20,465
Expected to vest	15,407	7,873
Exercised	6,128	8,709

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options.

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16. COMMITMENTS AND CONTINGENCIES

Leases — As a result of the Spin-Off, the Company leases from CareTrust real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities used in the Company's operations under the Master Leases. The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each Master Lease, the Company's individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. Commencing the third year, the rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. Annual rent expense under the Master Leases will be approximately $56,000 during each of the first two years of the Master Leases.

The Master Leases arrangement is commonly known as a triple-net lease. Accordingly, in addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor), (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties, (3) all insurance required in connection with the leased properties and the business conducted on the leased properties, (4) all facility maintenance and repair costs and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Total rent expense under the Master Leases was approximately $14,000 and $18,668 for the three and nine months ended September 30, 2014, respectively, as a result of the Spin-Off on June 1, 2014. There was no rent expense under the Master Leases in 2013.

At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If the Company elects to renew the term of a master lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the master lease.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. As of September 30, 2014, we were in compliance with the Master Leases' covenants.

The Company and CareTrust also entered into an Opportunities Agreement, which grants CareTrust the right to match any offer from a third party to finance the acquisition or development of any healthcare or senior-living facility by the Company or any of its affiliates for a period of one year following the Spin-Off. In addition, this agreement requires CareTrust to provide the Company, subject to certain exceptions, a right to either purchase and operate, or lease and operate, the affiliated facilities included in any portfolio of five or fewer healthcare or senior living facilities presented to the Company during the first year following the Spin-Off; provided that the portfolio is not subject to an existing lease with an operator or manager that has a remaining term of more than one year, and is not presented to the Company by or on behalf of another operator seeking lease or other financing. If the Company elects to lease and operate such a property or portfolio, the lease would be on substantially the same terms as the Master Leases.

The Company also leases certain affiliated facilities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. In addition, the Company leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $18,291 and $30,352 for the three and nine months ended September 30, 2014 and $3,518 and $10,400 for the three and nine months ended September 30, 2013, respectively.

Future minimum lease payments for all leases as of September 30, 2014 are as follows:

Year	Amount
Remaining 2014	$18,023
2015	71,789

2016	71,832
2017	71,851
2018	71,920
2019	70,897
Thereafter	676,241
	$1,052,553

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

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. The Company believes that it is in compliance in all material respects with all applicable laws and regulations.

A significant portion of the Company’s revenue is derived from Medicaid and Medicare, for which reimbursement rates are subject to regulatory changes and government funding restrictions. Any significant future change to reimbursement rates or regulation on how services are provided could have a material effect on the Company’s operations.

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 the Company.

Income Tax Examinations — During the third quarter of 2014, the IRS sent notification to the Company that the 2012 tax return will be examined. During the first quarter of 2012, the State of California initiated an examination of the Company's 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. See Note 13, Income Taxes.

Indemnities — From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from the Company’s use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of facilities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with the Company’s officers, directors and employees, under which the Company 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 the Company’s 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 the Company's operating subsidiaries. The Company, its 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.

In addition to the potential lawsuits and claims described above, the Company is 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 the Company's 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, the Company 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.

In July 2010, Congress passed the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The Dodd-Frank Act establishes rigorous standards and supervision to protect the economy and American consumers, investors and businesses. Included under Section 922 of the Dodd-Frank Act, the Securities and Exchange Commission (SEC) will be required to pay a reward to individuals who provide original information to the SEC resulting in monetary sanctions exceeding $1,000 in civil or criminal proceedings. The award will range from 10 to 30 percent of the amount recouped and the amount of the award shall be at the discretion of the SEC. The purpose of this reward program is to “motivate those with inside knowledge to come forward and assist the Government to identify and prosecute persons who have violated securities laws and recover money for victims of financial fraud.”

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 the Company's competitors. The Company expects 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 the Company and certain of its 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, the Company settled this class action suit, and the settlement was approved by the affected class and the Court. The Company has 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, are projected to be approximately $6,500, of which, approximately $1,500 of this amount was recorded during the year ended December 31, 2013, with the balance having been expensed in prior periods. The Company believes that the settlement will not have a material ongoing adverse effect on the Company’s 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 the Company’s business, financial condition, results of operations and cash flows.

The Company and its affiliates and 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. The Company does not believe that the ultimate resolution of these actions will have a material adverse effect on the Company’s 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 the Company’s business, financial condition, results of operations and cash flows.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company, its 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, its 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 — The Company is subject to reviews relating to Medicare services, billings and potential overpayments. The Company had one operation subject to probe review during the nine months ended September 30, 2014. The Company anticipates that these probe reviews will increase in frequency in the future. Further, the Company currently has 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. The Company has no affiliated facilities that are currently undergoing targeted review.

U.S. Government Inquiry — In late 2006, the Company learned that it 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. The Company recorded an initial estimated liability in the amount of $15,000 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, the Company and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, the Company recorded and announced an additional charge in the amount of $33,000 in the first quarter of 2013, increasing the total reserve to resolve the matter to $48,000 (the Reserve Amount).

In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the Department of Justice 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, the Company made a single lump-sum remittance to the government in the amount of $48,000 in October 2013. The Company has denied engaging in any illegal conduct, and has 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, the Company entered into a five-year corporate integrity agreement with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of the Company's 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 the Company 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. The Company is 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 the Company has 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. The Company is 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 the Company is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, the Company could be excluded from participation in federal healthcare programs and/or subject to prosecution.

Concentrations
Credit Risk — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's receivables from Medicare and Medicaid payor programs accounted for approximately 53.9% and 56.8% of its total accounts receivable as of September 30, 2014 and

December 31, 2013, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 70.3% and 70.6% of the Company’s revenue for the three and nine months ended September 30, 2014 and 71.2% and 72.2% during the three and nine months ended September 30, 2013, respectively.

Cash in Excess of FDIC Limits — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of November 3, 2014, the Company had approximately $2,640 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

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17. DISCONTINUED OPERATIONS

On March 25, 2013, the Company agreed to terms to sell DRX, a national urgent care franchise system for approximately $8,000, adjusted for certain assets and liabilities. The asset sale was effective on April 15, 2013. The sale resulted in a pre-tax loss of $2,837 for the nine months ended September 30, 2013. The assets acquired at the initial purchase of DRX, including

noncontrolling interest, were recorded at fair value. The initial fair value was greater than total cash paid to acquire all interests in DRX and the subsequent sale price. The sale of DRX has been accounted for as discontinued operations. Accordingly, the
results of operations of this business for all periods presented and the loss related to this divesture have been classified as discontinued operations in the accompanying condensed consolidated statements of income.

A summary of discontinued operations follows (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2014	2013	2014	2013
Revenue	$—	$—	$—	$728
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	—	(68)	—	(807)
Charges to discontinued operations for the excess carrying amount of goodwill and other indefinite-lived intangible assets	—	—	—	(2,837)
Facility rent—cost of services	—	—	—	(12)
Depreciation and amortization	—	—	—	(33)
Loss from discontinued operations	—	(68)	—	(2,961)
Benefit from income taxes	—	(38)	—	(1,157)
Loss from discontinued operations, net of income tax	$—	$(30)	$—	$(1,804)

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Item 2. Management's Discussion and Analysis of Financial Condition and Results of Operations

You should read the following discussion and analysis in conjunction with our unaudited condensed consolidated financial statements and the related notes thereto contained in Part I, Item 1 of this Report. The information contained in this Quarterly Report on Form 10-Q is not a complete description of our business or the risks associated with an investment in our common stock. We urge you to carefully review and consider the various disclosures made by us in this Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Annual Report on Form 10-K (Annual Report), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Forms 10-Q and 8-K, for additional information. The section entitled “Risk Factors” contained in Part II, Item 1A of this Report, and similar discussions in our other SEC filings, also describe some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

This Report contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to the Company’s expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, 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,” “continue,” “ongoing,” similar expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. 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” contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this 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 Management’s Discussion and Analysis of Financial Condition and Results of Operations, the words, “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our affiliated facilities, the Service Center and 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 verbiage in this quarterly report is not meant to imply that any of our affiliated facilities, the Service Center or the Captive are operated by the same entity. This Management’s Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with our consolidated financial statements and related notes included in the Annual Report.

