ENSIGN GROUP, INC
Form 10-Q
August 02, 2018
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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, 2018.

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)

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, smaller reporting company, or an emerging growth company. See the definitions of “large accelerated filer,” “accelerated filer,” “smaller reporting company,” and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	Accelerated filer	Non-accelerated filer	Smaller reporting company	Emerging growth company
x	o	o	o	o

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the

Exchange Act. o

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

As of July 31, 2018, 52,086,994 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, 2018
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PART I.

Item 1. Financial Statements

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

	June 30, 2018	December 31, 2017
Assets		
Current assets:		
Cash and cash equivalents	$27,184	$42,337
Accounts receivable—less allowance for doubtful accounts of $1,643 and $43,961 at June 30, 2018 and December 31, 2017, respectively (Note 3)	251,042	265,068
Investments—current	12,952	13,092
Prepaid income taxes	8,590	19,447
Prepaid expenses and other current assets	27,801	28,132
Total current assets	327,569	368,076
Property and equipment, net	591,580	537,084
Insurance subsidiary deposits and investments	31,396	28,685
Escrow deposits	2,652	228
Deferred tax assets	12,731	12,745
Restricted and other assets	21,046	16,501
Intangible assets, net	32,605	32,803
Goodwill	81,019	81,062
Other indefinite-lived intangibles	25,249	25,249
Total assets	$1,125,847	$1,102,433
Liabilities and equity		
Current liabilities:		
Accounts payable	$39,018	$39,043
Accrued wages and related liabilities	89,462	90,508
Accrued self-insurance liabilities—current	24,826	22,516
Other accrued liabilities	66,972	63,815
Current maturities of long-term debt	10,058	9,939
Total current liabilities	230,336	225,821
Long-term debt—less current maturities	268,066	302,990
Accrued self-insurance liabilities—less current portion	53,775	50,220
Deferred rent and other long-term liabilities	11,645	11,268
Deferred gain related to sale-leaseback (Note 16)	11,746	12,075
Total liabilities	575,568	602,374
Commitments and contingencies (Notes 14, 16 and 17)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 54,531 and 52,033 shares issued and outstanding at June 30, 2018, respectively, and 53,675 and 51,360 shares issued and outstanding at December 31, 2017, respectively (Note 18)	54	53
Additional paid-in capital	274,982	266,058
Retained earnings	303,157	264,691

Common stock in treasury, at cost, 1,932 shares at June 30, 2018 and December 31, 2017, respectively	(38,405)	(38,405)
Total Ensign Group, Inc. stockholders' equity	539,788	492,397
Non-controlling interest	10,491	7,662
Total equity	550,279	500,059
Total liabilities and equity	$1,125,847	$1,102,433

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,	
	2018	2017	2018	2017
Revenue				
Service revenue	$459,222	$415,270	$915,243	$824,664
Assisted and independent living revenue	37,164	33,009	73,277	65,355
Total revenue	496,386	448,279	988,520	890,019
Expense				
Cost of services	396,132	366,946	786,375	722,433
(Return of unclaimed class action settlement)/charges related to class action lawsuit (Note 17)	—	—	(1,664)	11,000
(Gains)/losses related to divestitures (Note 6 and 16)	—	(1,286)	—	2,731
Rent—cost of services (Note 16)	34,472	32,585	68,322	64,485
General and administrative expense	22,386	17,253	47,490	38,523
Depreciation and amortization	11,621	10,750	23,243	21,264
Total expenses	464,611	426,248	923,766	860,436
Income from operations	31,775	22,031	64,754	29,583
Other income (expense):				
Interest expense	(3,869)	(3,053)	(7,482)	(6,498)
Interest income	562	288	1,010	578
Other expense, net	(3,307)	(2,765)	(6,472)	(5,920)
Income before provision for income taxes	28,468	19,266	58,282	23,663
Provision for income taxes	6,142	6,886	12,663	8,326
Net income	22,326	12,380	45,619	15,337
Less: net income attributable to noncontrolling interests	315	163	476	279
Net income attributable to The Ensign Group, Inc.	$22,011	$12,217	$45,143	$15,058
Net income per share attributable to The Ensign Group, Inc.:				
Basic	$0.42	$0.24	$0.87	$0.30
Diluted	$0.41	$0.23	$0.84	$0.29
Weighted average common shares outstanding:				
Basic	51,880	50,705	51,733	50,736
Diluted	54,251	52,548	53,909	52,593
Dividends per share	$0.0450	$0.0425	$0.0900	$0.0850

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,	
	2018	2017
Cash flows from operating activities:		
Net income	$45,619	$15,337
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	23,243	21,264
Amortization of deferred financing fees	588	509
Amortization of deferred gain on sale-leaseback (Note 16)	(329)	(92)
Impairment of long-lived assets	860	111
Deferred income taxes	14	61
Provision for doubtful accounts (Note 3)	972	14,647
Share-based compensation	4,829	4,600
Income tax refund	11,000	—
Change in operating assets and liabilities		
Accounts receivable (Note 3)	13,476	(14,289)
Prepaid income taxes	(143)	(10,041)
Prepaid expenses and other assets	(3,454)	(4,533)
Insurance subsidiary deposits and investments	(2,571)	(4,358)
Charge related to class action lawsuit (Note 17)	—	11,000
Liabilities related to operational closures (Note 6 and 16)	—	2,620
Accounts payable	(74)	(4,379)
Accrued wages and related liabilities	(1,046)	(11,985)
Income taxes payable	—	(1,182)
Other accrued liabilities	2,531	1,550
Accrued self-insurance liabilities	5,349	3,759
Deferred rent liability	376	321
Net cash provided by operating activities	101,240	24,920
Cash flows from investing activities:		
Purchase of property and equipment	(24,295)	(23,013)
Cash payments for business acquisitions (Note 7)	—	(41,645)
Cash payments for asset acquisitions (Note 7)	(55,546)	(310)
Escrow deposits	(2,652)	(23,925)
Escrow deposits used to fund acquisitions	228	1,582
Cash proceeds from sale-leaseback (Note 16)	—	38,000
Cash proceeds from the sale of assets and insurance proceeds	1,610	1,017
Restricted and other assets	(589)	(332)
Net cash used in investing activities	(81,244)	(48,626)
Cash flows from financing activities:		
Proceeds from revolving credit facility and other debt (Note 14)	405,000	460,000
Payments on revolving credit facility and other debt (Note 14)	(439,922)	(451,052)
Issuance of common stock upon exercise of options	4,778	2,249
Repurchase of shares of common stock (Note 18)	—	(7,288)
Dividends paid	(4,695)	(4,350)
Non-controlling interest distribution	(292)	—

Purchase of non-controlling interest	—	(83)
Payments of deferred financing costs	(18)	—
Net cash used in financing activities	(35,149)	(524)
Net decrease in cash and cash equivalents	(15,153)	(24,230)
Cash and cash equivalents beginning of period	42,337	57,706
Cash and cash equivalents end of period	$27,184	$33,476

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
	2018	2017
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$7,321	$7,160
Income taxes	$12,925	$19,543
Non-cash financing and investing activity:		
Accrued capital expenditures	$3,600	$5,130
Note receivable from sale of ancillary business and asset acquisition	$282	$—

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Dollars, shares and options 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 other ancillary businesses. As of June 30, 2018, the Company operated 235 facilities, 46 home health, hospice and home care agencies and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oklahoma, 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 and other ancillary services. The Company's operating subsidiaries have a collective capacity of approximately 19,300 operational skilled nursing beds and 5,200 assisted living and independent living units. As of June 30, 2018, the Company owned 67 of its 235 affiliated facilities and leased an additional 168 facilities through long-term lease arrangements and had options to purchase twelve of those 168 facilities. As of December 31, 2017, the Company owned 63 of its 230 affiliated facilities and leased an additional 167 facilities through long-term lease arrangements and had options to purchase eleven of those 167 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, 2018 and for the three and six months ended June 30, 2018 and 2017 (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, 2017 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, and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The condensed consolidated financial statements include the accounts of all entities controlled by the Company through its ownership

of a majority voting interest. The Company presents noncontrolling interest within the equity section of its condensed 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 condensed consolidated statements of income.

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 Interim 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, 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.

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

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 — On January 1, 2018, the Company adopted Accounting Standards Codification Topic 606, Revenue from Contracts with Customers (ASC 606) applying the modified retrospective method. Results for reporting periods beginning January 1, 2018 are presented under ASC 606, while prior period amounts are not adjusted and continue to be reported under the accounting standards in effect for the prior period. The adoption of ASC 606 did not have a material impact on the measurement nor on the recognition of revenue of contracts, for which all revenue had not been recognized, as of January 1, 2018, therefore no cumulative adjustment has been made to the opening balance of retained earnings at the beginning of 2018. See Note 3, Revenue and Accounts Receivable.

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, net of estimates for variable consideration. The allowance for doubtful accounts reflects the Company's best estimate of probable losses inherent in the accounts receivable balance. The Company determines the allowance based on known troubled accounts and other currently available evidence. See Note 3, Revenue and Accounts Receivable.

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 $705 and $860 during the three and six months ended June 30, 2018, respectively. The Company recorded an asset impairment charge of $111 during the three and six months ended June 30, 2017.

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.

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 below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. The Company did not identify any intangible asset or goodwill impairment during the three or six months ended June 30, 2018 and 2017. See further discussion at Note 10, Goodwill and Other Indefinite-Lived Intangible Assets.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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. The combined self-insured retention is $500 per claim, subject to an additional one-time deductible of $750 for California affiliated operations and a separate, one-time, deductible of $1,000 for non-California operations. For all affiliated operations, except those located in Colorado, the third-party coverage above these limits is $1,000 per claim, $3,000 per operation, with a $5,000 blanket aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits is $1,000 per claim and $3,000 per operation, which is independent of the aforementioned 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 $43,139 and $38,998 as of June 30, 2018 and December 31, 2017, 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 the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 per occurrence. 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 $23,865 and $23,621 as of June 30, 2018 and December 31, 2017, respectively. In addition, the Company has recorded an asset and equal liability of $5,911 and $5,394 at June 30, 2018 and December 31, 2017, 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 11 Restricted and Other Assets.

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 $5,686 and $4,723 as of June 30, 2018 and December 31, 2017, 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

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

that could be material to net income. If the Company's actual liability exceeds its estimates of loss, its future earnings, cash flows and financial condition would be adversely affected.

Income Taxes — Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company's assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The Company generally expects to fully utilize its deferred tax assets; however, when necessary, the Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized.
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.
The Tax Cuts and Jobs Act (the Tax Act), which was enacted in December 2017, decreased the corporate income tax rate from 35.0% to 21.0% beginning on January 1, 2018. The Company's actual effective tax rate for fiscal 2018 may differ from management's estimate due to changes in interpretations and assumptions, and the excess tax benefits impact of share-based payment awards. See Note 13, Income Taxes for further detail.

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

Share-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.

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.

Recent Accounting Standards Adopted by the Company

In 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. Under this new standard and subsequently issued amendments, revenue is recognized at the time a good or service is transferred to a customer for the amount of consideration received. Entities

may apply the new standard either retrospectively to each period presented (full retrospective method) or retrospectively with the cumulative effect recognized in beginning retained earnings as of the date of adoption (modified retrospective method). The Company adopted the new revenue standard as of January 1, 2018 using the modified retrospective transition method. The adoption of ASC 606 did not have a material impact on the measurement nor on the recognition of revenue of contracts for which all revenue had not been recognized as of January 1, 2018, therefore no cumulative adjustment has been made to the opening balance of retained earnings at the beginning of 2018. The comparative information has not been restated and continues to be reported under the accounting standards in effect for the period presented.

In May 2017, the FASB issued amended authoritative guidance to provide guidance on types of changes to the terms or conditions of share-based payments awards to which an entity would be required to apply modification accounting under ASC 718. The new guidance was effective for the Company in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on the Company's consolidated financial statements.

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

In January 2017, the FASB issued amended authoritative guidance to clarify the definition of a business and reduce diversity in practice related to the evaluation of whether transactions should be accounted for as acquisitions (or disposals) of assets or businesses. The new provisions provide the requirements needed for an integrated set of assets and activities (the set) to be a business and also establish a practical way to determine when a set is not a business. The accounting standards update (ASU) provides a screen to determine when an integrated set of assets and activities is not a business. The more robust framework helps entities to narrow the definition of outputs created by the set and align it with how outputs are described in the new revenue standard. The new guidance was effective for the Company in the first quarter of fiscal year 2018. The Company's acquisitions during the six months ended June 30, 2018 were classified as asset acquisitions as the fair value of assets acquired is concentrated in a single asset. Some of these acquisitions would have been classified as business combinations prior to the adoption of the ASU. The Company anticipates that future acquisitions will be classified as a mixture of business and asset acquisitions under the new guidance.

