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	—% 13.8 %		NM
Skilled mix by nursing revenue	—% 35.5 %		NM

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* Campus represents a facility that offers both skilled nursing and 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.

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(1) Same Facility results represent all facilities purchased prior to January 1, 2015.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2015 to December 31, 2016.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2017.

(4) Facility Closed results represents closed operations during the three months ended June 30, 2017, which were excluded from Same Store and Transitioning results for the three months ended June 30, 2017, for comparison purposes.

(5) 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.

Transitional and skilled services revenue increased $33.3 million, or 8.9% in the second quarter of 2018 or $41.8 million and 11.2% on a pro forma basis. Of the $33.3 million increase, Medicare and managed care revenue increased $8.7 million, or 5.0%, Medicaid custodial revenue increased $18.7 million, or 13.1%, private and other revenue increased $2.5 million, or 7.3%, and Medicaid skilled revenue increased $3.4 million, or 13.6%.

Transitional and skilled services revenue generated by Same Facilities increased $5.8 million, or 2.1%, which includes the impact of the adoption of ASC 606. Without the adoption of ASC 606 impact, Same Facilities increased $11.7 million, or 4.2%, on a comparable basis. The comparable same store revenue (without the impact of the adoption of ASC 606) was driven by the following factors:

- Our skilled mix revenue increased by $4.3 million, or 3.1%, and our skilled mix days increased by 0.6%. The majority of the increase is related to an increase in other skilled revenue of $4.2 million, or 18.8%, mainly driven by an increase in other skilled days of 11.7% and other skilled revenue per patient day of 6.4%.
- Our overall Medicare revenue increased by $0.6 million, or 0.8%, primarily due to an increase in Medicare revenue per patient day as part of our continuous shift toward higher acuity patients.
- We continued to experience a growth in revenue with our Medicaid plans. Our Medicaid revenue, excluding Medicaid-skilled revenue, increased by $5.1 million, or 4.8%, mainly driven by Medicaid days increased by 0.8%.
- We also experienced an increase in Medicaid revenue per patient day of 4.0% as a result of our participation in the quality improvement programs and the supplemental programs in various states.

Transitional and skilled services revenue generated by Transitioning Facilities increased $3.8 million, or 4.1%, which includes the impact of the adoption of ASC 606. Without the adoption of ASC 606 impact, Transitioning Facilities increased $5.8 million, or 6.3%, on a comparable basis. This is due to increases in total patient days and revenue per patient day of 3.8% and 1.2%, respectively. We continued to experience a growth in revenue with our Medicaid and managed care plans. Our Medicaid revenue, excluding Medicaid-skilled revenue, increased by $5.4 million, or 16.2%, mainly driven by a 7.4% increase Medicaid days . We also experienced an increase in Medicaid revenue per patient day of 8.2% as a result of our participation in the quality improvement programs and supplemental programs in various states. Our overall managed care revenue increased by $1.9 million, or 10.7%, mainly driven by an increase in managed care days of 8.8%.

Transitional and skilled services revenue generated by Recently Acquired Facilities increased by approximately $23.9 million, mainly due to eight operations we acquired between July 1, 2017 and June 30, 2018 in four states. In addition, Recently Acquired Facilities in the second quarter of 2017 included three newly built facilities that had low occupancy rates during the start up period. Accordingly, the occupancy rate in the second quarter of 2017 was impacted by the lower census due to start up operations at newly opened facilities.

In the future, if we acquire additional turnaround or start up operations, we expect to see lower occupancy and skilled mix, and these metrics are expected to vary from period to period based upon the maturity of the facilities within our portfolio. Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth.

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

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	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Skilled Nursing Average Daily Revenue Rates:								
Medicare	$615.55	$599.86	$516.78	$504.49	$534.46	$499.43	$582.05	$567.65
Managed care	461.65	455.74	410.59	417.24	422.43	377.38	445.48	444.65
Other skilled	486.12	456.99	349.01	379.94	444.55	650.86	467.19	446.94
Total skilled revenue	528.70	516.37	455.64	459.54	484.99	481.16	507.68	500.59
Medicaid	221.75	213.21	194.38	179.62	212.69	179.72	213.86	203.49
Private and other payors	225.93	202.58	196.96	194.61	230.57	196.36	217.35	199.90
Total skilled nursing revenue	$318.56	$305.91	$269.45	$266.13	$274.57	$251.58	$302.01	$293.84

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 2.6% and 2.4%, respectively. The increase is attributable to the 1.0% net market basket percentage that became effective in October 2017, which was preceded by a 2.4% net market basket increase that went into effect in October 2016. In addition, the increase in Medicare daily rates was the result of a continuing shift towards higher acuity patients.

