ENSIGN GROUP, INC
Form 10-Q
August 01, 2016
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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 June 30, 2016.
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 x	Accelerated filer o	Non-accelerated filer o	Smaller reporting company o

(Do not check if a smaller reporting company)

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 July 28, 2016, 50,481,330 shares of the registrant's common stock were outstanding.

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND SIX MONTHS ENDED JUNE 30, 2016
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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)

	June 30, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$33,519	$ 41,569
Accounts receivable—less allowance for doubtful accounts of $33,654 and $30,308 at June 30, 2016 and December 31, 2015, respectively	226,623	209,026
Investments—current	3,503	2,004
Prepaid income taxes	7,873	8,141
Prepaid expenses and other current assets	16,496	18,827
Total current assets	288,014	279,567
Property and equipment, net	347,203	299,633
Insurance subsidiary deposits and investments	31,018	32,713
Escrow deposits	6,704	400
Deferred tax asset	20,823	20,852
Restricted and other assets	12,507	9,631
Intangible assets, net	44,910	45,431
Goodwill	69,650	40,886
Other indefinite-lived intangibles	19,246	18,646
Total assets	$840,075	$ 747,759
Liabilities and equity		
Current liabilities:		
Accounts payable	$38,085	$ 36,029
Accrued wages and related liabilities	72,019	78,890
Accrued self-insurance liabilities—current	20,829	18,122
Other accrued liabilities	47,353	46,205
Current maturities of long-term debt	634	620
Total current liabilities	178,920	179,866
Long-term debt—less current maturities	183,722	99,051
Accrued self-insurance liabilities—less current portion	43,365	37,881
Deferred rent and other long-term liabilities	9,975	3,976
Total liabilities	415,982	320,774
Commitments and contingencies (Notes 16, 18 and 19)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 52,366 and 50,403 shares issued and outstanding at June 30, 2016, respectively, and 51,918 and 51,370 shares issued and outstanding at December 31, 2015, respectively (Note 3)	52	51
Additional paid-in capital (Note 3)	244,755	235,076
Retained earnings	209,778	193,420
	(31,131)	(1,223)

Common stock in treasury, at cost, 1,527 and 123 shares at June 30, 2016 and December 31, 2015, respectively (Note 3)		
Total Ensign Group, Inc. stockholders' equity	423,454	427,324
Non-controlling interest	639	(339)
Total equity	424,093	426,985
Total liabilities and equity	$840,075	$ 747,759

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 June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Revenue	$410,517	$311,056	$793,750	$617,585
Expense:				
Cost of services	330,538	248,292	636,846	489,748
Losses related to operational closure (Note 18)	—	—	7,935	—
Rent—cost of services (Note 18)	30,741	19,066	57,732	38,031
General and administrative expense	19,657	15,335	37,045	29,751
Depreciation and amortization	9,772	6,379	18,069	12,896
Total expenses	390,708	289,072	757,627	570,426
Income from operations	19,809	21,984	36,123	47,159
Other income (expense):				
Interest expense	(1,446)	(567)	(2,816)	(1,233)
Interest income	278	195	513	361
Other expense, net	(1,168)	(372)	(2,303)	(872)
Income before provision for income taxes	18,641	21,612	33,820	46,287
Provision for income taxes	7,278	8,379	13,167	17,964
Net income	11,363	13,233	20,653	28,323
Less: net income (loss) attributable to noncontrolling interests	37	45	155	(37)
Net income attributable to The Ensign Group, Inc.	$11,326	$13,188	$20,498	$28,360
Net income per share attributable to The Ensign Group, Inc.:				
Basic	$0.23	$0.26	$0.41	$0.57
Diluted	$0.22	$0.25	$0.39	$0.55
Weighted average common shares outstanding:				
Basic	50,274	50,949	50,476	49,391
Diluted	51,931	52,866	52,134	51,272
Dividends per share	$0.0400	$0.0375	$0.0800	$0.0750

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)

	Six Months Ended June 30,	
	2016	2015
Cash flows from operating activities:		
Net income	$ 20,653	$ 28,323
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	18,069	12,896
Amortization of deferred financing fees	313	296
Fixed assets impairment	137	—
Write-off of deferred financing fee	197	—
Deferred income taxes	3	16
Provision for doubtful accounts	12,081	8,468
Share-based compensation	4,665	3,226
Excess tax benefit from share-based compensation	(1,534)	(1,900)
Change in operating assets and liabilities		
Accounts receivable	(29,295)	(49,735)
Prepaid income taxes	268	(1,728)
Prepaid expenses and other assets	2,337	(3,909)
Insurance subsidiary deposits and investments	196	(676)
Losses related to operational closure (Note 18)	7,558	—
Accounts payable	545	(654)
Accrued wages and related liabilities	(6,871)	1,770
Income taxes payable	(195)	—
Other accrued liabilities	760	7,991
	6,814	2,301

Accrued self-insurance liabilities				
Deferred rent liability	127		123	
Net cash provided by operating activities	36,828		6,808	
Cash flows from investing activities:				
Purchase of property and equipment	(36,443	)	(28,774	)
Cash payment for business acquisitions	(56,081	)	(61,007	)
Cash payment for asset acquisitions	(777	)	(15,853	)
Escrow deposits	(6,704	)	(3,344	)
Escrow deposits used to fund business acquisitions	400		16,153	
Use of restricted cash	—		3,601	
Cash proceeds from the sale of property and equipment and insurance proceeds	371		—	
Restricted and other assets	(623	)	(203	)
Net cash used in investing activities	(99,857	)	(89,427	)
Cash flows from financing activities:				
Proceeds from revolving credit facility (Note 16)	332,000		129,000	
Payments on revolving credit facility and other debt (Note 16 and Note 3)	(247,316	)	(154,118	)
Proceeds from common stock offering (Note 3)	—		112,078	
Issuance costs in connection with common stock offering (Note 3)	—		(5,751	)
Issuance of treasury stock upon exercise of options	92		16	
Issuance of common stock upon exercise of options	4,124		3,344	
Repurchase of shares of common stock (Note 3)	(30,000	)	—	

Dividends paid	(4,097	)	(3,629	)
Excess tax benefit from share-based compensation	1,561		1,906	
Payments of deferred financing costs	(1,385	)	—	
Net cash provided by financing activities	54,979		82,846	
Net (decrease) increase in cash and cash equivalents	(8,050	)	227	
Cash and cash equivalents beginning of period	41,569		50,408	
Cash and cash equivalents end of period	$ 33,519		$ 50,635	

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
	2016	2015
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$2,699	$1,280
Income taxes	$11,552	$17,766
Non-cash financing and investing activity:		
Accrued capital expenditures	$5,682	$4,244
Refundable deposits assumed as part of business acquisition	$—	$3,488
Debt assumed as part of asset acquisition	$—	$6,248

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. The Company, through its operating subsidiaries, is a provider of health care services across the post-acute care continuum as well as, urgent care centers and other ancillary businesses. As of June 30, 2016, the Company operated 206 facilities, 35 home health, hospice and home care agencies, 17 urgent care centers and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oregon, South Carolina, 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, home care, hospice, urgent care and other ancillary services. The Company's operating subsidiaries have a collective capacity of approximately 22,000 operational skilled nursing, assisted living and independent living beds. As of June 30, 2016, the Company owned 34 of its 206 affiliated facilities and leased an additional 172 facilities through long-term lease arrangements, and had options to purchase 23 of those 172 facilities. As of December 31, 2015, the Company owned 32 of its 186 affiliated facilities and leased an additional 154 facilities through long-term lease arrangements, and had options to purchase 20 of those 154 facilities.

Certain of the Company’s wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide certain 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.

Each of the Company's affiliated operations 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 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 subsidiaries, are operated by The Ensign Group, Inc.

Other Information — The accompanying condensed consolidated financial statements as of June 30, 2016 and for the three and six months ended June 30, 2016 and 2015 (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, 2015 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. 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 (GAAP). The Company is the sole member or shareholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing and assisted living operations, home health, hospice and home care 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 June 30, 2016.

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

On December 9, 2015, the Company announced a two-for-one stock split of its outstanding shares of common stock. The stock split was effected in the form of a stock dividend, paid on December 23, 2015 to shareholders of record at the close of business on December 17, 2015. Common stock began trading at the split-adjusted price on December 24, 2015. All applicable share numbers and per share amounts presented in the notes to condensed consolidated financial statements and the condensed consolidated statements of income have been retroactively adjusted to reflect the stock split. The par value of the Company's common stock remained unchanged at $0.001 per share.

Reclassifications - Prior period results reflect reclassifications, for comparative purposes, related to the early adoption of authoritative guidance for the presentation of deferred taxes. Deferred tax assets have been presented on the balance sheet as a non-current asset for all periods presented. Historically, these assets were classified as either current or non-current assets, as applicable.

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

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 patients 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 66.4% and 65.8% of the Company's revenue for the three and six months ended June 30, 2016, respectively, and 68.5% and 68.8% for the three and six months ended June 30, 2015, 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 adjustments to revenue which were not material to the Company's consolidated revenue for the three and six months ended June 30, 2016 and 2015.

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

Skilled Nursing, Assisted and Independent Living 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 or rate on a per patient, daily basis or as services are performed.

Home Health Revenue

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if patient care was unusually costly; (b) a low utilization payment adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or 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. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and its estimate of the average percentage complete based on visits performed.

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 59 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 recorded an impairment charge of $137 related to the closure of one

facility during the six months ended June 30, 2016. The Company did not identify any asset impairment during the three months ended June 30, 2016 or during the three and six months ended June 30, 2015.

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. 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 of up to 20 years.

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

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. 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 (operating segment) below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. See further discussion at Note 12, 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 claim, 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 California affiliated facilities, the third-party coverage above these limits was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate limit. For all facilities outside of California, except those located in Colorado, the third-party coverage above these limits was $1,000 per claim, $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 claim and $3,000 per facility for skilled nursing facilities, which is independent of the aforementioned blanket aggregate limits that apply outside of Colorado. The self-insured retention and deductible limits for general and professional liability and workers' compensation for all states (except Texas and Washington for 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 $34,257 and $29,772 as of June 30, 2016 and December 31, 2015, respectively.

The Company’s operating subsidiaries are self-insured for workers’ compensation in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed $500 per occurrence. 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 per occurrence. As of July 1, 2014, the Company’s operating subsidiaries in all other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $350 per occurrence. In Washington, the operating subsidiaries' coverage is financed through premiums paid by the employers and employees. The claims and pay benefits are managed through a state insurance pool. Outside of California, Texas, and Washington, the Company has

purchased insurance coverage that insures individual claims that exceed $350 per accident. In all states except Washington, 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 $19,664 and $18,276 as of June 30, 2016 and December 31, 2015, respectively.

In addition, the Company has recorded an asset and equal liability of $4,258 and $2,881 at June 30, 2016 and December 31, 2015, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis. See Note 13, Restricted and Other Assets.

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

The Company self-funds medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 for each covered person with an additional one-time aggregate individual stop loss deductible of $75. Beginning 2016, the Company's policy does not include the additional one-time aggregate individual stop loss deductible of $75. The Company’s accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $6,015 and $5,074 as of June 30, 2016 and December 31, 2015, 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 have been presented on the balance sheet as a non-current asset for all periods presented related to the early adoption of authoritative guidance for the presentation of deferred taxes. Historically, these assets were classified as either current or non-current assets, as applicable. There is no effect on the condensed consolidated statements of income or condensed consolidated statements of cash flow.

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 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 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.

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Leases and Leasehold Improvements - At the inception of each lease, the Company performs an evaluation to determine whether the lease should be classified as an operating or capital lease. The Company records rent expense for operating leases that contain scheduled rent increases on a straight-line basis over the term of the lease. The lease term used for straight-line rent expense is calculated from the date the Company is given control of the leased premises through the end of the lease term. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements, as well as the period over which the Company records straight-line rent expense.

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) Accounting Standards Codification (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. For any new pronouncements announced, the Company considers whether the new pronouncements could alter previous generally accepted accounting principles and determines whether any new or modified principles will have a material impact on the Company's reported financial position or operations in the near term. The applicability of any standard is subject to the formal review of the Company's financial management and certain standards are under consideration.

In April 2016, the FASB issued its standard to simplify several aspects the accounting for employee share-based payment transactions, which includes the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. This guidance will be effective for annual periods beginning after December 15, 2016, which will be the Company's fiscal year 2017, with early adoption permitted. The Company is currently assessing whether the adoption of the guidance will have a material impact on its consolidated financial statements.

In March 2016, the FASB issued its standard to amend the principal-versus-agent implementation guidance and illustrations in the Board’s new revenue standard, which includes accounting implication related to (1) determining the appropriate unit of account under the revenue standard’s principal-versus-agent guidance and (2) applying the indicators of whether an entity is a principal or an agent in accordance with the revenue standard’s control principle. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be the Company's fiscal year 2018. The guidance has the same effective date as the new revenue standard and the Company is required to adopt the guidance by using the same transition method it would use to adopt the new revenue standard. The Company is currently assessing whether the adoption of the guidance will have a material impact on its consolidated financial statements.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2018, which will be the Company's fiscal year 2019, with early adoption permitted. The adoption of this standard is expected to have a material impact on the Company's financial position. The Company is currently assessing the material impact of adopting the guidance on

our consolidated financial statements.

In January 2016, the FASB issued amended authoritative guidance which makes targeted improvements for financial instruments. The new provisions impact certain aspects of recognition, measurement, presentation and disclosure requirements of financial instruments. Specifically, the guidance will (i) require equity investments to be measured at fair value with changes in fair value recognized in net income, (ii) simplify the impairment assessment of equity investments without readily determinable fair values, (iii) eliminate the requirement to disclose the method and assumptions used to estimate fair value for financial instruments measured at amortized cost, and (iv) require separate presentation of financial assets and financial liabilities by measurement category. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2017, which will be the Company's fiscal year 2018, with early adoption not permitted. The Company does not expect the adoption of the guidance will have a material impact on its consolidated financial statements.

In May 2014, the FASB and International Accounting Standards Board issued their final standard on revenue from contracts with customers that outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. The new standard supersedes most current revenue recognition guidance, including industry-specific guidance. In July 2015, the FASB formally deferred for one year the effective date of the new revenue standard and decided to permit entities to early adopt the standard. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be the

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Company's fiscal year 2018. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

3. COMMON STOCK

Common Stock Repurchase Program

On November 4, 2015 and February 9, 2016, the Company announced that its Board of Directors authorized two stock repurchase programs, under which the Company may repurchase up to $15,000 of its common stock under each program for a period of 12 months. Under these programs, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. During the first quarter of 2016, the Company repurchased 1,452 shares of its common stock for a total of $30,000 and the repurchase programs expired upon the repurchase of the full authorized amount under the plans. The Company did not have stock repurchase programs in place during the three months ended June 30, 2016 or during the three and six months ended June 30, 2015.

Common Stock Offering

In February 2015, the Company completed a common stock offering, issuing 5,467 shares at approximately $20.50 per share. After deducting underwriting discounts and commissions of $5,604, excluding other issuance costs of $357, the Company received net proceeds of $106,474. The Company then used $94,000 of the net proceeds to pay off outstanding amounts under its credit facility.

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.

As discussed in Note 2, Summary of Significant Accounting Policies, all per share and shares outstanding amounts presented below reflect the two-for-one stock split that was effected in the fourth quarter of 2015.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Numerator:				
Net Income	$11,363	$13,233	$20,653	$28,323
Less: net income (loss) attributable to noncontrolling interests	37	45	155	(37)
Net income attributable to The Ensign Group, Inc.	$11,326	$13,188	$20,498	$28,360
Denominator:				
Weighted average shares outstanding for basic net income per share	50,274	50,949	50,476	49,391
Basic net income per common share attributable to The Ensign Group, Inc.	$0.23	$0.26	$0.41	$0.57

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Numerator:				
Net Income	$11,363	$13,233	$20,653	$28,323
Less: net income (loss) attributable to noncontrolling interests	37	45	155	(37)
Net income attributable to The Ensign Group, Inc.	$11,326	$13,188	$20,498	$28,360
Denominator:				
Weighted average common shares outstanding	50,274	50,949	50,476	49,391
Plus: incremental shares from assumed conversion [1]	1,657	1,917	1,658	1,881
Adjusted weighted average common shares outstanding	51,931	52,866	52,134	51,272
Diluted net income per common share attributable to The Ensign Group, Inc.	$0.22	$0.25	$0.39	$0.55

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 850 and 774 for the three and six months ended June 30, 2016, respectively, and 213 and 285 for the three and six months ended June 30, 2015, respectively.

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 unobservable 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 June 30, 2016 and December 31, 2015:

	June 30, 2016			December 31, 2015		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$33,519	$ —	$ —	$41,569	$ —	$ —

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 2, Summary of Significant Accounting Policies for further discussion of the Company's significant accounting policies.

Debt Security Investments - Held to Maturity

At June 30, 2016 and December 31, 2015, the Company had approximately $34,521 and $34,717, 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, as of June 30, 2016, the debt security investments are held in AA, A and BBB+ rated debt

securities.

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6. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and six months ended June 30, 2016 and 2015 is summarized in the following tables:

	Three Months Ended June 30,			
	2016		2015	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$132,763	32.3 %	$100,873	32.4 %
Medicare	119,443	29.1	95,396	30.7
Medicaid — skilled	20,661	5.0	16,745	5.4
Total Medicaid and Medicare	272,867	66.4	213,014	68.5
Managed care	65,178	15.9	47,633	15.3
Private and other payors[1]	72,472	17.7	50,409	16.2
Revenue	$410,517	100.0 %	$311,056	100.0 %

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

	Six Months Ended June 30,			
	2016		2015	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$250,338	31.6 %	$202,502	32.8 %
Medicare	229,721	28.9	189,752	30.7
Medicaid — skilled	42,327	5.3	32,282	5.3
Total Medicaid and Medicare	522,386	65.8	424,536	68.8
Managed care	129,721	16.4	93,963	15.2
Private and other payors[1]	141,643	17.8	99,086	16.0
Revenue	$793,750	100.0 %	$617,585	100.0 %

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

Accounts receivable as of June 30, 2016 and December 31, 2015 is summarized in the following table:

	June 30, 2016	December 31, 2015
Medicaid	$96,999	$ 90,677
Managed care	63,244	56,411
Medicare	53,707	49,970
Private and other payors	46,327	42,276
	260,277	239,334
Less: allowance for doubtful accounts	(33,654)	(30,308)
Accounts receivable, net	$226,623	$ 209,026

7. BUSINESS SEGMENTS

The Company has two reportable operating segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of the Company's business and (2) home health and hospice services, which includes the Company's home health, home care and hospice businesses. The Company's Chief Executive Officer, who is the chief operating decision maker, or CODM, reviews financial information at the operating segment level.

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The Company also reports an “all other” category that includes results from its urgent care centers and other ancillary operations. The urgent care centers and other ancillary operations are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. The reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. The "all other" category also includes operating expenses that the Company does not allocate to operating segments as these expenses are not included in the segment operating performance measures evaluated by the CODM. See also Note 12, Goodwill and Other Indefinite-Lived Intangible Assets for comparative information on changes in the carrying amount of goodwill by segment.

As of June 30, 2016, TSA services included 206 wholly-owned affiliated skilled nursing facilities that provide skilled nursing and rehabilitative care services, as well as wholly-owned affiliated assisted and independent living facilities that provide room and board and social services. Home health, home care and hospice services were provided to patients through the Company's 35 agencies. The Company's urgent care services, which is included in the "all other" category, were provided to patients by the Company's wholly owned urgent care operating subsidiaries. As of June 30, 2016, the Company held majority membership interests in other ancillary operations, which operating results are included in the "all other" category.

The Company evaluates performance and allocates capital resources to each segment based on an operating model that is designed to maximize the quality of care provided and profitability. General and administrative expenses are not allocated to any segment for purposes of determining segment profit or loss, and are included in the "all other" category in the selected segment financial data that follows. The accounting policies of the reporting segments are the same as those described in Note 2, Summary of Significant Accounting Policies. The Company's CODM does not review assets by segment in his resource allocation and therefore assets by segment are not disclosed below.