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 127 facilities, eleven home health and ten hospice operations, fourteen urgent care centers and a mobile x-ray and diagnostic company as of September 30, 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 September 30, 2014, we owned 9 of our 127 affiliated facilities and operated an additional 118 facilities under long-term lease arrangements, and had options to purchase two of those 118 facilities.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of September 30, 2014:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	9	2	116	127

Percent of total	7.1	%	1.6	%	91.3	%	100.0	%
Operational skilled nursing, assisted living and independent living beds	1,067		414		12,555		14,036	
Percent of total	7.6	%	3.0	%	89.4	%	100.0	%

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The Ensign Group, Inc. (collectively, Ensign or the Company) is a holding company with no direct operating assets, employees or revenues. Our subsidiaries and affiliates are operated by separate, independent entities, each of which has its own management, employees and assets. One of our wholly-owned subsidiaries, referred to as the Service Center, provides 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 verbiage in this quarterly report is not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by The Ensign Group or the same entity.
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. The Spin-Off was effective from and after June 1, 2014 with shares of CareTrust common stock distributed on June 2, 2014. 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 of the Company, 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 Condensed 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 the 2014 Credit Facility agreement 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 September 30, 2014, there were no borrowings outstanding under the New Credit Facility. See further details at Note 14, Debt of Notes to Condensed Consolidated Statements of Income.

Facility Acquisition History

	December 31,								September 30,
	2006	2007	2008	2009	2010	2011	2012	2013	2014
Cumulative number of facilities	57	61	63	77	82	102	108	119	127
Cumulative number of operational skilled nursing, assisted living and independent living beds	6,667	7,105	7,324	8,948	9,539	11,702	12,198	13,204	14,036

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The following table sets forth the location of our affiliated facilities and the number of operational beds located at our facilities as of September 30, 2014:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	WI	Total
Number of facilities	37	16	26	12	7	8	6	3	5	5	2	127
Operational skilled nursing beds, assisted living and independent living units	4,117	2,446	3,146	1,360	587	739	477	304	366	356	138	14,036

In the first quarter of 2014, we acquired a skilled nursing facility in Arizona and a transitional care managing company in Idaho for an aggregate purchase price of $9.1 million, which was paid in cash. The acquisition in Arizona added 196 operational skilled nursing beds to our operating subsidiaries. The acquisition in Idaho 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 facilities, one assisted living facility, one home health, one hospice agency and one primary care group in four states for an aggregate purchase price of $29.3 million, which was paid in cash. The acquisitions of the three skilled nursing and one assisted living facilities 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 facilities in Utah and California, which we previously operated under a long-term lease agreement, for an aggregate purchase price of approximately $7.5 million, which was paid in cash. 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 Washington and Colorado. 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.

On July 1, 2014, we entered into a long-term lease agreement and assumed the operations of one skilled nursing facility in Washington. The acquisition added 67 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 lease.

On July 1, 2014, we acquired a hospice agency in Colorado for approximately $1.9 million, which was paid in cash. This acquisition did not impact on the number of beds operated by our operating subsidiaries.

On August 1, 2014, we acquired a home health agency in California for approximately $1.3 million which was paid in cash. This acquisition did not impact on the number of beds operated by our operating subsidiaries.

On August 21, 2014, we acquired a hospice license in Arizona for approximately $0.4 million, which was paid in cash. This acquisition did not impact on the number of beds operated by our operating subsidiaries.

On September 24, 2014, we acquired an assisted living facility in Arizona for approximately $4.8 million, which was purchased with a combination of cash and the assumption of an existing HUD-insured loan. This acquisition added 135 operational assisted living units to the our operating subsidiaries.

See further discussion of facility acquisitions in Note 7, Acquisitions in Notes to Condensed Consolidated Financial Statements.

Key Performance Indicators

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

- 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

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residents that are included in this population represent very high acuity residents 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 residents 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. 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 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):

	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
Skilled Mix:				
Days	27.1 %	26.0 %	27.6 %	26.6 %
Revenue	50.2 %	49.7 %	50.9 %	50.4 %
Quality Mix:				
Days	40.3 %	39.9 %	40.6 %	40.1 %
Revenue	59.5 %	59.5 %	60.1 %	59.8 %

Occupancy. We define occupancy 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 define occupancy in operational beds as the ratio of actual patient days during any measurement period to the number of available patient days for that period. 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:

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	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
Occupancy:				
Operational beds at end of period	14,036	13,204	14,036	13,204
Available patient days	1,279,872	1,214,768	3,716,881	3,496,000
Actual patient days	994,995	940,054	2,895,265	2,701,513
Occupancy percentage (based on operational beds)	77.7 %	77.4 %	77.9 %	77.3 %

Revenue Sources

Our total revenue represents revenue derived primarily from providing services to patients and residents of skilled nursing facilities, and to a lesser extent from assisted living facilities and ancillary services. We receive service revenue from Medicaid, Medicare, private payors and other third-party payors, and managed care sources. The sources and amounts of our revenue are determined by a number of factors, including bed capacity and occupancy rates of our healthcare affiliated facilities, the mix of patients at our affiliated facilities and the rates of reimbursement among payors. Payment for ancillary services varies based upon the service provided and the type of payor.

The following table sets forth our total revenue by payor source and as a percentage of total revenue for the periods indicated:

	Three Months Ended September 30,				Nine Months Ended September 30 ,			
	2014		2013		2014		2013	
	$	%	$	%	$	%	$	%
	(Dollars in thousands)							
Revenue:								
Medicaid	$91,707	35.2 %	$81,802	35.7 %	$260,986	34.8 %	$237,301	35.5 %
Medicare	78,056	29.9	72,138	31.5	231,860	30.9	218,214	32.7
Medicaid-skilled	13,614	5.2	9,204	4.0	36,575	4.9	26,616	4.0
Total	183,377	70.3	163,144	71.2	529,421	70.6	482,131	72.2
Managed Care	36,562	14.0	30,886	13.5	105,316	14.0	87,446	13.1
Private and Other(1)	40,902	15.7	35,231	15.3	115,800	15.4	97,971	14.7
Total revenue	$260,841	100.0 %	$229,261	100.0 %	750,537	100.0 %	667,548	100.0 %

(1) Private and other payors includes revenue from urgent care centers and other ancillary services.

Critical Accounting Policies Update

There have been no significant changes during the three-month period ended September 30, 2014 to the items that we disclosed as our critical accounting policies and estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K filed with the SEC.

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.

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- 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 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.

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 affiliated skilled nursing facilities 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.

Centers for Medicare and Medicaid Services (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 estimates that aggregate payments to skilled nursing facilities will 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 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, reflects a 2.5% market basket increase, reduced by a 0.7% MFP adjustment mandated

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by the PPACA. This increase was 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 0.30%, 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 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 includes 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 projects that Medicare payments to home health agencies in calendar year 2014 will 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 updates 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 implement 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 has projected the impact of these changes will 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 FY 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 would update fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices will see an estimated 1.0% increase in their payments for fiscal year 2014. The hospice payment increase is 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 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 implement 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 has projected the impact of these changes will result in a 0.9% increase in payments to hospice providers.

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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% 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 delayed significant cuts in Medicare rates for physician services until December 31, 2013. The statute also 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 residents' 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 residents' 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.

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 the Centers for Medicare and Medicaid Services 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. 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,

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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 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.

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 PPACA 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:

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- 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 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. 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.

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,

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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.