Our average Medicaid rates increased 5.1% primarily due to our participation in supplemental Medicaid payment programs and quality improvement programs in various states.

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

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Percentage of Skilled Nursing Revenue:								
Medicare	24.5 %	25.4 %	25.9 %	29.6 %	22.7 %	35.3 %	24.7 %	26.7 %
Managed care	18.0	18.4	19.4	19.0	11.8	6.6	17.8	18.3
Other skilled	9.6	8.5	3.0	3.4	4.0	2.1	7.7	7.1
Skilled mix	52.1	52.3	48.3	52.0	38.5	44.0	50.2	52.1
Private and other payors	7.7	7.9	10.5	10.8	12.1	11.9	8.6	8.7
Quality mix	59.8	60.2	58.8	62.8	50.6	55.9	58.8	60.8
Medicaid	40.2	39.8	41.2	37.2	49.4	44.1	41.2	39.2
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Percentage of Skilled Nursing Days:								
Medicare	12.6 %	13.1 %	13.5 %	15.6 %	11.6 %	17.8 %	12.8 %	13.9 %
Managed care	12.3	12.4	12.7	12.1	7.6	4.4	12.0	12.2
Other skilled	6.4	5.7	2.3	2.4	2.4	0.8	4.9	4.6
Skilled mix	31.3	31.2	28.5	30.1	21.6	23.0	29.7	30.7
Private and other payors	11.1	11.5	14.5	14.7	15.0	15.3	12.4	12.5
Quality mix	42.4	42.7	43.0	44.8	36.6	38.3	42.1	43.2
Medicaid	57.6	57.3	57.0	55.2	63.4	61.7	57.9	56.8
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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Assisted and Independent Living Services

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Resident fee revenue	$37,164	$33,009	$4,155	12.6 %
Number of facilities at period end	51	46	5	10.9 %
Number of campuses at period end	22	21	1	4.8 %
Occupancy percentage (units)	75.2 %	77.4 %		(2.2)%
Average monthly revenue per unit	$2,863	$2,799	$64	2.3 %

Assisted and independent living revenue of $37.2 million increased 12.6% on a comparable basis, primarily due to an increase in average monthly revenue per unit of 2.3% and revenue generated from the addition of six assisted and independent living operations in three states between July 1, 2017 and June 30, 2018, partially offset by the decrease in occupancy of 2.2%.

Home Health and Hospice Services

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Home health and hospice revenue				
Home health services	$21,321	$17,871	$3,450	19.3 %
Hospice services	19,928	16,750	3,178	19.0
Total home health and hospice revenue	$41,249	$34,621	$6,628	19.1 %
Pro forma(1)				
Home health and hospice revenue				
Home health services	$21,701	$17,871	$3,830	21.4 %
Hospice services	20,083	16,750	3,333	19.9
Total home health and hospice revenue	$41,784	$34,621	$7,163	20.7 %
Home health services:				
Average Medicare Revenue per Completed Episode	$3,064	$3,140	$(76)	(2.4)%
Hospice services:				
Average Daily Census	1,290	1,020	270	26.5 %

(1) 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.

Home health and hospice revenue increased $6.6 million, or 19.1%, or $7.2 million and 20.7% on a pro forma basis. Of the $6.6 million increase, Medicare and managed care revenue increased $5.2 million, or 17.7%. The increase in revenue is primarily due to the increase in volume in existing agencies, coupled with the addition of three home health and hospice operations in three states between July 1, 2017 and June 30, 2018.

Cost of Services

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

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	Three Months Ended June 30,		
	2018	2018 Pro Forma (1)	2017
	(Dollars in thousands)		
Transitional and skilled services	$329,768	$338,310	$311,477
Assisted and independent living services	24,407	24,407	21,923
Home health and hospice services	34,148	34,684	29,041
All other	7,809	7,809	4,505
Total cost of services	$396,132	$405,210	$366,946

(1) 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.