Segment revenues by major payor source were as follows:

	Three Months Ended June 30, 2016				
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$130,052	$2,711	$—	$132,763	32.3 %
Medicare	99,184	20,259	—	119,443	29.1
Medicaid-skilled	20,661	—	—	20,661	5.0
Subtotal	249,897	22,970	—	272,867	66.4
Managed care	61,121	4,057	—	65,178	15.9
Private and other	60,107	1,466	10,899	72,472	17.7
Total revenue	$371,125	$28,493	$10,899	$410,517	100.0 %
	Three Months Ended June 30, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$98,461	$2,412	$—	$100,873	32.4 %

Medicare	81,831	13,565	—	95,396	30.7
Medicaid-skilled	16,745	—	—	16,745	5.4
Subtotal	197,037	15,977	—	213,014	68.5
Managed care	45,241	2,392	—	47,633	15.3
Private and other	39,358	1,575	9,476	50,409	16.2
Total revenue	$281,636	$19,944	$9,476	$311,056	100.0 %

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	Six Months Ended June 30, 2016					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$245,052	$5,286	$—	$250,338	31.6	%
Medicare	190,828	38,893	—	229,721	28.9	
Medicaid-skilled	42,327	—	—	42,327	5.3	
Subtotal	478,207	44,179	—	522,386	65.8	
Managed care	121,660	8,061	—	129,721	16.4	
Private and other	116,641	2,919	22,083	141,643	17.8	
Total revenue	$716,508	$55,159	$22,083	$793,750	100.0	%

	Six Months Ended June 30, 2015					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$198,168	$4,334	$—	$202,502	32.8	%
Medicare	163,521	26,231	—	189,752	30.7	
Medicaid-skilled	32,282	—	—	32,282	5.3	
Subtotal	393,971	30,565	—	424,536	68.8	
Managed care	89,348	4,615	—	93,963	15.2	
Private and other	77,090	3,080	18,916	99,086	16.0	
Total revenue	$560,409	$38,260	$18,916	$617,585	100.0	%

The following table sets forth selected financial data consolidated by business segment:

	Three Months Ended June 30, 2016				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$371,125	$28,493	$10,899		$410,517
Intersegment revenue (1)	781	—	694	(1,475)	—
Total revenue	$371,906	$28,493	$11,593	$ (1,475)	$410,517
Segment income (loss) (2)	$36,098	$4,349	$(20,638)	$ —	$19,809
Interest expense, net of interest income					(1,168)
Income before provision for income taxes					$18,641
Depreciation and amortization	$7,775	$229	$1,768	$ —	$9,772

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.

(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services. General and administrative expense is included in "All Other" category.

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	Three Months Ended June 30, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$281,636	$19,944	$9,476		$311,056
Intersegment revenue (1)	573	—	188	(761)	—
Total revenue	$282,209	$19,944	$9,664	$ (761)	$311,056
Segment income (loss) (2)	$35,067	$2,996	$(16,079)	$ —	$21,984
Interest expense, net of interest income					(372)
Income before provision for income taxes					$21,612
Depreciation and amortization	$4,877	$224	$1,278	$ —	$6,379

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.
(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services. General and administrative expense is included in "All Other" category.

	Six Months Ended June 30, 2016				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$716,508	$55,159	$22,083		$793,750
Intersegment revenue (1)	1,491	—	965	(2,456)	—
Total revenue	$717,999	$55,159	$23,048	$ (2,456)	$793,750
Segment income (loss) (2)	$66,954	$7,525	$(38,356)	$ —	$36,123
Interest expense, net of interest income					(2,303)
Income before provision for income taxes					$33,820
Depreciation and amortization	$14,077	$496	$3,496	$ —	$18,069

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.
(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services. General and administrative expense is included in "All Other" category.

	Six Months Ended June 30, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$560,409	$38,260	$18,916		$617,585
Intersegment revenue (1)	1,047	—	391	(1,438)	—
Total revenue	$561,456	$38,260	$19,307	$ (1,438)	$617,585
Segment income (loss) (2)	$72,366	$5,671	$(30,878)	$ —	$47,159

Interest expense, net of interest income					(872)
Income before provision for income taxes					$46,287
Depreciation and amortization	$9,826	$445	$2,625	$ —	$12,896

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.
(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services. General and administrative expense is included in "All Other" category.

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8. ACQUISITIONS

The Company’s acquisition focus is to purchase or lease operating subsidiaries that are complementary to the Company’s current affiliated operations, 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 accounted for using the acquisition method of accounting. The Company also enters into long-term leases that may 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 six months ended June 30, 2016, the Company expanded its operations with the addition of one home health agency and two hospice agencies. In addition, the Company acquired eighteen stand-alone skilled nursing operations through purchases, a long-term master lease agreement and a sub-lease agreement. As part of this acquisition, the Company acquired the real estate at two of the skilled nursing operations and entered into long term leases for sixteen skilled nursing operations. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company has also invested in new ancillary services that are complementary to its existing TSA services and home health and hospice businesses. The aggregate purchase price for these acquisitions for the six months ended June 30, 2016 was $56,292. The expansion of skilled nursing operations added 2,177 operational skilled nursing beds operated by the Company's operating subsidiaries. The Company entered into a separate operations transfer agreement with the prior operator as part of each transaction.

The Company also entered into three long-term lease agreements for newly constructed post-acute care campuses, which added 230 operational skilled nursing beds and 95 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 six months ended June 30, 2016 and 2015:

	Six Months Ended June 30,	
	2016	2015
Land	$866	$8,321
Building and improvements	16,056	44,877
Equipment, furniture, and fixtures	7,998	2,204
Assembled occupancy	1,220	287
Definite-lived intangible assets	363	360
Goodwill	28,790	2,512
Favorable leases	393	2,069
Other indefinite-lived intangible assets	600	3,865
Other assets acquired, net of liabilities assumed	6	—
Total acquisitions	$56,292	$64,495

Subsequent to June 30, 2016, the Company entered into one long-term agreement for newly constructed post-acute care campus and acquired one stand-alone skilled nursing operation for a purchase price of $5,500, which included real estate. The expansion of the skilled nursing operations added 231 operational skilled nursing beds and 40 operational assisted living units operated by the Company's operating subsidiaries.

9. ACQUISITIONS - PRO FORMA FINANCIAL INFORMATION

The Company has established an acquisition strategy that is focused on identifying acquisitions within its target markets that offer the greatest opportunity for investment return at attractive prices. The facilities acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming facilities, is often inadequate, inaccurate or unavailable. As a result, the Company has developed an acquisition assessment program that is based on existing and potential resident mix, the local available market, referral sources and operating expectations based on the Company's experience with its existing facilities. Following an acquisition, the Company implements a well-developed integration program to provide a plan for transition and generation of profits from facilities that have a history

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of significant operating losses. Consequently, the Company believes that prior operating results are not meaningful as the information is not generally representative of the Company's current operating results or indicative of the integration potential of its newly acquired facilities.

The following table represents pro forma results of consolidated operations as if the acquisitions acquired from January 1, 2016 through the issuance date of the financial statements had occurred at the beginning of 2015, after giving effect to certain adjustments.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Revenue	$425,468	$352,180	$849,331	$699,832
Net income attributable to The Ensign Group, Inc.	11,477	13,213	20,363	28,252
Diluted net income per common share	$0.22	$0.25	$0.39	$0.55

Our pro forma assumptions are as follows:

- Revenues and operating costs were based on actual results from the prior operator or from regulatory filings where available. If actual results were not available, revenues and operating costs were estimated based on available partial operating results of the prior operator of the facility, or if no information was available, estimates were derived from the Company’s post-acquisition operating results for that particular facility. Prior year results for the 2016 acquisitions were obtained from available financial information provided by prior operators or available cost reports filed by the prior operators.

- Interest expense is based upon the purchase price and average cost of debt borrowed during each respective year when applicable, and depreciation is calculated using the purchase price allocated to the related assets through acquisition accounting.

The foregoing unaudited pro forma information is not indicative of what the results of operations would have been if the acquisitions had actually occurred at the beginning of the periods presented, and is not intended as a projection of future results or trends. Included in the table above are pro forma revenue generated during the three and six months ended June 30, 2016, by individually immaterial business acquisitions completed through the issuance date of the Interim Financial Statements of $14,951 and $55,581, respectively, $41,124 and $82,247 for the three and six months ended June 30, 2015, respectively. Included in the table above are pro forma income and loss generated during the three and six months ended June 30, 2016, by individually immaterial business acquisitions completed through the issuance date of the financial statements of $151 and $135, respectively, and $25 and $108, for the three and six months ended June 30, 2015, respectively.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

10. PROPERTY AND EQUIPMENT— Net

Property and equipment, net consist of the following:

	June 30, 2016	December 31, 2015
Land	$42,888	$ 41,451
Buildings and improvements	171,598	151,434
Equipment	145,868	114,752
Furniture and fixtures	5,659	5,504
Leasehold improvements	77,712	68,405
Construction in progress	1,586	781
	445,311	382,327
Less: accumulated depreciation	(98,108)	(82,694)
Property and equipment, net	$347,203	$ 299,633

See Note 8, Acquisitions for information on acquisitions during the six months ended June 30, 2016.

11. INTANGIBLE ASSETS — Net

		June 30, 2016			December 31, 2015		
Intangible Assets	Weighted Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	24.7	$483	$ (68)	$415	$604	$ (577)	$27
Favorable leases	27.8	43,248	(4,257)	38,991	43,248	(2,923)	40,325
Assembled occupancy	0.3	1,817	(1,208)	609	4,779	(4,476)	303
Facility trade name	30.0	733	(256)	477	733	(244)	489
Customer relationships	17.4	5,653	(1,235)	4,418	5,300	(1,013)	4,287
Total		$51,934	$ (7,024)	$44,910	$54,664	$ (9,233)	$45,431

Amortization expense was $1,410 and $2,497 for the three and six months ended June 30, 2016, respectively, and $665 and $1,818 for the three and six months ended June 30, 2015, respectively. Of the $2,497 in amortization expense incurred during the six months ended June 30, 2016, approximately $913 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. In addition, the Company identified intangible assets that have become fully amortized during the year and removed the fully amortized balances from the gross asset and accumulated amortization amounts.

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

Year	Amount
2016 (remainder)	$2,882
2017	3,049
2018	3,049
2019	2,920
2020	2,276
2021	2,836

Thereafter	27,898
	$44,910

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12. 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 by segment as of and for the six months ended June 30, 2016:

	Goodwill			
	TSA Services	Home Health and Hospice Services	All Other	Total
January 1, 2016	$17,759	$16,102	$7,025	$40,886
Purchase price adjustment	—	—	(26)	(26)
Additions	26,415	245	2,130	28,790
June 30, 2016	$44,174	$16,347	$9,129	$69,650

As of June 30, 2016, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes. See further discussion of goodwill acquired at Note 8, Acquisitions.

Other indefinite-lived intangible assets consists of the following:

	June 30, 2016	December 31, 2015
Trade name	$1,915	$ 1,915
Medicare and Medicaid Licenses	17,331	16,731
	$19,246	$ 18,646

13. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	June 30, 2016	December 31, 2015
Debt issuance costs, net	$2,896	$ 2,021
Long-term insurance losses recoverable asset	4,258	2,881
Deposits with landlords	4,519	3,969
Capital improvement reserves with landlords and lenders	834	760
Restricted and other assets	$12,507	$ 9,631

Included in restricted and other assets as of June 30, 2016, 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.

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14. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2016	December 31, 2015
Quality assurance fee	$4,019	$ 6,120
Refunds payable	15,424	13,252
Deferred revenue	5,058	6,696
Cash held in trust for patients	2,372	3,016
Resident deposits	5,918	5,884
Dividends payable	2,045	2,072
Property taxes	5,752	4,230
Charges related to operational closure	1,987	—
Other	4,778	4,935
Other accrued liabilities	$47,353	$ 46,205

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

15. INCOME TAXES

The Company is not currently under examination by any major income tax jurisdiction. During 2016, the statutes of limitations will lapse on the Company's 2012 Federal tax year and certain 2011 and 2012 state tax years. The Company does not believe the Federal or state statute lapses 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 six months ended June 30, 2016 or 2015.

The Company recorded total pre-tax charges and expenses related to the closure of one facility during the six months ended June 30, 2016 for a total charge of $7,935. There were no similar charges during the three months ended June 30, 2016. The Company recorded estimated tax benefits of $0 and $3,065 for the three and six months ended June 30, 2016, respectively. Similar charges did not occur during the three and six months ended June 30, 2015. See Note 18, Leases.

16. DEBT

Long-term debt consists of the following:

	June 30, 2016	December 31, 2015
Credit facility with SunTrust, interest payable monthly and quarterly	$170,000	$ 85,000
Mortgage loans and promissory note, principal and interest payable monthly, interest at fixed rate	14,356	14,671
	184,356	99,671
Less current maturities	(634)	(620)
	$183,722	$ 99,051

Amended Credit Facility with a Lending Consortium Arranged by SunTrust (the Amended Credit Facility)
On February 5, 2016, the Company amended its existing revolving credit facility with a lending consortium arranged by SunTrust to increase its aggregate principal amount available to $250,000 (the Amended Credit Facility). Under the Amended

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Credit Facility, the Company may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $150,000. The interest rates applicable to loans under the Amended Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.75% to 1.75% per annum or LIBOR plus a margin ranging from 1.75% to 2.75% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, the Company will pay a commitment fee on the unused portion of the commitments under the Amended Credit Facility that will range from 0.30% to 0.50% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and our subsidiaries. Loans made under the Amended Credit Facility are not subject to interim amortization. The Company is not required to repay any loans under the Amended Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Amended Credit Facility. The Company is permitted to prepay all or any portion of the loans under the Amended Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders. As of June 30, 2016, the Company's operating subsidiaries had $170,000 outstanding under the Amended Credit Facility.

The Amended Credit Facility is secured by a pledge of stock of the Company's material operating subsidiaries as well as a first lien on substantially all of its personal property. The Amended Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its operating 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 Amended Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum Consolidated Total Net Debt to consolidated EBITDA ratio (which shall be increased to 3.50:1.00 for the current fiscal quarter and the immediate following three fiscal quarters), and a minimum interest/rent coverage ratio (which cannot be below 1.50:1.00). The majority of lenders can require that the Company and its operating subsidiaries mortgage certain of its real property assets to secure the Amended Credit Facility if an event of default occurs, the Consolidated Total Net Debt to consolidated EBITDA ratio is above 2.75:1.00 for two consecutive fiscal quarters, or its 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 Consolidated Total Net Debt to consolidated EBITDA ratio is below 2.75:1.00 for two consecutive fiscal quarters, or its liquidity is above 10% of the Aggregate Revolving Commitment Amount (as defined in the agreement) or ninety consecutive days, as applicable. As of June 30, 2016, the Company was in compliance with all loan covenants.

On July 19, 2016, the Company entered into the second amendment to the Amended Credit Facility (Second Amended Credit Facility), which amended the existing credit agreement, dated as of February 5, 2016, to increase the aggregate principal amount up to $450,000 comprised of a $300,000 revolving credit facility and a $150,000 term loan. Borrowings under the term loan portion of the Second Amended Credit Facility mature on February 5, 2021 and amortize in equal quarterly installments, in an aggregate annual amount equal to 5.0% per annum of the original principal amount. The interest rates and commitment fee applicable to the Second Amended Credit Facility are similar to the Amended Credit Facility. Except as set forth in the Second Amended Credit Facility, all other terms and conditions of the Amended Credit Facility remained in full force and effect as described above.

As of July 29, 2016, there was approximately $177,000 outstanding under the Second Amended Credit Facility.

Mortgage Loans and Promissory Note

The Company had outstanding indebtedness under mortgage loans and promissory note issued in connection with various acquisitions. The mortgage loans are insured with the U.S. Department of Housing and Urban Development

(HUD), which subjects the Company's operating subsidiaries to HUD oversight and periodic inspections. The mortgage loans and note bear fixed interest rates between 2.6% and 5.3% per annum. Amounts borrowed under the mortgage loans may be prepaid starting after the second anniversary of the notes subject to prepayment fees of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% per year for years three through eleven of the loan. There is no prepayment penalty after year eleven. The term of the mortgage loans and note is between 12 and 33 years. The mortgage loans and note are secured by the real property comprising the facilities and the rents, issues and profits thereof, as well as all personal property used in the operation of the facilities. As of June 30, 2016, the Company's operating subsidiaries had $14,356 outstanding under the mortgage loans and note, of which $634 is classified as short-term and the remaining $13,722 is classified as long-term. As of June 30, 2016, the Company was in compliance with all loan covenants.

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.

Off-Balance Sheet Arrangements

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As of June 30, 2016, the Company had approximately $2,310 on the Amended Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

17. OPTIONS AND AWARDS

All per share amounts and numbers of common shares outstanding presented below reflect the two-for-one stock split that was effected in the fourth quarter of 2015. See further details in Note 2, Summary of Significant Accounting Policies.

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 consolidated condensed statements of income for the three and six months ended June 30, 2016 and 2015 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.

Stock Options

The Company has three option plans, 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), all of which have been approved by the Company's stockholders. The total number of shares available under all of the Company’s stock incentive plans was 3,252 as of June 30, 2016.

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 288 options and 214 restricted stock awards from the 2007 Plan during the six months ended June 30, 2016 .

The Company used the following assumptions for stock options granted during the three months ended June 30, 2016 and 2015:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2016	121	1.49%	6.5 years	41.1%	0.79%
2015	150	1.71%	6.5 years	40.0%	0.62%

The Company used the following assumptions for stock options granted during the six months ended June 30, 2016 and 2015:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2016	288	1.40%	6.5 years	39.2%	0.78%
2015	294	1.58%	6.5 years	42.1%	0.63%

For the six months ended June 30, 2016 and 2015, 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
2016	288	$ 19.76	$ 7.42
2015	294	$ 22.57	$ 9.23

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 June 30, 2016 and 2015 and therefore, the intrinsic value was $0 at date of grant.

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The following table represents the employee stock option activity during the six months ended June 30, 2016:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2016	5,448	$ 10.36	2,526	$ 6.35
Granted	288	19.76		
Forfeited	(50)	12.56		
Exercised	(288)	5.90		
June 30, 2016	5,398	$ 11.08	2,795	$ 7.52

The following summary information reflects stock options outstanding, vested and related details as of June 30, 2016:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2006	1.93 - 2.05	44	115	1	44
2008	2.56 - 4.06	457	675	2	457
2009	4.06 - 4.56	621	1,329	3	621
2010	4.77 - 4.96	158	382	4	158
2011	5.90 - 7.99	194	657	5	158
2012	6.56 - 7.96	570	2,101	6	338
2013	7.98 - 11.49	661	3,227	7	312
2014	10.55 - 18.94	1,790	10,109	8	652
2015	21.47 - 25.24	616	5,590	9	55
2016	19.58 - 19.89	287	2,530	10	—
Total		5,398	$ 26,715		2,795

Restricted Stock Awards

The Company granted 52 and 214 restricted stock awards during the three and six months ended June 30, 2016, respectively. The Company granted 51 and 181 restricted stock awards during the three and six months ended June 30, 2015, respectively. All awards were granted at an exercise price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the six months ended June 30, 2016 ranged from $19.58 to $23.23. A summary of the status of the Company's non-vested restricted stock awards as of June 30, 2016 and changes during the six months ended June 30, 2016 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2016	425	$ 19.79

Granted	214	21.06
Vested	(198)	19.97
Forfeited	(5)	18.90
Nonvested at June 30, 2016	436	$ 20.34

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During the three and six months ended June 30, 2016, the Company granted 8 and 16 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 $21.26 to $23.23 based on the market price on the grant date.

Total share-based compensation expense recognized for the three and six months ended June 30, 2016 and 2015 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Share-based compensation expense related to stock options	$1,319	$1,165	$2,503	$2,121
Share-based compensation expense related to restricted stock awards	652	434	1,200	850
Share-based compensation expense related to stock awards to non-employee directors	166	134	319	255
Total	$2,137	$1,733	$4,022	$3,226

In future periods, the Company expects to recognize approximately $14,846 and $7,654 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of June 30, 2016. Future share-based compensation expense will be recognized over 3.3 and 3.6 weighted average years for unvested options and restricted stock awards, respectively. There were 2,603 unvested and outstanding options at June 30, 2016, of which 2,437 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at June 30, 2016 was 6.3 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of and for the six months ended June 30, 2016 and as of and for the twelve months ended December 31, 2015 is as follows:

Options	June 30, 2016	December 31, 2015
Outstanding	$55,019	$ 67,508
Vested	37,786	41,128
Expected to vest	15,479	23,508
Exercisable	4,294	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.