In March 2018, we adopted ASU 2018-05, Income Taxes (Topic 740): Amendments to the SEC Paragraphs Pursuant to SEC Staff Accounting Bulletin No. 118, which updates the income tax accounting in U.S. GAAP to reflect the Securities and Exchange Commission (SEC) interpretive guidance released in December 2017, when the Tax Act was signed into law. Additional information regarding the adoption of this standard is contained in Note 13, Income Taxes.

In October 2016, the FASB issued amended authoritative guidance to require companies to recognize the income tax consequences of an intra-entity transfer of an asset, other than inventory, when the transfer occurs. The new guidance is required to be applied on a modified retrospective basis through a cumulative-effect adjustment directly to retained earnings as of the beginning of the period of adoption. The new guidance was effective for the Company in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on the Company's consolidated financial statements.

In August 2016, the FASB issued amended authoritative guidance to reduce the diversity in practice related to the presentation and classification of certain cash receipts and cash payments in the statement of cash flows. The new provisions target cash flow issues related to (i) debt prepayment or debt extinguishment costs, (ii) settlement of debt instruments with coupon rates that are insignificant relative to effective interest rates, (iii) contingent consideration payments made after a business combination, (iv) proceeds from settlement of insurance claims, (v) proceeds from the settlement of corporate-owned life insurance and bank-owned life insurance policies, (vi) distributions received from equity method investees, (vii) beneficial interests in securitization transactions and (viii) separately identifiable cash flows and application of the predominance principle. The new guidance was effective for the Company in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on the Company's consolidated financial statements.

Accounting Standards Recently Issued But Not Yet Adopted by the Company

In January 2017, the FASB issued amended authoritative guidance to simplify and reduce the cost and complexity of the goodwill impairment test. The new provisions eliminate step 2 from the goodwill impairment test and shifts the concept of impairment from a measure of loss when comparing the implied fair value of goodwill to its carrying amount to comparing the fair value of a reporting unit with its carrying amount. The FASB also eliminated the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment or step 2 of the goodwill impairment test. The new guidance does not amend the optional qualitative assessment of goodwill impairment. This guidance is effective for annual periods beginning after December 15, 2019, which will be the Company's fiscal year 2020, with early adoption permitted. The adoption of this standard is not expected to have a

material impact on the Company's 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 Company is currently evaluating the impact this guidance will have on its consolidated financial statements and disclosures and expects that this adoption will result in a material increase in the assets and liabilities on its consolidated balance sheets, primarily related to leases of facilities. The Company is in the process of cataloging its existing lease contracts and implementing changes to the systems, related processes and controls. The Company is planning to elect the several practical expedients upon transition, including retaining the lease classification for any leases that

exist prior to adoption of the standard and the application date to be the beginning of the adoption period, which is January 1, 2019.

3. REVENUE AND ACCOUNTS RECEIVABLE

The Company's revenue is derived primarily from providing healthcare services to its patients. Revenues are recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care. The healthcare services in transitional and skilled, home health and hospice patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct. Additionally, there may be ancillary services which are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when, those services are rendered.

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in the net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company’s estimates, the Company adjusts these estimates, which would affect net service revenue in the period such variances become known.
Revenue from the Medicare and Medicaid programs accounted for 68.2% and 68.0% of the Company's revenue for the three and six months ended June 30, 2018, respectively, and 68.2% for both the three and six months ended June 30, 2017. Settlement with Medicare and Medicaid payors for retroactive adjustments due to audits and reviews are considered variable consideration and are included in the determination of the estimated transaction price. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company’s historical settlement activity. Consistent with healthcare industry practices, any changes to these revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. The Company recorded adjustments to revenue which were not material to the Company's consolidated revenue or Interim Financial Statements for the three and six months ended June 30, 2018 and 2017.
Disaggregation of Revenue
The Company disaggregates revenue from contracts with its patients by reportable operating segments and payors. The Company determines that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors. A reconciliation of disaggregated revenue to segment revenue as well as revenue by payor is provided in Note 6, Business Segments.
The Company’s service specific revenue recognition policies are as follows:
Transitional and Skilled Nursing Revenue
The Company’s revenue is derived primarily from providing long-term healthcare services to patients and is recognized on the date services are provided at amounts billable to individual patients, adjusted for estimates for variable consideration. For patients under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts or rate, adjusted for

estimates for variable consideration, on a per patient, daily basis or as services are performed.

Assisted and Independent Living Revenue

The Company's assisted and independent living revenue consists of fees for basic housing and assisted living care. Accordingly, we record revenue when services are rendered on the date services are provided at amounts billable to individual residents. Residency agreements are generally for a term of 30 days, with resident fees billed monthly in advance. For patients under reimbursement arrangements with Medicaid, revenue is recorded based on contractually agreed-upon amounts or rates on a per resident, daily basis or as services are rendered.

Home Health Revenue

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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. Revenue is also adjusted for estimates for variable consideration. 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, and adjusted for estimates for variable consideration, 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, net of estimates for variable consideration. 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, including 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 to other accrued liabilities.

Impact of New Revenue Guidance on Financial Statement Line Items

The following tables summarize the impacts of adopting ASC 606 on the Company’s condensed consolidated statements of income for the three and six months ended June 30, 2018. There was no impact to the condensed consolidated balance sheet as of June 30, 2018 or condensed consolidated statements of cash flows for the six months ended June 30, 2018, as such, no pro forma information is provided in the Interim Financial Statements.

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Total revenue				
As Reported	$496,386	$448,279	$988,520	$890,019
Adjustments	9,078	—	17,882	—
Pro forma as if the previous accounting guidance was in effect	$505,464	$448,279	$1,006,402	$890,019
Cost of Services:				
As Reported	$396,132	$366,946	$786,375	$722,433
Adjustments	9,078	—	17,882	—
Pro forma as if the previous accounting guidance was in effect	$405,210	$366,946	$804,257	$722,433
Total Expense:				
As Reported	$464,611	$426,248	$923,766	$860,436
Adjustments	9,078	—	17,882	—
Pro forma as if the previous accounting guidance was in effect	$473,689	$426,248	$941,648	$860,436

The majority of what was previously presented as bad debt expense under operating expenses has been incorporated as an implicit price concession factored into the calculation of net revenues, as shown in the "Adjustments" line in the table above. Subsequent material events that alter the payor's ability to pay are recorded as bad debt expense. The Company's bad debt expense and bad debt as a percent of total revenue for the three and six months ended June 30, 2018 was $402 and 0.1%, and $972 and 0.1%, respectively, and for the three and six months ended June 30, 2017 was $7,297 and 1.6%, and $14,647 and 1.6%, respectively.

Prior period results reflect reclassifications, for comparative purposes, related to the adoption of ASC 606, for the presentation of the Company’s assisted and independent living revenues. Historically, the Company only presented total revenue for all revenue services. This reclassification had no effect on the reported results of operations.

Revenue for the three and six months ended June 30, 2018 and 2017 is summarized in the following tables:

	Three Months Ended June 30,					
	2018		2018 Pro Forma (2)		2017	
	Revenue	% of Revenue	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$173,169	34.9 %	$176,689	35.0 %	$152,637	34.0 %
Medicare	136,813	27.6	138,027	27.3	128,151	28.6
Medicaid — skilled	28,298	5.7	28,935	5.7	24,913	5.6
Total Medicaid and Medicare	338,280	68.2	343,651	68.0	305,701	68.2
Managed care	80,150	16.1	81,786	16.2	74,925	16.7
Private and other payors[(1)]	77,956	15.7	80,027	15.8	67,653	15.1
Revenue	$496,386	100.0 %	$505,464	100.0 %	$448,279	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the three months ended June 30, 2018 and 2017.

(2) The 2018 pro forma results reflect balances assuming previous accounting guidance was still in effect.

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	Six Months Ended June 30,					
	2018		2018 Pro Forma (2)		2017	
	Revenue	% of Revenue	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$340,794	34.5 %	$346,998	34.5 %	$300,908	33.8 %
Medicare	276,127	27.9	278,408	27.7	258,072	29.0
Medicaid — skilled	55,340	5.6	56,473	5.6	47,930	5.4
Total Medicaid and Medicare	672,261	68.0	681,879	67.8	606,910	68.2
Managed care	163,866	16.6	167,631	16.7	150,486	16.9
Private and other payors[1]	152,393	15.4	156,892	15.5	132,623	14.9
Revenue	$988,520	100.0 %	$1,006,402	100.0 %	$890,019	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the six months ended June 30, 2018 and 2017.
(2) The 2018 pro forma results reflect balances assuming previous accounting guidance was still in effect.

Balance Sheet Impact

Included in the Company's condensed consolidated balance sheet are contract assets, comprised of billed accounts receivable and unbilled receivables which are the result of the timing of revenue recognition, billings and cash collections, as well as, contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no material contract liabilities or activity as of and for the three and six months ended June 30, 2018 related to its transitional and skilled services, and home health and hospice services segments.

Accounts receivable as of June 30, 2018 and December 31, 2017 is summarized in the following table:

	June 30, 2018	2018 Pro Forma (1)	December 31, 2017
Medicaid	$93,002	$107,670	$119,441
Managed care	54,582	67,286	68,930
Medicare	47,068	53,400	55,667
Private and other payors	58,033	69,817	64,991
	252,685	298,173	309,029
Less: allowance for doubtful accounts	(1,643)	(47,131)	(43,961)
Accounts receivable, net	$251,042	$251,042	$265,068

(1) The 2018 pro forma results reflect balances assuming previous accounting guidance was still in effect.

Practical Expedients and Exemptions

As the Company's contracts with its patients have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, Other Assets and Deferred Costs, and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

4. COMPUTATION OF NET INCOME PER COMMON SHARE

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

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

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Numerator:				
Net income	$22,326	$12,380	$45,619	$15,337
Less: net income attributable to noncontrolling interests	315	163	476	279
Net income attributable to The Ensign Group, Inc.	$22,011	$12,217	$45,143	$15,058
Denominator:				
Weighted average shares outstanding for basic net income per share	51,880	50,705	51,733	50,736
Basic net income per common share attributable to The Ensign Group, Inc.	$0.42	$0.24	$0.87	$0.30

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,	
	2018	2017	2018	2017
Numerator:				
Net income	$22,326	$12,380	$45,619	$15,337
Less: net income attributable to noncontrolling interests	315	163	476	279
Net income attributable to The Ensign Group, Inc.	$22,011	$12,217	$45,143	$15,058
Denominator:				
Weighted average common shares outstanding	51,880	50,705	51,733	50,736
Plus: incremental shares from assumed conversion [1]	2,371	1,843	2,176	1,857
Adjusted weighted average common shares outstanding	54,251	52,548	53,909	52,593
Diluted net income per common share attributable to The Ensign Group, Inc.	$0.41	$0.23	$0.84	$0.29

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 196 and 398 for the three and six months ended June 30, 2018, respectively 1,378 and 1,312 for the three and six months ended June 30, 2017, 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, 2018 and December 31, 2017:

	June 30, 2018			December 31, 2017		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$27,184	$ —	$ —	$42,337	$ —	$ —

The Company's 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, the Company assesses its 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.

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Debt Security Investments - Held to Maturity

At June 30, 2018 and December 31, 2017, the Company had approximately $44,348 and $41,777, 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 based on Level 1. The Company has the intent and ability to hold these debt securities to maturity. Further, as of June 30, 2018, the debt security investments were held in AA, A and BBB+ rated debt securities.

6. BUSINESS SEGMENTS

The Company has three reportable operating segments: (1) transitional and skilled services, which includes the operation of skilled nursing facilities; (2) assisted and independent living services, which includes the operation of assisted and independent living facilities; and (3) 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 its chief operating decision maker, or CODM, reviews financial information at the operating segment level.

The Company also reports an “all other” category that includes results from its mobile diagnostics and other ancillary operations. These 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 are managed separately to provide greater visibility into those operations.

As of June 30, 2018, transitional and skilled services included 162 wholly-owned affiliated skilled nursing operations and 22 campuses that provide skilled nursing and rehabilitative care services and assisted and independent living services. The Company provided room and board and social services through 51 wholly-owned affiliated assisted and independent living operations and 22 campuses as mentioned above. Home health, home care and hospice services were provided to patients through 46 affiliated agencies. As of June 30, 2018, 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, 2018					
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$161,584	$ 8,677	$2,908	$—	$173,169	34.9 %
Medicare	108,237	—	28,576	—	136,813	27.6
Medicaid-skilled	28,298	—	—	—	28,298	5.7

Subtotal	298,119	8,677	31,484	—	338,280	68.2
Managed care	74,168	—	5,982	—	80,150	16.1
Private and other	36,231	28,487	3,783	9,455 (1)	77,956	15.7
Total revenue	$408,518	$ 37,164	$41,249	$9,455	$496,386	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the three months ended June 30, 2018.