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:

	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
Revenue	100.0 %	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)	80.3	81.2	80.1	80.6
U.S. Government inquiry settlement	—	—	—	5.0
Facility rent—cost of services	7.0	1.5	4.0	1.5
General and administrative expense	5.0	4.6	5.9	4.2
Depreciation and amortization	1.8	3.9	2.8	3.8
Total expenses	94.1	91.2	92.8	95.1
Income from operations	5.9	8.8	7.2	4.9
Other income (expense):				
Interest expense	(0.2)	(1.4)	(1.7)	(1.4)
Interest income	0.1	0.1	0.1	0.1
Other expense, net	(0.1)	(1.3)	(1.6)	(1.3)
Income before provision for income taxes	5.8	7.5	5.6	3.6
Provision for income taxes	2.6	2.9	2.4	1.7
Income from continuing operations	3.2	4.6	3.2	1.9
Loss from discontinued operations	—	—	—	(0.3)
Net income	3.2	4.6	3.2	1.6
Less: net loss attributable to the noncontrolling interests	(0.2)	—	(0.2)	—
Net income attributable to The Ensign Group, Inc.	3.4 %	4.6 %	3.4 %	1.6 %

	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
	(In thousands)			
Other Non-GAAP Financial Data:				
EBITDA[1]	$20,507	$28,936	$76,121	$58,204
Adjusted EBITDA[1][2]	21,064	31,939	86,724	99,453
EBITDAR[1]	38,683	32,340	106,129	68,260
Adjusted EBITDAR[1][2]	38,830	35,163	115,193	108,822

(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 Securities Exchange Act of 1934, as amended, define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income (loss) 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 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.

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(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 real estate assets in a newly formed publicly traded real estate investment trust (REIT);
- Legal costs incurred in connection with the U.S. Government inquiry;
- Settlement of a class action lawsuit;
- Results at our newly opened urgent care centers;
- Results at one newly constructed skilled nursing facility;
- Results at three independent living facilities transferred to CareTrust REIT 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 REIT.

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

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

	Three Months Ended September 30,		Nine Months Ended September 30 ,	
	2014	2013	2014	2013
	(In thousands)			
Consolidated statements of operations data:				
Net income	$8,371	$10,612	$22,945	$10,505
Less: net (loss) income attributable to noncontrolling interests	(535)	148	(1,494)	(179)
Loss from discontinued operations	—	30	—	1,804
Interest expense, net	265	3,040	12,055	9,078
Provision for income taxes	6,659	6,607	18,284	11,440
Depreciation and amortization	4,677	8,795	21,343	25,198
EBITDA	$20,507	$28,936	$76,121	$58,204
Facility rent—cost of services	18,176	3,404	30,008	10,056
EBITDAR	$38,683	$32,340	$106,129	$68,260
EBITDA	$20,507	$28,936	$76,121	$58,204
Charge related to the U.S. Government inquiry(a)	—	—	—	33,000
Expenses related to the Spin-Off(b)	—	1,648	8,871	1,857
Legal costs(c)	—	98	—	1,111
Settlement of class action lawsuit(d)	—	915	—	1,524
Urgent care center losses(e)	31	105	3	1,447
Earnings at three operations transferred to REIT(f)	—	—	(122)	—
Loss at skilled nursing facility not at full operation(g)	—	—	—	1,256
Acquisition related costs(h)	85	38	219	264
Costs incurred to recognize income tax credits(i)	31	19	93	103
Rent related to items(e), (f), and (g) above(j)	410	180	1,539	687
Adjusted EBITDA	$21,064	$31,939	$86,724	$99,453
Facility rent—cost of services	18,176	3,404	30,008	10,056
Less: rent related to items(e), (f) and (g) above(j)	(410)	(180)	(1,539)	(687)

Adjusted EBITDAR	$38,830	$35,163	$115,193	$108,822

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(a) Charges related to our resolution of any claims connected to the DOJ settlement.
(b) Expenses incurred in connection with the Company's spin-off of its real estate assets to a newly formed publicly traded real estate investment trust (REIT).
(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.

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(e) Results at newly opened urgent care centers, excluding rent, depreciation, interest and income taxes.
(f) Results at three independent living facilities which were transferred to CareTrust REIT as part of the Spin-Off transaction, excluding rent, depreciation, interest and income taxes.
(g) Losses incurred through the third 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.
(h) Costs incurred to acquire an operation which are not capitalizable.
(i) Costs incurred to recognize income tax credits which contributed to a decrease in effective tax rate.
(j) 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 REIT as part of the Spin-Off transaction, not included in items (e), (f) and (g) above.

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Three Months Ended September 30, 2014 Compared to Three Months Ended September 30, 2013

	Three Months Ended September 30,						
	2014		2013		Change	% Change	
	(Dollars in thousands)						
Total Facility Results:							
Revenue	$260,841		$229,261		$31,580	13.8	%
Number of facilities at period end	127		119		8	6.7	%
Actual patient days	994,995		940,054		54,941	5.8	%
Occupancy percentage — Operational beds	77.7	%	77.4	%		0.3	%
Skilled mix by nursing days	27.1	%	26.0	%		1.1	%
Skilled mix by nursing revenue	50.2	%	49.7	%		0.5	%

	Three Months Ended September 30,						
	2014		2013		Change	% Change	
	(Dollars in thousands)						
Same Facility Results(1):							
Revenue	$189,230		$178,797		$10,433	5.8	%
Number of facilities at period end	82		82		—	—	%
Actual patient days	713,682		701,049		12,633	1.8	%
Occupancy percentage — Operational beds	81.9	%	80.3	%		1.6	%
Skilled mix by nursing days	28.7	%	27.4	%		1.3	%
Skilled mix by nursing revenue	51.8	%	51.3	%		0.5	%

	Three Months Ended September 30,						
	2014		2013		Change	% Change	
	(Dollars in thousands)						
Transitioning Facility Results(2):							
Revenue	$36,333		$33,141		$3,192	9.6	%
Number of facilities at period end	25		25		—	—	%
Actual patient days	160,025		157,705		2,320	1.5	%
Occupancy percentage — Operational beds	71.3	%	70.3	%		1.0	%
Skilled mix by nursing days	19.6	%	19.2	%		0.4	%
Skilled mix by nursing revenue	41.4	%	39.8	%		1.6	%

	Three Months Ended September 30,					
	2014		2013		Change	% Change
	(Dollars in thousands)					
Recently Acquired Facility Results(3):						
Revenue	$35,278		$16,504		$18,774	NM
Number of facilities at period end	20		11		9	NM
Actual patient days	121,288		63,072		58,216	NM
Occupancy percentage — Operational beds	65.9	%	67.5	%		NM
Skilled mix by nursing days	24.1	%	20.8	%		NM
Skilled mix by nursing revenue	45.9	%	45.8	%		NM

	Three Months Ended September 30,	
	2014	2013

	(Dollars in thousands)		Change	% Change
Transferred to CareTrust(4):				
Revenue	$—	$819	$(819)	NM
Actual patient days	—	18,228	(18,228)	NM
Occupancy percentage — Operational beds	—%	75.0%		NM

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(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 (or "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 REIT as part of the Spin-Off transaction on June 1, 2014. These results were excluded from Same Facility and Transitioning Facility for the three months ended September 30, 2013 for comparison purposes.

Revenue. Revenue increased $31.5 million, or 13.8%, to $260.8 million for the three months ended September 30, 2014 compared to $229.3 million for the three months ended September 30, 2013. Of the $31.5 million increase, Medicare and managed care revenue increased $11.6 million, or 11.3%, Medicaid custodial revenue increased $9.9 million, or 12.1%, private and other revenue increased $5.6 million, or 15.8% and Medicaid skilled revenue increased $4.4 million, or 47.9%. Revenue generated by Recently Acquired Facilities increased by approximately $18.8 million. Since January 1, 2013, the Company has acquired nineteen facilities, five home health and five hospice operations in nine states.

Revenue generated by Same Facilities increased $10.4 million, or 5.8%, for the three months ended September 30, 2014 as compared to the three months ended September 30, 2013. This increase was primarily due to increases in managed care days and Medicare days of 5.5% and 0.2%, respectively, and increases in managed care revenue per patient day and Medicare revenue per patient day of 2.2% and 1.9%, respectively, during the three months ended September 30, 2014 as compared to the three months ended September 30, 2013.

Revenue at Transitioning Facilities increased $3.2 million, or 9.6% for the three months ended September 30, 2014 as compared to the three months ended September 30, 2013. This increase was due to the transitioning in Medicare days to managed care days, resulted in a decline of 5.8% in Medicare days and an increase of 41.6% in managed care days. Managed care revenue per day and Medicare revenue per patient day increased by 8.9% and 3.6%, respectively, during the three months ended September 30, 2014 as compared to the three months ended September 30, 2013. The increase in Medicare revenue per patient day at Transitioning Facilities was primarily due to the continuous shift towards higher acuity residents and variations in the impact of the market basket increase on revenue per patient day.