Equity Instrument Denominated in the Shares of a Subsidiary

On May 26, 2016, the Company implemented a management equity plan and granted stock options and restricted stock awards of a subsidiary of the Company to employees and management of that subsidiary (Subsidiary Equity Plan). These awards generally vest over a period of five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of the subsidiary. The awards can be put to the Company at various prescribed dates, which in no event is earlier than six months after vesting of the restricted awards or exercise of the stock options. The Company can also call the awards, generally upon employee termination.

The grant-date fair value of the 2016 awards is $4,623, which will be recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interests. The grant value was determined based on an independent valuation of the subsidiary shares. For the three and six months ended June 30, 2016, the Company expensed $643 in share-based compensation related to the Subsidiary Equity Plan. There was no expense incurred for the three and six months ended June 30, 2015 as the plan was implemented in the second quarter of 2016.

The aggregate number of the Company's common shares that would be required to settle these awards at current estimated fair values, including vested and unvested awards, at June 30, 2016 is 226. There was no comparable amount at June 30, 2015 as the plan was implemented in the second quarter of 2016.

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18. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 93 affiliated skilled nursing, assisted living and independent living facilities used in the Company's operations under eight "triple-net" master lease agreements (collectively, the Master Leases), which ranges 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. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and being continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases is subject to termination prior to the expiration of the 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.

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%. 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 $14,039 and $28,039 for the three and six months ended June 30, 2016, respectively, and $14,000 and $28,000 for the three and six months ended June 30, 2015, respectively.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. The Company is not aware of any defaults as of June 30, 2016.

During the first quarter of 2016, the Company voluntarily discontinued operations in one of its skilled nursing facilities in order to preserve the overall ability to serve the residents in surrounding counties after careful consideration and some clinical survey challenges. As part of this closure, the Company entered into an agreement with its landlord allowing for the closure of the property as well as other provisions to allow its landlord to transfer the property and the licenses free and clear of the applicable master lease. This arrangement will not impact the rent expense to be paid in 2016 or expected to be paid in future periods and will have no material impact on the Company's lease coverage ratios under the Master Leases. The Company recorded continued obligation under the lease and related closing expenses of $7,935, including the present value of rental payments of approximately $6,512, which was recognized in the first quarter of 2016. Residents of the affected facility were transferred to other local skilled nursing facilities.

The Company also leases certain affiliated operations and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company has entered into multiple lease agreements with various landlords to operate newly constructed state-of-the-art, full-service healthcare resorts upon completion of construction. The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. 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

$30,916 and $58,051 for the three and six months ended June 30, 2016, respectively, and $19,180 and $38,261 for the three and six months ended June 30, 2015, respectively.

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Future minimum lease payments for all leases as of June 30, 2016 are as follows:

Year	Amount
2016 (remainder)	66,091
2017	136,362
2018	143,338
2019	142,875
2020	142,023
2021	141,340
Thereafter	1,167,512
	$1,939,541

Thirty-seven of the Company’s affiliated facilities, excluding the facilities that are operated under the Master Leases with CareTrust, are operated under five separate 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.

In addition, a number of the Company's 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. The Company is not aware of any defaults as of June 30, 2016.

19. COMMITMENTS AND CONTINGENCIES

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.

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.

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.

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.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company has in the past been subject to class action litigation involving claims of alleged violations of regulatory requirements related to staffing. While the Company has been able to settle these claims without a material ongoing adverse effect on its business, future claims could be brought that may materially affect its business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. 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 operating 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.

Other claims and suits continue to be filed against us and other companies in our industry. By way of recent example, the Company defended a general/premise liability claim in San Luis Obispo, California, on behalf of an affiliated facility, involving an injury to a non-employee/contractor. The Company estimates that the settlement relative to this case will be approximately $1,586, which was recorded in the condensed consolidated financial statements in the quarter ended June 30, 2016. There will not be a material ongoing adverse effect on the Company's business, financial condition or results of operations in connection with the verdict.

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 and its operating 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, the Company's 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. As of June 30, 2016, eleven operating subsidiaries were subject to probe reviews, both pre- and post-payment. Five of these reviews have successfully closed and six are in process. The Company anticipates that these probe reviews will increase in frequency 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.

U.S. Government Inquiry — In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the DOJ and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. Pursuant to the Settlement Agreement, 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 (the CIA) with the Office of Inspector General-HHS. 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 a 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.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company has met the requirements of its second year under the Settlement Agreement and passed its IRO audits. 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 57.9% and 58.8% of its total accounts receivable as of June 30, 2016 and December 31, 2015, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 66.4% and 65.8% of the Company's revenue for the three and six months ended June 30, 2016, respectively, and 68.5% and 68.8% for the three and six months ended June 30, 2015, 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 July 29, 2016, the Company had approximately $1,400 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

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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 operations, 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 operations, 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 health care services across the post-acute care continuum, as well as urgent care centers and other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oregon, South Carolina, 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, urgent care and other ancillary services. As of June 30, 2016, we offered skilled nursing, assisted living and rehabilitative care services through 206 skilled nursing and assisted living facilities across 13 states. Of the 206 facilities, we owned 34 and operated an additional 172 facilities under long-term lease arrangements, and had options to purchase 23 of those 172 facilities. Our home health and hospice business provides home health, hospice and home care services from 35 agencies across nine states. Our 17 urgent care centers and ancillary operations are located in Arizona, California, Colorado, Utah and Washington.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of June 30, 2016:

	Owned	Leased (with a	Leased (without	Total

		Purchase Option)	a Purchase Option)	
Number of facilities	34	23	149	206
Percentage of total	16.5 %	11.2 %	72.3 %	100.0 %
Operational skilled nursing, assisted living and independent living beds	3,647	1,727	16,614	21,988
Percentage of total	16.6 %	7.8 %	75.6 %	100.0 %

The Ensign Group, Inc. (collectively, Ensign or the Company) is a holding company with no direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly-owned subsidiaries, referred to collectively as the Service Center, provide

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centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. We also have a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as coverage for certain workers' compensation insurance liabilities. References herein to the consolidated "Company" and "its" assets and activities, as well as the use of the terms "we," "us," "our" and similar terms in this quarterly report, are not meant to imply, nor should they be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group.

Recent Activities

Second Amended Credit Agreement - On July 19, 2016, we entered into the second amendment to the existing credit facility (Second Amended Credit Facility) to increase the aggregate principal amount up to $450.0 million comprised of a $300.0 million revolving credit facility and a $150.0 million term loan.

Common Stock Repurchase Program - During the first quarter of 2016, we repurchased 1.5 million shares of our common stock for a total of $30.0 million.

Closure of one facility - After careful consideration and some clinical survey challenges, we voluntarily discontinued operations in one of our skilled nursing facilities in order to preserve the overall ability to serve the residents in surrounding counties. The operation represented approximately 0.5% of our revenue and adjusted EBITDAR in 2015. As part of this closure, we entered into an agreement with our landlord allowing for the closure of the property as well as other provisions to allow our landlord to transfer the property and the licenses free and clear of the applicable master lease. This arrangement will not impact the rent expense to be paid in 2016 or expected to be paid in future periods and will have no material impact on our lease coverage ratios under the Master Leases. We recorded continued obligation under the lease and related closing expenses of $7.9 million, including the present value of rental payments of approximately $6.5 million, which was recognized in the first quarter of 2016. Residents of the affected facility were transferred to other local skilled nursing facilities in an orderly fashion and in accordance with their individual clinical needs.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of June 30, 2016:

	CA	AZ	TX	WI	UT	CO	WA	ID	NE	IA	SC	KS	NV	Total
Cumulative number of skilled nursing, assisted and independent living operations	48	28	46	17	15	11	10	9	7	5	4	3	3	206
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	4,989	4,288	5,584	899	1,613	870	943	719	662	356	426	335	304	21,988

As of June 30, 2016, we provided home health and hospice services through our 35 agencies in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington.

During the six months ended June 30, 2016, we expanded our operations with the addition of one home health agency and two hospice agencies. In addition, we acquired eighteen stand-alone skilled nursing operations through purchases, a long-term master lease agreement and a sub-lease agreement. As part of this acquisition, we acquired the real estate at two of the skilled nursing operations and entered into long term leases for sixteen skilled nursing operations. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. We also have invested in new ancillary services that are complementary to our existing TSA services and home health and hospice businesses. The aggregate purchase price for these acquisitions was $56.3 million. The expansion of skilled nursing operations added 2,177

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operational skilled nursing beds operated by our operating subsidiaries. We entered into a separate operations transfer agreement with the prior operator as part of each transaction.

We also entered into three long-term lease agreements for newly constructed post-acute care campuses, which added 230 operational skilled nursing beds and 95 operational assisted living units, operated by our operating subsidiaries.

Subsequent to June 30, 2016, we entered into one long-term agreement for newly constructed post-acute care campus and acquired one stand-alone skilled nursing operation for a purchase price of $5.5 million, which included real estate. The expansion of the skilled nursing operations added 231 operational skilled nursing beds and 40 operational assisted living units operated by our operating subsidiaries.

For further discussion of our acquisitions, see Note 8, Acquisitions in the Notes to Condensed Consolidated Financial Statements.

Key Performance Indicators

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

Transitional, Skilled and Assisted Living Services

- Routine revenue. Routine revenue is generated by the contracted daily rate charged for all contractually inclusive skilled nursing services. The inclusion of therapy and other ancillary treatments varies by payor source and by contract. Services provided outside of the routine contractual agreement are recorded separately as ancillary revenue, including Medicare Part B therapy services, and are not included in the routine revenue definition.
- Skilled revenue. The amount of routine revenue generated from patients in the skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs. The other skilled patients that are included in this population represent very high acuity patients who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care. Skilled revenue excludes any revenue generated from our assisted living services.
- Skilled mix. The amount of our skilled revenue as a percentage of our total routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving services at the skilled nursing facilities divided by the total number of days patients (less days from assisted living services) from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Quality mix. The amount of routine non-Medicaid revenue as a percentage of our total routine revenue. Quality mix (in days) represents the number of days our non-Medicaid patients are receiving services at the skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Average daily rates. The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period.
- Occupancy percentage (operational beds). The total number of patients occupying a bed in a skilled nursing, assisted living or independent living facility as a percentage of the beds in a facility which are available for occupancy during the measurement period.
- Number of facilities and operational beds. The total number of skilled nursing, assisted living and independent living facilities that we own or operate and the total number of operational beds associated with these facilities.

Skilled and Quality Mix. Like most skilled nursing providers, we measure both patient days and revenue by payor. Medicare, managed care and other skilled patients, whom we refer to as high acuity patients, typically require a higher level of skilled nursing and rehabilitative care. Accordingly, Medicare and managed care reimbursement rates are typically higher than from other payors. In most states, Medicaid reimbursement rates are generally the lowest of all payor types. Changes in the payor mix can significantly affect our revenue and profitability.

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

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Skilled Mix:				
Days	31.3%	30.1%	31.9%	30.2%
Revenue	52.7%	53.4%	53.6%	53.2%
Quality Mix:				
Days	43.6%	42.7%	43.7%	42.7%
Revenue	60.8%	62.0%	61.7%	61.7%

Occupancy. We define occupancy derived from our transitional, skilled and assisted services as the ratio of actual patient days (one patient day equals one patient occupying one bed for one day) during any measurement period to the number of beds in facilities which are available for occupancy during the measurement period. The number of licensed and independent living beds in a skilled nursing, assisted living or independent living facility that are actually operational and available for occupancy may be less than the total official licensed bed capacity. This sometimes occurs due to the permanent dedication of bed space to alternative purposes, such as enhanced therapy treatment space or other desirable uses calculated to improve service offerings and/or operational efficiencies in a facility. In some cases, three- and four-bed wards have been reduced to two-bed rooms for resident comfort, and larger wards have been reduced to conform to changes in Medicare requirements. These beds are seldom expected to be placed back into service. We believe that reporting occupancy based on operational beds is consistent with industry practices and provides a more useful measure of actual occupancy performance from period to period.

The following table summarizes our overall occupancy statistics for the periods indicated:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Occupancy:				
Operational beds at end of period	21,988	16,019	21,988	16,019
Available patient days	1,921,625	1,437,100	3,708,138	2,804,929
Actual patient days	1,465,625	1,121,158	2,842,504	2,198,396
Occupancy percentage (based on operational beds)	76.3 %	78.0 %	76.7 %	78.4 %

Home Health and Hospice

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

The following table summarizes our overall home health and hospice statistics for the periods indicated:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Home health services:				
Medicare Episodic Admissions	2,037	1,672	4,194	3,415
Average Medicare Revenue per Completed Episode	$2,950	$2,954	$2,937	$2,984
Hospice services:				
Average Daily Census	898	562	871	552

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Segments

We have two reportable segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of our business; and (2) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker (CODM), reviews financial information at the operating segment level.

We also report an “all other” category that includes results from our urgent care centers and other ancillary operations. Our urgent care centers and other ancillary businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations.

Revenue Sources

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

	Three Months Ended June 30, 2016						
	TSA Services		Home Health and Hospice Services		All Other		
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %
Medicaid	$127,789	$ 2,263	$1,100	$1,611	$—	$132,763	32.3 %
Medicare	99,184	—	8,078	12,181	—	119,443	29.1
Medicaid-skilled	20,661	—	—	—	—	20,661	5.0
Subtotal	247,634	2,263	9,178	13,792	—	272,867	66.4
Managed care	61,121	—	3,825	232	—	65,178	15.9
Private and other	31,662	28,445	1,413	53	10,899	(1) 72,472	17.7
Total revenue	$340,417	$ 30,708	$14,416	$14,077	$10,899	$410,517	100.0 %

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

	Three Months Ended June 30, 2015						
	TSA Services		Home Health and Hospice Services		All Other		
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %
Medicaid	$97,203	$ 1,258	$1,209	$ 1,203	$ —	$100,873	32.4 %
Medicare	81,831	—	6,248	7,317	—	95,396	30.7
Medicaid-skilled	16,745	—	—	—	—	16,745	5.4
Subtotal	195,779	1,258	7,457	8,520	—	213,014	68.5
Managed care	45,241	—	2,313	79	—	47,633	15.3
Private and other	24,689	14,669	1,524	51	9,476	(1) 50,409	16.2
Total revenue	$265,709	$ 15,927	$11,294	$ 8,650	$ 9,476	$311,056	100.0 %

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

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	Six Months Ended June 30, 2016							
	TSA Services		Home Health and Hospice Services		All Other			
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %	
Medicaid	$240,570	$ 4,482	$2,142	$3,144	$—	$250,338	31.6	%
Medicare	190,828	—	15,731	23,162	—	229,721	28.9	
Medicaid-skilled	42,327	—	—	—	—	42,327	5.3	
Subtotal	473,725	4,482	17,873	26,306	—	522,386	65.8	
Managed care	121,660	—	7,628	433	—	129,721	16.4	
Private and other	60,246	56,395	2,823	96	22,083 (1)	141,643	17.8	
Total revenue	$655,631	$ 60,877	$28,324	$26,835	$22,083	$793,750	100.0	%

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

	Six Months Ended June 30, 2015							
	TSA Services		Home Health and Hospice Services		All Other			
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %	
Medicaid	$195,830	$ 2,338	$2,023	$2,312	$—	$202,502	32.8	%
Medicare	163,521	—	12,189	14,042	—	189,752	30.7	
Medicaid-skilled	32,282	—	—	—	—	32,282	5.3	
Subtotal	391,633	2,338	14,212	16,354	—	424,536	68.8	
Managed care	89,348	—	4,455	159	—	93,963	15.2	
Private and other	49,198	27,892	2,989	91	18,916 (1)	99,086	16.0	
Total revenue	$530,179	$ 30,230	$21,656	$16,604	$18,916	$617,585	100.0	%

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

Transitional, Skilled and Assisted Living Services

Skilled Nursing Operations. Within our skilled nursing operations, we generate our revenue from Medicaid, private pay, managed care and Medicare payors. We believe that our skilled mix, which we define as the number of days our Medicare, managed care and other skilled patients are receiving services at our skilled nursing operations divided by the total number of days patients are receiving services at our skilled nursing operations, from all payor sources (less days from assisted living and independent living services) for any given period, is an important indicator of our success in attracting high-acuity patients because it represents the percentage of our patients who are reimbursed by Medicare, managed care and other skilled payors, for whom we receive higher reimbursement rates.

We are participating in the established supplemental payment program in various states that provides supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as county hospital districts. Several of our operating subsidiaries, entered into transactions with several such hospital districts providing for the transfer of the licenses for those skilled nursing facilities to the hospital districts. Each affected operating subsidiary agreement between the hospital district and our subsidiary is terminable by either party to fully restore the prior license status.

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

Home Health and Hospice Services

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Home Health. We provided home health care in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington as of June 30, 2016. We derive the majority of our revenue from our home health business from Medicare and managed care. The payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The home health prospective payment system (PPS) provides home health agencies with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin. There are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits was fewer than five; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (c) a payment adjustment based upon the level of therapy services required; (d) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes in the base episode payments established by the Medicare program; (f) adjustments to the base episode payments for case mix and geographic wages; and (g) recoveries of overpayments.

Hospice. As of June 30, 2016, we provided hospice care in Arizona, California, Colorado, Idaho, Iowa, Texas, Utah and Washington. We derive substantially all of the revenue from our hospice business from Medicare reimbursement. The estimated payment rates are daily rates for each of the levels of care we deliver. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimate amounts due back to Medicare if a cap has been exceeded.

Beginning January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) has provided for two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, beginning January 1, 2016, Medicare is also reimbursing for a service intensity add-on (SIA). The SIA is based on visits made in the last seven days of life by a registered nurse (RN) or medical social worker (MSW) for patients in a routine level of care.

Other

As of June 30, 2016, we operated urgent care clinics in Colorado and Washington. Our urgent care centers provide daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. As of June 30, 2016, we held majority membership interests in our other ancillary operations. Payment for these services varies and is based upon the service provided. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk.

Critical Accounting Policies Update

There have been no significant changes during the three months ended June 30, 2016 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 for the year ended December 31, 2015, filed with the SEC.

Industry Trends

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

- Shift of Patient Care to Lower Cost Alternatives. The growth of the senior population in the United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.
- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.

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- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.
- Accountable Care Organizations and Reimbursement Reform. A significant goal of federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization (ACO) models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing demonstration and mandatory programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. On April 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018. In March 2016, CMS announced that its 30% target for 2016 was reached in January 2016.

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

Effects of Changing Prices

Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our skilled nursing operations under a 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.

Our Medicare reimbursement rates and procedures for our home health and hospice operations are based on the severity of the patient's condition, his or her service needs and other factors relating to the cost of providing services and supplies. Our home health rates and services are bundled into 60-day episodes of care. Payments can be adjusted for: (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment (LUPA) if the number of visits during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, and larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) a payment adjustment if we are unable to perform periodic therapy assessments; (f) 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; (g) changes in the base episode payments established by the Medicare program; (h) adjustments to the base episode payments for case mix and geographic

wages; and (i) recoveries of overpayments.

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, the ACA). The reforms contained in the ACA have affected our operating subsidiaries in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. These reforms include the possible modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers.

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On April 27, 2016, CMS added six new quality measures to its consumer-based Nursing Home Compare website. These quality measures include the rate of rehospitalization, emergency room use, community discharge, improvements in function, independently worsened and antianxiety or hypnotic medication among nursing home residents. Beginning in July 2016, CMS will incorporate all of these measures, except for the antianxiety/hypnotic medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings.

On February 2, 2016, CMS issued its final rule concerning face-to-face requirements for Medicaid home health services. Under the rule, the Medicaid home health service definition was revised consistent with applicable sections of the PPACA and H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The rule also requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule also requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician provider (NPP) must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than six months prior to the start of services.