The following pro forma table demonstrates the impact of adopting ASC 606 on the Company's segment revenues by major payor source for the three months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

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	Three Months Ended June 30, 2018 (Pro forma)					
	Transitional and Skilled Services	Assisted and Independent Living Services (2)	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$164,988	$ 8,677	$3,024	$—	$176,689	35.0 %
Medicare	109,220	—	28,807	—	138,027	27.3
Medicaid-skilled	28,935	—	—	—	28,935	5.7
Subtotal	303,143	8,677	31,831	—	343,651	68.0
Managed care	75,650	—	6,136	—	81,786	16.2
Private and other	38,268	28,487	3,817	9,455 (1)	80,027	15.8
Total revenue	$417,061	$ 37,164	$41,784	$9,455	$505,464	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the three months ended June 30, 2018.

	Three Months Ended June 30, 2017					
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$142,833	$ 7,203	$2,601	$—	$152,637	34.0 %
Medicare	104,450	—	23,701	—	128,151	28.6
Medicaid-skilled	24,913	—	—	—	24,913	5.6
Subtotal	272,196	7,203	26,302	—	305,701	68.2
Managed care	69,265	—	5,660	—	74,925	16.7
Private and other	33,756	25,806	2,659	5,432 (1)	67,653	15.1
Total revenue	$375,217	$ 33,009	$34,621	$5,432	$448,279	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the three months ended June 30, 2017.

	Six Months Ended June 30, 2018					
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$318,095	$ 16,941	$5,758	$—	$340,794	34.5 %
Medicare	220,190	—	55,937	—	276,127	27.9
Medicaid-skilled	55,340	—	—	—	55,340	5.6
Subtotal	593,625	16,941	61,695	—	672,261	68.0
Managed care	151,968	—	11,898	—	163,866	16.6
Private and other	69,941	56,336	7,414	18,702 (1)	152,393	15.4
Total revenue	$815,534	$ 73,277	$81,007	$18,702	$988,520	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the six months ended June 30, 2018.

The following pro forma table demonstrates the impact of adopting ASC 606 on the Company's segment revenues by major payor source for the six months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

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	Six Months Ended June 30, 2018 (Pro forma)					
	Transitional and Skilled Services	Assisted and Independent Living Services (2)	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$324,092	$ 16,941	$5,965	$—	$346,998	34.5 %
Medicare	221,997	—	56,411	—	278,408	27.7
Medicaid-skilled	56,473	—	—	—	56,473	5.6
Subtotal	602,562	16,941	62,376	—	681,879	67.8
Managed care	155,348	—	12,283	—	167,631	16.7
Private and other	74,372	56,336	7,482	18,702 (1)	156,892	15.5
Total revenue	$832,282	$ 73,277	$82,141	$18,702	$1,006,402	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the six months ended June 30, 2018.

	Six Months Ended June 30, 2017					
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$281,658	$ 14,239	$5,011	$—	$300,908	33.8 %
Medicare	212,379	—	45,693	—	258,072	29.0
Medicaid-skilled	47,930	—	—	—	47,930	5.4
Subtotal	541,967	14,239	50,704	—	606,910	68.2
Managed care	139,621	—	10,865	—	150,486	16.9
Private and other	65,968	51,116	5,185	10,354 (1)	132,623	14.9
Total revenue	$747,556	$ 65,355	$66,754	$10,354	$890,019	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the six months ended June 30, 2017.

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

	Three Months Ended June 30, 2018					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$408,518	$ —	$41,249	$9,455	$ —	$459,222
Assisted and independent living revenue	—	37,164	—	—	—	37,164
Revenue from external customers	$408,518	$ 37,164	$41,249	$9,455	$ —	$496,386
Intersegment revenue(1)	645	—	—	1,112	(1,757)	—
Total revenue	$409,163	$ 37,164	$41,249	$10,567	$ (1,757)	$496,386
Segment income (loss)(2)	$43,210	$ 4,966	$6,268	$(22,669)	$ —	$31,775
Interest expense, net of interest income						$(3,307)
Income before provision for income taxes						$28,468

Depreciation and amortization	$7,708	$ 1,863	$281	$1,769	$ —	$11,621

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense for the three months ended June 30, 2018 is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

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The following pro forma table demonstrates the impact of adopting ASC 606 on the Company's selected financial data consolidated by business segment for the three months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

	Three Months Ended June 30, 2018 (Pro forma)					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$417,061	$ —	$41,784	$9,455	$ —	$468,300
Assisted and independent living revenue	—	37,164	—	—	—	37,164
Revenue from external customers	$417,061	$ 37,164	$41,784	$9,455	$ —	$505,464
Intersegment revenue(1)	645	—	—	1,112	(1,757)	—
Total revenue	$417,706	$ 37,164	$41,784	$10,567	$ (1,757)	$505,464
Segment income (loss)(2)	$43,210	$ 4,966	$6,268	$(22,669)	$ —	$31,775
Interest expense, net of interest income						$(3,307)
Income before provision for income taxes						$28,468
Depreciation and amortization	$7,708	$ 1,863	$281	$1,769	$ —	$11,621

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense for the three months ended June 30, 2018 is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

	Three Months Ended June 30, 2017					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$375,217	$ —	$34,621	$5,432	$ —	$415,270
Assisted and independent living revenue	—	$ 33,009	$—	$—	—	33,009
Revenue from external customers	$375,217	$ 33,009	$34,621	$5,432	$ —	$448,279
Intersegment revenue(1)	631	—	—	729	(1,360)	—
Total revenue	$375,848	$ 33,009	$34,621	$6,161	$ (1,360)	$448,279
Segment income (loss)(2)	$31,704	$ 3,657	$4,923	$(18,253)	$ —	$22,031
Interest expense, net of interest income						$(2,765)
Income before provision for income taxes						$19,266
Depreciation and amortization	$7,204	$ 1,492	$230	$1,824	$ —	$10,750

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense during the three months ended June 30, 2017 is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

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	Six Months Ended June 30, 2018					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$815,534	$ —	$81,007	$18,702	$ —	$915,243
Assisted and independent living revenue	—	$ 73,277	$—	$—	—	73,277
Revenue from external customers	$815,534	$ 73,277	$81,007	$18,702	$ —	$988,520
Intersegment revenue(1)	1,334	—	—	2,194	(3,528)	—
Total revenue	$816,868	$ 73,277	$81,007	$20,896	$ (3,528)	$988,520
Segment income (loss)(2)	$89,405	$ 9,629	$12,326	$(46,606)	$ —	$64,754
Interest expense, net of interest income						$(6,472)
Income before provision for income taxes						$58,282
Depreciation and amortization	$15,510	$ 3,460	$526	$3,747	$ —	$23,243

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense, including the return of unclaimed class action settlement for the six months ended June 30, 2018, is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

The following pro forma table demonstrates the impact of adopting ASC 606 on the Company's selected financial data consolidated by business segment for the six months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

	Six Months Ended June 30, 2018 (Pro forma)					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$832,282	$ —	$82,141	$18,702	$ —	$933,125
Assisted and independent living revenue	—	73,277	—	—	—	73,277
Revenue from external customers	$832,282	$ 73,277	$82,141	$18,702	$ —	$1,006,402
Intersegment revenue(1)	1,334	—	—	2,194	(3,528)	—
Total revenue	$833,616	$ 73,277	$82,141	$20,896	$ (3,528)	$1,006,402
Segment income (loss)(2)	$89,405	$ 9,629	$12,326	$(46,606)	$ —	$64,754
Interest expense, net of interest income						$(6,472)
Income before provision for income taxes						$58,282
Depreciation and amortization	$15,510	$ 3,460	$526	$3,747	$ —	$23,243

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense, including the return of unclaimed class action settlement for the six months ended June 30, 2018, is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

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	Six Months Ended June 30, 2017					
	Transitional and Skilled Services(3)	Assisted and Independent Living Services(3)	Home Health and Hospice Services	All Other	Elimination	Total
Service revenue	$747,556	$ —	$66,754	$10,354	$ —	$824,664
Assisted and independent living revenue	—	$ 65,355	$—	$—	—	65,355
Revenue from external customers	$747,556	$ 65,355	$66,754	$10,354	$ —	$890,019
Intersegment revenue(1)	1,375	—	—	1,613	(2,988)	—
Total revenue	$748,931	$ 65,355	$66,754	$11,967	$ (2,988)	$890,019
Segment income (loss)(2)	$63,494	$ 8,096	$9,217	$(51,224)	$ —	$29,583
Interest expense, net of interest income						$(5,920)
Income before provision for income taxes						$23,663
Depreciation and amortization	$14,157	$ 3,115	$466	$3,526	$ —	$21,264

(1) Intersegment revenue represents services provided at the Company's operating subsidiaries to the Company's other business lines.
(2) Segment income (loss) includes depreciation and amortization expense and excludes general and administrative expense and interest expense for transitional and skilled services, assisted and independent living services and home health and hospice services segments. General and administrative expense, including charges related to class action lawsuit during the six months ended June 30, 2017, is included in the "All Other" category.
(3) The Company's campuses represent facilities that offer skilled nursing, assisted and/or independent living services. Revenue and expenses related to skilled nursing, assisted and independent living services have been allocated and recorded in the respective reportable segment. Due to the adoption of ASC 606, the presentation of revenue changed from presenting total revenue to service revenue and assisted and independent living revenue.

The Company's transitional and skilled services segment income for the six months ended June 30, 2017 included continued obligations under the lease related to closed operations, lease termination costs and related closing expenses of $4,017. This amount includes the present value of future rental payments of approximately $2,715 and long-lived assets impairment of $111. See Note 16, Leases for further detail. Included in the three months ended June 30, 2017 is the loss recovery of $1,286 related to a facility that was closed in the prior year.

7. ACQUISITIONS

The acquisition focus of the subsidiaries is to purchase or lease operations that are complementary to the current affiliated operations, accretive to the business or otherwise advance the Company's strategy. The results of all 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's affiliated operations also enter into long-term leases that may include options to purchase the facilities. As a result, from time to time, the affiliated operations will acquire facilities that has been operating under third-party leases.
On January 1, 2018, the Company adopted Accounting Standards Codification Topic 805, Clarifying the Definition of a Business (ASC 805) prospectively, which changes the definition of a business to assist entities with evaluating when a set of transferred assets and activities is deemed to be a business. Determining whether a transferred set constitutes a business is important because the accounting for a business combination differs from that of an asset acquisition. The definition of a business also affects the accounting for dispositions. Under the new standard, when substantially all of the fair value of assets acquired is concentrated in a single asset, or a group of similar assets, the assets acquired would

not represent a business and business combination accounting would not be required. The new standard may result in more transactions being accounted for as asset acquisitions rather than business combinations. The Company anticipates that future acquisitions will be classified as a mixture of business and asset acquisitions under the new guidance.

During the six months ended June 30, 2018, the Company expanded its operations through a combination of a long-term lease and real estate purchases, with the addition of two stand-alone skilled nursing operations, two stand-alone assisted living operations and one campus operation. The Company did not acquire any material assets or assume any liabilities other than tenant's post-assumption rights and obligations under the long-term lease. The addition of these operations added 428 operational skilled nursing beds and 218 assisted living units to be operated by the Company's affiliated operating subsidiaries. In addition, with the stand-alone skilled nursing operation acquisition, the Company acquired real estate that included an adjacent long-term acute care hospital that is currently operated by a third party under a lease arrangement. The Company entered into a separate operations

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transfer agreement with the prior operator as part of each transaction. In addition, in June 2018, the Company acquired an office building for a purchase price of $31,500 to accommodate its growing Service Center team. The aggregate purchase price for these acquisitions during the six months ended June 30, 2018 was $55,546. Substantially all of the fair value of the assets acquired is concentrated in property and equipment and as such, the transactions were classified as asset acquisitions in accordance with ASC 805.
During the six months ended June 30, 2017, the Company acquired operations for an aggregate purchase price of $41,763, consisting of land of $3,595, building and improvements of $24,527, equipment of $2,298, goodwill of $6,059, other indefinite-lived intangible assets of $4,548, assembled occupancy of $410 and other liabilities assumed of $326.

Subsequent to June 30, 2018, the Company acquired one stand-alone skilled nursing operation, one home health agency and one home care agency for an aggregate purchase price of $4,125. The addition of these operations added 40 operational skilled nursing beds operated by the Company's operating subsidiaries. As of the date of this report, the preliminary allocation of the purchase price for the acquisitions acquired in the second quarter and subsequent to June 30, 2018 was not completed as necessary valuation information was not yet available. As such, the determination whether these acquisitions should be classified as business combinations or asset acquisitions under ASC 805 could change.

8. PROPERTY AND EQUIPMENT— Net
Property and equipment, net consist of the following:

	June 30, 2018	December 31, 2017
Land	$60,876	$49,081
Buildings and improvements	386,868	342,641
Equipment	191,064	181,530
Furniture and fixtures	5,427	5,244
Leasehold improvements	104,096	97,221
Construction in progress	9,015	5,460
	757,346	681,177
Less: accumulated depreciation	(165,766)	(144,093)
Property and equipment, net	$591,580	$537,084

See Note 7, Acquisitions for information on acquisitions during the six months ended June 30, 2018.