The following table reflects the change in the skilled nursing average daily revenue rates by payor source, excluding services that are not covered by the daily rate:

	Three Months Ended September 30,								
	Same Facility		Transitioning		Acquisitions		Total		%
	2014	2013	2014	2013	2014	2013	2014	2013	Change
Skilled Nursing Average Daily Revenue Rates:									
Medicare	$560.92	$550.66	$484.03	$467.35	$512.84	$475.17	$546.67	$535.03	2.2 %
Managed care	412.44	403.44	417.71	383.64	465.20	468.39	418.22	406.35	2.9 %
Other skilled	446.54	467.02	834.01	690.75	316.85	-	436.48	471.27	(7.4)%
Total skilled revenue	489.91	487.50	478.48	458.82	459.08	472.20	485.93	484.01	0.4 %
Medicaid	181.89	173.47	162.31	164.02	168.06	145.78	178.30	170.81	4.4 %
Private and other payors	191.81	187.04	170.35	167.05	187.45	150.75	185.52	178.62	3.9 %
Total skilled nursing revenue	$271.41	$261.26	$226.54	$221.60	$241.15	$214.51	$262.64	$253.35	3.7 %

Medicare daily rates increased by 2.2%. This rate was impacted by a 1.3% market basket increase, which went into effect in October 2013 and the continuous shift towards higher acuity residents. The decrease in Other skilled rates was primarily due to the broadening of skilled services in various states. The average Medicaid rate increased 4.4% for the three months ended September 30, 2014 relative to the same period in the prior year, primarily due to increases in rates in various states.

Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth. In the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we anticipate our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio.

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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 affiliated skilled nursing facilities over various periods. The following tables set forth our percentage of skilled nursing patient revenue and days by payor source:

	Three Months Ended September 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2014	2013	2014	2013	2014	2013	2014	2013
Percentage of Skilled Nursing Revenue:								
Medicare	28.9 %	30.2 %	31.9 %	33.5 %	22.5 %	25.9 %	28.6 %	30.4 %
Managed care	15.8	15.5	7.7	5.1	17.6	19.9	15.1	14.5
Other skilled	7.1	5.6	1.8	1.2	5.8	—	6.5	4.8
Skilled mix	51.8	51.3	41.4	39.8	45.9	45.8	50.2	49.7
Private and other payors	7.4	7.9	21.5	22.2	11.8	13.2	9.3	9.8
Quality mix	59.2	59.2	62.9	62.0	57.7	59.0	59.5	59.5
Medicaid	40.8	40.8	37.1	38.0	42.3	41.0	40.5	40.5
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

	Three Months Ended September 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2014	2013	2014	2013	2014	2013	2014	2013
Percentage of Skilled Nursing Days:								
Medicare	14.0 %	14.3 %	14.9 %	15.9 %	10.6 %	11.7 %	13.7 %	14.4 %
Managed care	10.4	10.0	4.2	3.0	9.2	9.1	9.5	9.0
Other skilled	4.3	3.1	0.5	0.3	4.3	—	3.9	2.6
Skilled mix	28.7	27.4	19.6	19.2	24.1	20.8	27.1	26.0
Private and other payors	10.4	11.1	28.7	29.6	15.2	18.7	13.2	13.9
Quality mix	39.1	38.5	48.3	48.8	39.3	39.5	40.3	39.9
Medicaid	60.9	61.5	51.7	51.2	60.7	60.5	59.7	60.1
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $23.5 million, or 12.6%, to $209.7 million for the three months ended September 30, 2014 compared to $186.2 million for the three months ended September 30, 2013. Cost of services as a percentage of total revenue decreased to 80.3% for the three months ended September 30, 2014 as compared to 81.2% for the three months ended September 30, 2013. The decrease was primarily related to $2.0 million decline in general and professional liability insurance expenses during the three months ended September 30, 2014 as compared to the three months ended September 30, 2013.

Facility Rent — Cost of Services. Facility rent — cost of services increased $14.8 million to $18.2 million for the three months ended September 30, 2014 compared to $3.4 million for the three months ended September 30, 2013. Facility rent-cost of service as a percent of total revenue increased to 7.0% for the three months ended September 30, 2014 from 1.5% for the three months ended September 30, 2013. The increase in rent was primarily due to new lease agreements under the Master Leases entered into with CareTrust associated with 94 affiliated skilled nursing, assisted living and independent living facilities in connection with the Spin-Off and new leases for newly opened urgent care centers and skilled nursing facilities. Rent expense under the Master Leases is expected to be $4.7 million on a monthly basis for the initial 2 years.

General and Administrative Expense. General and administrative expense increased $2.4 million to $13.0 million for the three months ended September 30, 2014 compared to $10.6 million for the three months ended September 30, 2013. General and administrative expenses increased as a percent of total revenue to 5.0% for the three months ended September 30, 2014 as compared to 4.6% for the three months ended September 30, 2013. The $2.4 million increase was primarily due to operational growth during the quarter.

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Depreciation and Amortization. Depreciation and amortization expense decreased $4.1 million, or 46.6% to $4.7 million for the three months ended September 30, 2014 compared to $8.8 million for the three months ended September 30, 2013. Depreciation and amortization expense decreased as a percent of total revenue to 1.8% for the three months ended September 30, 2014 as compared to 3.9% for the three months ended September 30, 2013. This decrease was primarily related to the transfer of real properties to CareTrust in connection with the Spin-Off, offset by additional depreciation of newly acquired properties at Recently Acquired Facilities. Included in the $1.1 million depreciation and amortization expense at Recently Acquired Facilities is $0.2 million of amortization expense of patient base intangible assets which are amortized over four to eight months.

Other Income (Expense). Other expense, net decreased $2.7 million to $0.3 million for the three months ended September 30, 2014 compared to $3.0 million for the three months ended September 30, 2013. Other expense as a percent of revenue decreased to 0.1% for the three months ended September 30, 2014 as compared to 1.3% for the three months ended September 30, 2013. This decrease was primarily related to the decrease in interest expenses as a result of the repayments of outstanding debt in connection with the Spin-Off.

Provision for Income Taxes. Provision for income taxes as a percentage of revenue decrease to 2.6% for the three months ended September 30, 2014 as compared to 2.9% for the three months ended September 30, 2013. This decrease resulted from the decrease in income before income taxes of $2.2 million, or 12.9%.

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Nine Months Ended September 30, 2014 Compared to Nine Months Ended September 30, 2013

	Nine Months Ended September 30 ,			
	2014	2013		
	(Dollars in thousands)		Change	% Change
Total Facility Results:				
Revenue	$750,537	$667,548	$82,989	12.4 %
Number of facilities at period end	127	119	8	6.7 %
Actual patient days	2,895,265	2,701,513	193,752	7.2 %
Occupancy percentage — Operational beds	77.9 %	77.3 %		0.6 %
Skilled mix by nursing days	27.6 %	26.6 %		1.0 %
Skilled mix by nursing revenue	50.9 %	50.4 %		0.5 %

	Nine Months Ended September 30 ,			
	2014	2013		
	(Dollars in thousands)		Change	% Change
Same Facility Results(1):				
Revenue	$563,303	$535,278	$28,025	5.2 %
Number of facilities at period end	82	82	—	— %
Actual patient days	2,115,181	2,078,207	36,974	1.8 %
Occupancy percentage — Operational beds	81.8 %	80.2 %		1.6 %
Skilled mix by nursing days	29.3 %	28.0 %		1.3 %
Skilled mix by nursing revenue	52.5 %	51.8 %		0.7 %

	Nine Months Ended September 30 ,			
	2014	2013		
	(Dollars in thousands)		Change	% Change
Transitioning Facility Results(2):				
Revenue	$104,933	$96,249	$8,684	9.0 %
Number of facilities at period end	25	25	—	— %
Actual patient days	473,841	460,949	12,892	2.8 %
Occupancy percentage — Operational beds	71.2 %	69.3 %		1.9 %
Skilled mix by nursing days	19.9 %	19.8 %		0.1 %
Skilled mix by nursing revenue	41.4 %	40.7 %		0.7 %

	Nine Months Ended September 30 ,			
	2014	2013		
	(Dollars in thousands)		Change	% Change
Recently Acquired Facility Results(3):				
Revenue	$81,053	$33,390	$47,663	NM
Number of facilities at period end	20	11	9	NM
Actual patient days	278,227	107,210	171,017	NM
Occupancy percentage — Operational beds	65.6 %	64.4 %		NM
Skilled mix by nursing days	23.2 %	19.9 %		NM
Skilled mix by nursing revenue	46.2 %	46.4 %		NM

	Nine Months Ended September 30,			
	2014	2013		
	(Dollars in thousands)		Change	% Change

Transferred to CareTrust(4):				
Revenue	$1,248	$2,631	$(1,383)	NM
Actual patient days	28,016	55,147	(27,131)	NM
Occupancy percentage — Operational beds	70.3%	76.5%		NM

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(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 (or "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 REIT as part of the Spin-Off transaction on June 1, 2014. The five months results of the three independent living facilities were excluded from Same Facility and Transitioning Facility for the nine months ended September 30, 2014 for comparison purposes. The nine months results of the three independent living facilities were excluded from Same Facility and Transitioning Facility for the nine months ended September 30 2013 for comparison purposes.