On July 25, 2016, CMS issued a proposed rule to implement mandatory bundled payment programs for cardiac care and hip/femur procedures. The two new mandatory programs mirror the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models in that actual episode payments would be retrospectively compared against a target price. Similar to CJR, participating hospitals would be at risk for Medicare Part A and B payments in the inpatient admission and 90 days post-discharge. BPCI episodes would continue to take precedence over episodes in the CJR program and in the new cardiac bundled payment program. The cardiac model would be mandatory in 98 randomly selected geographic areas and the hip/femur procedure model would be mandatory in the same 67 geographic areas that were selected for CJR. CMS is also providing “Cardiac Rehabilitation Incentive Payments”, which can be used by hospitals to facilitate cardiac rehabilitation plans and adherence. The incentive will be provided to hospitals in 45 of the 98 geographic areas included in the mandatory bundled payment program and 45 geographic areas outside of the program. The proposed rule has a tentative start date of July 1, 2017 for a running period of five performance years.

On November 16, 2015, CMS issued the final rule for a new mandatory CJR model focusing on coordinated, patient-centered care. Under this model, the hospital in which the hip or knee replacement takes place is accountable for the costs and quality of care from the time of the surgery through 90 days after, or an “episode” of care. Depending on the hospital’s quality and cost performance during the episode, the hospital either earns a financial reward or is required to repay Medicare for a portion of the costs. This payment is intended to give hospitals an incentive to work with physicians, home health agencies and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. This model initially covers 67 geographic areas throughout the country and most hospitals in those regions are required to participate. Following the implementation of the CJR program on April 1, 2016, our Medicare revenues derived from our affiliated skilled nursing facilities and other post-acute services related to lower extremity joint replacement hospital discharges could be increased or decreased in those geographic areas identified by CMS for mandatory participation in the bundled payment program.

On July 13, 2015, CMS released a proposed rule that would reform requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in Medicare and Medicaid. The rule would reorder, clarify, and update regulations that the agency has not reviewed comprehensively since 1991. Under the proposed rule, facilities are required to 1) create interim care plans within 48 hours of admission, notify a resident’s physician after a change in status, engage in interdisciplinary care planning, have a practitioner assess the patient in-person prior to a transfer to the hospital, and improve clinical records to ensure providers have the necessary information to decide on hospitalization; 2) conduct comprehensive assessments of their staff and patient needs, apply current requirements for antipsychotic drugs to all psychotropic drugs, and require physicians to document their response to irregularities identified by consultant pharmacists; 3) conduct assessments of their resident population, implement and update periodically an infection prevention and control program, and establish an antibiotic stewardship program; 4) address requirements related to behavioral health services, ensuring facilities have adequate

staffing to meet the needs of residents with mental illness and cognitive impairment; and 5) conduct assessments of their patient populations and related care needs to determine adequate staffing levels (i.e., number and skillsets) for nursing, behavioral health, and nutritional services. CMS estimates that these proposed regulations would cost facilities nearly $46.5 million in the first year and over $40.6 million in subsequent years. However, these amounts would vary considerably among organizations. In addition to the monetary costs, these regulations may create compliance issues, as state regulators and surveyors interpret requirements that are less explicit.

Skilled Nursing

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CMS Payment Rules. On July 29, 2016, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the proposed rule continue to shift Medicare payments from volume to value. CMS projects that aggregate payments to skilled nursing facilities will increase by a net 2.4% for fiscal year 2017. This estimate increase reflected a 2.7% market basket increase, reduced by a 0.3% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA). This final rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports. The Value-Based Purchasing Program final rule specifies the skilled nursing facility 30-day potentially preventable readmission measure, which assesses the facility-level risk standardized rate of unplanned, potentially preventable hospital readmissions for skilled nursing facility patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital. There is also finalized additional policies related to the Value-Based Purchasing Program including: establishing performance standards; establishing baseline and performance periods; adopting a performance scoring methodology; and providing confidential feedback reports to the skilled nursing facilities.

On July 30, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by 1.2% for fiscal year 2016. This estimate increase reflected a 2.3% market basket increase, reduced by a 0.6% point forecast error adjustment and further reduced by 0.5% MFP adjustment required by the Patient Protection and Affordable Care Act (PPACA). This final rule also identified a new skilled nursing facility value-based purchasing program and all-cause all-condition hospital readmission measure.

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% MFP adjustment required by PPACA.

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.

Home Health

On June 6, 2016, CMS issued proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2017. Under this proposed rule, CMS projects that Medicare payments will be reduced by 1.0%. This decrease reflects a 2.3% reduction in the rebasing adjustments in the home health prospective payment system and a negative 0.97% adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth, 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; and the effects of the proposed increase to the fixed-dollar loss (FDL) ratio used in determining outlier payments; partially offset by the home health payment update percentage of 2.3%.

On November 5, 2015, CMS issued final payment changes to the Medicare HH PPS for calendar year 2016. Under this rule, CMS projects that Medicare payments will be reduced by 1.4%. This decrease reflects a 1.9% home health payment update percentage; a 0.9% decrease in payments due to the 0.97% payment reduction to the national, standardized 60-day episode payment rate to account for nominal case-mix growth from 2012 through 2014; and a 2.4% decrease in payments due to the third year of the four-year phase-in of 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. Along with the payment update, CMS is revising the ICD-10-CM translation list and adding certain initial encounter codes to the HH PPS Grouper based upon revised ICD-10-CM coding guidance.

Pursuant to the rule, CMS is also implementing a Home Health Value-Based Purchasing model effective for calendar year 2016, in which all Medicare-certified home health agencies (HHAs) in selected states will be required to participate. The model would apply a payment reduction or increase to current Medicare-certified HHA payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 3.0% in the first payment adjustment year, 5.0% in the second payment adjustment year, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years. CMS estimates that implementing a home health value-based model will result in a 1.4% decrease in Medicare payments to home health agencies across the industry.

Lastly, CMS implemented a standardized cross-setting measure for calendar year 2016. The Home Health Conditions of Participation (CoPs) require home health agencies to submit OASIS assessments as a condition of payment and also for quality

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measurement purposes. Home health agencies that do not submit quality measure data to CMS will see a 2.0% reduction in their annual home health payment update percentage. Under the rule, all home health agencies are required to submit both admission and discharge OASIS assessments for a minimum of 70.0% of all patients with episodes of care occurring during the reporting period starting July 1, 2015. The rule will incrementally increase this compliance threshold by 10.0% in each of the subsequent periods (July 1, 2016 and July 1, 2017) to reach 90.0%.

On October 30, 2014, CMS announced payment changes to the Medicare HH PPS for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the 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 NRS conversion factor. CMS is also finalizing three changes to the face-to-face encounter requirements under the ACA. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if each 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.

Hospice

On July 29, CMS issued its final rule outlining fiscal year 2017 Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries. Under the final rule, hospices will see a 2.1% increase in their payments effective October 1, 2016. The hospice payment increase will be the net result of 2.7% inpatient hospital market basket update, reduced by a 0.3% productivity adjustment and by a 0.3% adjustment set by the Affordable Care Act. The hospice cap amount for fiscal year 2017 will be increased by 2.1% to $28,404.99, which is equal to the 2016 cap amount of $27,820.75 updated by the FY 2017 hospice payment update percentage of 2.1%. In addition, this rule would propose changes to the hospice quality reporting program, including care surveys and two new quality measures that will assess hospice staff visits to patients and caregivers in the last three and seven days of life and the percentage of hospice patients who received care processes consistent with guidelines.

On July 31, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.1% increase in their payments effective October 1, 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 2.4% minus 0.3% for reductions required by law) and 1.2% decrease in payments to hospices due to updated wage data and the phase-out of its wage index budget neutrality adjustment factor (BNAF), offset by the newly announced Core Based Statistical Areas (CBSA) delineation impact of 0.2%. The rule also created two different payment rates for routine home care (RHC) that would result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for 61 or more days of hospice care and a Service Intensity Add-On (SIA) Payment for fiscal year 2016 and beyond in conjunction with the proposed RHC rates.

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS’ seven-year phase-out of its wage index 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.

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

Annual limitations on beneficiary incurred expenses for outpatient therapy services under Medicare Part B are commonly referred to as “therapy caps.” All beneficiaries began a new cap year on January 1, 2015 since the therapy caps are determined on

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a calendar year basis. For physical therapy (PT) and speech-language pathology services (SLP) combined, the limit on incurred expenses is $1,960 in 2016 compared to $1,940 in 2015. For occupational therapy (OT) services, the limit is $1,960 for both 2016 and 2015. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

An “exceptions process” to the therapy caps exists; however, manual policies relevant to the exceptions process apply only when exceptions to the therapy caps are in effect. The therapy exception process, which under previous legislation was due to expire, was extended and the expected SGR of 21% to the Physician Fee Screen for outpatient therapy services was repealed through the MACRA. Under the legislation, the therapy cap exception extends through December 31, 2017. The application of the therapy caps, and related provisions, to outpatient hospitals is also extended until January 1, 2018.

A manual medical review process, as part of the therapy exceptions process, applies to therapy claims when a beneficiary’s incurred expenses exceed a threshold amount of $3,700 annually. Specifically, combined PT and SLP services that exceed $3,700 are subject to manual medical review, as well as OT services that exceed $3,700. A beneficiary’s incurred expenses apply towards the manual medical review thresholds in the same manner as it applies to the therapy caps. Manual medical review was in effect through a post-payment review system until March 31, 2015. On February 9, 2016, MACRA modified the requirement for manual medical review for services over the $3,700 therapy thresholds to eliminate the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process.

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 was also required to 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, after which the members of the class were given the opportunity for re-review of their claims. The major provisions of this settlement agreement have been implemented by CMS, which could favorably impact Medicare coverage reimbursement for our services. However, health care providers may be subject to liability in the event they fail to appropriately adapt to the newly clarified reimbursement rules and consequently overbill state Medicaid programs in connection with services rendered to dual-eligible Medicare patients (i.e., by not maximizing Medicare coverage before billing Medicaid).

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 Part II, Item 1A Risk Factors under the headings 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.

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Results of Operations

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
Revenue	100.0 %	100.0 %	100.0 %	100.0 %
Expenses:				
Cost of services	80.5	79.8	80.2	79.3
Losses related to operational closure	—	—	1.0	—
Rent—cost of services	7.5	6.1	7.3	6.2
General and administrative expense	4.8	4.9	4.7	4.8
Depreciation and amortization	2.4	2.1	2.3	2.1
Total expenses	95.2	92.9	95.5	92.4
Income from operations	4.8	7.1	4.5	7.6
Other income (expense):				
Interest expense	(0.4)	(0.2)	(0.4)	(0.2)
Interest income	0.1	0.1	0.1	0.1
Other expense, net	(0.3)	(0.1)	(0.3)	(0.1)
Income before provision for income taxes	4.5	7.0	4.2	7.5
Provision for income taxes	1.8	2.7	1.7	2.9
Net income	2.7	4.3	2.5	4.6
Less: net income (loss) attributable to the noncontrolling interests	—	—	—	—
Net income attributable to The Ensign Group, Inc.	2.7 %	4.3 %	2.5 %	4.6 %

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In thousands)			
Other Non-GAAP Financial Data:				
EBITDA[1]	$29,544	$28,318	$54,037	$60,092
Adjusted EBITDA[1][2]	37,492	31,738	75,066	64,146
EBITDAR[1]	60,285	47,384	111,769	98,123
Adjusted EBITDAR[1][2]	65,512	50,277	128,136	101,161

(1) EBITDA, EBITDAR, Adjusted EBITDA and Adjusted EBITDAR are supplemental non-GAAP financial measures. Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Exchange Act define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income from continuing operations, adjusted for net losses attributable to noncontrolling interest, before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude 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:

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- 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, rent — cost of services, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the amount of debt that we have incurred, whether an operation is owned or leased, the date of acquisition of a facility or business, and the tax law of the state in which a business unit operates. 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 condensed consolidated financial statements and related notes included elsewhere in this document.

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

- results at our urgent care centers (including the portion related to non-controlling interest);

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- breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder;
- acquisition-related costs;
- stock-based compensation expense;
- costs incurred for facilities currently being constructed and other start-up operations;
- costs incurred related to new systems implementation;
- professional service fees including costs incurred to recognize income tax credits;
- results at one closed facility, including continued obligation under the lease and related closing expenses;
- insurance reserves in connection with the settlement of a general liability claim; and

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2016	2015	2016	2015
	(In thousands)		(In thousands)	
Consolidated statements of income data:				
Net income	$11,363	$13,233	$20,653	$28,323
Less: net income (loss) attributable to noncontrolling interests	37	45	155	(37)
Interest expense, net	1,168	372	2,303	872
Provision for income taxes	7,278	8,379	13,167	17,964
Depreciation and amortization	9,772	6,379	18,069	12,896
EBITDA	$29,544	$28,318	$54,037	$60,092
Facility rent—cost of services	30,741	19,066	57,732	38,031
EBITDAR	$60,285	$47,384	$111,769	$98,123
EBITDA	$29,544	$28,318	$54,037	$60,092
Urgent care center earnings(a)	(811)	(625)	(1,867)	(1,565)
Costs incurred for facilities currently being constructed and other start-up operations(b)	449	462	1,812	608
Results at closed facility, including continued obligations and closing expenses(c)	206	—	8,331	—
Stock-based compensation expense(d)	2,780	1,733	4,665	3,226
Insurance reserve in connection with the settlement of a general liability claim(e)	1,586	—	1,586	—
Acquisition related costs(f)	748	438	893	590
Costs incurred related to new systems implementation and professional service fee(g)	269	885	947	1,198
Breakup fee, net of costs, received in connection with a public auction(h)	—	—	—	(1,019)
Rent related to items(a),(b) and (c) above	2,721	527	4,662	1,016
Adjusted EBITDA	$37,492	$31,738	$75,066	$64,146
Rent—cost of services	30,741	19,066	57,732	38,031
Less: rent related to items(a),(b) and (c) above	(2,721)	(527)	(4,662)	(1,016)
Adjusted EBITDAR	$65,512	$50,277	$128,136	$101,161

(a) Operating results at urgent care centers. This amount excluded rent, depreciation and interest of $0.9 million and $1.7 million for the three and six months ended June 30, 2016, respectively, and $0.8 million and $1.6 million for the three and six months ended June 30, 2015, respectively. The results also excluded the net loss attributable to the

variable interest entity associated with our urgent care business.

(b) Costs incurred for facilities currently being constructed and other start-up operations. This amount excluded rent, depreciation and interest of $2.3 million and $3.8 million for the three and six months ended June 30, 2016, respectively. Rent, depreciation and interest expenses were not material for the three and six months ended June 30, 2015.

(c) Results at closed facility during three and six months ended June 30, 2016, including fair value of continued obligation under lease agreement and related closing expenses of $7.9 million and operating loss of $0.2 million for both the three and six months ended June 30, 2016. This amount excluded rent and depreciation of $0.1 million for the six months ended June 30, 2016.

(d) Stock-based compensation expense incurred during the three and six months ended June 30, 2016 and 2015.

(e) Insurance reserves in connection with the settlement of a general liability claim.

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(f) Costs incurred to acquire an operation which are not capitalizable.
(g) Costs incurred related to new systems implementation and income tax credits which contributed to a decrease in effective tax rate.
(h) Breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder.

Three Months Ended June 30, 2016 Compared to the Three Months Ended June 30, 2015

Revenue

	Three Months Ended June 30,					
	2016			2015		
	Revenue Dollars	Revenue Percentage		Revenue Dollars	Revenue Percentage	
	(Dollars in thousands)					
TSA services:						
Skilled nursing facilities	$340,417	82.9	%	$265,709	85.4	%
Assisted and independent living facilities	30,708	7.5		15,927	5.1	
Total TSA services	371,125	90.4		281,636	90.5	
Home health and hospice services:						
Home health	14,416	3.5		11,294	3.6	
Hospice	14,077	3.4		8,650	2.8	
Total home health and hospice services	28,493	6.9		19,944	6.4	
All other (1)	10,899	2.7		9,476	3.1	
Total revenue	$410,517	100.0	%	$311,056	100.0	%

(1) Includes revenue from services provided at our urgent care clinics and other ancillary operations.

Consolidated revenue increased $99.5 million, or 32.0%, compared to the same quarter in the prior year. TSA services revenue increased by $89.5 million, or 31.8%, mainly attributable to the increase in patient days, revenue per patient day skilled mix and the impacts of acquisitions. Home health and hospice services revenue increased by $8.5 million, or 42.9%, mainly due to an increase in volume and average daily census in existing agencies combined with acquisitions. Revenue from acquisitions increased consolidated revenue by $81.4 million in the second quarter of 2016 as compared to the same quarter of 2015.

TSA Services

	Three Months Ended June 30,					
	2016		2015			
	(Dollars in thousands)				Change	% Change
Total Facility Results:						
Skilled nursing revenue	$340,417		$265,709		$74,708	28.1 %
Assisted and independent living revenue	30,708		15,927		14,781	92.8 %
Total TSA services revenue	$371,125		$281,636		$89,489	31.8 %
Number of facilities at period end	206		150		56	37.3 %
Actual patient days	1,465,625		1,121,158		344,467	30.7 %
Occupancy percentage — Operational beds	76.3	%	78.0	%		(1.7)%
Skilled mix by nursing days	31.3	%	30.1	%		1.2 %
Skilled mix by nursing revenue	52.7	%	53.4	%		(0.7)%

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	Three Months Ended June 30,			
	2016	2015		
	(Dollars in thousands)		Change	% Change
Same Facility Results(1):				
Skilled nursing revenue	$225,787	$211,994	$13,793	6.5 %
Assisted and independent living revenue	9,360	9,217	143	1.6 %
Total TSA services revenue	$235,147	$221,211	$13,936	6.3 %
Number of facilities at period end	106	106	—	— %
Actual patient days	842,405	849,485	(7,080)	(0.8)%
Occupancy percentage — Operational beds	78.8 %	80.1 %		(1.3)%
Skilled mix by nursing days	30.4 %	30.1 %		0.3 %
Skilled mix by nursing revenue	51.1 %	53.6 %		(2.5)%

	Three Months Ended June 30,			
	2016	2015		
	(Dollars in thousands)		Change	% Change
Transitioning Facility Results(2):				
Skilled nursing revenue	$42,284	$40,069	$2,215	5.5 %
Assisted and independent living revenue	4,754	4,389	365	8.3 %
Total TSA services revenue	$47,038	$44,458	$2,580	5.8 %
Number of facilities at period end	29	29	—	— %
Actual patient days	186,096	182,708	3,388	1.9 %
Occupancy percentage — Operational beds	73.3 %	71.9 %		1.4 %
Skilled mix by nursing days	34.1 %	31.8 %		2.3 %
Skilled mix by nursing revenue	55.9 %	54.6 %		1.3 %

	Three Months Ended June 30,			
	2016	2015		
	(Dollars in thousands)		Change	% Change
Recently Acquired Facility Results(3):				
Skilled nursing revenue	$72,346	$11,883	$60,463	NM
Assisted and independent living revenue	16,594	2,321	14,273	NM
Total TSA services revenue	$88,940	$14,204	$74,736	NM
Number of facilities at period end	71	14	57	NM
Actual patient days	437,124	80,217	356,907	NM
Occupancy percentage — Operational beds	73.1 %	73.0 %		NM
Skilled mix by nursing days	32.1 %	29.6 %		NM
Skilled mix by nursing revenue	55.6 %	50.7 %		NM

	Three Months Ended June 30,			
	2016	2015		
	(Dollars in thousands)		Change	% Change
Facility Closed(4):				
Skilled nursing revenue	—	1,763	$(1,763)	NM

Assisted and independent living revenue	—	—	—	NM
Total TSA services revenue	$—	$1,763	$(1,763)	NM
Actual patient days	—	8,748	(8,748)	NM
Occupancy percentage — Operational beds	—%	70.2%		NM
Skilled mix by nursing days	—%	10.5%		NM
Skilled mix by nursing revenue	—%	26.9%		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2013.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2013 to December 31, 2014.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2015.

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(4) Facility Closed represent the result of one facility closed during the first quarter of 2016. These results were excluded from Same Facility results for three months ended June 30, 2016 and 2015 for comparison purposes.

TSA services revenue increased $89.5 million, or 31.8%, compared to the same quarter in the prior year. Of the $89.5 million increase, Medicare and managed care revenue increased $33.2 million, or 26.2%, Medicaid custodial revenue increased $31.6 million, or 32.1%, private and other revenue increased $20.8 million, or 52.7%, and Medicaid skilled revenue increased $3.9 million, or 23.4%.