9. INTANGIBLE ASSETS — Net

		June 30, 2018			December 31, 2017		
Intangible Assets	Weighted Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	8.8	$1,483	$ (162)	$1,321	$483	$ (99)	$384
Favorable leases	30.2	35,116	(7,558)	27,558	35,116	(6,568)	28,548
Assembled occupancy	0.4	2,767	(2,733)	34	2,659	(2,631)	28
Facility trade name	30.0	733	(305)	428	733	(293)	440
	17.3	4,933	(1,669)	3,264	4,933	(1,530)	3,403

Customer relationships						
Total	$45,032	$ (12,427)	$32,605	$43,924	$ (11,121)	$32,803

Amortization expense was $691 and $1,306 for the three and six months ended June 30, 2018, respectively, and $690 and $1,302 for the three and six months ended June 30, 2017, respectively.

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

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Year	Amount
2018 (remainder)	$1,500
2019	2,933
2020	1,593
2021	1,497
2022	1,471
2023	1,409
Thereafter	22,202
	$32,605

10. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The Company tests goodwill during the fourth quarter of each year or more often if events or circumstances indicate there may be impairment. The Company performs its analysis for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment, in accordance with the provisions of Accounting Standards Codification topic 350, Intangibles—Goodwill and Other (ASC 350). This guidance provides the option to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value, a "Step 0" analysis. If, based on a review of qualitative factors, it is more likely than not that the fair value of a reporting unit is less than its carrying value, the Company performs "Step 1" of the traditional two-step goodwill impairment test 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, 2018:

	Goodwill				
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services	All Other	Total
January 1, 2018	$45,486	$ 3,958	$24,322	$7,296	$81,062
Purchase price adjustment	—	—	56	(99)	(43)
June 30, 2018	$45,486	$ 3,958	$24,378	$7,197	$81,019

The Company anticipates that the majority of total goodwill recognized will be fully deductible for tax purposes as of June 30, 2018. See further discussion of goodwill acquired at Note 7, Acquisitions.

Other indefinite-lived intangible assets consists of the following:

	June 30, 2018	December 31, 2017
Trade name	$1,181	$ 1,181

Medicare and Medicaid licenses	24,068	24,068
	$25,249	$ 25,249

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11. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	June 30, 2018	December 31, 2017
Debt issuance costs, net	$2,345	$ 2,799
Long-term insurance losses recoverable asset	5,911	5,394
Deposits with landlords	9,755	5,981
Capital improvement reserves with landlords and lenders	2,847	2,327
Note receivable from sale of ancillary business	188	—
Restricted and other assets	$21,046	$ 16,501

Included in restricted and other assets as of June 30, 2018, are anticipated insurance recoveries related to the Company's workers' compensation, 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.

12. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2018	December 31, 2017
Quality assurance fee	$4,845	$ 4,864
Refunds payable	24,864	21,661
Deferred revenue	4,697	7,066
Cash held in trust for patients	2,859	2,609
Resident deposits	6,851	6,574
Dividends payable	2,367	2,328
Property taxes	8,309	10,088
Operational closure liability	891	910
Other	11,289	7,715
Other accrued liabilities	$66,972	$ 63,815

Quality assurance fee represents amounts payable to Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Utah, Washington and Wisconsin as a result of a mandated fee based on patient days or licensed beds. Refunds payable includes payables related to overpayments, duplicate payments and credit balances from various payor sources. 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. Operational closure liability includes the short-term portion of the closing costs that are payable within the next 12 months. The remaining long-term portion is included in other long-term liabilities in the accompanying condensed consolidated balance sheets.

13. INCOME TAXES

Effective January 1, 2018, the Tax Act reduced the corporate rate from 35.0% to 21.0%.The final impact of U.S. tax reform may differ, possibly materially, due to factors such as changes in interpretations of the Tax Act, any legislative action to address uncertainties that arise because of the Tax Act, and additional guidance that may be issued by the

U.S. government.

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The Company has adopted ASU 2018-05, Income Taxes (Topic 740): Amendments to SEC Paragraph Pursuant to SEC Staff Accounting Bulletin No. 118, which allows the company to record provisional amounts during the period of enactment. Any change to the provisional amounts will be recorded as an adjustment to the provision for income taxes in the period the amounts are determined. The measurement period ends when the company has obtained, prepared and analyzed the information necessary to finalize its accounting, but cannot extend beyond one year of the enactment date.

As of June 30, 2018 the Company has not completed its accounting for the tax effects of the enactment of the Tax Act. The Company continues to analyze certain aspects of the Tax Act and refine the estimates of its calculations, which could potentially impact the measurement of the Company's tax balances. In the three and six months ended June 30, 2018, there were no adjustments to the provisional amounts recorded in the period ended December 31, 2017.

The Company recorded income tax expense of $12,663 for the six months ended June 30, 2018, or 21.7% of earnings before income taxes, compared to 35.2% for the six month period ended June 30, 2017. The Company’s effective tax rate for 2018 includes the benefit of the lower federal income tax rate of 21.0%, offset by various non-deductible expenses including the impact of non-deductible compensation from the enactment of the Tax Act. The effective tax rate for the six months ended June 30, 2018 also includes stock-based compensation benefits offset by return of unclaimed class action settlement funds.

The Company is not currently under examination by any major income tax jurisdiction. During 2018, the statutes of limitations will lapse on the Company's 2014 Federal tax year and certain 2013 and 2014 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 six months ended June 30, 2018 or 2017.

14. DEBT

Long-term debt consists of the following:

	June 30, 2018	December 31, 2017
Term loan with SunTrust, interest payable quarterly	$136,875	$ 140,625
Credit facility with SunTrust	20,000	50,000
Mortgage loans and promissory note, principal and interest payable monthly, interest at fixed rate	124,222	125,394
	281,097	316,019
Less: current maturities	(10,058)	(9,939)
Less: debt issuance costs	(2,973)	(3,090)
	$268,066	$ 302,990

Credit Facility with a Lending Consortium Arranged by SunTrust

The Company maintains a credit facility with a lending consortium arranged by SunTrust (as amended to date, the Credit Facility). The Company originally entered into the Credit Facility in an aggregate principal amount of $150,000 in May 2014. Under the Credit Facility, the Company could seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $75,000. The interest rates applicable to loans under the Credit Facility are, at the Company’s option, equal to either a base rate plus a margin ranging from 1.25% to 2.25% per annum or LIBOR plus a margin ranging from 2.25% to 3.25% per annum, based on the debt to Consolidated EBITDA ratio of the Company

and its operating subsidiaries as defined in the agreement. In addition, the Company will pay a commitment fee on the unused portion of the commitments under the Credit Facility that will range from 0.30% to 0.50% per annum, depending on the debt to Consolidated EBITDA ratio of the Company and its operating subsidiaries. Loans made under the Credit Facility are not subject to interim amortization. The Company is not required to repay any loans under the Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Credit Facility.

On February 5, 2016, the Company amended its existing revolving credit facility to increase its aggregate principal amount available to $250,000 (the Amended Credit Facility). Under the 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 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 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 its subsidiaries. The Company is permitted to prepay all or any portion of the loans under the credit facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders.

On July 19, 2016, the Company entered into the second amendment to the credit facility (Second Amended Credit Facility), which amended the existing credit agreement to increase the aggregate principal amount up to $450,000. The Second Amended Credit Facility is 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 discussed below. 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 below.

The Credit Facility is guaranteed, jointly and severally, by certain of the Company’s wholly owned subsidiaries, and 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 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 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 first 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, 2018, the Company's operating subsidiaries had $156,875 outstanding under the Credit Facility. The outstanding balance on the term loan was $136,875, of which $7,500 is classified as short-term and the remaining $129,375 is classified as long-term. The outstanding balance on the revolving Credit Facility was $20,000, which is classified as long-term. The Company was in compliance with all loan covenants as of June 30, 2018.

As of July 30, 2018, there was approximately $156,875 outstanding under the Credit Facility.

Mortgage Loans and Promissory Note

In December 2017, seventeen of the Company's subsidiaries entered into mortgage loans in the aggregate amount of $112,000. The mortgage loans are insured with Department of Housing and Urban Development (HUD), which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans and note bear fixed interest rates of 3.3% per annum. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of

the principal balance on the date of prepayment. During the first three years, the prepayment fee is 10% and is reduced by 3% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms of the mortgage loans are 30 to 35-years. The borrowings were arranged by Lancaster Pollard Mortgage Company, LLC, and insured by HUD. Loan proceeds were used to pay down previously drawn amounts on Ensign's revolving line of credit. In addition to refinancing existing borrowings, the proceeds of the HUD-insured debt helped fund acquisitions, to renovate and upgrade existing and future facilities, to cover working capital needs and for other business purposes.

In addition to the HUD mortgage loans above, the Company had outstanding indebtedness under mortgage loans insured with HUD and a promissory note issued in connection with various acquisitions. These 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 the note is between 12 and 33 years. The mortgage loans and note are secured by the real property

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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, 2018, the Company's operating subsidiaries had $124,222 outstanding under the mortgage loans and note, of which $2,558 is classified as short-term and the remaining $121,664 is classified as long-term. The Company was in compliance with all loan covenants as of June 30, 2018.

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

As of June 30, 2018, the Company had approximately $6,354 on the credit facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

15. OPTIONS AND AWARDS

Stock-based compensation expense consists of share-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company’s condensed consolidated statements of income for the three and six months ended June 30, 2018 and 2017 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.

2017 Omnibus Incentive Plan - The Company has one active stock incentive plan, the 2017 Omnibus Incentive Plan (the 2017 Plan). The 2017 Plan provides for the issuance of 6,881 shares of common stock. The number of shares available to be issued under the 2017 Plan will be reduced by (i) one share for each share that relates to an option or stock appreciation right award and (ii) 2.5 shares for each share which relates to an award other than a stock option or stock appreciation right award (a full-value award). Granted non-employee director options vest and become exercisable in three equal annual installments, or the length of the term if less than 3 years, on the completion of each year of service measured from the grant date. All other options generally vest over 5 years at 20% per year on the anniversary of the grant date. Options expire 10 years from the date of grant. At June 30, 2018, there were 5,184 unissued shares of common stock available for issuance under this plan.

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 395 options and 274 restricted stock awards from the 2017 Plan during the six months ended June 30, 2018.

Stock Options

The Company used the following assumptions for stock options granted during the three months ended June 30, 2018 and 2017:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2018	227	2.7%	6.2 years	32.0%	0.5%
2017	124	1.9%	6.3 years	35.8%	0.9%

The Company used the following assumptions for stock options granted during the six months ended June 30, 2018 and 2017:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2018	395	2.7%	6.2 years	32.0%	0.6%
2017	280	2.0%	6.3 years	35.8%	0.8%

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For the six months ended June 30, 2018 and 2017, 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
2018	395	$ 32.33	$ 11.15
2017	280	$ 19.55	$ 6.84

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, 2018 and 2017 and therefore, the intrinsic value was $0 at the date of grant.

The following table represents the employee stock option activity during the six months ended June 30, 2018 and 2017:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2018	4,739	$ 13.08	2,776	$ 10.07
Granted	395	32.33		
Forfeited	(53)	17.48		
Exercised	(591)	7.76		
June 30, 2018	4,490	$ 15.42	2,716	$ 11.35

The following summary information reflects stock options outstanding, vested and related details as of June 30, 2018:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2008	2.56 - 4.06	25	42	0	25
2009	4.06 - 4.56	346	746	1	346
2010	4.77 - 4.96	86	211	2	86
2011	5.90 - 7.99	92	318	3	92
2012	6.56 - 7.96	320	1,186	4	320
2013	7.98 - 11.49	482	2,345	5	434
2014	10.55 - 18.94	1,344	7,642	6	995
2015	21.47 - 25.24	513	4,671	7	240
2016	18.79 - 19.89	432	3,013	8	129
2017	18.64 - 22.90	455	3,179	9	49

2018	26.53 - 36.61	395	4,393	10	—
Total		4,490	27,746		2,716

Restricted Stock Awards

The Company granted 217 and 274 restricted stock awards during the three and six months ended June 30, 2018, respectively. The Company granted 46 and 99 restricted stock awards during the three and six months ended June 30, 2017, respectively. All awards were granted at an issued 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, 2018 and 2017 ranged from $23.61 to $36.61 and $18.47 to $20.68, respectively. The fair value per share includes quarterly stock awards to non-employee directors.

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A summary of the status of the Company's non-vested restricted stock awards as of June 30, 2018 and changes during the three and six months ended June 30, 2018 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2018	383	$ 20.65
Granted	274	34.24
Vested	(81)	21.08
Forfeited	(10)	21.41
Nonvested at June 30, 2018	566	$ 27.15

During the three and six months ended June 30, 2018, the Company granted 8 and 15 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 $23.61 to $27.97 based on the market price on the grant date.