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Revenue. Revenue increased $83.0 million, or 12.4%, to $750.5 million for the nine months ended September 30, 2014 compared to $667.5 million for the nine months ended September 30, 2013. Of the $83.0 million increase, Medicare and managed care revenue increased $31.5 million, or 10.3%, Medicaid custodial revenue increased $23.7 million, or 10.0%, private and other revenue increased $17.8 million, or 18.2% and Medicaid skilled revenue increased $10.0 million, or 37.4%. Revenue generated by Recently Acquired Facilities increased by approximately $47.7 million. Since January 1, 2013, the Company has acquired nineteen facilities, five home health and five hospice operations in nine states.

Revenue generated by Same Facilities increased $28.0 million, or 5.2%, for the nine months ended September 30, 2014 as compared to the nine months ended September 30, 2013. This increase was primarily due to increases in managed care days and Medicare days of 4.9% and 0.5%, respectively, and an increase in managed care revenue per patient day of 3.9% during the nine months ended September 30, 2014 as compared to the nine months ended September 30, 2013. Medicare revenue per patient day for the nine months ended September 30, 2014 at Same Facilities was consistent with the nine months ended September 30, 2013.

Revenue at Transitioning Facilities increased $8.7 million, or 9.0% for the nine months ended September 30, 2014 as compared to the nine months ended September 30, 2013. This increase was due to the transitioning in Medicare days to managed care days, resulted in a decline of 6.6% in Medicare days and an increase of 38.5% in managed care days. Medicare revenue per patient day and managed care revenue per patient day increased by 1.8% and 5.5%, respectively, for the nine months ended September 30, 2014 as compared to the nine months ended September 30, 2013. The increase in Medicare revenue per patient day at Transitioning Facilities was primarily due to the continuous shift towards higher acuity residents and variations in the impact of the market basket increase on revenue per patient day.

The following table reflects the change in the skilled nursing average daily revenue rates by payor source, excluding services that are not covered by the daily rate:

	Nine Months Ended September 30 , Same Facility		Transitioning		Acquisitions		Total		% Change
	2014	2013	2014	2013	2014	2013	2014	2013	
Skilled Nursing Average Daily Revenue Rates:									
Medicare	$561.42	$557.23	$476.04	$467.66	$504.91	$490.67	$546.34	$541.89	0.8 %
Managed care	411.33	396.02	411.71	390.30	462.66	465.71	415.80	397.77	4.5 %
Other skilled	439.24	465.01	806.09	686.13	311.85	-	437.26	468.85	(6.7)%
Total skilled revenue	490.55	489.22	472.14	460.87	463.57	481.76	486.96	486.20	0.2 %
Medicaid	181.62	174.96	161.40	163.32	159.70	136.42	177.50	172.24	3.1 %
Private and other payors	192.36	186.92	172.08	167.62	178.34	147.77	185.33	179.35	3.3 %
Total skilled nursing revenue	$273.09	$264.16	$226.12	$223.28	$233.19	$207.52	$263.80	$256.68	2.8 %

Medicare daily rates increased by 0.8%. This rate was impacted by a 1.3% net market basket increase, which went into effect in October 2013. These market basket increases were offset by a 2.0% sequestration reduction, which went into effect on April 1, 2013. The decrease in Other skilled rates was primarily due to the broadening of skilled services in various states. The average Medicaid rate increased 3.1% for the nine months ended September 30, 2014 relative to the same period in the prior year, primarily due to increases in rates in various states.

Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth. In the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we anticipate our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio.

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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 affiliated skilled nursing facilities over various periods. The following tables set forth our percentage of skilled nursing patient revenue and days by payor source:

	Nine Months Ended September 30 ,							
	Same Facility		Transitioning		Acquisitions		Total	
	2014	2013	2014	2013	2014	2013	2014	2013
Percentage of Skilled Nursing Revenue:								
Medicare	30.2 %	31.3 %	32.7 %	35.0 %	22.9 %	30.3 %	29.9 %	31.7 %
Managed care	15.7	15.1	6.9	4.7	19.5	16.1	15.1	13.9
Other skilled	6.6	5.4	1.8	1.0	3.8	—	5.9	4.8
Skilled mix	52.5	51.8	41.4	40.7	46.2	46.4	50.9	50.4
Private and other payors	7.3	7.6	22.0	21.9	11.8	13.9	9.2	9.4
Quality mix	59.8	59.4	63.4	62.6	58.0	60.3	60.1	59.8
Medicaid	40.2	40.6	36.6	37.4	42.0	39.7	39.9	40.2
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

	Nine Months Ended September 30 ,							
	Same Facility		Transitioning		Acquisitions		Total	
	2014	2013	2014	2013	2014	2013	2014	2013
Percentage of Skilled Nursing Days:								
Medicare	14.7 %	14.9 %	15.6 %	16.7 %	10.6 %	12.8 %	14.4 %	15.0 %
Managed care	10.5	10.0	3.8	2.7	9.8	7.1	9.6	9.0
Other skilled	4.1	3.1	0.5	0.4	2.8	—	3.6	2.6
Skilled mix	29.3	28.0	19.9	19.8	23.2	19.9	27.6	26.6
Private and other payors	10.3	10.8	28.8	29.1	15.5	19.8	13.0	13.5
Quality mix	39.6	38.8	48.7	48.9	38.7	39.7	40.6	40.1
Medicaid	60.4	61.2	51.3	51.1	61.3	60.3	59.4	59.9
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $63.4 million, or 11.8%, to $601.5 million for the nine months ended September 30, 2014 compared to $538.1 million for the nine months ended September 30, 2013. Cost of services as a percent of total revenue is 80.1% for the nine months ended September 30, 2014, which is consistent with the nine months ended September 30, 2013.

Charge Related to U.S. Government Inquiry. We recorded an additional charge in the amount of $33.0 million during the three months ended March 31, 2013 related to the investigation into some of our subsidiaries conducted by the DOJ. As the investigation was settled in 2013, there were no additional charges incurred during the nine months ended September 30, 2014.