TSA services revenue generated by Same Facilities increased $13.9 million, or 6.3%, compared to the same quarter in the prior year. This increase reflects the following:

- Managed care revenue increased by $2.0 million, or 6.1%, which was driven by a 5.4% increase in managed care days as well as a 0.9% increase in managed care revenue per patient day.
- Medicaid revenue, including Medicaid skilled revenue, increased by $12.7 million, or 13.6%, which was driven by a 16.3% increase in Medicaid revenue per patient day driven by the quality improvement program in California, supplemental programs in Utah as well as the add-on to the reimbursement rate, partially offset by a 1.0% decrease in Medicaid days.
- Medicare revenue decreased by $2.2 million, or 3.3%, which was driven by a 8.4% decrease in Medicare days, partially offset by a 3.3% increase in Medicare revenue per patient day.

TSA services revenue generated by Transitioning Facilities increased $2.6 million, or 5.8%, compared to the same quarter in the prior year. This is due to increases in total patient days and revenue per patient day of 1.9% and 5.0%, respectively.

TSA services revenue generated by Recently Acquired Facilities increased by approximately $74.7 million compared to the same quarter in the prior year. Since January 1, 2015, we have acquired 71 facilities in thirteen 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 for our turnaround acquisitions. In the future, if we acquire additional turnaround operations 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. In 2016, our metrics for Recently Acquired Facilities include strategic acquisitions that have higher occupancy rates, higher skilled mix days and skilled mix revenue.

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 June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Skilled Nursing Average Daily Revenue Rates:								
Medicare	$581.48	$562.69	$557.12	$555.42	$494.81	$452.97	$555.11	$554.72
Managed care	424.79	421.17	461.67	458.59	409.62	428.20	427.43	428.94
Other skilled	468.47	468.38	351.42	324.76	384.43	666.11	440.25	448.95
Total skilled revenue	505.99	499.85	478.37	477.00	453.45	459.54	489.49	494.31
Medicaid	215.90	185.58	190.70	182.54	168.98	185.95	202.11	184.80
Private and other payors	207.64	189.48	213.58	192.98	181.61	193.58	201.41	189.87
Total skilled nursing revenue	303.93	280.60	291.18	277.29	262.10	268.65	292.40	$278.71

Medicare daily rates at Same Facilities increased by 3.3% compared to the same quarter in the prior year. The increase was attributable by a 1.2% net market basket increase, which went into effect in October 2015, compared to a net market basket increase of 2.0%, which went into effect in October 2014. The increase in Medicare daily rates also was

impacted by the continuous shift towards higher acuity patients.

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The average Medicaid rates increased 9.4% primarily due to increases in rates in various states, supplemental Medicaid payments received from the supplemental payment programs in Utah and the quality improvement program in California, as well as the add-on to the reimbursement rate.

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 June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Revenue:								
Medicare	27.8 %	30.7 %	23.1 %	24.4 %	32.5 %	35.0 %	28.2 %	29.9 %
Managed care	15.6	15.7	26.5	25.0	19.6	11.3	17.8	16.9
Other skilled	7.7	7.2	6.3	5.2	3.5	4.4	6.7	6.6
Skilled mix	51.1	53.6	55.9	54.6	55.6	50.7	52.7	53.4
Private and other payors	7.9	8.2	8.1	8.1	9.2	15.6	8.1	8.6
Quality mix	59.0	61.8	64.0	62.7	64.8	66.3	60.8	62.0
Medicaid	41.0	38.2	36.0	37.3	35.2	33.7	39.2	38.0
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Days:								
Medicare	14.4 %	15.3 %	12.1 %	12.2 %	17.2 %	20.8 %	14.8 %	15.0 %
Managed care	11.1	10.5	16.7	15.1	12.5	7.1	12.1	11.0
Other skilled	4.9	4.3	5.3	4.5	2.4	1.7	4.4	4.1
Skilled mix	30.4	30.1	34.1	31.8	32.1	29.6	31.3	30.1
Private and other payors	12.3	12.1	10.9	11.5	13.3	21.8	12.3	12.6
Quality mix	42.7	42.2	45.0	43.3	45.4	51.4	43.6	42.7
Medicaid	57.3	57.8	55.0	56.7	54.6	48.6	56.4	57.3
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Home Health and Hospice Services

	Three Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Results:				
Home health and hospice revenue				
Home health services	$14,416	$11,294	$3,122	27.6 %
Hospice services	14,077	8,650	5,427	62.7
Total home health and hospice revenue	$28,493	$19,944	$8,549	42.9 %
Home health services:				
Medicare Episodic Admissions	2,037	1,672	365	21.8 %
Average Medicare Revenue per Completed Episode	$2,950	$2,954	$(4)	(0.1)%
Hospice services:				
Average Daily Census	898	562	336	59.8 %

Home health and hospice revenue increased $8.5 million, or 42.9%, compared to the same quarter in the prior year. Of the $8.5 million increase, Medicare and managed care revenue increased $8.4 million, or 52.4%. The increase in revenue is primarily due to the increase in volume and average daily census in existing agencies, coupled with the addition of nine home health, hospice and home care operations in five states since January 1, 2015.

Cost of Services

The following table sets forth our total cost of services by each of our reportable segments and our "All Other" category for the periods indicated (dollars in thousands):

	Three Months Ended June 30,							
	2016				2015			
	TSA Services	Home Health and Hospice	All Other	Total	TSA Services	Home Health and Hospice	All Other	Total
Cost of service dollars	$297,505	$23,547	$9,486	$330,538	$223,478	$16,449	$8,365	$248,292

Consolidated cost of services increased $82.2 million, or 33.1%, compared to the same quarter in the prior year primarily due to acquisitions for all segments, including the All Other category. Cost of services for all acquisitions accounted for 24.0% of consolidated costs of services during the second quarter of 2016 compared to 5.2% in the same period in 2015.

TSA Services

	Three Months Ended June 30,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$297,505	$223,478	$74,027	33.1 %
Revenue percentage	80.2 %	79.4 %		0.8 %

Cost of services related to our TSA services segment increased $74.0 million, or 33.1%, compared to the same quarter in the prior year due to additional costs at Recently Acquired Facilities of $59.9 million and organic operational growth. Cost of service increased as a percentage of revenue to 80.2%. The main component of the increase is start-up costs related newly constructed post-acute care campuses and increases in health and general liability of $7.0 million. Same Facilities cost of services as a percentage of revenue decreased slightly to 79.0% from 79.1% during the three months ended June 30, 2015.

Home Health and Hospice Services

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	Three Months Ended June 30,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$23,547	$16,449	$7,098	43.2 %
Revenue percentage	82.6 %	82.5 %		0.1 %

Cost of services related to our home health and hospice services segment increased $7.1 million, or 43.2%, compared to the same quarter in the prior year due to additional costs at agencies acquired during 2016 of $4.1 million and organic operational growth. Cost of services as a percentage of total revenue increased slightly by 0.1% primarily due to costs related to start-up and transitioning operations. We have generally experienced higher costs due to the addition of resources at our newly acquired and start-up agencies.

Rent — Cost of Services. Rent — cost of services increased $11.7 million, or 61.2%, to $30.7 million. Rent - cost of service as a percentage of total revenue increased by 1.4% to 7.5%. The additional increase in rent was primarily due to new leases for newly opened and acquired operations.

General and Administrative Expense. General and administrative expense increased $4.3 million, or 28.2%, to $19.7 million. The increase was primarily due to the operational growth during 2016, coupled with an increase in expenses incurred to acquire new operations and additional share-based compensation expense related to the new management subsidiary equity plan. In addition, general and administrative expense as a percentage of revenue decreased slightly as a percentage of revenue by 0.1% to 4.8%.

Depreciation and Amortization. Depreciation and amortization expense increased $3.4 million, or 53.2%, to $9.8 million. Depreciation and amortization expense increased slightly as a percentage of total revenue by 0.3% to 2.4%. This increase was primarily related to the additional depreciation incurred as a result of our newly acquired operations of $2.1 million.

Other Expense, net. Other expense, net increased $0.8 million to $1.2 million. Other expense as a percentage of revenue increased by 0.2% to 0.3%. The increase is due the additional borrowings under the Amended Credit Facility.

Provision for Income Taxes. The provision for income taxes is based upon our projected income for each respective accounting period and includes the effect of certain non-taxable and non-deductible items. Our effective tax rate was 39.0% for the three months ended June 30, 2016 compared to 38.9% for the same period in 2015.

Six Months Ended June 30, 2016 Compared to the Six Months Ended June 30, 2015

Revenue

	Six Months Ended June 30,			
	2016		2015	
	Revenue Dollars	Revenue Percentage	Revenue Dollars	Revenue Percentage
	(Dollars in thousands)			
TSA services:				
Skilled nursing facilities	$655,631	82.6 %	$530,179	85.8 %
Assisted and independent living facilities	60,877	7.7	30,230	4.9
Total TSA services	716,508	90.3	560,409	90.7
Home health and hospice services:				
Home health	28,324	3.6	21,656	3.5
Hospice	26,835	3.4	16,604	2.7
Total home health and hospice services	55,159	7.0	38,260	6.2
All other (1)	22,083	2.7	18,916	3.1
Total revenue	$793,750	100.0 %	$617,585	100.0 %

(1) Includes revenue from services provided at our urgent care clinics and other ancillary operations.

Consolidated revenue increased $176.2 million, or 28.5%, compared to the same period in prior year. TSA services revenue increased by $156.1 million, or 27.9%, mainly attributable to the increase in patient days, revenue per patient day, skilled mix

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and the impact of acquisitions. Home health and hospice services revenue increased by $16.9 million, or 44.2%, mainly due to an increase in volume and average daily census in existing agencies combined with acquisitions. Revenue from acquisitions increased consolidated revenue by $143.9 million during the six months ended June 30, 2016 as compared to the same period in 2015.

TSA Services

	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Skilled nursing revenue	$655,631	$530,179	$125,452	23.7 %
Assisted and independent living revenue	60,877	30,230	30,647	101.4 %
Total TSA services revenue	$716,508	$560,409	$156,099	27.9 %
Number of facilities at period end	206	150	56	37.3 %
Actual patient days	2,842,504	2,198,396	644,108	29.3 %
Occupancy percentage — Operational beds	76.7 %	78.4 %		(1.7)%
Skilled mix by nursing days	31.9 %	30.2 %		1.7 %
Skilled mix by nursing revenue	53.6 %	53.2 %		0.4 %

	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Skilled nursing revenue	$449,545	$427,549	$21,996	5.1 %
Assisted and independent living revenue	18,467	18,280	187	1.0 %
Total TSA services revenue	$468,012	$445,829	$22,183	5.0 %
Number of facilities at period end	106	106	—	— %
Actual patient days	1,698,652	1,694,987	3,665	0.2 %
Occupancy percentage — Operational beds	79.4 %	80.3 %		(0.9)%
Skilled mix by nursing days	30.9 %	30.3 %		0.6 %
Skilled mix by nursing revenue	52.3 %	53.5 %		(1.2)%

	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Skilled nursing revenue	$86,223	$80,640	$5,583	6.9 %
Assisted and independent living revenue	9,341	8,755	586	6.7 %
Total TSA services revenue	$95,564	$89,395	$6,169	6.9 %
Number of facilities at period end	29	29	—	— %
Actual patient days	374,345	364,555	9,790	2.7 %
Occupancy percentage — Operational beds	73.7 %	71.8 %		1.9 %
Skilled mix by nursing days	34.5 %	31.4 %		3.1 %
Skilled mix by nursing revenue	56.4 %	54.2 %		2.2 %

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	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Skilled nursing revenue	$119,243	$18,331	$100,912	NM
Assisted and independent living revenue	33,069	3,195	29,874	NM
Total TSA services revenue	$152,312	$21,526	$130,786	NM
Number of facilities at period end	71	14	57	NM
Actual patient days	766,262	120,913	645,349	NM
Occupancy percentage — Operational beds	72.5 %	74.5 %		NM
Skilled mix by nursing days	33.9 %	26.3 %		NM
Skilled mix by nursing revenue	56.5 %	46.9 %		NM

	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Facility Closed(4):				
Skilled nursing revenue	$620	$3,659	$(3,039)	NM
Assisted and independent living revenue	—	—	—	NM
Total TSA services revenue	$620	$3,659	$(3,039)	NM
Actual patient days	3,245	17,941	(14,696)	NM
Occupancy percentage — Operational beds	30.7 %	72.4 %		NM
Skilled mix by nursing days	9.6 %	13.0 %		NM
Skilled mix by nursing revenue	14.0 %	31.6 %		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2013.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2013 to December 31, 2014.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2015.

(4) Facility Closed represent the results of one facility that closed during the first quarter of 2016. These results were excluded from Same Facility results for six months ended June 30, 2016 and 2015 for comparison purposes. Included in the six months ended June 30, 2016 results is one month of operation as the facility was closed in February 2016; as such, the metrics are not comparable to the results during the six months ended June 30, 2015.

TSA services revenue increased $156.1 million, or 27.9%, compared to the same six month period in the prior year. Of the $156.1 million increase, Medicare and managed care revenue increased $59.6 million, or 23.6%, Medicaid custodial revenue increased $46.9 million, or 23.7%, private and other revenue increased $39.5 million, or 51.3%, and Medicaid skilled revenue increased $10.0 million, or 31.1%.

TSA services revenue generated by Same Facilities increased $22.2 million, or 5.0%, compared to the six months ended June 30, 2015. This increase reflects the following:

- Managed care revenue increased by $8.8 million, or 13.2%, which was driven by a 10.6% increase in managed care days as well as a 1.6% increase in managed care revenue per patient day.
- Medicaid revenue, including Medicaid skilled revenue, increased by $17.8 million, or 9.4%, which was driven by a 0.9% increase in Medicaid days driven by the quality improvement program in California, supplemental programs in

Utah and Texas and the add-on to the reimbursement rate, as well as a 8.7% increase in Medicaid revenue per patient day.

- Medicare revenue decreased by $6.2 million, or 4.5%, which was driven by a 9.2% decrease in Medicare days, partially offset by a 2.8% increase in Medicare revenue per patient day.

TSA services revenue generated by Transitioning Facilities increased $6.2 million, or 6.9%, compared to the six months ended June 30, 2015. This increase is due to increases in total patient days and revenue per patient day of 2.7% and 5.0%, respectively.

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TSA services revenue generated by Recently Acquired Facilities increased by approximately $130.8 million compared to the same six month period in the prior year, which was driven by an increase by patient days due to newly acquired facilities. Since January 1, 2015, we have acquired 71 facilities in thirteen 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 for our turnaround acquisitions. In the future, if we acquire additional turnaround operations 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. In 2016, our metrics for Recently Acquired Facilities include strategic acquisitions that have higher occupancy rates, higher skilled mix days and skilled mix revenue.

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:

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Skilled Nursing Average Daily Revenue Rates:								
Medicare	$580.14	$564.51	$557.08	$556.26	$492.44	$451.51	$556.51	$558.20
Managed care	423.08	416.35	463.87	461.45	410.07	412.68	427.65	425.87
Other skilled	467.33	473.75	350.59	324.95	389.41	669.14	439.46	456.13
Total skilled revenue	503.07	500.66	478.42	480.87	451.99	461.00	488.82	496.10
Medicaid	206.35	189.91	189.43	183.02	175.67	184.53	198.28	188.20
Private and other payors	203.57	189.94	223.90	202.20	190.29	190.81	203.59	191.62
Total skilled nursing revenue	297.95	284.22	292.81	278.95	271.05	258.71	291.81	$281.59

Medicare daily rates at Same Facilities increased by 2.8% compared to the six months ended June 30, 2015. The increase was attributable by a 1.2% net market basket increase, which went into effect in October 2015, compared to a net market basket increase of 2.0%, which went into effect in October 2014. The increase in Medicare daily rates also was impacted by the continuous shift towards higher acuity patients.

The average Medicaid rates increased 5.4% primarily due to increases in rates in various states, supplemental Medicaid payments received from the supplemental payment programs in Utah and Texas and the quality improvement program in California, as well as the add-on to the reimbursement rate.

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:

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Revenue:								
Medicare	28.0 %	31.1 %	22.9 %	23.8 %	32.7 %	31.4 %	28.2 %	29.9 %
Managed care	16.5	15.4	27.0	26.0	19.5	9.7	18.4	16.8
Other skilled	7.8	7.0	6.5	4.4	4.3	5.8	7.0	6.5
Skilled mix	52.3	53.5	56.4	54.2	56.5	46.9	53.6	53.2
Private and other payors	7.9	8.0	8.1	8.6	8.5	17.0	8.1	8.5
Quality mix	60.2	61.5	64.5	62.8	65.0	63.9	61.7	61.7
Medicaid	39.8	38.5	35.5	37.2	35.0	36.1	38.3	38.3
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Days:								
Medicare	14.3 %	15.6 %	12.0 %	11.9 %	18.0 %	18.0 %	14.7 %	15.1 %
Managed care	11.6	10.5	17.0	15.7	12.9	6.1	12.5	11.1
Other skilled	5.0	4.2	5.5	3.8	3.0	2.2	4.7	4.0
Skilled mix	30.9	30.3	34.5	31.4	33.9	26.3	31.9	30.2
Private and other payors	11.9	12.1	10.7	11.9	12.2	23.0	11.8	12.5
Quality mix	42.8	42.4	45.2	43.3	46.1	49.3	43.7	42.7
Medicaid	57.2	57.6	54.8	56.7	53.9	50.7	56.3	57.3
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Home Health and Hospice Services

	Six Months Ended June 30,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Results:				
Home health and hospice revenue				
Home health services	$28,324	$21,656	$6,668	30.8 %
Hospice services	26,835	16,604	10,231	61.6
Total home health and hospice revenue	$55,159	$38,260	$16,899	44.2 %
Home health services:				
Medicare Episodic Admissions	4,194	3,415	779	22.8 %
Average Medicare Revenue per Completed Episode	$2,937	$2,984	$(47)	(1.6)%
Hospice services:				
Average Daily Census	871	552	319	57.8 %

Home health and hospice revenue increased $16.9 million, or 44.2%, compared to the six months ended June 30, 2015. Of the $16.9 million increase, Medicare and managed care revenue increased $16.1 million, or 52.2%. The increase in revenue is primarily due to the increase in volume and average daily census in existing agencies, coupled with the addition of nine home health, hospice and home care operations in five states since January 1, 2015.

Cost of Services (exclusive of losses related to operational closure, rent and depreciation and amortization shown separately)

The following table sets forth our total cost of services by each of our reportable segments and our "All Other" category for the periods indicated (dollars in thousands):

	Six Months Ended June 30,							
	2016				2015			
	TSA Services	Home Health and Hospice	All Other	Total	TSA Services	Home Health and Hospice	All Other	Total
Cost of service dollars	$571,808	$46,390	$18,648	$636,846	$441,841	$31,609	$16,298	$489,748

Consolidated cost of services increased $147.0 million, or 30.0%, compared to the same quarter in the prior year primarily due to acquisitions for all segments, including the All Other category. Cost of services for all acquisitions accounted for 21.2% of consolidated costs of services during the six months ended June 30, 2016 compared to 4.0% in the same period in 2015.

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TSA Services

	Six Months Ended June 30,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$571,808	$441,841	$129,967	29.4 %
Revenue percentage	79.8 %	78.8 %		1.0 %

Cost of services related to our TSA services segment increased $130.0 million, or 29.4%, compared to the six months ended June 30, 2016 in the prior year due to additional costs at Recently Acquired Facilities of $103.9 million and organic operational growth. Cost of service increased as a percentage of revenue to 79.8%. The main component of the increase is start-up costs related newly constructed post-acute care campuses and increases in general liability of $5.7 million. Same Facilities cost of services as a percentage of revenue increased to 79.3% from 78.7% during the six months ended June 30, 2015 mainly due to the increase in general liability and health insurance expenses of $4.9 million.

Home Health and Hospice Services

	Six Months Ended June 30,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$46,390	$31,609	$14,781	46.8 %
Revenue percentage	84.1 %	82.6 %		1.5 %

Cost of services related to our home health and hospice services segment increased $14.8 million, or 46.8%, compared to the same quarter in the prior year due to additional costs at agencies acquired during 2016 of $8.2 million and organic operational growth. Cost of services as a percentage of total revenue increased by 1.5% primarily due to costs related to start-up and transitioning operations. We have generally experienced higher costs due to the addition of resources at our newly acquired and start-up agencies.