Share-based compensation expense recognized for the Company's equity incentive plans for the three and six months ended June 30, 2018 and 2017 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Share-based compensation expense related to stock options	$1,292	$1,319	$2,508	$2,526
Share-based compensation expense related to restricted stock awards	675	588	1,253	1,140
Share-based compensation expense related to stock options and restricted stock awards to non-employee directors	210	132	387	264
Total	$2,177	$2,039	$4,148	$3,930

In future periods, the Company expects to recognize approximately $12,634 and $14,265 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of June 30, 2018. Future share-based compensation expense will be recognized over 3.4 and 4.2 weighted average years for unvested options and restricted stock awards, respectively. There were 1,774 unvested and outstanding options at June 30, 2018, of which 1,671 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at June 30, 2018 was 5.9 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of June 30, 2018 and December 31, 2017 is as follows:

Options	June 30, 2018	December 31, 2017
Outstanding	$91,791	$ 44,060
Vested	66,452	33,976
Expected to vest	22,276	9,311
Exercisable	12,616	10,481

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.

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The grant-date fair value of the awards is recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interests. The grant value was determined based on an independent valuation of the subsidiary shares. For the three and six months ended June 30, 2018, the Company expensed $343 and $681, respectively, in share-based compensation related to the Subsidiary Equity Plan. For the three and six months ended June 30, 2017, the Company expensed $337 and $670, respectively, in share-based compensation related to the Subsidiary Equity Plan.

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, 2018 and 2017 is 235 and 269, respectively.

16. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 92 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 range in terms 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. If the Company elects to renew the term of a Master Lease, the renewal will be effective to all, but not less than all, of the leased property then subject to the Master Lease.

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

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 $14,538 and $28,956 for the three and six months ended June 30, 2018, respectively, and $14,217 and $28,333 for the three and six months ended June 30, 2017, 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, 2018.

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

$34,476 and $68,640 for the three and six months ended June 30, 2018, respectively, and $32,851 and $64,843 for the three and six months ended June 30, 2017, respectively.

Thirty-one 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.

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In first quarter of 2017, the Company voluntarily discontinued operations at one of its skilled nursing facilities after determining that the facility could not competitively operate in the marketplace without substantial investment renovating the building. After careful consideration, the Company determined that the costs to renovate the facility could outweigh the future returns from the operation. 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 does not impact the rent expense paid in 2017, or expected to be paid in future periods, and has no material impact on the Company's lease coverage ratios under the Master Leases. The Company recorded a continued obligation liability under the lease and related closing expenses of $2,830, including the present value of rental payments of approximately $2,715 during the first quarter of 2017. Residents of the affected facility were transferred to local skilled nursing facilities.

In March 2017, the Company entered into definitive agreements to sell the properties of two skilled nursing facilities and one assisted living community. The transaction closed in the second quarter of 2017. Upon closing the transaction, the Company leased the properties under a triple-net master lease with an initial 20-year term, with three 5-year optional extensions, at CPI-based annual escalators. The Company received $38,000 in proceeds. The carrying value for the sale was $24,847. Under applicable accounting guidance, the master lease was classified as an operating lease. The Company recognized a deferred gain on the transaction of $13,153 during the second quarter of 2017 that is amortized over the life of the lease.

During the first quarter of 2017, the Company terminated its lease obligations on four transitional care facilities that were under development at that time and one newly constructed stand-alone skilled nursing operation. The Company recorded $1,187 in lease termination costs and long-lived asset impairment.

Future minimum lease payments for all leases as of June 30, 2018 are as follows:

Year	Amount
2018 (remainder)	$69,670
2019	139,128
2020	138,720
2021	138,427
2022	136,815
2023	135,683
Thereafter	976,868
	$1,735,311

17. 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. Included in these laws and regulations is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires healthcare providers (among other things) to safeguard the privacy and security of certain health information. In late December 2016, the Company learned of a potential issue at one of its independent operating entities in Arizona which involved the limited and inadvertent disclosure of certain confidential information. The issue has been internally investigated, addressed and disclosed as is required by law. The Company believes that it is presently in compliance in all material respects with applicable HIPAA 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 by the Company's operating subsidiary, (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, do not expressly state or include a specific or maximum dollar amount. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's balance sheets for any of the periods presented.

U.S. Department of Justice Civil Investigative Demand - On May 31, 2018, the Company received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating the Company to determine whether the Company has violated the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of the Company's skilled nursing facilities with persons who served as medical directors, advisory board participants or other referral sources. The CID covers the period from October 3, 2013 to the present, and is limited in scope at this time to ten of the Company's Southern California skilled nursing facilities. As a general matter, the Company's operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. The Company is fully cooperating with the U.S. Department of Justice to promptly respond to the CID. However, the Company cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company.

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 its operating subsidiaries do 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, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and the Company is routinely subjected to varying types of claims. One particular type of suit arises from alleged violations of minimum staffing requirements for skilled nursing facilities in those states which have enacted

such requirements. 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 deficiency, a citation, a civil money penalty, or litigation. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements. The Company expects the plaintiff's bar to continue to be aggressive in their pursuit of these staffing and similar claims.

The Company and its operating subsidiaries have 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 the Company and other companies in its industry. If there were a significant increase in the number of these claims or an increase in amounts due as a result of these claims, this could materially adversely affect the Company’s business, financial condition, results of operations, and cash flows.

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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. A significant increase in the number of these claims, or an increase in the amounts due as a result of these claims, could materially adversely affect the Company’s business, financial condition, results of operations and cash flows.

In August of 2011, the Company was named as a Defendant in a class action litigation alleging violations of state and federal wage and hour law. In January of 2017, the Company participated in an initial mediation session with plaintiffs' counsel. As a result of this discussion and due to (i) the fact no class had been certified (ii) the lack of specificity as to legal theories put forth by the plaintiffs (iii) the nature of the remedies sought and (iv) the lack of any basis on which to compute estimated compensatory and/or exemplary damages, the Company could not predict what the outcome of the pending class action lawsuit would be, what the timing of the ultimate resolution of this lawsuit would be, or an estimate and/or range of possible loss related to it.

In March of 2017, the Company was invited to engage in further settlement discussions to determine whether a resolution of the case in advance of a decision on class certification was possible. In April of 2017, the Company reached an agreement in principle to settle the subject class action litigation, without any admission of liability and subject to approval by the California Superior Court. Based upon the change in case status, the Company recorded an accrual for estimated probable losses of $11,000, exclusive of legal fees, in the first quarter of 2017. The Company funded the settlement amount of $11,000 in December of 2017, and the funds were distributed to the class members in the first quarter of 2018. The Company received $1,664 related to settlement funds that class members declined to claim during the settlement process, and the recoveries were recorded in the first quarter of 2018.

Other claims and suits continue to be filed against the Company and other companies in its industry. By way of example, a general/premises liability lawsuit was filed against one of the Company’s independent operating entities, in connection with an alleged injury to a non-employee/contractor. Further, another one of the Company’s independent operating entities was sued on allegations of professional negligence.

The Company cannot predict or provide any assurance as to the possible outcome of any inquiry, investigation or litigation. If any litigation were to proceed through trial, and the Company and its operating subsidiaries 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, 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 arrangements.

Medicare Revenue Recoupments — The Company is subject to regulatory reviews relating to Medicare services, billings and potential overpayments as a result of Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC), Program Safeguard Contractors (PSC) and Medicaid Integrity Contributors (MIC) programs. As of June 30, 2018, four of the Company's operating subsidiaries had probe reviews scheduled and in process, both pre- and post-payment. The Company anticipates that these probe reviews will increase in frequency in the future. If a facility fails a probe review and subsequent re-probes, the facility could then be subject to extended pre-pay review or extrapolation of the identified error rate to all billing in the same time period. None of the Company's operating subsidiaries are currently on extended prepayment review, although that may occur in the future. In addition, as of June 30, 2018, a ZPIC review was recently concluded at one of the Company's hospice subsidiaries, and the results from the audit are currently under appeal.

U.S. Government Inquiry and Corporate Integrity Agreement — In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the DOJ, which 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

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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.

The Company and its operating subsidiaries have continued to meet the requirements under the Settlement Agreement and pass its IRO audits. Participation in federal healthcare programs by the Company's operating subsidiaries 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 55.4% and 56.7% of its total accounts receivable as of June 30, 2018 and December 31, 2017, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 68.2% and 68.0% of the Company's revenue for the three and six months ended June 30, 2018, respectively, and 68.2% for both the three and six months ended June 30, 2017.
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 30, 2018, the Company had approximately $1,072 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

18. COMMON STOCK
As approved by the Board of Directors on April 3, 2018, the Company entered into a stock repurchase program pursuant to which the Company may repurchase up to $30,000 of its common stock under the program for a period of approximately 11 months. Under this program, 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. The stock repurchase program is scheduled to expire on February 20, 2019. To date, the Company has not purchased any shares pursuant to this stock repurchase program.

On February 8, 2017, the Company announced that its Board of Directors authorized a stock repurchase program, under which the Company may repurchase up to $30,000 of its common stock under the program for a period of 12 months. The stock repurchase program expired on February 8, 2018. During the three and six months ended June 30, 2017, the Company repurchased 69 and 412 shares of its common stock for a total of $1,220 and $7,288, respectively.

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.

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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 the Annual Report.

Overview

We are a provider of health care services across the post-acute care continuum, as well as other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oklahoma, 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 and other ancillary services. As of June 30, 2018, we offered skilled nursing, assisted living and rehabilitative care services through 235 skilled nursing and assisted living. Of the 235 facilities, we owned 67 and operated an additional 168 facilities under long-term lease arrangements, and had options to purchase 12 of those 168 facilities. Our home health and hospice business provides home health, hospice and home care services from 46 agencies across eleven states.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of June 30, 2018:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	67	12	156	235
Percentage of total	28.5 %	5.1 %	66.4 %	100.0 %
Operational skilled nursing beds	3,700	1,207	14,360	19,267
Percentage of total	19.2 %	6.3 %	74.5 %	100.0 %
Assisted and independent living units	2,180	184	2,869	5,233
Percentage of total	41.7 %	3.5 %	54.8 %	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 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

Adoption of Revenue Recognition Standard - On January 1, 2018, we adopted Accounting Standards Codification Topic 606, Revenue from Contracts with Customers (ASC 606) under the modified retrospective method. The new revenue standard outlines a single, comprehensive model requiring revenue to be recognized upon transfer of control of the promised goods or services to

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the customer at an amount that reflects the consideration the Company expects to be entitled to in exchange for those goods or services. The adoption of ASC 606 did not have a material impact on the measurement nor the recognition of revenue of contracts for which all revenue had not been recognized as of January 1, 2018.

The new accounting standard had the following effects on our presentation and disclosure:

•The majority of what was previously presented as bad debt expense under operating expenses has been incorporated as an implicit price concession factored into of the calculation of net revenues. Subsequent material changes in those implicit price concessions that are the result of an adverse change in a patient's ability to pay are recorded as bad debt expense. We did not have material bad debt expense as of June 30, 2018. See Note 3, Revenue and Accounts Receivable, in the Notes to the Condensed Consolidated Financial Statements.

•Prior period results reflect reclassifications, for comparative purposes, for the presentation of assisted and independent living revenue. Historically, we have only presented total revenue for all revenue services. This reclassification had no effect on the reported results of operations.

Class action lawsuit - In the first quarter of 2017, we recorded an estimated liability of $11.0 million related to the settlement of a class action lawsuit. We funded the settlement in the amount of $11.0 million in December 2017, and the funds were distributed to the class members in the first quarter of 2018. We received $1.7 million related to settlement funds that class members declined to claim during the settlement process, and the recoveries were recorded in the first quarter of 2018.

Common Stock Repurchase Program - As approved by the Board of Directors on April 3, 2018, we entered into a stock repurchase program pursuant to which the Company may repurchase up to $30.0 million of our common stock under the program for a period of approximately 11 months. To date, the Company has not purchased any shares pursuant to this stock repurchase program.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds and units located at our facilities as of June 30, 2018:

	TX	CA	AZ	WI	UT	CO	WA	ID	NE	KS	IA	SC	NV	Total
Number of facilities														
Skilled nursing operations	43	39	25	2	16	9	9	6	4	—	4	4	1	162
Assisted and independent living services	6	6	6	19	1	5	1	3	1	—	—	—	3	51
Campuses(1)	5	3	1	—	1	1	—	1	2	6	2	—	—	22
Number of operational beds/units														
Operational skilled nursing beds	5,794	4,163	3,442	138	1,740	766	841	544	413	542	368	424	92	19,267
Assisted and independent living units	605	735	1,250	758	106	619	98	274	304	142	31	—	311	5,233

(1) Campus represents a facility that offers both skilled nursing and assisted and/or independently living services.

As of June 30, 2018, we provided home health and hospice services through our 46 agencies in Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah and Washington.