Facility Rent — Cost of Services. Facility rent — cost of services increased $19.9 million to $30.0 million for the nine months ended September 30, 2014 compared to $10.1 million for the nine months ended September 30, 2013. Facility rent-cost of services as a percent of total revenue increased to 4.0% for the nine months ended September 30, 2014 from 1.5% for the nine months ended September 30, 2013. The increase in rent was primarily due to new lease agreements under eight Master Leases entered into with CareTrust associated with 94 affiliated skilled nursing, assisted living and independent living facilities in connection with the Spin-Off and new leases for newly opened

urgent care centers and skilled nursing facilities. Rent expense under the Master Leases is expected to be $4.7 million on a monthly basis for the initial 2 years.
General and Administrative Expense. General and administrative expense increased $16.1 million, or 56.9%, to $44.4 million for the nine months ended September 30, 2014 compared to $28.3 million for the nine months ended September 30, 2013. General and administrative expenses increased as a percent of total revenue to 5.9% for the nine months ended September 30, 2014 as compared to 4.2% for the nine months ended September 30, 2013. The $16.1 million increase was primarily due to costs incurred

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in connection with the Company's spin-off of its real estate assets to a newly formed publicly traded real estate investment trust (REIT) of $8.9 million. Excluding the costs incurred in connection with the Spin-Off, general and administrative expense as a percentage of revenue is 4.7% for the nine months ended September 30, 2014.
Depreciation and Amortization. Depreciation and amortization expense decreased $3.9 million, or 15.5%, to $21.3 million for the nine months ended September 30, 2014 compared to $25.2 million for the nine months ended September 30, 2013. Depreciation and amortization expense decreased as a percent of total revenue to 2.8% for the nine months ended September 30, 2014 as compared to 3.8% for the nine months ended September 30, 2013. This decrease was primarily related to the transfer of real properties to CareTrust in connection with the Spin-Off, offset by additional depreciation of $1.0 million at Recently Acquired Facilities. Of the $1.0 million increase at Recently Acquired Facilities, $0.4 million represented amortization expense of patient base intangible assets which are amortized over four to eight months. The transfer of real properties to CareTrust in connection with the Spin-Off resulted in a reduction in depreciation expense, offset by the increase in depreciation related to newly acquired facilities and completion of renovations on a monthly go-forward basis.
Other Income (Expense). Other expense, net increased $3.0 million, or 33.0%, to $12.1 million for the nine months ended September 30, 2014 compared to $9.1 million for the nine months ended September 30, 2013. Other expense as a percent of revenue increased to 1.6% for the nine months ended September 30, 2014 as compared to 1.3% for the nine months ended September 30, 2013. This increase was primarily related to 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 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. Excluding the losses incurred in connection with the Spin-Off and the termination of the interest-rate swap, other expense, net as a percentage of revenue is 0.8% for the nine months ended September 30, 2014.
Provision for Income Taxes. Provision for income taxes increased $6.9 million, or 60.5%, to $18.3 million for the nine months ended September 30, 2014 as compared to $11.4 million for the nine months ended September 30, 2013. This increase resulted from the increase in income before income taxes of $17.5 million, which was primarily the result of the charge of $33.0 million incurred during the three months ended March 31, 2013 related to the settlement of the DOJ investigation. Included in income before income taxes for the nine months ended September 30, 2014 are charges of $8.9 million in connection with the Spin-Off, including repayment penalties and the write off of unamortized debt discount and deferred financing costs upon retirement of outstanding debt of $4.1 million, recognized loss related to the termination of the interest-rate swap of $1.7 million, increases in rent expense related to the Master Leases of $18.7 million, offset by decreases in depreciation expense related to the transfer of real properties to CareTrust in connection with the Spin-Off and permanent non-deductible transaction costs related to the Spin-Off.

Liquidity and Capital Resources
Our primary sources of liquidity have historically been derived from our cash flow from operations and long-term debt secured by our real property and our revolving credit facilities.
Historically, we have financed the majority of our facility acquisitions primarily through refinancing of existing affiliated facilities, and cash generated from operations. Cash paid for business acquisitions was $43.0 million and $45.4 million for the nine months ended September 30, 2014 and 2013, respectively. Cash paid for assets acquisitions was $7.9 million for the nine months ended September 30, 2014. There were no asset acquisitions executed during the nine months ended September 30, 2013. Where we enter into a facility lease agreement, we typically do not pay any material amount to the prior facility operator, nor do we acquire any assets or assume any liabilities, other than our rights and obligations under the new lease and operations transfer agreement, as part of the transaction. Total capital expenditures for property and equipment were $42.1 million and $21.9 million for the nine months ended September 30, 2014 and 2013, respectively. We currently have a combined $50.0 million budgeted for renovation projects for 2014.

We believe our current cash balances, our cash flow from operations and the revolving credit facility (the 2014 Credit Facility) of $150.0 million, will be sufficient to cover our operating needs for at least the next 12 months. We may in the future seek to raise additional capital to fund growth, capital renovations, operations and other business activities, but such additional capital may not be available on acceptable terms, on a timely basis, or at all.

Our cash and cash equivalents as of September 30, 2014 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of September 30, 2014, we held debt security investments of approximately $24.1 million, which were split between AA-, A-, and BBB-rated securities. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material

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effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

In connection with the Spin-Off, CareTrust assumed the mortgage debt of approximately $48.5 million, and issued additional mortgage debt of approximately $50.7 million, related to certain of the properties it acquired, and issued $260.0 million in aggregate principal amount of senior unsecured notes. $220.8 million of the proceeds from the issuance of the notes was transferred to us in connection with the contribution of assets to CareTrust prior to the Spin-Off. We used the proceeds to repay certain outstanding third-party bank debt and other indebtedness and the third quarter dividend payments. We are planing to utilize all the remaining amount of $6.7 million as of September 30, 2014 to make dividend payments within the next twelve months

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

	Nine Months Ended September 30 ,	
	2014	2013
	(In thousands)	
Net cash provided by operating activities	$66,687	$57,110
Net cash used in investing activities	(99,407)	(57,046)
Net cash provided by financing activities	6,171	5,248
Net (decrease) increase in cash and cash equivalents	(26,549)	5,312
Cash and cash equivalents at beginning of period	65,755	40,685
Cash and cash equivalents at end of period	$39,206	$45,997

Nine Months Ended September 30, 2014 Compared to Nine Months Ended September 30, 2013

Net cash provided by operations for the nine months ended September 30, 2014 was $66.7 million compared to $57.1 million for the nine months ended September 30, 2013, an increase of $9.6 million. This increase was primarily due to the decrease in prepayment of income taxes and timing of the payment of accounts payable and accrued expenses partially offset by increased accounts receivable.

Net cash used in investing activities for the nine months ended September 30, 2014 was $99.4 million compared to $57.0 million for the nine months ended September 30, 2013, an increase of $42.4 million. The increase was primarily the result of purchases of property and equipment and asset acquisitions of $42.1 million and $7.9 million, respectively, during the nine months ended September 30, 2014, compared to $21.9 million and $0.0 million, respectively, during the nine months ended September 30, 2013, an increase of $28.1 million. The increase in purchases of property and equipment during the nine months ended September 30, 2014 was in effort to finalize numerous renovation projects in advance of the REIT Spin-Off transaction.

Net cash provided by financing activities for the nine months ended September 30, 2014 was $6.2 million as compared to $5.2 million for the nine months ended September 30, 2013, an increase of $1.0 million. This increase in net cash provided by financing activities was primarily due to higher excess tax benefit from share based compensation expense for the nine months ended September 30, 2014 compared to the nine months ended September 30, 2013. The net effect of the financing cash flows related to the Spin-Off did not significantly affect overall net cash flows from financing activities for the nine months ended September 30, 2014.

Principal Debt Obligations and Capital Expenditures

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 on September 24, 2014. The term of the mortgage loan is for 25 years with monthly principal and interest payments. The balance of the loan is due on October 1, 2037. With the exception of the HUD-insured loan, we have no other borrowings outstanding as of September 30, 2014.

New Credit Facility with a Lending Consortium Arranged by SunTrust (the 2014 Credit Facility)
On May 30, 2014, we entered into the 2014 Credit Facility in an aggregate principal amount of $150.0 million from a syndicate of banks and other financial institutions. Under the 2014 Credit Facility, we may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $75.0 million. The interest rates applicable to loans under the 2014 Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 1.25% to 2.25% per annum or LIBOR plus a margin ranging from 2.25% to 3.25% per annum, based on the debt to Consolidated EBITDA ratio (as defined in the

agreement). In addition, we will pay a commitment fee on the unused portion of the commitments under the 2014 Credit Facility that will range from 0.30% to 0.50% per annum, depending on the debt to Consolidated EBITDA ratio of the Company and its subsidiaries. Loans made under the 2014 Credit Facility are not subject to interim amortization. We are not required to repay any loans under the 2014 Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the 2014 Credit Facility. We are permitted to prepay all or any portion of the loans under the 2014 Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders. In connection with the 2014 Credit Facility, we incurred financing costs of approximately $2.0 million, which was capitalized and amortized over the term of the 2014 Credit Facility. As of September 30, 2014 there were no borrowings outstanding under the 2014 Credit Facility.