Consolidated cost of services increased $29.2 million, or 8.0%, or $38.3 million and 10.4% on a pro forma basis. Consolidated cost of services as a percentage of revenue decreased by 2.1% to 79.8%, or 1.7% to 80.2% on a pro forma basis.

Transitional and Skilled Services

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$329,768	$311,477	$18,291	5.9 %
Cost of service (Pro Forma (1))	338,310	311,477	26,833	8.6 %
Revenue percentage	80.7 %	83.0 %		(2.3)%
Revenue percentage (Pro Forma (1))	81.1 %	83.0 %		(1.9)%

(1) 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.

Cost of services related to our transitional and skilled services segment increased $18.3 million, or 5.9%, due primarily to additional costs at Recently Acquired Facilities of $18.3 million. Cost of services as a percentage of revenue decreased to 80.7%, mainly due to operational improvements.

Assisted and Independent Living Services

	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$24,407	$21,923	$2,484	11.3 %
Revenue percentage	65.7 %	66.4 %		(0.7)%

Cost of services related to our assisted and independent living services segment increased $2.5 million, or 11.3%, primarily due to recently acquired operations and organic operational growth. Cost of services as a percentage of total revenue decreased to 65.7% due to operational improvements.

Home Health and Hospice Services

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	Three Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$34,148	$29,041	$5,107	17.6 %
Cost of service (Pro Forma (1))	34,684	29,041	5,643	19.4 %
Revenue percentage	82.8 %	83.9 %		(1.1)%
Revenue percentage (Pro Forma (1))	83.0 %	83.9 %		(0.9)%

(1) 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.

Cost of services related to our home health and hospice services segment increased $5.1 million, or 17.6%, due to newly acquired operations and organic operational growth. Cost of services as a percentage of total revenue decreased by 1.1% primarily due to stronger collections, which resulted in higher revenue under the new revenue accounting guidance. In the prior year, this adjustment was classified as bad debt expense.

(Return of unclaimed class action settlement)/charges related to class action lawsuit. We funded the settlement of a class action lawsuit in December 2017 in the amount of $11.0 million, and the funds were distributed to the class members in the first quarter of 2018. We recorded recoveries of $1.7 million related to settlement funds that class members declined to claim during the settlement process during the first quarter of 2018.

(Gain)/losses related to operational divestitures. In the second quarter of 2017, we recovered $1.3 million of losses related to an operation that was closed in 2016. The loss recovery was recorded as a gain in the second quarter of 2017. These charges did not recur during the three months ended June 30, 2018.

Rent — cost of services. Our rent — cost of services as a percentage of total revenue decreased by 0.3% to 7.0% primarily due to more of our acquisitions including real estate assets as compared to leased properties in prior periods.
General and administrative expense. Our general and administrative expense rate increased by 0.7% to 4.5%, mainly related to wages to support growth and an increase in incentives due to operational improvements.
Depreciation and amortization. Depreciation and amortization expense increased $0.9 million, or 8.1%, to $11.6 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations. Depreciation and amortization decreased 0.1%, to 2.3%, as a percentage of revenue.
Other expense, net. Other expense, net remained consistent as a percentage of revenue at 0.7%, or $3.3 million. Other expense mainly includes interest expense related to borrowings under our credit facility and HUD mortgages.
Provision for income taxes. Our effective tax rate was 21.6% for the three months ended June 30, 2018 compared to 35.7% for the same period in 2017. The lower effective tax rate reflects the lower corporate tax rate of The Tax Act and an additional tax benefit from share-based payment awards. The lower effective tax rate was partially offset by increases in certain non-taxable and non-deductible items including the impact of non-deductible compensation. See Note 13, Income Taxes, in the Notes to Condensed Consolidated Financial Statements for further discussion.