During the six months ended June 30, 2018, we expanded our operations through a combination of a long-term lease and real estate purchases, with the addition of two stand-alone skilled nursing operations, two stand-alone assisted living operations and one campus operation. We did not acquire any material assets or assume any liabilities other than tenant's post-assumption rights and obligations under the long-term lease. The addition of these operations added 428 operational skilled nursing beds and 218 assisted living units to be operated by our operating subsidiaries. In addition, with one stand-alone skilled nursing operation acquisition, we acquired real estate that included an adjacent long-term acute care hospital that is currently operated by a third party under a lease arrangement. In addition, in June 2018, we acquired an office building for a purchase price of $31.5 million to accommodate our growing Service Center team. The aggregate purchase price for these acquisitions during the six months

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ended June 30, 2018 was $55.5 million. Subsequent to June 30, 2018, we acquired one stand-alone skilled nursing operation and one home health agency for an aggregate purchase price of $4.1 million. The addition of these operations added 40 operational skilled nursing beds operated by our operating subsidiaries.

For further discussion of our acquisitions, see Note 7, 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. Revenue associated with these metrics are generated based on contractually agreed-upon amounts or rate, excluding the estimates of variable consideration under revenue recognition standard, ASC 606. These indicators and their definitions include the following:

Transitional and Skilled Services

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

Skilled 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 skilled nursing routine revenue and as a percentage of total skilled nursing patient days:

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	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Skilled Mix:				
Days	29.7%	30.7%	30.7%	31.4%
Revenue	50.2%	52.1%	51.2%	52.7%
Quality Mix:				
Days	42.1%	43.2%	42.8%	43.6%
Revenue	58.8%	60.8%	59.7%	61.2%

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Occupancy for transitional and skilled services:				
Operational beds at end of period	19,267	18,403	19,267	18,403
Available patient days	1,735,633	1,650,276	3,426,846	3,265,074
Actual patient days	1,330,057	1,232,842	2,645,027	2,442,106
Occupancy percentage (based on operational beds)	76.6%	74.7%	77.2%	74.8%

Assisted and Independent Living Services

• Occupancy. We define occupancy derived from our assisted and independent living services as the ratio of actual number of days our units are occupied during any measurement period to the number of units in facilities which are available for occupancy during the measurement period.

• Average monthly revenue per unit. The revenue for a period at an assisted and independent living facility divided by actual occupied units for that revenue source for that given period.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
Occupancy for assisted and independent living services:				
Occupancy percentage (units)	75.2%	77.4%	75.4%	77.1%
Average monthly revenue per unit	$2,863	$2,799	$2,860	$2,818

Home Health and Hospice

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Average Medicare revenue per completed episode. The average amount of revenue for each completed 60-day episode generated from patients who are receiving care under Medicare reimbursement programs.

- Average daily census. The average number of patients who are receiving hospice care as a percentage of total number of patient days.

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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,	
	2018	2017	2018	2017
Home health services:				
Average Medicare revenue per completed episode	$3,064	$3,140	$2,951	$3,058
Hospice services:				
Average daily census	1,290	1,020	1,275	1,011

Segments

We have three reportable segments: (1) transitional and skilled services, which includes the operation of skilled nursing facilities; (2) assisted and independent living services, which includes the operation of assisted and independent living facilities; and (3) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

We also report an “all other” category that includes revenue from our mobile diagnostics and other ancillary operations. Our mobile diagnostics and other ancillary operations 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, 2018						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$161,584	$ 8,677	$1,232	$1,676	$—	$173,169	34.9 %
Medicare	108,237	—	10,486	18,090	—	136,813	27.6
Medicaid-skilled	28,298	—	—	—	—	28,298	5.7
Subtotal	298,119	8,677	11,718	19,766	—	338,280	68.2
Managed care	74,168	—	5,857	125	—	80,150	16.1
Private and other	36,231	28,487	3,746	37	9,455 (1)	77,956	15.7
Total revenue	$408,518	$ 37,164	$21,321	$19,928	$9,455	$496,386	100.0 %

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

The following pro forma table demonstrates the impact of adopting ASC 606 on our segment revenues by major payor source for the three months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

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	Three Months Ended June 30, 2018 (Pro forma)						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$164,988	$ 8,677	$1,329	$1,695	$—	$176,689	35.0 %
Medicare	109,220	—	10,594	18,213	—	138,027	27.3
Medicaid-skilled	28,935	—	—	—	—	28,935	5.7
Subtotal	303,143	8,677	11,923	19,908	—	343,651	68.0
Managed care	75,650	—	6,001	135	—	81,786	16.2
Private and other	38,268	28,487	3,777	40	9,455 (1)	80,027	15.8
Total revenue	$417,061	$ 37,164	$21,701	$20,083	$9,455	$505,464	100.0 %

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

	Three Months Ended June 30, 2017						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$142,833	$ 7,203	$995	$1,606	$—	$152,637	34.0 %
Medicare	104,450	—	8,867	14,834	—	128,151	28.6
Medicaid-skilled	24,913	—	—	—	—	24,913	5.6
Subtotal	272,196	7,203	9,862	16,440	—	305,701	68.2
Managed care	69,265	—	5,448	212	—	74,925	16.7
Private and other	33,756	25,806	2,561	98	5,432 (1)	67,653	15.1
Total revenue	$375,217	$ 33,009	$17,871	$16,750	$5,432	$448,279	100.0 %

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

	Six Months Ended June 30, 2018						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$318,095	$ 16,941	$2,215	$3,543	$—	$340,794	34.5 %
Medicare	220,190	—	20,353	35,584	—	276,127	27.9
Medicaid-skilled	55,340	—	—	—	—	55,340	5.6
Subtotal	593,625	16,941	22,568	39,127	—	672,261	68.0
Managed care	151,968	—	11,590	308	—	163,866	16.6
Private and other	69,941	56,336	7,347	67	18,702 (1)	152,393	15.4
Total revenue	$815,534	$ 73,277	$41,505	$39,502	$18,702	$988,520	100.0 %

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

The following pro forma table demonstrates the impact of adopting ASC 606 on our segment revenues by major payor source for the six months ended June 30, 2018, by showing revenue amounts as if the previous accounting guidance was still in effect.

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	Six Months Ended June 30, 2018 (Pro forma)						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$324,092	$ 16,941	$2,389	$3,576	$—	$346,998	34.5 %
Medicare	221,997	—	20,546	35,865	—	278,408	27.7
Medicaid-skilled	56,473	—	—	—	—	56,473	5.6
Subtotal	602,562	16,941	22,935	39,441	—	681,879	67.8
Managed care	155,348	—	11,951	332	—	167,631	16.7
Private and other	74,372	56,336	7,411	71	18,702 (1)	156,892	15.5
Total revenue	$832,282	$ 73,277	$42,297	$39,844	$18,702	$1,006,402	100.0 %

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

	Six Months Ended June 30, 2017						
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %
			Home Health Services	Hospice Services			
Medicaid	$281,658	$ 14,239	$1,925	$3,086	$—	$300,908	33.8 %
Medicare	212,379	—	17,500	28,193	—	258,072	29.0
Medicaid-skilled	47,930	—	—	—	—	47,930	5.4
Subtotal	541,967	14,239	19,425	31,279	—	606,910	68.2
Managed care	139,621	—	10,472	393	—	150,486	16.9
Private and other	65,968	51,116	5,025	160	10,354 (1)	132,623	14.9
Total revenue	$747,556	$ 65,355	$34,922	$31,832	$10,354	$890,019	100.0 %

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

Transitional and Skilled Services

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 supplemental payment programs 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 Services.

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

Home Health and Hospice Services

Home Health. We provided home health care in Arizona, California, Colorado, Idaho, Iowa, Oklahoma, Oregon, Texas, Utah and Washington as of June 30, 2018. 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

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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, 2018, we provided hospice care in Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah and Washington. We derive the majority 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.

The Centers for Medicare & Medicaid Services (CMS) 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, 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, 2018, 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

On January 1, 2018, we adopted Accounting Standard Codification 606 applying the modified retrospective method. Results for reporting periods beginning January 1, 2018 are presented under ASC 606, while prior period amounts are not adjusted and continue to be reported under the accounting standards in effect for the prior period. The adoption of ASC 606 did not have a material impact on the measurement nor on the recognition of revenue of contracts for which all revenue had not been recognized as of January 1, 2018, therefore no cumulative adjustment has been made to the opening balance of retained earnings at the beginning of 2018. See Note 3, Revenue and Accounts Receivable, in the Notes to Condensed Consolidated Financial Statements, for our revenue recognition policy under ASC 606.

Other than our adoption of ASC 606 above, there have been no significant changes during the six months ended June 30, 2018 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, 2017, 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, and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.

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- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. Due to the increasing demands from hospitals and insurance carriers to implement sophisticated and expensive reporting systems, we believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.
- Accountable Care Organizations and Reimbursement Reforms. 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. On December 1, 2017, CMS finalized changes to the Comprehensive Care for Joint Replacement (CJR) Model, as well as the cancellation of care coordination through mandatory Episode Payments and Cardiac Rehabilitation Incentive Payment Model, and rescinded the regulations governing these models. Through the final rule, CMS canceled the Episode Payment Models, which were scheduled to begin on January 1, 2018 and implemented certain revisions to CJR, including giving certain hospitals a one-time option to choose whether to continue participation. The changes in the final rule allow the agency to engage providers in future voluntary efforts, including additional voluntary episode-based payment models, but removes the mandatory episode payment models.

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

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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. The recent presidential and congressional elections in the United States could result in significant changes in, and uncertainty with respect to, legislation, regulation, implementation of Medicare and/or Medicaid, and government policy that could significantly impact our business and the health care industry. We continually monitor these developments in an effort to respond to the changing regulatory environment impacting our business.

On April 6, 2018, CMS announced that starting in April 2018, CMS will use Payroll Based Journals (PBJ) data to calculate the staffing ratings used in the Nursing Home Five Star Quality Rating System. CMS is using a new risk adjustment methodology to calculate the nursing staff component of the Star Rating. Additionally, the staffing information will be calculated using the number of hours facility staff are paid to work each day. Salaried employee information will not reflect actual hours worked, but instead will be limit to eight hours a day. The staffing information is electronically submitted each quarter, and will be adjusted based on the expected level of staff needed given the number and acuity of the residents in the facility. In April 2018, new ratings' thresholds were rolled out resulting in some facilities changing in their rating based on the new system. Additionally, because the PBJ data is used to calculate the staffing Star Rating, some facilities might see an increase or decrease in their overall Star rating depending on whether their PBJ data will positively or negatively impact them.

On February 12, 2018, the President rolled out a new White House budget for fiscal year 2019, which froze the Medicare market basket rate at 2.4%. As a result, the Congressional Budget Office has estimated a $1.9 billion reduction in Medicare spending over the next decade. The 2019 fiscal year begins October 1 of 2018.

On October 4, 2016, CMS released a final rule that reforms the requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in the Medicare and Medicaid programs. The regulations have not been updated since 1991 and have been revised to improve quality of life, care and services in LTC facilities, optimize resident safety, reflect current professional standards and improve the logical flow of the regulations. The regulations became effective November 28, 2016 and are being implemented in three phases. The first phase was effective November 28, 2016, the second phase was effective November 28, 2017 and the third phase becomes effective November 28, 2019.

A few highlights from the new regulation include the following:

- investigate and report all allegations of abusive conduct, and refrain from employing individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property;
- document a transfer or discharge in the medical record and exchange certain information to a receiving provider or facility when a resident is transferred;
- develop and implement a baseline care plan for each resident within 48 hours of their admission that includes instructions to provide effective and person-centered care that meets professional standards of quality care;
- develop and implement a discharge planning process that prepares residents to be active partners in post-discharge care;
- provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being;
- add a competency requirement for determining the sufficiency of nursing staff;

- require that a pharmacist reviews a resident’s medical chart during each monthly drug regiment review;
- refrain from charging a Medicare resident for loss or damage of dentures;
- provide each resident with a nourishing, palatable and well-balanced diet;

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- conduct, document and annually review a facility-wide assessment to determine what resources are necessary to care for its residents;
- refrain from entering into a binding arbitration agreement until after a dispute arises between the parties;
- develop, implement and maintain an effective comprehensive, data-driven quality assurance and performance improvement program;
- develop an Infection Prevention and Control Program; and
- require their operating organization have in effect a compliance and ethics program.

CMS estimates that the average cost per facility for compliance with the new rule to be approximately $62,900 in the first year and approximately $55,000 in subsequent years. However, these amounts vary per organization. In addition to the monetary costs, these regulations may create compliance issues, as state regulators and surveyors interpret requirements that are less explicit. On June 8, 2017, CMS issued a proposed rule that would remove the provisions prohibiting binding pre-dispute arbitration agreements, but would retain other provisions that protect the interests of LTC residents.

On September 16, 2016, CMS issued its final rule concerning emergency preparedness requirements for Medicare and Medicaid participating providers, specifically skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). The rule is designed to ensure providers and suppliers have comprehensive and integrated emergency policies and procedures in place, in particular during natural and man-made disasters. Under the rule, facilities are required to 1) document risk assessment and emergency planning; 2) develop and implement policies and procedures based on that risk assessment; 3) develop and maintain an emergency preparedness communication plan in compliance with both federal and state law; and 4) develop and maintain an emergency preparedness training and testing program.