Rent — Cost of Services. Rent — cost of services increased $19.7 million, or 51.8%, to $57.7 million. Rent - cost of service as a percentage of total revenue increased by 1.1% to 7.3%. The additional increase in rent was primarily due to new leases for newly opened and acquired operations.

Losses on operational closure - We recorded charges of $7.9 million related to the close of one facility in February 2016, which represents the present value of rental payments of $6.5 million related to continued obligation under the lease and related closing expenses. These charges did not occurred in 2015.

General and Administrative Expense. General and administrative expense increased $7.3 million, or 24.5%, to $37.0 million. The increase was primarily due to the operational growth during 2016 coupled with an increase in expenses incurred to acquire new operations and additional share-based compensation expense related to the new management subsidiary equity plan. In addition, general and administrative expense decreased slightly as a percentage of revenue by 0.1% to 4.7%.

Depreciation and Amortization. Depreciation and amortization expense increased $5.2 million, or 40.1%, to $18.1 million. Depreciation and amortization expense increased slightly as a percentage of total revenue by 0.2% to 2.3%. This increase was primarily related to the additional depreciation incurred as a result of our newly acquired operations of $3.1 million.

Other Expense, net. Other expense, net increased $1.4 million to $2.3 million. Other expense as a percentage of revenue increased slightly by 0.2% to 0.3%. The increase is due the additional borrowings under the Amended Credit

Facility.

Provision for Income Taxes. The provision for income taxes is based upon our projected income for each respective accounting period and includes the effect of certain non-taxable and non-deductible items. Our effective tax rate was 38.9% for the six months ended June 30, 2016 compared to 38.8% for the same period in 2015. The effective income tax rate in 2016 included charges related to operational closure at one of our operating facilities.

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Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flows from operations and long-term debt secured by our real property and our revolving credit facilities.

Historically, we have financed the majority of our acquisitions primarily through financing of our operating subsidiaries through mortgages, our revolving credit facility, and cash generated from operations. Cash paid for business acquisitions was $56.1 million and $61.0 million for the six months ended June 30, 2016 and 2015, respectively. Total capital expenditures for property and equipment were $36.4 million and $28.8 million for the six months ended June 30, 2016 and 2015, respectively. We currently have approximately $60.0 million budgeted for renovation projects for 2016. We believe our current cash balances, our cash flow from operations and the amounts available under our credit facility will be sufficient to cover our operating needs for at least the next 12 months.

We may in the future seek to raise additional capital to fund growth, capital renovations, operations and other business activities, but such additional capital may not be available on acceptable terms, on a timely basis, or at all.

Our cash and cash equivalents as of June 30, 2016 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2016, we held debt security investments of approximately $34.5 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 following table presents selected data from our consolidated statement of cash flows for the periods presented:

	Six Months Ended June 30,	
	2016	2015
	(In thousands)	
Net cash provided by operating activities	$36,828	$6,808
Net cash used in investing activities	(99,857)	(89,427)
Net cash provided by financing activities	54,979	82,846
Net (decrease) increase in cash and cash equivalents	(8,050)	227
Cash and cash equivalents at beginning of period	41,569	50,408
Cash and cash equivalents at end of period	$33,519	$50,635

Six Months Ended June 30, 2016 Compared to Six Months Ended June 30, 2015

Net cash provided by operating activities for the six months ended June 30, 2016 increased by $30.0 million. The increase was primarily due to the timing in accounts receivable collections and payments of the other operating assets and liabilities such as payment of other accrued expenses.

Net cash used in investing activities in the second quarter of 2016 increased by $10.5 million. The increase was due to the increase in capital expenditures of $7.7 million. The increase in capital expenditures in 2016 resulted from our continued investments to constructing new facilities in existing and new markets and expanding and renovating our existing operations.

Net cash provided by financing activities decreased by $27.8 million. This decrease was primarily due to the repurchases of common stock of $30.0 million during the six months ended June 30, 2016 that did not occur in 2015.

Principal Debt Obligations and Capital Expenditures

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

On February 5, 2016, we amended our existing revolving credit facility with a lending consortium arranged by SunTrust to increase our aggregate principal amount available to $250.0 million (the Amended Credit Facility). Under the Amended Credit Facility, we may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $150.0 million. The interest rates applicable to loans under the Amended Credit Facility are, at our option, equal to either a base rate plus a margin

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ranging from 0.75% to 1.75% per annum or LIBOR plus a margin ranging from 1.75% to 2.75% per annum, based on the Consolidated Total Net 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 Amended Credit Facility that will range from 0.3% to 0.5% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and our subsidiaries. Loans made under the Amended Credit Facility are not subject to interim amortization. We are not required to repay any loans under the Amended Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Amended Credit Facility. We are permitted to prepay all or any portion of the loans under the Amended Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders. As of June 30, 2016, our operating subsidiaries had $170.0 million outstanding under the Amended Credit Facility.

The Amended Credit Facility is secured by a pledge of stock of our material operating subsidiaries as well as a first lien on substantially all of our personal property. The Amended Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and our operating 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 Amended Credit Facility, we must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum Consolidated Total Net Debt to Consolidated EBITDA ratio (which shall be increased to 3.50:1.00 for the current fiscal quarter and the immediate following three fiscal quarters), and a minimum interest/rent coverage ratio (which cannot be below 1.50:1.00). The majority of lenders can require that we and our operating subsidiaries mortgage certain of our real property assets to secure the Amended Credit Facility if an event of default occurs, the Consolidated Total Net Debt to Consolidated EBITDA ratio is above 2.75:1.00 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 Consolidated Total Net Debt to Consolidated EBITDA ratio is below 2.75:1.00 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 June 30, 2016, we were in compliance with all loan covenants.

On July 19, 2016, we entered into the second amendment to the Amended Credit Facility (Second Amended Credit Facility), which amended the existing credit agreement, dated as of February 5, 2016, to increase the aggregate principal amount up to $450.0 million comprised of a $300.0 million revolving credit facility and a $150.0 million term loan. Borrowings under the term loan portion of the Second Amended Credit Facility amortized in equal quarterly installments commencing on February 5, 2021, in an aggregate annual amount equal to 5.0% per annum of the original principal amount. The interest rates and commitment fee applicable to the Second Amended Credit Facility are similar to the Amended Credit Facility. Except as set forth in the Second Amended Credit Facility, all other terms and conditions of the Amended Credit Facility remained in full force and effect as described above.

As of July 29, 2016, there was approximately $177.0 million outstanding under the Second Amended Credit Facility.

Mortgage Loans and Promissory Note

We have outstanding indebtedness under mortgage loans and promissory note issued in connection with various acquisitions. The mortgage loans are insured with the U.S. Department of Housing and Urban Development (HUD), which subjects our operating subsidiaries to HUD oversight and periodic inspections. The mortgage loans and note bear fixed interest rates between 2.6% and 5.3% per annum. Amounts borrowed under the mortgage loans may be prepaid starting after the second anniversary of the notes subject to prepayment fees of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% per year for years three through eleven of the loan. There is no prepayment penalty after year eleven. The terms of the mortgage loans and note are between 12 and 33

years. The mortgage loans and note are secured by the real property comprising the facilities and the rents, issues and profits thereof, as well as all personal property used in the operation of the facilities. As of June 30, 2016, our operating subsidiaries had $14.3 million outstanding under the mortgage loans and note, of which $0.6 million is classified as short-term and the remaining $13.7 million is classified as long-term.

Contractual Obligations, Commitments and Contingencies

We lease from CareTrust REIT, Inc. (CareTrust) real property associated with 93 affiliated skilled nursing, assisted living and independent living facilities used in our operations under the Master Leases as a result of the tax free spin-off (Spin-Off). The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%.

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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 $28.0 million for the three and six months ended June 30, 2016 and 2015, respectively.

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 June 30, 2016, we were in compliance with the Master Leases' covenants.

During the first quarter of 2016, we voluntarily discontinued operations in one of our skilled nursing facilities in order to preserve the overall ability to serve the residents in surrounding counties after careful consideration and some clinical survey challenges. As part of this closure, we entered into an agreement with our landlord allowing for the closure of the property as well as other provisions to allow our landlord to transfer the property and the licenses free and clear of the applicable master lease. This arrangement will not impact the rent expense to be paid in 2016 or expected to be paid in future periods and will have no material impact on our lease coverage ratios under the Master Leases.

We also lease certain affiliated facilities and our administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. We have entered into multiple lease agreements with various landlords to operate newly constructed state-of-the-art, full-service healthcare resorts upon completion of construction. The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, we lease certain of our equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $30.9 million and $58.1 million for the three and six months ended June 30, 2016, respectively, and $19.2 million and $38.3 million for the three and six months ended June 30, 2015, respectively.

Thirty-seven of our affiliated facilities, excluding the facilities that are operated under the Master Leases from CareTrust, are operated under five separate 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 June 30, 2016.

U.S. Government Inquiry

In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern

California. We resolved and settled the matter for $48.0 million in 2013.

In October 2013, we and the government executed a final settlement agreement in accordance with the April agreement and we remitted full payment of $48.0 million. In addition, we executed a five-year corporate integrity agreement with the Office of Inspector General HHS as part of the resolution.
See additional description of our contingencies in Notes 16, Debt, 18, Leases and 19, Commitments and Contingencies in Notes to Condensed Consolidated Financial Statements.

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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 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 SEC under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) Accounting Standards Codification™ (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to us. 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 2016, the FASB issued its standard to simplify several aspects the accounting for employee share-based payment transactions, which includes the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. This guidance will be effective for annual periods beginning after December 15, 2016, which will be our fiscal year 2017, with early adoption permitted. We are currently assessing whether the adoption of the guidance will have a material impact on our consolidated financial statements.

In March 2016, the FASB issued its standard to amend the principal-versus-agent implementation guidance and illustrations in the Board's new revenue standard, which includes accounting implication related to (1) determining the appropriate unit of account under the revenue standard's principal-versus-agent guidance and (2) applying the indicators of whether an entity is a principal or an agent in accordance with the revenue standard's control principle. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be our fiscal year 2018. The guidance has the same effective date as the new revenue standard and we are required to adopt the guidance by using the same transition method we would use to adopt the new revenue standard. We are currently assessing whether the adoption of the guidance will have a material impact on our consolidated financial statements.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would

generally result in lease expense being recognized on a straight-line basis over the lease term. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2018, which will be our fiscal year 2019, with early adoption permitted. The adoption of this standard is expected to have a material impact on our financial position. We are currently assessing the material impact of adopting the guidance on our consolidated financial statements.

In January 2016, the FASB issued amended authoritative guidance which makes targeted improvements for financial instruments. The new provisions impact certain aspects of recognition, measurement, presentation and disclosure requirements of financial instruments. Specifically, the guidance will (i) require equity investments to be measured at fair value with changes in fair value recognized in net income, (ii) simplify the impairment assessment of equity investments without readily determinable fair values, (iii) eliminate the requirement to disclose the method and assumptions used to estimate fair value for financial instruments measured at amortized cost, and (iv) require separate presentation of financial assets and financial liabilities by measurement category. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2017,

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which will be our fiscal year 2018, with early adoption not permitted. We do not expect the adoption of the guidance will have a material impact on our consolidated financial statements.

In May 2014, the FASB and International Accounting Standards Board issued their final standard on revenue from contracts with customers that outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. The new standard supersedes most current revenue recognition guidance, including industry-specific guidance. In July 2015, the FASB formally deferred for one year the effective date of the new revenue standard and decided to permit entities to early adopt the standard. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be our fiscal year 2018. We are currently assessing whether the adoption of the guidance will have a material impact on our consolidated financial statements.

Off-Balance Sheet Arrangements

As of June 30, 2016, we had approximately $2.3 million on the Amended Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

Item 3. Quantitative and Qualitative Disclosures about Market Risk

Interest Rate Risk. We are exposed to risks associated with market changes in interest rates. The Amended Credit Facility exposes us to variability in interest payments due to changes in LIBOR interest rates. We manage our exposure to this market risk by monitoring available financing alternatives. Our mortgages and promissory notes require principal and interest payments through maturity pursuant to amortization schedules.

Our mortgages generally contain provisions that allow us to make repayments earlier than the stated maturity date. In some cases, we are not allowed to make early repayment prior to a cutoff date. Where prepayment is permitted, we are generally allowed to make prepayments only at a premium which is often designed to preserve a stated yield to the note holder. These prepayment rights may afford us opportunities to mitigate the risk of refinancing our debts at maturity at higher rates by refinancing prior to maturity.
At June 30, 2016, our subsidiaries had $170.0 million outstanding under the Amended Credit Facility. On July 19, 2016, we entered into the Second Amended Credit Facility with a lending consortium arranged by SunTrust to make available a credit facility consisting of a $300.0 million revolving line of credit and a $150.0 million term loan component. Under the Second Amended Credit Facility, we may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $150.0 million. Borrowings under the Second Amended Credit Facility bear interest, at our option, equal to either a base rate plus a premium or LIBOR plus a premium. In addition, we are subject to pay a commitment fee on the unused portion of the commitments under the Second Amended Credit Facility discussed in Item 2 of this Quarterly Report under the heading “Liquidity and Capital Resources.” The loans under the Second Amended Credit Facility matures on February 5, 2021. Our exposure to fluctuations in interest rates may increase or decrease in the future with increases or decreases in the outstanding amount under the Second Amended Credit Facility.

Our cash and cash equivalents as of June 30, 2016 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2016, we held debt security investments of approximately $34.5 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 June 30, 2016 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

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Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended, 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 June 30, 2016, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

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PART II.

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, 2015. In addition, for more information regarding our legal proceedings, please see Note 19, 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.

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

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the Federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by FERA, health care providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government can argue, therefore, that a FCA violation can occur without any affirmative fraudulent action or statement, as long as it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also

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

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and we are routinely subjected to varying types of claims. One particular type of suit arises from alleged violations of state-established minimum staffing requirements for skilled nursing facilities. Failure to meet these requirements can, among other things, jeopardize a facility's compliance with conditions of participation under certain state and federal healthcare programs; it may also subject the facility to a notice of deficiency, a citation, civil monetary penalty, or litigation. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements, and have become more prevalent in the wake of a previous substantial jury award against one of our competitors. We expect the plaintiffs' bar to continue to be aggressive in their pursuit of these staffing and similar claims.

We have in the past been subject to class action litigation involving claims of violations of various regulatory requirements. While we have been able to settle these claims without a material ongoing adverse effect on our business, future claims could be

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brought that may materially affect our business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in the industry. By way of recent example, we defended a general/premise liability claim in San Luis Obispo, California, on behalf of an affiliated facility, involving an injury to a non-employee/contractor. We estimate that the settlement relative to this case will be approximately $1.6 million, which was recorded in the condensed consolidated financial statements in the quarter ended June 30, 2016. There will not be a material ongoing adverse effect on our business, financial condition or results of operations in connection with the verdict.

Item 1A. Risk Factors

Risks Related to Our Business and Industry

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

We derived 37.3% and 36.9% of our revenue from the Medicaid program for the three and six months ended June 30, 2016, respectively, and 37.8% and 38.1% of our revenue from the Medicaid program for the three and six months ended June 30, 2015, respectively. We derived 29.1% and 28.9% of our revenue from the Medicare program for the three and six months ended June 30, 2016, respectively, and 30.7% of our revenue from the Medicare program for each of the three and six months ended June 30, 2015, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our patients.

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting base rates or basis of payment, retroactive rate adjustments, annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to Medicare beneficiaries, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates and frequency at which these programs reimburse us for our services. For example, the Medicaid Integrity Contractor (MIC) program is increasing the scrutiny placed on Medicaid payments, and could result in recoupments of alleged overpayments in an effort to rein in Medicaid spending. Recent budget proposals and legislation at both the federal and state levels have called for cuts in reimbursement for health care providers participating in the Medicare and Medicaid programs. Enactment and implementation of measures to reduce or delay reimbursement could result in substantial reductions in our revenue and profitability. Payors may disallow our requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable because either adequate or additional documentation was not provided or because certain services were not covered or considered reasonably necessary. Additionally, revenue from these payors can be retroactively adjusted after a new examination during the claims settlement process or as a result of post-payment audits. New legislation and regulatory proposals could impose further limitations on government payments to healthcare providers.

In addition, on October 1, 2010, the next generation of the Minimum Data Set (MDS) 3.0 was implemented, creating significant changes in the methodology for calculating the resource utilization group (RUG) category under Medicare Part A, most notably eliminating Section T. Because therapy does not necessarily begin upon admission, MDS 2.0 and the RUGS-III system included a provision to capture therapy services that are scheduled to occur but have not yet been provided in order to calculate a RUG level that better reflects the level of care the recipient would actually

receive. This is eliminated with MDS 3.0, which creates a new category of assessment called the Medicare Short Stay Assessment. This assessment provides for calculation of a rehabilitation RUG for patients discharged on or before day eight who received less than five days of therapy.

On February 2, 2016, CMS issued its final rule concerning face-to-face requirements for Medicaid home health services. Under the rule, the Medicaid home health service definition was revised consistent with applicable sections of the PPACA and H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The rule also requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule also requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician provider (NPP) must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than 6 months prior to the start of services.

On July 25, 2016, CMS issued a proposed rule to implement mandatory bundled payment programs for cardiac care and hip/femur procedures. The two new mandatory programs mirror the Bundled Payments for Care Improvement (BPCI) and

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Comprehensive Care for Joint Replacement (CJR) models in that actual episode payments would be retrospectively compared against a target price. Similar to CJR, participating hospitals would be at risk for Medicare Part A and B payments in the inpatient admission and 90 days post-discharge. BPCI episodes would continue to take precedence over episodes in the CJR program and in the new cardiac bundled payment program. The cardiac model would be mandatory in 98 randomly selected geographic areas and the hip/femur procedure model would be mandatory in the same 67 geographic areas that were selected for CJR. CMS is also providing "Cardiac Rehabilitation Incentive Payments", which can be used by hospitals to facilitate cardiac rehabilitation plans and adherence. The incentive will be provided to hospitals in 45 of the 98 geographic areas included in the mandatory bundled payment program and 45 geographic areas outside of the program. The proposed rule has a tentative start date of July 1, 2017 for a running period of five performance years.

On November 16, 2015, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for a new mandatory Comprehensive Care for Joint Replacement (CJR) model focusing on coordinated, patient-centered care. Under this model, the hospital in which the hip or knee replacement takes place is accountable for the costs and quality of care from the time of the surgery through 90 days after, or an "episode" of care. Depending on the hospital's quality and cost performance during the episode, the hospital either earns a financial reward or is required to repay Medicare for a portion of the costs. This payment is intended to give hospitals an incentive to work with physicians, home health agencies and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. This model initially covers 67 geographic areas throughout the country and most hospitals in those regions are required to participate. Following the implementation of the CJR program on April 1, 2016, our Medicare revenues derived from our affiliated skilled nursing facilities and other post-acute services related to lower extremity joint replacement hospital discharges could be increased or decreased in those geographic areas identified by CMS for mandatory participation in the bundled payment program.

On October 1, 2015, International Classification of Diseases (ICD) 10 was implemented as the new medical coding system. Some of the main points include: Claims with antibiotic removal devices (ARDs) on or after October 1, 2015 must contain a valid ICD-10 code. CMS will reject MDS assessments if a Section I diagnosis code version does not apply for the ARD entered. Flexibility is being provided to physician providers with coding, but this flexibility will not be passed on to facility-based providers, including skilled nursing facilities that are providing Part B services.

On July 13, 2015, CMS released a proposed rule that would reform requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in Medicare and Medicaid. The rule would reorder, clarify, and update regulations that the agency has not reviewed comprehensively since 1991. Under the proposed rule, facilities are required to 1) create interim care plans within 48 hours of admission, notify a resident's physician after a change in status, engage in interdisciplinary care planning, have a practitioner assess the patient in-person prior to a transfer to the hospital, and improve clinical records to ensure providers have the necessary information to decide on hospitalization; 2) conduct comprehensive assessments of their staff and patient needs, apply current requirements for antipsychotic drugs to all psychotropic drugs, and require physicians to document their response to irregularities identified by consultant pharmacists; 3) conduct assessments of their resident population, implement and update periodically an infection prevention and control program, and establish an antibiotic stewardship program; 4) address requirements related to behavioral health services, ensuring facilities have adequate staffing to meet the needs of residents with mental illness and cognitive impairment; and 5) conduct assessments of their patient populations and related care needs to determine adequate staffing levels (i.e., number and skillsets) for nursing, behavioral health, and nutritional services. CMS estimates that these proposed regulations would cost facilities nearly $46.5 million in the first year and over $40.6 million in subsequent years. However, these amounts would vary considerably among organizations. In addition to the monetary costs, these regulations may create compliance issues, as state regulators and surveyors interpret requirements that are less explicit.