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

Revenue

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	Six Months Ended June 30,					
	2018		2018 Pro Forma (2)		2017	
	Revenue $	Revenue %	Revenue $	Revenue %	Revenue $	Revenue %
	(Dollars in thousands)					
Transitional and skilled services	$815,534	82.5 %	$832,282	82.7 %	$747,556	84.0 %
Assisted and independent living services	73,277	7.4	73,277	7.3	65,355	7.3
Home health and hospice services:						
Home health	41,505	4.2	42,297	4.2	34,922	3.9
Hospice	39,502	4.0	39,844	4.0	31,832	3.6
Total home health and hospice services	81,007	8.2	82,141	8.2	66,754	7.5
All other [(1)]	18,702	1.9	18,702	1.8	10,354	1.2
Total revenue	$988,520	100.0 %	$1,006,402	100.0 %	$890,019	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 six 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 $98.5 million, or 11.1%. On a pro forma basis, revenue increased $116.4 million or 13.1%. 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 $68.0 million, or 9.1%, 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 $7.9 million, or 12.1%, 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 $14.3 million, or 21.4%, 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 $69.2 million during the six 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 six months ended June 30, 2018 and 2017:

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Transitional and skilled revenue (As Reported)	$815,534	$747,556	$67,978	9.1 %
Transitional and skilled revenue (Pro forma (5))	832,282	747,556	84,726	11.3 %
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	2,645,027	2,442,106	202,921	8.3 %
Occupancy percentage — Operational beds	77.2 %	74.8 %		2.4 %
Skilled mix by nursing days	30.7 %	31.4 %		(0.7)%

Skilled mix by nursing revenue	51.2	%	52.7	%	(1.5	)%

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	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Transitional and skilled revenue (As Reported)	$560,724	$548,410	$12,314	2.2 %
Transitional and skilled revenue (Pro forma (5))	572,170	548,410	23,760	4.3 %
Number of facilities at period end	108	108	—	— %
Number of campuses at period end*	11	11	—	— %
Actual patient days	1,741,558	1,730,523	11,035	0.6 %
Occupancy percentage — Operational beds	78.8 %	78.2 %		0.6 %
Skilled mix by nursing days	31.7 %	31.5 %		0.2 %
Skilled mix by nursing revenue	52.6 %	52.6 %		— %

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Transitional and skilled revenue (As Reported)	$198,537	$188,605	$9,932	5.3 %
Transitional and skilled revenue (Pro forma (5))	202,656	188,605	14,051	7.4 %
Number of facilities at period end	40	40	—	— %
Number of campuses at period end*	9	9	—	— %
Actual patient days	705,192	672,779	32,413	4.8 %
Occupancy percentage — Operational beds	74.7 %	71.3 %		3.4 %
Skilled mix by nursing days	30.4 %	31.2 %		(0.8)%
Skilled mix by nursing revenue	50.5 %	53.2 %		(2.7)%

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Transitional and skilled revenue (As Reported)	$56,273	$8,673	$47,600	NM
Transitional and skilled revenue (Pro forma (5))	57,456	8,673	48,783	NM
Number of facilities at period end	14	7	7	NM
Number of campuses at period end*	2	1	1	NM
Actual patient days	198,277	33,229	165,048	NM
Occupancy percentage — Operational beds	73.0 %	36.1 %		NM
Skilled mix by nursing days	22.5 %	23.2 %		NM
Skilled mix by nursing revenue	39.7 %	44.6 %		NM

	Six Months Ended June 30,			
	2018	2017	Change	% Change

	(Dollars in thousands)			
Facility Closed Results(4):				
Skilled nursing revenue	$—	$1,868	$(1,868)	NM
Actual patient days	—	5,575	(5,575)	NM
Occupancy percentage — Operational beds	—%	34.3 %		NM
Skilled mix by nursing days	—%	46.7 %		NM
Skilled mix by nursing revenue	—%	71.5 %		NM

* Campus represents a facility that offers both skilled nursing and 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.

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(1) Same Facility results represent all facilities purchased prior to January 1, 2015.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2015 to December 31, 2016.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2017.

(4) Facility Closed results represents closed operations during the six months ended June 30, 2017, which were excluded from Same Store and Transitioning results for the six months ended June 30, 2017, for comparison purposes.

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

Transitional and skilled services revenue increased $68.0 million, or 9.1% in the second quarter of 2018 or $84.7 million and 11.3% on a pro forma basis. Of the $68.0 million increase, Medicare and managed care revenue increased $20.2 million, or 5.7%, Medicaid custodial revenue increased $36.4 million, or 12.9%, private and other revenue increased $4.0 million, or 6.0%, and Medicaid skilled revenue increased $7.4 million, or 15.5%.