On June 9, 2017, CMS issued revised requirements for emergency preparedness for Medicare and Medicaid participating providers, including long-term care facilities, hospices, and home health agencies. The revised requirements update the conditions of participation for such providers. Specifically, outpatient facilities, such as home health agencies, are required to ensure that patients with limited mobility are addressed within the emergency plan; home health agencies are also required to develop and implement emergency preparedness policies and procedures that are reviewed and updated at least annually and each patient must have an individual plan; hospice-operated inpatient care facilities are required to provide subsistence needs for hospice employees and patients and a means to shelter in place patients and employees who remain in the hospice; all hospices and home health agencies must implement procedures to follow up with on duty staff and patients to determine services that are needed in the event that there is an interruption in services during or due to an emergency; hospices must train their employees in emergency preparedness policies and long-term care facilities are required to share emergency preparedness plans and policies with family members and resident representatives.

On July 29, 2016, CMS issued its final rule laying out the performance standards relating to preventable hospital readmissions from skilled nursing facilities. The final 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 final rule includes the SNF 30-Day Potentially Preventable Readmission Measure as the SNF all condition risk adjusted potentially preventable hospital readmission measure. This 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 measure is claims-based, requiring no additional data collection or submission burden for SNFs.

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for a new Cardiac Rehabilitation Incentive (CR) model, which includes mandatory bundled payment programs for an acute myocardial infarction (AMI) episode of care or a coronary artery bypass graft (CABG) episode of care, and modifications to the

existing Comprehensive Care for Joint Replacement (CJR) model to include surgical hip/femur fracture treatment episodes. The new mandatory cardiac programs mirror the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models in that actual episode payments will be retrospectively compared against a target price. Similar to CJR, participating hospitals will 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 will be mandatory in 98 randomly selected geographic areas and the hip/femur procedure model will 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

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in 45 of the 98 geographic areas included in the mandatory bundled payment program and 45 geographic areas outside of the program. On December 1, 2017, CMS issued a final rule which officially canceled the Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model, rescinding the regulations governing these models. Additionally, the final rule implemented certain revisions to the CJR program, including making participation voluntary for approximately half of the geographic areas, along with other technical refinements. These regulation changes became effective January 1, 2018 and are effective for five performance years.

On January 9, 2018, CMS launched a new voluntary bundled payment called Bundled Payments for Care Improvement Advanced (BPCI Advanced), which will replace the BPCI initiative that terminates on September 30, 2018. The Model Performance Period for BPCI Advanced commences on October 1, 2018 and runs through December 31, 2023. Under the advanced bundled payment model, participants can earn additional payment if all expenditures for a beneficiary's episode of care are under a spending target that factors in quality. The BPCI Advanced model changes the BPCI initiative in a number of ways. Most importantly, it eliminates the BPCI Model 3 which allows post-acute care providers to participate as episode initiators. Episode initiators under the new BPCI Advanced initiative are called Non-Convener Participants and only include Acute Care Hospitals and Physician Group Practices. As a result, once BCPI Advanced is implemented, post-acute care providers will only be able to participate as "Convener Participants." A Convener Participant is a participant that brings together the episode initiators, which are the Acute Care Hospital or the Physician Group Practice. The Convener Participant facilitates coordination among the episode initiators and bears and apportions financial risk under BCPI Advanced. Thus post-acute care providers may only participate in BPCI Advanced as Convener Participants.

Of note, BPCI Advanced will qualify as the first Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program (QPP). In 2015, Congress passed the Medicare Access and Chip Reauthorization Act (MACRA). MACRA requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid who participate in Medicare. QPP creates two tracks for physician payment - the Merit-Based Incentive Payment System (MIPS) track and the Advanced APM track. Under MIPS, providers have to report a range of performance metrics and their payment amount is adjusted based on their performance. Under Advanced APMs, providers take on financial risk to earn the Advanced APM incentive payment that they are participating in.

Skilled Nursing

CMS Payment Rules. On July 31, 2018, CMS issued its final rule outlining fiscal year 2019 Medicare payment rates for skilled nursing facilities. As a function of the Bipartisan Budget Act of 2018, the SNF market basket percentage is set to a statutorily required 2.4%. Under the final rule, CMS will be replacing the existing case-mix methodology, the Resource Utilization Group (RUG-IV) model, with a new Patient-Driven Payment Model (PDPM), effective October 1, 2019. The new PDPM is expected to better account for patient characteristics by relating payment to patients' conditions and clinical needs rather than on volume-based services. The PDPM is also expected to reduce systemic complexity and save SNFs approximately $2.0 billion over 10 years in administrative costs. A budget neutrality factor was used to satisfy the requirement that PDPM be budget neutral relative to RUG-IV, given that the intent with the new model is not to change the aggregate amount of Medicare payments to SNFs, but to more accurately reflect resource utilization without incentivizing inappropriate care delivery. Additionally, the rule finalizes updates to the SNF Quality Reporting Program and the Skilled Nursing Facility Value-Based Purchasing (VBP) Program, that will affect Medicare payment beginning on October 1, 2018.

On July 31, 2017, CMS issued its final rule outlining fiscal year 2018 Medicare payment rates for skilled nursing facilities. Under the final rule, the market basket index is revised and rebased by updating the base year from 2010 to 2014 and adding a new cost category for Installation, Maintenance, and Repair Services. The rule also includes revisions to the SNF Quality Reporting Program, including measure and standardized patient assessment data policies, as well as policies related to public display. In addition, it finalized policies for the Skilled Nursing Facility Value-Based Purchasing Program that will affect Medicare payment to SNFs beginning in fiscal year 2019 and

clarification of the requirements regarding the composition of professionals for the survey team. The final rule uses a market basket percentage of 1% to update the federal rates, but if a SNF fails to submit quality reporting program requirements there will be a 2% reduction to the market basket update for the fiscal year involved. Thus, the increase in the proposed federal rates may increase the amount of our reimbursements for SNF services so long as we meet the reporting requirements.

On July 29, 2016, CMS issued its final rule outlining fiscal year 2017 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the finalized rule continue to shift Medicare payments from volume to value. The aggregate payments to skilled nursing facilities increased 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 (ACA). This final rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the

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Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports.

The Value-Based Purchasing Program rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare. The 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. This SNF Value-Based Purchasing Program will start on October 1, 2018.

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 July 2, 2018, CMS published a proposed rule that updates the Medicare Home Health Prospective Payment System (HH PPS) rates and wage index that would begin taking effect on January 1, 2019, and broader changes to the Medicare payment methodology that would go into effect on January 1, 2020. CMS estimates the update will result in a 2.1% increase in payments to Home Health Agencies in 2019. This increase reflects the effects of a 2.8% market basket update, reduced by a 0.7% Multifactor Productivity (MFP) adjustment, although for HHAs that do not submit the required quality data, payments will be reduced by an additional 2.0%. The proposal also extends the rural add-on payment for calendar years 2019 through 2022. The renamed Patient Driven Grouping Model (PDGM) proposes case-mix methodology refinements, which eliminate the use of therapy thresholds for case-mix adjustment purposes, and proposes to change the unit of payment from a 60-day episode of care to a 30-day period of care, beginning on or after January 1, 2020. There is also a proposal regarding how CMS would determine whether 30-day periods of care are subject to a Low-Utilization Payment Adjustment (LUPA). CMS announced that implementation of the measures is intended to occur in a budget-neutral manner. In addition, the proposed rule makes changes to both measures and calculations for the Home Health Value-Based Purchasing (HHVBP) Model and Home Health Quality Reporting Program (HH QRP), and includes information on the implementation of temporary transitional payments and Accreditation for infusion therapy services beginning on October 1, 2018.

On November 1, 2017, CMS issued a final rule that became effective on January 1, 2018 and updated the calendar year 2018 Medicare payment rates and the wage index for home health agencies serving Medicare beneficiaries. The rule also finalized proposals for the Home Health Value-Based Purchasing Model and the Home Health Quality Reporting Program. Under the final rule. Medicare payments will be reduced by 0.4%. This decrease reflects the effects of a 1.0% home health payment update percentage, an adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9%, and the distributional effects of a -0.5% reduction in payments due to the sunset of the rural add-on provision.

On January 13, 2017, CMS issued a final rule that modernized the Home Health Conditions of Participation (CoPs). This rule is a continuation of CMS's effort to improve quality of care while streamlining provider requirements to reduce unnecessary procedural requirements. The rule makes significant revisions to the conditions currently in place, including (1) adding new conditions of participation related to quality assurance and performance improvement programs (QAPI) and infection control; and (2) expanding or revising requirements related to patient rights,

comprehensive evaluations, coordination and care planning, home health aide training and supervision, and discharge and transfer summary and time frames. The new CoPs became effective on January 13, 2018.

On October 31, 2016, CMS issued final payment changes to the Medicare HH PPS for calendar year 2017. Under this rule, Medicare payments were reduced by 0.7%. This decrease reflects a negative 0.97% adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth from 2012 through 2014; a 2.3% reduction in payments due to the final 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; and the effects of the revised fixed-dollar loss (FDL) ratio used in determining outlier payments; partially offset by the home health payment update percentage of 2.5%.

Hospice

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On August 1, 2018, CMS issued its final rule outlining the fiscal year 2019 Medicare payment rates, wage index, and cap amount for hospices serving Medicare beneficiaries. Under the final rule, the hospice payment update percentage is 1.8%, which reflects a market basket update of 2.9%, reduced by 0.8% for MFP adjustment, as well as another 0.3% reduction, which decreases are mandated by the Affordable Care Act. The hospice payment update percentage will be reduced by an additional 2.0%, for a net -0.2%, for hospices that do not submit the required quality data. The final rule also specifies that the hospice cap will be updated using the hospice payment update rather than the consumer price index, thus it's anticipated there will be a 1.8% increase in aggregate cap payments made to hospices annually. The final rule also includes language that reflects the change in the Bipartisan Budget Act of 2018 which recognizes physician assistants as attending physicians for Medicare hospice beneficiaries, effective January 1, 2019. This may positively impact reimbursement from Medicare as this may increase the number of episodes that can be reimbursed. Additionally, the rule finalizes changes to the Hospice Quality Reporting Program (HQRP), also effective January 1, 2019, including changes to the data review and correction timeline for data submitted using the Hospice Item Set.

On August 1, 2017, CMS issued its final rule outlining the fiscal year 2018 Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries. The final rule uses a net market basket percentage increase of 1.0% to update the federal rates, as mandated by section 411(d) of the MACRA. Although, if a hospice fails to comply with quality reporting program requirements, there will be a 2.0% reduction to the market basket update for the fiscal year involved. The hospice cap amount for fiscal year 2018 was increased by 1.0%, which is equal to the 2017 cap amount updated by the fiscal year 2018 hospice payment update percentage of 1.0%. In addition, this rule discusses changes to the Hospice Quality Reporting Program (HQRP), including changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey measures and plans for sharing HQRP data in fiscal year 2017.

On July 29, 2016, 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, there was a net 2.1% increase in hospice payments effective October 1, 2016. The hospice payment increase was 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 ACA. The hospice cap amount for fiscal year 2017 increased by 2.1%, which is equal to the 2016 cap amount updated by the fiscal year 2017 hospice payment update percentage of 2.1%. In addition, this rule changes the HQRP requirements, including care surveys and two new quality measures that 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.

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, 2018 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 was $2,010 in 2018 compared to $1,980 in 2017. For occupational therapy (OT) services, the limit was $2,010 for 2018 compared to $1,980 in 2017. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018. This new law includes several provisions related to Medicare payments for services beginning on January 1, 2018. With regard to payment

for outpatient therapy services, the law repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold above for services that are medically necessary. The new law retains the targeted medical review process, but at a lower threshold amount. It also extends several recently expired Medicare legislative provisions affecting health care providers and beneficiaries, including the Medicare physician fee schedule work geographic adjustment floor.

On July 12, 2018, CMS issued a proposed rule that revises the payment policies under the Medicare Physician Fee Schedule and includes other revisions to Medicare Part B and the Quality Payment Program for CY 2019 (the "2019 Proposed Physician Fee Schedule Rule"). One of the proposed revisions relates to functional reporting by therapists who provide outpatient services. To date therapists that provide outpatient services are required to include functional status information and at certain intervals the patient's severity on claims for such therapy services. CMS had been using the functional reporting data to aid in recommending changes to, and reforming, Medicare payment for outpatient therapy services that were subject to the statutory therapy caps; but the Bipartisan Budget Act of 2018 repealed the therapy caps and the functional data reporting no longer serves a quantifiable purpose. Thus, the proposed rule would discontinue functional status reporting requirements for outpatient therapy services effective

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January 1, 2019. This would reduce the reporting burden on therapists providing outpatient services and increase the amount of time that therapists can spend with their patients. This may result in greater reimbursement for outpatient therapy services as therapists who provide outpatient services may spend more time with patients.