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

methods of payment for our services and the underlying regulatory environment. These reforms include the possible modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers.

On July 29, 2016, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the proposed rule continue to shift Medicare payments from volume to value. CMS projects that aggregate payments to skilled nursing facilities will increase by a net 2.4% for fiscal year 2017. This estimate increase reflected a 2.7% market basket increase, reduced by a 0.3% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA). This final rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports. The Value-Based Purchasing Program final rule specifies the skilled

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nursing facility 30-day potentially preventable readmission measure, which assesses the facility-level risk standardized rate of unplanned, potentially preventable hospital readmissions for skilled nursing facility patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital. There is also finalized additional policies related to the Value-Based Purchasing Program including: establishing performance standards; establishing baseline and performance periods; adopting a performance scoring methodology; and providing confidential feedback reports to the skilled nursing facilities.

On July 30, 2015, CMS published its final rule outlining fiscal year 2016 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by 1.2% for fiscal year 2016. This estimate increase reflected a 2.3% market basket increase, reduced by a 0.6% point forecast error adjustment and further reduced by 0.5% MFP adjustment required by the Patient Protection and Affordable Care Act (PPACA). This final rule also identified a new skilled nursing facility value-based purchasing program and all-cause all-condition hospital readmission measure.

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% MFP adjustment required by PPACA.

On June 6, 2016, CMS issued proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2017. Under this proposed rule, CMS projects that Medicare payments will be reduced by 1.0%. This decrease reflects a 2.3% reduction in the rebasing adjustments in the home health prospective payment system and a negative 0.97% adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth, 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; and the effects of the proposed increase to the fixed-dollar loss (FDL) ratio used in determining outlier payments; partially offset by the home health payment update percentage of 2.3%.

On November 5, 2015, CMS issued a final rule updating the Medicare HH PPS rates and wage index for calendar year 2016. In the final rule, CMS implemented the third year of the four year phase-in of rebasing adjustments to the HH PPS payment rates as required by PPACA. In addition, CMS will decrease the national, standardized 60-day episode payment amount by 0.97% in each year for calendar years 2016, 2017 and 2018. Pursuant to the rule, CMS is also implementing a Home Health Value-Based Purchasing model effective for calendar year 2016, in which all Medicare-certified HHAs will be required to participate. In the aggregate, CMS estimates that the net impact of the payment provisions of the final rule will result in a decrease of 1.4%, or $260 million, in aggregate Medicare payments to HHAs for calendar year 2016.

Pursuant to the rule, CMS is also implementing a Home Health Value-Based Purchasing model effective for calendar year 2016, in which all Medicare-certified home health agencies (HHAs) in selected states will be required to participate. The model would apply a payment reduction or increase to current Medicare-certified HHA payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 3.0% in the first payment adjustment year, 5.0% in the second payment adjustment year, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years. CMS estimates that implementing a home health value-based model will result in a 1.4% decrease in Medicare payments to home health agencies across the industry.

Lastly, CMS implemented a standardized cross-setting measure for calendar year 2016. The Home Health Conditions of Participation (CoPs) require home health agencies to submit OASIS assessments as a condition of payment and also

for quality measurement purposes. Home health agencies that do not submit quality measure data to CMS will see a 2.0% reduction in their annual home health payment update percentage. Under the rule, all home health agencies are required to submit both admission and discharge OASIS assessments for a minimum of 70.0% of all patients with episodes of care occurring during the reporting period starting July 1, 2015. The rule will incrementally increase this compliance threshold by 10.0% in each of the subsequent periods (July 1, 2016 and July 1, 2017) to reach 90.0%.

On October 30, 2014, CMS announced payment changes to the Medicare HH PPS for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the 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 ACA. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if a 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

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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 July 29, CMS issued its final rule outlining fiscal year 2017 Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries. Under the final rule, hospices will see a 2.1% increase in their payments effective October 1, 2016. The hospice payment increase will be the net result of 2.7% inpatient hospital market basket update, reduced by a 0.3% productivity adjustment and by a 0.3% adjustment set by the Affordable Care Act. The hospice cap amount for fiscal year 2017 will be increased by 2.1% to $28,404.99, which is equal to the 2016 cap amount of $27,820.75 updated by the FY 2017 hospice payment update percentage of 2.1%. In addition, this rule would propose changes to the hospice quality reporting program, including care surveys and two new quality measures that will assess hospice staff visits to patients and caregivers in the last three and seven days of life and the percentage of hospice patients who received care processes consistent with guidelines.

On July 31, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.1% increase in their payments effective October 1, 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 2.4% minus 0.3% for reductions required by law) and a 1.2% decrease in payments to hospices due to updated wage data and the phase-out of its wage index budget neutrality adjustment factor (BNAF), offset by the newly announced Core Based Statistical Areas (CBSA) delineation impact of 0.2%. The rule also created two different payment rates for routine home care (RHC) that would result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for 61 or more days of hospice care and a Service Intensity Add-On (SIA) Payment for fiscal year 2016 and beyond in conjunction with the proposed RHC rates.

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS’ seven-year phase-out of its wage index 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 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 maintained the 0.5% update for such services through December 31, 2014 and provides a 0.0% update to the 2015 Medicare Physician Fee Schedule (MPFS) through March 31, 2015. Among other things, this law provides the framework for implementation of a value-based purchasing program for skilled nursing facilities. Under this legislation HHS is required to develop by October 1, 2016 measures and performance standards regarding preventable hospital readmissions from skilled nursing facilities. Beginning October 1, 2018, HHS will withhold 2% of Medicare payments to all skilled nursing facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

On April 25, 2016, CMS published a proposed rule laying out the performance standards relating to preventable hospital readmissions from skilled nursing facilities. The proposed rule includes the SNF 30-day All Cause Readmission Measure which assesses the risk-standardized rate of all-cause, all condition, unplanned inpatient

hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from admission to an inpatient prospective payment system hospital, CAH or psychiatric hospital. The proposed rule includes the SNF 30-Day Potentially Preventable Readmission Measure as the SNF all condition risk adjusted potentially preventable hospital readmission measure. This proposed measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital. Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable. This proposed measure is claims-based, requiring no additional data collection or submission burden for SNFs.

In addition, the proposed rule states, beginning in 2019, the achievement performance standard for skilled nursing facilities for quality measures specified under the SNF Value Based Purchasing Program ("SNF VBP") will be the 25th percentile of national SNF performance on the quality measure during the applicable baseline period. This will affect the value based incentive payments paid to skilled nursing facilities.

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On April 16, 2015, the President signed into law MACRA. This bill includes a number of provisions, including replacement of the Sustainable Growth Rate (SGR) formula used by Medicare to pay physicians with new systems for establishing annual payment rate updates for physicians' services. In addition, it increases premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels and makes numerous other changes to Medicare and Medicaid.

On October 30, 2015, CMS released a final rule (with comment period) addressing, among other things, implementation of certain provisions of MACRA, including the implementation of the new Merit-Based Incentive Payment System (MIPS). The current Value-Based Payment Modifier program is set to expire in 2018, with MIPS to begin in 2019. The October 30, 2015 final rule added measures where gaps exist in the current Physician Quality Reporting System (PQRS), which is used by CMS to track the quality of care provided to Medicare beneficiaries. The final rule also excludes services furnished in SNFs from the definition of primary care services for purposes of the Shared Savings Program. The final rule could impact our revenue in the future.

The Improving Medicare Post-Acute Care Transformation Act of 2014 (the IMPACT Act), which was signed into law on October 6, 2014, requires the submission of standardized assessment data for quality improvement, payment and discharge planning purposes across the spectrum of post-acute care providers (PACs), including skilled nursing facilities and home health agencies. The IMPACT Act will require PACs to begin reporting: (1) standardized patient assessment data at admission and discharge by October 1, 2018 for post acute care providers, including skilled nursing facilities by January 1, 2019 for home health agencies; (2) new quality measures, including functional status, skin integrity, medication reconciliation, incidence of major falls, and patient preference regarding treatment and discharge at various intervals between October 1, 2016 and January 1, 2019; and (3) resource use measures, including Medicare spending per beneficiary, discharge to community, and hospitalization rates of potentially preventable readmissions by October 1, 2016 for post-acute care providers, including skilled nursing facilities and by January 1, 2017 for home health agencies. Failure to report such data when required would subject a facility to a two percent reduction in market basket prices then in effect.

The IMPACT Act further requires HHS and the Medicare Payment Advisory Commission (MedPAC), a commission chartered by Congress to advise it on Medicare payment issues, to study alternative PAC payment models, including payment
based upon individual patient characteristics and not care setting, with corresponding Congressional reports required based on
such analysis. The IMPACT Act also included provisions impacting Medicare-certified hospices, including: (1) increasing survey frequency for Medicare-certified hospices to once every 36 months; (2) imposing a medical review process for facilities with a high percentage of stays in excess of 180 days; and (3) updating the annual aggregate Medicare payment cap.

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 created a Commission on Long Term Care, the goal of which was 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.

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

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

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

Medicaid, which is largely administered by the states, is a significant payor for our skilled nursing services. Rapidly increasing Medicaid spending, combined with slow state revenue growth, has led many states to institute measures aimed at controlling spending growth. For example, in February 2009, the California legislature approved a new budget to help relieve a $42 billion budget deficit. The budget package was signed after months of negotiation, during which time California's governor declared a fiscal state of emergency in California. The new budget implemented spending cuts in several areas, including Medi-Cal spending. Further, California initially had extended its cost-based Medi-Cal long-term care reimbursement system enacted through Assembly Bill 1629 (A.B.1629) through the 2009-2010 and 2010-2011 rate years with a growth rate of up to five percent for both years. However, due to California's severe budget crisis, in July 2009, the State passed a budget-balancing proposal that eliminated this five percent growth cap by amending the current statute to provide that, for the 2009-2010 and 2010-2011 rate years, the weighted

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

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

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

We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations.

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

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

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

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

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To address potential fraud and abuse in federal health care programs, including Medicare and Medicaid, PPACA includes provider screening and enhanced oversight periods for new providers and suppliers, as well as enhanced penalties for submitting false claims. It also provides funding for enhanced anti-fraud activities. The new law imposes enrollment moratoria in elevated risk areas by requiring providers and suppliers to establish compliance programs. PPACA also provides the federal government with expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud. Section 6402 of the PPACA provides that Medicare and Medicaid payments may be suspended pending a "credible investigation of fraud," unless the Secretary of HHS 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, 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 27, 2016, CMS added six new quality measures to its consumer-based Nursing Home Compare website. These quality measures include the rate of rehospitalization, emergency room use, community discharge, improvements in function, independently worsened and antianxiety or hypnotic medication among nursing home residents. Beginning in July 2016, CMS will incorporate all of these measures, except for the antianxiety/hypnotic

medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings.

On July 6, 2015, CMS announced a proposal to launch Home Health Value-Based Purchasing model to test whether incentives for better care can improve outcomes in the delivery of home health services. The model would apply a payment reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 5.0% in each of the first two payment adjustment years, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years.

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.

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

We cannot predict what effect these changes will have on our business, including the demand for our services or the amount of reimbursement available for those services. However, it is possible these new laws may lower reimbursement and adversely affect our business.

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

In addition, the Affordable Care Act could result in sweeping changes to the existing U.S. system for the delivery and financing of health care. The details for implementation of many of the requirements under the Affordable Care Act will depend on the promulgation of regulations by a number of federal government agencies, including the HHS. It is impossible to predict the outcome of these changes, what many of the final requirements of the Health Reform Law will be, and the net effect of those requirements on us. As such, we cannot predict the impact of the Affordable Care Act on our business, operations or financial performance.

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

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

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

Our success depends upon our ability to retain and attract nurses, Certified Nurse Assistants (CNAs) and therapists. Our success also depends upon our ability to retain and attract skilled management personnel who are responsible for the day-to-day operations of each of our affiliated facilities. Each facility has a facility leader responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Depending upon the size of the facility, each facility leader is supported by facility staff that is directly responsible for day-to-day care of the patients and marketing and community outreach programs. Other key positions supporting each facility may include individuals responsible for physical, occupational and speech therapy, food service and

maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

We operate one or more affiliated skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, 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

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regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.

Increased competition for or a shortage of nurses or other trained personnel, or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge to the patients of our operating subsidiaries. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility. An increase in costs associated with, or a shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

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

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

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 in extended

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prepayment review, although some may be placed on prepayment review in the future. As of June 30, 2016, we have eleven operating subsidiaries that were subject to probe reviews, both pre- and post-payment. Five of these reviews have successfully closed and six are in process.

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, HHS has adopted a rule that requires CMS to charge user fees to healthcare facilities cited during regular certification, recertification or substantiated complaint surveys for deficiencies, which require a revisit to assure that corrections have been made. CMS is also increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey facilities more consistently.

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other 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. In the first quarter of 2016, we elected to voluntarily close one operating subsidiary as a result of multiple regulatory deficiencies in order to avoid continued strain on our staff and other resources and to avoid restrictions on our ability to acquire new facilities or expand or operate existing facilities. In addition, from time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements. If we elect to voluntary close any operations in

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the future or to opt to stop accepting new patients pending completion of a state or federal survey, it could negatively impact our financial condition and results of operation.

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.

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 five operating subsidiaries from the program to date. Other operating subsidiaries may be identified for such status in the future.

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

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

The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006 for patients with certain conditions or multiple complexities whose therapy services are reimbursed under Medicare Part B. A significant portion of the patients in our affiliated skilled nursing facilities and patients served by our rehabilitation therapy programs whose therapy is reimbursed under Medicare Part B have qualified for the exceptions to these reimbursement caps. DRA added Section 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, including the Protecting Access to Medicare Act of 2014. All beneficiaries began a new cap year on January 1, 2015 since the therapy caps are

determined on a calendar year basis. For physical therapy (PT) and speech-language pathology services (SLP) combined, the limit on incurred expenses is $1,960 in 2016 compared to $1,940 in 2015. For occupational therapy (OT) services, the limit is $1,960 in 2016 compared to $1,960 in 2015. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

The Multiple Procedure Payment Reduction (MPPR) continues at a 50% reduction applied to therapy procedure codes 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.

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The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Most recently, the therapy cap exception was extended through December 31, 2017 pursuant to MACRA.

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

With respect to our hospice operating subsidiaries, overall payments made by Medicare to each provider number are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we are required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. During the six months ended June 30, 2016, we recorded $0.4 million of hospice cap expense.

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;
- 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 a corporate integrity agreement, 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

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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. The PPACA supplements FERA by imposing an affirmative obligation on health care providers to return an overpayment to CMS within 60 days of "identification" or the date any corresponding cost report is due, whichever is later. On August 3, 2015, the U.S. District Court for the Southern District of New York held that the 60 day clock following "identification" of an overpayment begins to run when a provider is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained. On February 12, 2016, CMS published a final rule with respect to Medicare Parts A and B clarifying that providers have an obligation to proactively exercise "reasonable diligence," and that the 60 day clock begins to run after the reasonable diligence period has concluded, which may take at most 6 months from the from receipt of credible information, absent extraordinary circumstances. Retention of any overpayment beyond this period may result in FCA liability. 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 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, HHS 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;

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- 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;

- 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 operating subsidiaries were decertified or excluded from participating in Medicaid or Medicare programs, our revenue would be adversely affected.

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The Office of the Inspector General or other regulatory authorities may choose to more closely scrutinize billing practices in areas where we operate or propose to expand, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.

In March 2016, the OIG released a report entitled "Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care." The report analyzed the results of a medical record review of 2012 hospice general inpatient care stays to estimate the percentage of such stays that were billed inappropriately, and found that hospices billed one-third of general inpatient stays inappropriately, costing Medicare $268 million in 2012. Consequently, the OIG recommended, and CMS concurred with such recommendations, that CMS (1) increase its oversight of hospice general inpatient stay claims and review Part D payments for drugs for hospice beneficiaries; (2) ensure that a physician is involved in the decision to use general inpatient care; (3) conduct prepayment reviews for lengthy general inpatient care stays; (4) increase surveyor efforts to ensure that hospices meet care planning requirements; (5) establish additional enforcement remedies for poor hospice performance; and (6) follow up on inappropriate general inpatient care stays.

In September 2015, the OIG released a report entitled "The Medicare Payment System for Skilled Nursing Facilities Needs to Be Reevaluated." Among other things, the report used Medicare cost reports to compare Medicare payments to skilled nursing facilities' costs for therapy over a ten year period, and found that Medicare payments for therapy greatly exceeded skilled nursing facilities' costs for therapy. The OIG recommended, and CMS concurred with such recommendations, that CMS evaluate the extent to which Medicare payment rates for therapy should be reduced, change the method for paying for therapy, adjust Medicare payments to eliminate any increases that are unrelated to beneficiary characteristics, and strengthen oversight of Skilled Nursing Facility billing.

In January 2015, the OIG released a report entitled "Medicare Hospices Have Financial Incentives to Provide Care in Assisted Living Facilities." The report analyzed all Medicare hospices claims from 2007 through 2012, and raised concerns about the financial incentives created by the current payment system and the potential for hospices-especially for-profit hospices-to target beneficiaries in assisted living facilities because they may offer the hospices the greatest financial gain. Accordingly, the report recommended that CMS reform payments to reduce the incentive for hospices to target beneficiaries with certain diagnoses and those likely to have long stays, target certain hospices for review, develop and adopt claims-based measures of quality, make hospice data publicly available for the beneficiaries, and provide additional information to hospices to educate them about how they compare to their peers. CMS concurred with all five recommendations.

In August 2012, the OIG released a report entitled "Inappropriate and Questionable Billing for Medicare Home Health Agencies." The report analyzed data from home health, inpatient hospital, and skilled nursing facilities claims from 2010 to identify inappropriate home health payments. The report found that in 2010, Medicare made overpayments largely in connection with three specific errors: overlapping with claims for inpatient hospital stays, overlapping with claims for skilled nursing facility stays, or billing for services on dates after beneficiaries' deaths. The report also concluded that home health agencies with questionable billing were located mostly in Texas, Florida, California, and Michigan. The report recommended that CMS implement claims processing edits or improve existing edits to prevent inappropriate payments for the three specific errors referenced above, increase monitoring of billing for home health services, enforce and consider lowering the ten percent cap on the total outlier payments a home health agency may receive annually, consider imposing a temporary moratorium on new home health agency enrollments in Florida and Texas, and take appropriate action regarding the inappropriate payments identified and home health agencies with questionable billing. CMS concurred with all five recommendations. Moratoria were subsequently put in place, and effective January 29, 2016, moratoria on new home health agencies and home health agency sub-units were extended for an additional six months in various counties in Florida, Michigan, Texas and Illinois. Additionally, following recommendations made by the OIG in an April 2014 report entitled "Limited Compliance with Medicare's Home

Health Face-to-Face Documentation Requirements," CMS committed to implement a plan for oversight of home health agencies through Supplemental Medical Review Contractor audits of every home health agency in the country.

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

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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.

In addition, in its 2016 Work Plan, the OIG indicated that it will review compliance with various aspects of the skilled nursing facility prospective payment system, including the documentation requirement in support of the claims paid by Medicare. According to the 2016 Work Plan, prior OIG reviews found that Medicare payments for therapy greatly exceeded skilled nursing facilities’ cost for therapy, and the OIG found that skilled nursing facilities have increasingly billed for the highest level of therapy even though key beneficiary characteristics remained largely the same. The OIG’s 2016 Work Plan provides that the OIG will review Medicare payments for portable x-ray equipment and services to determine whether payments were correct and were supported by documentation.