Transitional and skilled services revenue generated by Same Facilities increased $12.3 million, or 2.2%, which includes the impact of the adoption of ASC 606. Without the adoption of ASC 606 impact, Same Facilities increased $23.8 million, or 4.3%, on a comparable basis. The comparable revenue (without the impact of the adoption of ASC 606) was driven by the following factors:

- Our skilled mix revenue increased by $10.8 million, or 3.9%, and our skilled mix days increased by 1.3%. The majority of the increases is related to an increase in other skilled and skilled managed care revenue. Our other skilled revenue increased by $8.7 million, or 20.0%, mainly driven by an increase in other skilled days of 13.6% and other skilled revenue per patient day of 5.7%. Our skilled managed care revenue increased by $3.3 million, or 3.4%, due to an increase in managed care days of 0.7% and an increase in managed care revenue per patient day of 2.6%.
- We continued to experience a growth in revenue with our Medicaid plans. Our Medicaid revenue, excluding Medicaid-skilled revenue, increased by $9.6 million, or 4.5%, mainly driven by Medicaid days increased by 1.0%. We also experienced an increase in Medicaid revenue per patient day of 3.5% as a result of our participation in the quality improvement programs and the supplemental programs in various states.

Transitional and skilled services revenue generated by Transitioning Facilities increased $9.9 million, or 5.3%, which includes the impact of the adoption of ASC 606. Without the adoption of ASC 606 impact, Transitioning Facilities increased $14.1 million, or 7.4%, on a comparable basis. This is due to increases in total patient days and revenue per patient day of 4.8% and 2.1%, respectively. We continued to experience a growth in revenue with our Medicaid and managed care plans. Our Medicaid revenue, excluding Medicaid-skilled revenue, increased by $9.9 million, or 15.0%, mainly driven by a 6.5% increase in Medicaid days . We also experienced an increase in Medicaid revenue per patient day of 8.0% as a result of our participation in the quality improvement programs and supplemental programs in various states. Our overall managed care revenue increased by $5.0 million, or 13.8%, mainly driven by an increase in managed care days of 14.1%.

Transitional and skilled services revenue generated by Recently Acquired Facilities increased by approximately $47.6 million, mainly due to eight operations we acquired between July 1, 2017 and June 30, 2018 in four states. In addition, Recently Acquired Facilities in the first six months of 2017 included three newly built facilities that had low occupancy rates during the start up period. Accordingly, the occupancy rate in the six months ended June 30, 2017 was impacted by the lower census due to start up operations at newly opened facilities.

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

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	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Skilled Nursing Average Daily Revenue Rates:								
Medicare	$612.97	$598.57	$515.68	$503.88	$527.57	$495.95	$578.24	$566.07
Managed care	460.62	449.01	409.68	418.85	421.00	374.41	444.31	440.45
Other skilled	484.37	458.35	357.20	373.36	460.15	650.86	467.16	446.23
Total skilled revenue	526.67	513.76	456.62	460.06	485.62	478.44	505.91	498.60
Medicaid	221.47	214.02	193.93	179.50	212.72	175.92	213.61	204.17
Private and other payors	225.56	204.56	202.76	198.19	229.50	193.64	218.67	202.29
Total skilled nursing revenue	$319.20	$307.20	$275.13	$269.58	$276.69	$249.30	$304.24	$296.08

Our Medicare daily rates at Same Facilities and Transitioning Facilities increase by 2.4% and 2.3%, respectively. The increase is attributable to the 1.0% net market basket percentage that became effective in October 2017, which was preceded by a 2.4% net market basket increase that went into effect in October 2016. In addition, the increase in Medicare daily rates was the result of a continuing shift towards higher acuity patients.

Our average Medicaid rates increased 4.6% primarily due to our participation in supplemental Medicaid payment programs and quality improvement programs in various states.