A second part of 2019 Proposed Physician Fee Schedule Rule details the plan to create a new billing modifier for services furnished in whole or in part by therapy assistants. The proposed rule also details that therapy assistant rates will be reduced to 85 percent of the applicable Part B payment amount for that service. The reduction in rates would be effective January 1, 2022. The rule proposes to establish two new therapy modifiers, one for Physical Therapy Assistants and one for Occupational Therapists when services are furnished in whole or in part. The new therapy modifiers would not be required until January 1, 2020. The proposed rule reduces the amount of reimbursement for the services provided by Physical Therapists and Occupational Therapists by 15%, thereby decreasing the amount of reimbursement received from such services.

The Multiple Procedure Payment Reduction (MPPR) continues at a 50% reduction, which is applied to therapy procedures by reducing payments for practice expense of the second and subsequent procedures when services provided under subsequent procedures 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.
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,		
	2018	2018 Pro forma (1)	2017	2018	2018 Pro forma (1)	2017
Revenue						
Service revenue	92.5 %	92.6 %	92.6 %	92.6 %	92.7 %	92.7 %
Assisted and independent living revenue	7.5	7.4	7.4	7.4	7.3	7.3
Total revenue	100.0	100.0	100.0	100.0	100.0	100.0
Expense						
Cost of services	79.8	80.2	81.9	79.5	79.9	81.2
(Return of unclaimed class action settlement)/charges related to class action lawsuit (Note 17)	—	—	—	(0.2)	(0.2)	1.2
(Gains)/losses related to divestitures (Note 6 and 16)	—	—	(0.3)	—	—	0.3
Rent—cost of services (Note 16)	7.0	6.8	7.3	6.9	6.9	7.3
General and administrative expense	4.5	4.4	3.8	4.8	4.7	4.3
Depreciation and amortization	2.3	2.3	2.4	2.4	2.3	2.4
Total expenses	93.6	93.7	95.1	93.4	93.6	96.7
Income from operations	6.4	6.3	4.9	6.6	6.4	3.3
Other income (expense):						
Interest expense	(0.8)	(0.8)	(0.7)	(0.8)	(0.7)	(0.7)
Interest income	0.1	0.1	0.1	0.1	0.1	0.1
Other expense, net	(0.7)	(0.7)	(0.6)	(0.7)	(0.6)	(0.6)
Income before provision for income taxes	5.7	5.6	4.3	5.9	5.8	2.7
Provision for income taxes	1.2	1.2	1.5	1.3	1.3	0.9
Net income	4.5	4.4	2.8	4.6	4.5	1.8
Less: net income attributable to noncontrolling interests	0.1	—	0.1	—	—	0.1
Net income attributable to The Ensign Group, Inc.	4.4 %	4.4 %	2.7 %	4.6 %	4.5 %	1.7 %

(1) The pro forma amounts in the table demonstrate the impact of adopting ASC 606 for the three and six months ended June 30, 2018 by presenting the percentages as if the previous accounting guidance was still in effect.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In thousands)			
Non-GAAP Financial Measures:				
Performance Metrics				
EBITDA	$43,081	$32,618	$87,521	$50,568
Adjusted EBITDA	46,321	38,124	92,956	79,209
Valuation Metric				
Adjusted EBITDAR	77,147	66,690	153,975	135,402

The following discussion includes references to EBITDA, Adjusted EBITDA and Adjusted EBITDAR which are non-GAAP financial measures (collectively, 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. These non-GAAP financial measures are used in addition to and in conjunction with results presented in

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accordance with GAAP. These non-GAAP financial measures should not be relied upon to the exclusion of GAAP financial measures. These non-GAAP financial measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

We believe the presentation of Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as interest 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 Non-GAAP Financial Measures:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;

- to allocate resources to enhance the financial performance of our business;

- to assess the value of a potential acquisition;

- to assess the value of a transformed operation's performance;

- to evaluate the effectiveness of our operational strategies; and

- to compare our operating performance to that of our competitors.

We typically use Non-GAAP Financial Measures to compare the operating performance of each operation. These measures are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the amount of debt that we have incurred, whether an operation is owned or leased, the date of acquisition of a facility or business, and the tax law of the state in which a business unit operates.

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

Despite the importance of these measures in analyzing our underlying business, designing incentive compensation and for our goal setting, Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, our Non-GAAP Financial Measures have limitations as analytical tools, and they should not be considered in isolation, or as a substitute for analysis of our results as reported in accordance with GAAP. Some of these limitations are:

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- 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 rent expenses, which are necessary to operate our leased operations, in the case of Adjusted EBITDAR;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using them only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business.

Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' Non-GAAP Financial Measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table below, along with our consolidated financial statements and related notes included elsewhere in this document.

We use the following Non-GAAP Financial Measures that we believe are useful to investors as key valuation and operating performance measures:

EBITDA

We believe EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate EBITDA as net income 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.

Adjusted EBITDA

We adjust EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance, in the case of Adjusted EBITDA. We believe that the presentation of Adjusted EBITDA, when combined with EBITDA and GAAP net income (loss) attributable to The Ensign Group, Inc., is beneficial to an investor's complete understanding of our operating performance.

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

- results at facilities currently being constructed and other start-up operations;
- return of unclaimed class action settlement funds, and charges related to the settlement of class action lawsuits;
- share-based compensation expense;
- results related to closed operations and operations not at full capacity, including continued obligations and closing expenses;
- transaction-related costs; and
- business interruption recoveries

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Adjusted EBITDAR

We use Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a commonly used measure by our management, research analysts and investors, to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures and leasing arrangements. Adjusted EBITDAR is a financial valuation measure that is not specified in GAAP. This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense.

The adjustments made and previously described in the computation of Adjusted EBITDA are also made when computing Adjusted EBITDAR. We calculate Adjusted EBITDAR by excluding rent-cost of services from Adjusted EBITDA.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2018	2017	2018	2017
	(In thousands)			
Consolidated statements of income data:				
Net income	$22,326	$12,380	$45,619	$15,337
Less: net income attributable to noncontrolling interests	315	163	476	279
Interest expense, net	3,307	2,765	6,472	5,920
Provision for income taxes	6,142	6,886	12,663	8,326
Depreciation and amortization	11,621	10,750	23,243	21,264
EBITDA	$43,081	$32,618	$87,521	$50,568
(Earnings)/losses related to facilities currently being constructed and other start-up operations(a)	(2,543)	(857)	(4,794)	(226)
(Return of unclaimed class action settlement)/charges related to the settlement of the class action lawsuit(b)	—	163	(1,664)	11,163
Share-based compensation expense(c)	2,520	2,376	4,829	4,600
Results related to closed operations and operations not at full capacity, including continued obligations and closing expenses(d)	209	(555)	325	4,364
Transaction-related costs(e)	83	360	111	448
Business interruption recoveries(f)	(675)	—	(675)	—
Rent related to items(a) and (d) above	3,646	4,019	7,303	8,292
Adjusted EBITDA	$46,321	$38,124	$92,956	$79,209
Rent—cost of services	34,472	32,585	68,322	64,485
Less: rent related to items(a) and (d) above	(3,646)	(4,019)	(7,303)	(8,292)
Adjusted EBITDAR	$77,147	$66,690	$153,975	$135,402

(a) Represents results related to facilities currently in the start up phase after construction was completed. This amount excludes rent, depreciation and interest expense.

(b) Return of unclaimed class action settlement funds or charges incurred in connection with the settlement of the class action lawsuit.

(c) Share-based compensation expense incurred.

(d) Represents results at closed operations and operations not at full capacity during the three and six months ended June 30, 2018 and 2017, including the fair value of continued obligation under the lease agreement and related closing expenses of $4.0 million for the six months ended June 30, 2017. Included in the three and six months ended June 30, 2017 results is the loss recovery of $1.3 million of certain losses related to a closed facility in 2016.

(e) Costs incurred to acquire operations which are not capitalizable.

(f) Business interruption recoveries related to insurance claims with respect to the California fires that occurred in the fourth quarter of 2017.

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Three Months Ended June 30, 2018 Compared to the Three Months Ended June 30, 2017

Revenue

	Three Months Ended June 30,					
	2018		2018 Pro Forma (2)		2017	
	Revenue $	Revenue %	Revenue $	Revenue %	Revenue $	Revenue %
	(Dollars in thousands)					
Transitional and skilled services	$408,518	82.3 %	$417,061	82.5 %	$375,217	83.7 %
Assisted and independent living services	37,164	7.5	37,164	7.4	33,009	7.4
Home health and hospice services:						
Home health	21,321	4.3	21,701	4.3	17,871	4.0
Hospice	19,928	4.0	20,083	4.0	16,750	3.7
Total home health and hospice services	41,249	8.3	41,784	8.3	34,621	7.7
All other [1]	9,455	1.9	9,455	1.8	5,432	1.2
Total revenue	$496,386	100.0 %	$505,464	100.0 %	$448,279	100.0 %

(1) Includes revenue from services generated in our other mobile diagnostic and ancillary services.
(2) The pro forma amounts in the table demonstrate the impact of adopting ASC 606 for the three months ended June 30, 2018 by presenting the dollars and percentages as if the previous accounting guidance was still in effect.

Our consolidated revenue increased $48.1 million, or 10.7%. On a pro forma basis, revenue increased $57.2 million or 12.8%. The following analysis incorporates the adoption of ASC 606. See pro forma 2018 numbers in the table below for a period over period comparative analysis.

Our transitional and skilled services revenue increased by $33.3 million, or 8.9%, mainly attributable to the increase in patient days, revenue per patient day and the impact of acquisitions. Our assisted and independent living services revenue increased by $4.2 million, or 12.6%, mainly due to the increase in average monthly revenue per unit compared to the prior year period, coupled with the impact of acquisitions. Our home health and hospice services revenue increased by $6.6 million, or 19.1%, mainly due to an increase in volume in existing agencies combined with new acquisitions. Revenue from operations acquired on or subsequent to January 1, 2017 for all segments increased our consolidated revenue by $34.7 million during the three months ended June 30, 2018 when compared to the same period in 2017.

Transitional and Skilled Services

The following table presents the transitional and skilled services revenue and key performance metrics by category during the three months ended June 30, 2018 and 2017:

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Transitional and skilled revenue (As Reported)	$408,518	$375,217	$33,301	8.9 %
Transitional and skilled revenue (Pro forma (5))	417,061	375,217	41,844	11.2 %
Number of facilities at period end	162	155	7	4.5 %

Number of campuses at period end*	22		21		1	4.8	%
Actual patient days	1,330,057		1,232,842		97,215	7.9	%
Occupancy percentage — Operational beds	76.6	%	74.7	%		1.9	%
Skilled mix by nursing days	29.7	%	30.7	%		(1.0	)%
Skilled mix by nursing revenue	50.2	%	52.1	%		(1.9	)%

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	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Transitional and skilled revenue (As Reported)	$280,477	$274,680	$5,797	2.1 %
Transitional and skilled revenue (Pro forma (5))	286,330	274,680	11,650	4.2 %
Number of facilities at period end	108	108	—	— %
Number of campuses at period end*	11	11	—	— %
Actual patient days	871,035	868,397	2,638	0.3 %
Occupancy percentage — Operational beds	78.3 %	78.0 %		0.3 %
Skilled mix by nursing days	31.3 %	31.2 %		0.1 %
Skilled mix by nursing revenue	52.1 %	52.3 %		(0.2)%

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Transitional and skilled revenue (As Reported)	$96,690	$92,875	$3,815	4.1 %
Transitional and skilled revenue (Pro forma (5))	98,693	92,875	5,818	6.3 %
Number of facilities at period end	40	40	—	— %
Number of campuses at period end*	9	9	—	— %
Actual patient days	348,385	335,472	12,913	3.8 %
Occupancy percentage — Operational beds	73.4 %	70.7 %		2.7 %
Skilled mix by nursing days	28.5 %	30.1 %		(1.6)%
Skilled mix by nursing revenue	48.3 %	52.0 %		(3.7)%

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Transitional and skilled revenue (As Reported)	$31,351	$7,489	$23,862	NM
Transitional and skilled revenue (Pro forma (5))	32,038	7,489	24,549	NM
Number of facilities at period end	14	7	7	NM
Number of campuses at period end*	2	1	1	NM
Actual patient days	110,637	28,424	82,213	NM
Occupancy percentage — Operational beds	74.1 %	45.9 %		NM
Skilled mix by nursing days	21.6 %	23.0 %		NM
Skilled mix by nursing revenue	38.5 %	44.0 %		NM

	Three Months Ended June 30,

	20182017	Change	% Change
	(Dollars in thousands)		
Facility Closed Results(4):			
Skilled nursing revenue	$— $173	$(173)	NM
Actual patient days	— 549	(549)	NM
Occupancy percentage — Operational beds	% 50.0 %		NM
Skilled mix by nursing days			