Efforts by officials and others to make or advocate for any increase in regulatory monitoring and oversight, adversely change RUG rates, reduce payment rates, revise methodologies for assessing and treating patients, conduct more frequent or intense reviews of our treatment and billing practices, or implement moratoria in areas where we operate or propose to expand, could reduce our reimbursement, increase our costs of doing business and otherwise adversely affect our business, financial condition and results of operations.

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

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

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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.

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 three and six months ended June 30, 2016, 66.4% and 65.8%, respectively, 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.

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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 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.

We have in the past been subject to class action litigation involving claims of violations of various regulatory requirements. While we have been able to settle these claims without a material ongoing adverse effect on our business, future claims could be brought that may materially affect our business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. For example, there has been 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

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litigation decided to disregard the corporate form, the resulting judgment could increase our liability and adversely affect our financial condition and results of operations.

On February 26, 2009, Congress reintroduced the Fairness in Nursing Home Arbitration Act of 2009. After failing to be enacted into law in the 110th Congress in 2008, the Fairness in Nursing Home Arbitration Act of 2009 was introduced in the 111th Congress and referred to the House and Senate judiciary committees in March 2009. The 111th Congress did not pass the bill and therefore has been cleared from the present agenda. This bill was reintroduced in the 112th Congress as the Fairness in Nursing Home Arbitration Act of 2012, and was referred to the House Judiciary committee. If enacted, this bill would require, among other things, that agreements to arbitrate nursing home disputes be made after the dispute has arisen rather than before prospective patients move in, to prevent nursing home operators and prospective patients from mutually entering into a pre-admission pre-dispute arbitration agreement. We use arbitration agreements, which have generally been favored by the courts, to streamline the dispute resolution process and reduce our exposure to legal fees and excessive jury awards. If we are not able to secure pre-admission arbitration agreements, our litigation exposure and costs of defense in patient liability actions could increase, our liability insurance premiums could increase, and our business may be adversely affected.

The U.S. Department of Justice has conducted an investigation into the billing and reimbursement processes of some of our operating subsidiaries, which could adversely affect our operations and financial condition.

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

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

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

If any additional litigation were to proceed in the future, and we are subjected to, alleged to be liable for, or agree to a settlement of, claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, our business, financial condition and results of operations and cash flows could be materially and adversely affected and our stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include our assumption of specific procedural and financial obligations going forward under a corporate integrity

agreement and/or other arrangement with the government.

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

As an operator of healthcare facilities, we have a program to help us comply with various requirements of federal and private healthcare programs. Our compliance program includes, among other things, (1) policies and procedures modeled after applicable laws, regulations, government manuals and industry practices and customs that govern the clinical, reimbursement and operational aspects of our subsidiaries, (2) training about our compliance process for all of the employees of our operating subsidiaries, our directors and officers, and training about Medicare and Medicaid laws, fraud and abuse prevention, clinical standards and practices, and claim submission and reimbursement policies and procedures for appropriate employees, and (3) internal controls that monitor, for example, the accuracy of claims, reimbursement submissions, cost reports and source documents, provision of patient care,

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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. Furthermore, failure to refund overpayments within required time frames (as described in greater detail above) could result in Federal False Claims Act (FCA) liability. 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.

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 impacted by our acquisition of new facilities and businesses. Subject to general market conditions and the availability of essential resources and leadership within our company, we continue to seek both single-and multi-facility acquisition and business acquisition opportunities that are consistent with our geographic, financial and operating objectives.

We face competition for the acquisition of facilities and businesses and expect this competition to increase. Based upon factors such as our ability to identify suitable acquisition candidates, 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.

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During the six months ended June 30, 2016, we continued to expand our operations with the addition of eighteen stand-alone skilled nursing operations, three newly constructed post-acute care campus, one home health and two hospice agencies with a total of 2,407 operational skilled nursing beds and 95 operational assisted living units. During the year ended December 31, 2015, we expanded our operations with the addition of 50 stand-alone skilled nursing and assisted living operations, seven home health, hospice and home care operations and three urgent care centers with a total of 2,580 operational skilled nursing beds and 2,391 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 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've had other affiliated facilities that have successfully graduated from the program. Other affiliated facilities may be identified for special focus 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

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expected benefits of the acquisition and would likely incur unanticipated costs and other challenges which could cause our business to suffer.

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

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

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

The post-acute care industry is highly competitive, and we expect that our industry 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.

On February 20, 2015, CMS modified the Five Star Quality Rating System for nursing homes to include the use of antipsychotics in calculating the star ratings, modified calculations for staffing levels and reflect higher standards for nursing

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homes to achieve a high rating on the quality measure dimension. Since the standards for performance on quality measures are increasing, the number of our 4 and 5 star facilities could be reduced. 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
- insurers or reinsurers are unable or unwilling to insure us or the industry at historical premiums and coverage levels.

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

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

With few exceptions, workers' compensation and employee health insurance costs have also increased markedly in recent years. To partially offset these increases, we have increased the amounts of our self-insured retention (SIR) and deductibles in connection with general and professional liability claims. We also have implemented a self-insurance program for workers compensation in all states, except Washington and Texas, and elected non-subscriber status for workers' compensation in Texas. In Washington, the insurance coverage is financed through premiums paid by the employers and employees. If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, or if the coverage levels we can economically obtain decline, our business may be adversely affected.

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

We have maintained general and professional liability insurance since 2002 and workers' compensation insurance since 2005 through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our self-insurance reimbursements (SIR) and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves based on an estimation process that uses

information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted.

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Further, because our SIR under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.

In May 2006, we began self-insuring our employee health benefits. With respect to our health benefits self-insurance, our reserves and premiums are computed based on a mix of company specific and general industry data that is not specific to our own company. Even with a combination of limited company-specific loss data and general industry data, our loss reserves are based on actuarial estimates that may not correlate to actual loss experience in the future. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.

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

Our affiliated facilities located in Arizona, California, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since 23.3% 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.

In addition, our affiliated facilities in Iowa, Nebraska, Kansas, South Carolina, Washington and Texas are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, tornadoes and flooding. These acts of nature may cause disruption to us, the employees of our operating subsidiaries and our affiliated facilities, which could have an adverse impact on the patients of our operating subsidiaries and our business. In order to provide care for the patients of our operating subsidiaries, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our affiliated facilities, and the availability of employees to provide services at our affiliated facilities. If the delivery of goods or the ability of employees to reach our affiliated facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our affiliated facilities and our business. Furthermore, the impact, or impending threat, of a natural disaster may require that we evacuate one or more facilities, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters and similar events is inherently uncertain. Such events could harm the patients and employees of our operating subsidiaries, severely damage or destroy one or more of our affiliated facilities, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.

We continue to maintain our right to inform the employees of our operating subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staffs at our affiliated facilities that have been approached to unionize have uniformly rejected union organizing efforts. If employees decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

The unwillingness on the part of both our management and staff to accede to union demands for “neutrality” and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International

Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union actively prosecuted a negative retaliatory publicity action, also known as a “corporate campaign,” against us and filed, promoted or participated in multiple legal actions against us. The union's campaign asserted, among other allegations, poor treatment of patients, inferior clinical services provided by the employees of our operating subsidiaries, poor treatment of the employees of our operating subsidiaries, and health code violations by our operating subsidiaries. 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.

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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 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 in the past 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.

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. Further, the expedited election rules adopted by the National Labor Relations Board took effect on April 14, 2015 and make it far easier for unions to organize employees. These and similar laws have the potential to facilitate unionization procedures or hinder employer responses thereto, which may hinder our ability to oppose unionization efforts and negatively affect our business.

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 June 30, 2016, we leased 172 of our 206 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,

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mortgage or operating lease arrangements, which could harm our operating subsidiaries and cause us to lose facilities or experience foreclosures.

As of June 30, 2016, our operating subsidiaries had $170.0 million outstanding under the Amended Credit Facility. On July 19, 2016, we entered into the Second Amended Credit Facility to increase the aggregate principal amount up to $450.0 million comprised of a $300.0 million revolving credit facility and a $150.0 million term loan. We also had other outstanding indebtedness of approximately $14.4 million as of June 30, 2016 under HUD-insured loans and promissory note issued in connection with various acquisitions with maturity dates ranging from 2027 through 2045.

In addition, we had $1.9 billion of future operating lease obligations as of June 30, 2016. We intend to continue financing our operating subsidiaries through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, our outstanding credit 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.

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

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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.

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

Our business is dependent on the proper functioning and availability of our computer systems and networks. While we have taken steps to protect the safety and security of our information systems and the patient health information and other data maintained within those systems, we cannot assure you that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect, we may be unable to anticipate these techniques or implement adequate preventive measures. In addition, hardware, software or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise the security of our information systems. Unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud or other forms of deceiving our employees or contractors.

On occasion, we have acquired additional information systems through our business acquisitions. We have upgraded and expanded our information system capabilities and have committed significant resources to maintain, protect, enhance existing systems and develop new systems to keep pace with continuing changes in technology, evolving industry and regulatory standards, and changing customer preferences.

We license certain third party software to support our operations and information systems. Our inability, or the inability of third party software providers, to continue to maintain and upgrade our information systems and software could disrupt or reduce the efficiency of our operations. In addition, costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our operations.

A cyber security attack or other incident that bypasses our information systems security could cause a security breach which may lead to a material disruption to our information systems infrastructure or business and may involve a significant loss of business or patient health information. If a cyber security attack or other unauthorized attempt to access our systems or facilities were to be successful, it could result in the theft, destructions, loss, misappropriation or release of confidential information or intellectual property, and could cause operational or business delays that may

materially impact our ability to provide various healthcare services. Any successful cyber security attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties and could subject us to substantial penalties under HIPAA and other federal and state privacy laws, in addition to private litigation with those affected.

Failure to maintain the security and functionality of our information systems and related software, or a failure to defend a cyber security attack or other attempt to gain unauthorized access to our systems, facilities or patient health information could expose us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, the OIG or state attorneys general), fines, private litigation with those affected by the data breach, loss of customers, disputes with payors and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

Our ability to maintain and enhance our operating subsidiaries and 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 Credit Facility, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available or available on terms favorable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our billing information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews. For example, 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,

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2011. AB X1 19 limited the 10% payment reduction to skilled-nursing providers to 14 months for the services provided on June 1, 2011 through July 31, 2012. The 10% reduction in provider payments was repaid by December 31, 2012. There can be no assurance that similar delays or reductions in our payment cycle of provider payments will not lead to material adverse consequences in the future.

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

Two 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. This facility was transferred to CareTrust as part of the Spin-Off.

Failure to comply with existing environmental laws could result in increased expenditures, litigation and potential loss to our business and in our asset value.

Our operating subsidiaries are subject to regulations under various federal, state and local environmental laws, primarily those relating to the handling, storage, transportation, treatment and disposal of medical waste; the identification and warning of the presence of asbestos-containing materials in buildings, as well as the encapsulation or removal of such materials; and the presence of other substances in the indoor environment.

Our affiliated facilities generate infectious or other hazardous medical waste due to the illness or physical condition of the patients. Each of our affiliated facilities has an agreement with a waste management company for the proper disposal of all infectious medical waste, but the use of a waste management company does not immunize us from alleged violations of such laws for operating subsidiaries for which we are responsible even if carried out by a third party, nor does it immunize us from third-party claims for the cost to cleanup disposal sites at which such wastes have been disposed.

Some of the affiliated facilities we lease, own or may acquire may have asbestos-containing materials. Federal regulations require building owners and those exercising control over a building's management to identify and warn their employees and other employers operating in the building of potential hazards posed by workplace exposure to installed asbestos-containing materials and potential asbestos-containing materials in their buildings. Significant fines can be assessed for violation of these regulations. Building owners and those exercising control over a building's management may be subject to an increased risk of personal injury lawsuits. Federal, state and local laws and regulations also govern the removal, encapsulation, disturbance, handling and disposal of asbestos-containing materials and potential asbestos-containing materials when such materials are in poor condition or in the event of construction, remodeling, renovation or demolition of a building. Such laws may impose liability for improper handling or a release into the environment of asbestos containing materials and potential asbestos-containing materials and may provide for fines to, and for third parties to seek recovery from, owners or operators of real properties for personal injury or improper work exposure associated with asbestos-containing materials and potential asbestos-containing materials. The presence of asbestos-containing materials, or the failure to properly dispose of or remediate such materials, also may adversely affect our ability to attract and retain patients and staff, to borrow when

using such property as collateral or to make improvements to such property.

The presence of mold, lead-based paint, underground storage tanks, contaminants in drinking water, radon and/or other substances at any of the affiliated facilities we lease, own or may acquire may lead to the incurrence of costs for remediation, mitigation or the implementation of an operations and maintenance plan and may result in third party litigation for personal injury or property damage. Furthermore, in some circumstances, areas affected by mold may be unusable for periods of time for repairs, 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.

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In addition, because environmental laws vary from state to state, expansion of our operating subsidiaries to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our affiliated facilities.

If we fail to safeguard the monies held in our patient trust funds, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties.

Each of our affiliated facilities is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the amount of money that was misappropriated. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties pursuant to federal and state laws.

We are a holding company with no operations and rely upon our multiple independent operating subsidiaries to provide us with the funds necessary to meet our financial obligations. Liabilities of any one or more of our subsidiaries could be imposed upon us or our other subsidiaries.

We are a holding company with no direct operating assets, employees or revenues. Each of our affiliated facilities is operated through a separate, wholly-owned, independent subsidiary, which has its own management, employees and assets. Our principal assets are the equity interests we directly or indirectly hold in our multiple operating and real estate holding subsidiaries. As a result, we are dependent upon distributions from our subsidiaries to generate the funds necessary to meet our financial obligations and pay dividends. Our subsidiaries are legally distinct from us and have no obligation to make funds available to us. The ability of our subsidiaries to make distributions to us will depend substantially on their respective operating results and will be subject to restrictions under, among other things, the laws of their jurisdiction of organization, which may limit the amount of funds available for distribution to investors or shareholders, agreements of those subsidiaries, the terms of our financing arrangements and the terms of any future financing arrangements of our subsidiaries.

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

We are subject to both state and federal income taxes. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in tax laws and regulations, changes in our interpretations of tax laws, including pending tax law changes. In addition, in certain cases more than one state in which we operate has indicated an intent to attempt to tax the same assets and activities, which could result in double taxation if successful. Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.

We are subject to the continuous examination of our income tax returns by the Internal Revenue Service and other local, state and foreign tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. The outcomes from these continuous examinations could adversely affect our provision for income taxes and estimated income tax liabilities.

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

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

Section 355 of the Code, and we received tax opinions from our tax advisor and counsel, substantially to the effect that, with respect to such requirements on which the IRS will not rule, such requirements have been satisfied. The IRS Ruling, and the tax opinions that we received from our tax advisor and counsel, rely on, among other things, certain facts, representations, assumptions and undertakings, including those relating to the past and future conduct of our and CareTrust's businesses, and the IRS Ruling and the tax opinions would not be valid if such facts, representations, assumptions and undertakings were incorrect in any material respect. Notwithstanding the IRS Ruling and the tax opinions, the IRS could determine the Spin-Off should be treated as a taxable transaction for U.S. federal income tax purposes if it determines any of the facts, representations, assumptions or undertakings that were included in the request for the IRS Ruling are false or have been violated or if it disagrees with the conclusions in the opinions that are not covered by the IRS Ruling.

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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 Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement. The failure to pay or maintain dividends could adversely affect our stock price.

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

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

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

In February 2015, we completed a common stock offering, issuing approximately 5.5 million shares at approximately $20.50 per share to pay off outstanding amounts under our credit facility.

In the future, we may attempt to increase our capital resources by offering debt or additional equity securities, including commercial paper, medium-term notes, senior or subordinated notes, preferred shares or shares of our common stock. Upon liquidation, holders of our debt securities and preferred shares, and lenders with respect to other borrowings, would receive a distribution of our available assets prior to any distribution to the holders of our common stock. Additional equity offerings may dilute the economic and voting rights of our existing stockholders or reduce the market price of our common stock, or both.

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Because our decision to issue securities in any future offering will depend on market conditions and other factors beyond our control, we cannot predict or estimate the amount, timing or nature of our future offerings. Thus, holders of our common stock bear the risk of our future offerings reducing the market price of our common stock and diluting their shareholdings in us. We also intend to continue to actively pursue acquisitions of facilities and may issue shares of stock in connection with these acquisitions.

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

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

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

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

Our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law contain provisions that could discourage transactions resulting in a change in control, which may negatively affect the market price of our common stock.

Our amended and restated certificate of incorporation and our amended and restated bylaws contain provisions that may enable our Board of Directors to resist a change in control. These provisions may discourage, delay or prevent a change in the ownership of our company or a change in our management, even if doing so might be beneficial to our stockholders. In addition, these provisions could limit the price that investors would be willing to pay in the future for shares of our common stock. Such provisions set forth in our amended and restated certificate of incorporation or our amended and restated bylaws include:

- our Board of Directors is authorized, without prior stockholder approval, to create and issue preferred stock, commonly referred to as “blank check” preferred stock, with rights senior to those of common stock;

- advance notice requirements for stockholders to nominate individuals to serve on our Board of Directors or to submit proposals that can be acted upon at stockholder meetings;

- our Board of Directors is classified so not all members of our board are elected at one time, which may make it more difficult for a person who acquires control of a majority of our outstanding voting stock to replace our directors;

- stockholder action by written consent is limited;
- special meetings of the stockholders are permitted to be called only by the chairman of our Board of Directors, our chief executive officer or by a majority of our Board of Directors;
- stockholders are not permitted to cumulate their votes for the election of directors;
- 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

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- stockholders are permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

We are also subject to the anti-takeover provisions of Section 203 of the General Corporation Law of the State of Delaware. Under these provisions, if anyone becomes an “interested stockholder,” we may not enter into a “business combination” with that person for three years without special approval, which could discourage a third party from making a takeover offer and could delay or prevent a change of control. For purposes of Section 203, “interested stockholder” means, generally, someone owning more than 15% or more of our outstanding voting stock or an affiliate of ours that owned 15% or more of our outstanding voting stock during the past three years, subject to certain exceptions as described in Section 203.

These and other provisions in our amended and restated certificate of incorporation, amended and restated bylaws and Delaware law could discourage acquisition proposals and make it more difficult or expensive for stockholders or potential acquirers to obtain control of our Board of Directors or initiate actions that are opposed by our then-current Board of Directors, including delaying or impeding a merger, tender offer or proxy contest involving us. Any delay or prevention of a change of control transaction or changes in our Board of Directors could cause the market price of our common stock to decline.

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Item 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

The information set forth below is included for the purpose of providing the disclosure required under “Item 5.02 - Departure of Directors of Certain Officers; Election of Directors; Appointment of Certain Officers; Compensatory Arrangements of Certain Officers” of a Current Report on Form 8-K.

On May 26, 2016, the Company adopted the Cornerstone Healthcare, Inc. 2016 Omnibus Incentive Plan (the Subsidiary Plan), which is a management equity plan for a subsidiary of the Company, Cornerstone Healthcare, Inc., a Nevada corporation (Cornerstone or the Subsidiary). The Company also granted stock options and restricted stock awards to employees and management of Cornerstone as well as the following executive officers of the Company: Christopher Christensen, Suzanne Snapper, Barry Port and Chad Keetch. Under the Subsidiary Plan, the current and future equity awards vest over a period of years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of the Subsidiary. Accordingly, these awards only have value to the extent the relevant Cornerstone business appreciates in value above the initial value utilized to determine the exercise price. Once vested, the awards can be put to the Company for settlement at fair value, beginning six months after the vesting date. The Company can also call the awards, generally post-employment, for settlement at fair value. The foregoing summary of the Subsidiary Plan is qualified by reference to the text of the Subsidiary Plan and relevant grant agreements, which are filed herewith as Exhibits 10.2 and 10.3 to this Report and incorporated herein by reference.

Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
10.1	Second Amended Credit Agreement as of July 19, 2016, by and among The Ensign Group, Inc., SunTrust Bank, as administrative agent, and the lenders party thereto (incorporated by reference to Exhibit 10.1 to our current report on Form 8-K filed on July 25, 2016)
10.2	Cornerstone Healthcare, Inc. 2016 Omnibus Incentive Plan
10.3	Stockholders Agreement
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.

August 1, 2016 BY: /s/ SUZANNE D. SNAPPER
Suzanne D. Snapper
Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

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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)