The 2014 Credit Facility is guaranteed, jointly and severally, by certain of our wholly owned subsidiaries. The 2014 Credit Facility contain customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and our subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the 2014 Credit Facility, we must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum debt to consolidated EBITDA ratio, and a minimum interest/rent coverage ratio. The majority of lenders can require that the Company and its subsidiaries mortgage certain of their real property assets to secure the 2014 Credit Facility if an event of default occurs, the debt to consolidated EBITDA ratio is above 2.50:1.00 for two consecutive fiscal quarters, or our liquidity is equal or less than 10% of the Aggregate Revolving Commitment Amount as defined in the agreement for ten consecutive business days, provided that such mortgages will no longer be required if the event of default is cured, the debt to consolidated EBITDA ratio is below 2.50:1.00 for two consecutive fiscal quarters, or our liquidity is above 10% of the Aggregate Revolving Commitment Amount as defined in the agreement or ninety consecutive days, as applicable. As of September 30, 2014, we are in compliance with all loan covenants.

Mortgage Loan with Red Mortgage Capital, LLC

On September 24, 2014, we acquired an assisted living facility in Arizona. The acquisition was purchased with a combination of cash and the assumption of an existing mortgage loan with Red Mortgage Capital, LLC of approximately $3.4 million. The mortgage loan is insured with the U.S. Department of Housing and Urban Development (HUD), which subjects our facility to HUD oversight and periodic inspections. The mortgage loan bears interest at the rate of 2.55% per annum. Amounts borrowed under the mortgage loan may be prepaid starting after the second anniversary of the note subject to prepayment fees of 9.0% of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% a year for years three through 11 of the loan. There is no prepayment penalty after year 11. The term of the mortgage loan is for 25 years, with monthly principal and interest payments commencing on September 12, 2012 and the balance due on October 1, 2037. The mortgage loan was secured by the real property comprising the facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

CareTrust Indebtedness

Immediately before the Spin-Off on May 30, 2014, while CareTrust was a wholly-owned subsidiary of the Company, CareTrust raised $260.0 million of debt financing, which was part of the net assets contributed to CareTrust as part of the Spin-Off. See Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust.
Senior Credit Facility with Six-Bank Lending Consortium Arranged by SunTrust and Wells Fargo (the Senior Credit Facility)

On July 15, 2011, we entered into the Senior Credit Facility in an aggregate principal amount of up to $150.0 million comprised of a $75.0 million revolving credit facility and a $75.0 million term loan advanced in one drawing on July 15, 2011. Borrowings under the term loan portion of the Senior Credit Facility amortize in equal quarterly installments that commenced on September 30, 2011, in an aggregate annual amount equal to 5.0% per annum of the original principal amount. Amounts borrowed pursuant to the Senior Credit Facility are guaranteed by certain of our wholly-owned subsidiaries and secured by substantially all of our personal property. To reduce the risk related to interest rate fluctuations, we, on behalf of the subsidiaries, entered into an interest rate swap agreement to effectively fix the interest rate on the term loan portion of the Senior Credit Facility. See further details of the interest rate swap at Note 5, Fair Value Measurements in Notes to Condensed Consolidated Financial Statements.

On May 30, 2014, the Senior Credit Facility was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

Promissory Notes with RBS Asset Finance, Inc.

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On February 22, 2012, two of our real estate holding subsidiaries as Borrowers executed a promissory note in favor of RBS Asset Finance, Inc. (RBS) as Lender for an aggregate of $21.5 million (the 2012 RBS Loan). The 2012 RBS Loan was secured by a Commercial Deed of Trust, Security Agreement, Assignment of Leases and Rents and Fixture Filings on the two properties owned by the two Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2012 RBS Loan had a fixed interest rate of 4.75%.

On May 30, 2014, the RBS Loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

Promissory Note with RBS Asset Finance, Inc.

On December 31, 2010, four of our real estate holding subsidiaries as Borrowers executed a promissory note in favor of RBS as Lender for an aggregate of $35.0 million (2010 RBS Loan). The 2010 RBS Loan was secured by Commercial Deeds of Trust, Security Agreements, Assignment of Leases and Rents and Fixture Fillings on the four properties owned by the four Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2010 RBS Loan had a fixed interest rate of 6.04%.

On May 30, 2014, the RBS Loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of our independent real estate holding subsidiaries jointly entered into the Third Amended and Restated Loan Agreement with General Electric Capital Corporation (GECC), which consists of an approximately $55.7 million multiple-advance term loan (The Ten Project Note). The Ten Project Note was currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries.

On May 30, 2014, we entered into the Fifth Amended and Restated Loan Agreement, with GECC, which consisted of an additional loan of $55.7 million to an aggregate principal amount of $99.0 million. The Ten Project Note matures in May 2017 and are currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries. The initial term loan of $55.7 million was funded in advances, with each advance bearing interest at a separate rate. The interest rates range from 6.95% to 7.50% per annum. The additional loan of $50.7 million bears interest at a floating rate equal to the three month LIBOR plus 3.35%, reset monthly and subject to a LIBOR floor of 0.50%, with monthly principal and interest payments based on a 25 years amortization.

On May 30, 2014, The Ten Project Note was assumed by CareTrust in connection with the Spin-Off.

Promissory Notes with Johnson Land Enterprises, Inc.

On October 1, 2009, four of our subsidiaries entered into four separate promissory notes with Johnson Land Enterprises, LLC, for an aggregate of $10.0 million, as a part of our acquisition of three skilled nursing facilities in Utah.

On May 30, 2014, we repaid the majority of the four promissory notes with a portion of the proceeds received from CareTrust in connection with the Separation and Distribution Agreement. The remaining $0.6 million was assumed by CareTrust in connection with the Spin-Off.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with HUD, which subjects our Southland facility to HUD oversight and periodic inspections. This mortgage loan is secured by the real property comprising the Southland Care Center facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

On May 30, 2014, the mortgage loan was paid in full with a portion of the proceeds received from CareTrust in connection with the Spin-Off.

In connection with the debt retirements, we incurred losses of $5.7 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 swaps.

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Contractual Obligations, Commitments and Contingencies

As a result of the Spin-Off, we lease from CareTrust real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities used in our operations under eight master leases (the Master Leases). The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. Annual rent expense under the Master Leases will be approximately $56.0 million during each of the first two years of the Master Leases.

The Master Leases arrangement is commonly known as a triple-net lease. Accordingly, in addition to rent, we are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor), (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties, (3) all insurance required in connection with the leased properties and the business conducted on the leased properties, (4) all facility maintenance and repair costs and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Total rent expense under the Master Leases was approximately $14.0 million and $18.7 million for the three and nine months ended September 30, 2014, as a result of the Spin-Off on June 1, 2014. There was no rent expense under the Master Leases in 2013.

At our option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If we elect to renew the term of a master lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the master lease.

Among other things, under the Master Leases, we must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. As of September 30, 2014, we were in compliance with the Master Leases' covenants.

We also entered into an Opportunities Agreement with CareTrust, which grants CareTrust the right to match any offer from a third party to finance the acquisition or development of any healthcare or senior-living facility by us or any of our affiliates for a period of one year following the Spin-Off. In addition, this agreement requires CareTrust to provide us, subject to certain exceptions, a right to either purchase and operate, or lease and operate, the facilities included in any portfolio of five or fewer healthcare or senior living facilities presented to us during the first year following the Spin-Off; provided that the portfolio is not subject to an existing lease with an operator or manager that has a remaining term of more than one year, and is not presented to us by or on behalf of another operator seeking lease or other financing. If we elect to lease and operate such a property or portfolio, the lease would be on substantially the same terms as the Master Leases.

We also lease certain affiliated facilities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. In addition, we lease certain of our equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $18.3 million and $30.4 million for the three and nine months ended September 30, 2014 and $3.5 million and $10.4 million for the three and nine months ended September 30, 2013, respectively.

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Future minimum lease payments for all leases as of September 30, 2014 are as follows:

Year	Amount
Remaining 2014	18,023
2015	71,789
2016	71,832
2017	71,851
2018	71,920
2019	70,897
Thereafter	676,241
	1,052,553

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

In addition, a number of our individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the landlords under separate but cross-defaulted leases. We are not aware of any defaults as of September 30, 2014.

During the third quarter of 2014, we received a notification from the Internal Revenue Service (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. See Note 13, Income Taxes.

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 the 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 and the government executed a final settlement agreement in accordance with the April agreement and we remitted full payment of the Reserve Amount. In addition, we executed a corporate integrity agreement with the Office of Inspector General HHS as part of the resolution.

See additional description of our contingencies in Notes 14, Debt and 16, Commitments and Contingencies in Notes to Condensed Consolidated Financial Statements.

Inflation

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

Labor and supply expenses make up a substantial portion of our cost of services. Those expenses can be subject to increase in periods of rising inflation and when labor shortages occur in the marketplace. To date, we have generally been able to implement

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cost control measures or obtain increases in reimbursement sufficient to offset increases in these expenses. We may not be successful in offsetting future cost increases.

Recent Accounting Pronouncements

Except for rules and interpretive releases of the Securities and Exchange Commission (SEC) under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) 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 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 IASB 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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Item 3. Quantitative and Qualitative Disclosures about Market Risk

Interest Rate Risk. We are exposed to interest rate changes in connection with the revolving credit facility portion of the 2014 Credit Facility. The 2014 Credit Facility agreement exposes us to variability in interest payments due to changes in LIBOR interest rates. Historically, we entered into an interest rate swap agreement to reduce risk from volatility in the income statement. We terminated the swap agreement in May 2014 in connection with our repayment of the Senior Credit Facility. As of September 30, 2014, there was no outstanding interest rate swap contract. If we decide to borrow against the 2014 Credit Facility in the future, we may enter into new a interest rate swap agreement to reduce risk from volatility in the income statement on the term loan portion of the 2014 Credit Facility. As of September 30, 2014, we had no outstanding borrowings under the 2014 Credit Facility.

Our cash and cash equivalents as of September 30, 2014 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of September 30, 2014, we held debt security investments of approximately $24.1 million, which were split between AA-, A-, and BBB- rated securities. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of September 30, 2014, and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Item 4. Controls and Procedures

Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (Exchange Act)), as of the end of the period covered by this report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures are effective.

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended September 30, 2014, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Part II. Other Information

Item 1. Legal Proceedings

Certain legal proceedings in which we are involved are discussed in Part I, Item 3. Legal Proceedings, of our Annual Report on Form 10-K for the year ended December 31, 2013. In addition, for more information regarding our legal proceedings, please see Note 16, Commitments and Contingencies included in Part 1, Item 1 of this Form 10-Q.

We are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that services provided to patients have resulted in injury or death and claims related to employment and commercial matters. Although we intend to vigorously defend ourselves in these matters, there can be no assurance that the outcomes of these matters will not have a material adverse effect on our results of operations and financial condition. In certain states in which we have or have had operations, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law public policy prohibitions. There can be no assurance that we will not be liable for punitive damages awarded in litigation arising in states for which punitive damage insurance coverage is not available.

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

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 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, are projected to be approximately $6.5 million, of which, approximately $1.5 million of this amount was recorded during the year ended December 31, 2013, 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 the 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.

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Item 1A. Risk Factors

Our operations and financial results are subject to various risks and uncertainties, including those described below, that could adversely affect our business, financial condition, results of operations, cash flows, and trading price of our common stock. Please refer also to our Annual Report on Form 10-K (File No. 001-33757) for additional information concerning these and other uncertainties that could negatively impact the Company.

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 35.2% and 34.8% of our revenue from the Medicaid program for the three and nine months ended September 30, 2014, respectively, and 35.7% and 35.5%, for the three and nine months ended September 30, 2013. We derived 29.9% and 30.9%, of our revenue from the Medicare program for the three and nine months ended September 30, 2014 and 31.5% and 32.7%, for the three and nine months ended September 30, 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 residents.

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 residents 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 estimates that aggregate payments to skilled nursing facilities will 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, reflects 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 0.30%, 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 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 includes 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 projects that Medicare payments to home health agencies in calendar year 2014 will 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 updates 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 implement 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 has projected the impact of these changes will 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 FY 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 would update fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices will see an estimated 1.0% ($160 million) increase in their payments for fiscal year 2014. The hospice payment increase is 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 implement a net market basket increase of 1.6% consisting of a 2.6% market basket inflation increase, less offsets to the standard payment conversion

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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 has projected the impact of these changes will 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 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, 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 residents' 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 residents' 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 residents 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.

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) were enacted as law. These laws 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

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Secretary of Health and Human Services determines that good cause exists not to suspend payments. To the extent the Secretary 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 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.

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.

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

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on the promulgation of regulations by a number of federal government agencies, including the HHS. It is impossible to predict 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 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

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under the Medicare programs. Private pay sources also reserve the right to conduct audits. We believe that billing and reimbursement 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 September 30, 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

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with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other 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 to date has passed one of the two 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 residents 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 may be 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 nine months ended September 30, 2014, 70.6% 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, are projected to be approximately $6.5 million, of which, approximately $1.5 million of this amount was recorded in the fiscal year ended December 31, 2013 , 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 residents move in, to prevent nursing home operators and prospective residents 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 with the Office of Inspector General-HHS (the CIA). 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 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 nine months ended September 30, 2014, we acquired four stand-alone skilled nursing facilities, two assisted living facilities, two home health agencies, two hospice agencies, one primary care group and one transitional care management company with a total of 830 operational skilled nursing beds and 267 operational assisted living units. During the year ended December 31, 2013, we acquired seven stand-alone skilled nursing facilities, three stand-alone assisted living facilities, 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 underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have

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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. We currently have one affiliated facility on special focus facility status. To date, this affiliated facility has passed one of the two 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 residents 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 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 California, Texas and Arizona 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 Texas, Nebraska and Iowa 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 September 30, 2014, we leased 118 of our 127 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 September 30, 2014, we have no borrowings outstanding under the 2014 Credit Facility.

One 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. The balance of the loan due on October 1, 2037. With the exception of the HUD-insured loan, we have no other borrowings outstanding as of September 30, 2014.

In addition, we had $1.1 billion of future operating lease obligations as of September 30, 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 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.

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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.

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.

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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 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, 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.

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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 are 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.

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, 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.

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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 (the “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 of 1986, as amended (the “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 a tax opinion from our tax advisors, 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 opinion that we received from our tax advisors, 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 opinion would not be valid if

such facts, representations, assumptions and undertakings were incorrect in any material respect. Notwithstanding the IRS Ruling and the tax opinion, 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.

If the ownership of our common stock continues to be highly concentrated, it may prevent you and other stockholders from influencing significant corporate decisions and may result in conflicts of interest that could cause our stock price to decline.

Our current executive officers, directors and their affiliates, if they act together, will have substantial influence over the outcome of corporate actions requiring stockholder approval, including the election of directors, any merger, consolidation or sale of all or substantially all of our assets or any other significant corporate transactions. The significant concentration of stock ownership may adversely affect the trading price of our common stock due to investors' perception that conflicts of interest may exist or arise.

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, 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.

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, series of 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.

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.

In addition to the effect that the concentration of ownership by our significant stockholders may have, our amended and restated certificate of incorporation and our amended and restated bylaws contain provisions that may enable our management 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 amended and restated bylaws include:

- our board of directors are 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 are 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;

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- special meetings of the stockholders are permitted to be called only by the chairman of our board of directors, our chief executive officer or by a majority of our board of directors;
- stockholders are not permitted to cumulate their votes for the election of directors;
- newly created directorships resulting from an increase in the authorized number of directors or vacancies on our board of directors are filled only by majority vote of the remaining directors;
- our board of directors is expressly authorized to make, alter or repeal our bylaws; and
- stockholders are permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

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.

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 cause damage to our reputation and affect our relationships with our residents and ultimately harm our business.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds

None.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

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Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
3.2	Amendment to the Amended and Restated Bylaws, dated August 5, 2014 (incorporated be reference to Exhibit 3.2 to our current report on Form 8-K filed on August 8, 2014.
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	Interactive data file (furnished electronically herewith pursuant to Rule 406T of Regulation S-T)

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SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized.

	THE ENSIGN GROUP, INC.	
November 5, 2014	BY:	/s/ SUZANNE D. SNAPPER Suzanne D. Snapper Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

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