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

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Percentage of Skilled Nursing Revenue:								
Medicare	24.7%	25.9%	27.4%	30.7%	24.6%	36.5%	25.3%	27.3%
Managed care	18.5	18.6	20.0	19.2	11.4	6.3	18.4	18.6
Other skilled	9.4	8.1	3.1	3.3	3.7	1.8	7.5	6.8
Skilled mix	52.6	52.6	50.5	53.2	39.7	44.6	51.2	52.7
Private and other payors	7.5	7.8	10.3	10.4	11.2	13.7	8.5	8.5
Quality mix	60.1	60.4	60.8	63.6	50.9	58.3	59.7	61.2
Medicaid	39.9	39.6	39.2	36.4	49.1	41.7	40.3	38.8
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2018	2017	2018	2017	2018	2017	2018	2017
Percentage of Skilled Nursing Days:								
Medicare	12.8 %	13.3 %	14.6 %	16.4 %	12.8 %	18.3 %	13.3 %	14.3 %
Managed care	12.8	12.8	13.4	12.3	7.5	4.2	12.6	12.5
Other skilled	6.1	5.4	2.4	2.5	2.2	0.7	4.8	4.6
Skilled mix	31.7	31.5	30.4	31.2	22.5	23.2	30.7	31.4
Private and other payors	11.1	11.5	14.1	14.1	14.0	17.7	12.1	12.2
Quality mix	42.8	43.0	44.5	45.3	36.5	40.9	42.8	43.6
Medicaid	57.2	57.0	55.5	54.7	63.5	59.1	57.2	56.4
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Assisted and Independent Living Services

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Resident fee revenue	$73,277	$65,355	$7,922	12.1 %
Number of facilities at period end	51	46	5	10.9 %
Number of campuses at period end	22	21	1	4.8 %
Occupancy percentage (units)	75.4 %	77.1 %		(1.7)%
Average monthly revenue per unit	$2,860	$2,818	$42	1.5 %

Assisted and independent living revenue of $7.9 million increased 12.1% on a comparable basis, primarily due to an increase in average monthly revenue per unit of 1.5% and revenue generated from the addition of six assisted and independent living operations in three states between July 1, 2017 and June 30, 2018, partially offset by the decrease in occupancy of 1.7%.

Home Health and Hospice Services

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Home health and hospice revenue				
Home health services	$41,505	$34,922	$6,583	18.9 %
Hospice services	39,502	31,832	7,670	24.1
Total home health and hospice revenue	$81,007	$66,754	$14,253	21.4 %
Pro forma(1)				
Home health and hospice revenue				
Home health services	$42,297	$34,922	$7,375	21.1 %
Hospice services	39,844	31,832	8,012	25.2
Total home health and hospice revenue	$82,141	$66,754	$15,387	23.1 %

Home health services:				
Average Medicare Revenue per Completed Episode	$2,951	$3,058	$(107)	(3.5)%
Hospice services:				
Average Daily Census	1,275	1,011	264	26.1 %

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

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Home health and hospice revenue increased $14.3 million, or 21.4%, or $15.4 million and 23.1% on a pro forma basis. Of the $14.3 million increase, Medicare and managed care revenue increased $11.3 million, or 19.9%. The increase in revenue is primarily due to the increase in volume and average daily census in existing agencies, coupled with the addition of three home health and hospice operations in three states between July 1, 2017 and June 30, 2018.

Cost of Services

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

	Six Months Ended June 30,		
	2018	2018 Pro Forma (1)	2017
	(Dollars in thousands)		
Transitional and skilled services	$656,009	$672,757	$615,110
Assisted and independent living services	47,881	47,881	42,900
Home health and hospice services	67,066	68,200	56,094
All other	15,419	15,419	8,329
Total cost of services	$786,375	$804,257	$722,433

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

Consolidated cost of services increased $63.9 million, or 8.9%, or $81.8 million and 11.3% on a pro forma basis. Consolidated cost of services as a percentage of revenue decreased by 1.7% to 79.5%, or 1.3% to 79.9% on a pro forma basis.

Transitional and Skilled Services

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$656,009	$615,110	40,899	6.6 %
Cost of service (Pro Forma (1))	672,757	615,110	57,647	9.4 %
Revenue percentage	80.4 %	82.3 %		(1.9)%
Revenue percentage (Pro Forma (1))	80.8 %	82.3 %		(1.5)%

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

Cost of services related to our transitional and skilled services segment increased $40.9 million, or 6.6%, due primarily to additional costs at Recently Acquired Facilities of $36.4 million and organic operational growth. Cost of services as a percentage of revenue decreased to 80.4%, mainly due to operational improvements.

Assisted and Independent Living Services

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$47,881	$42,900	4,981	11.6 %
Revenue percentage	65.3 %	65.6 %		(0.3)%

Cost of services related to our assisted and independent living services segment increased $5.0 million, or 11.6%, primarily due to recently acquired operations and organic operational growth. Cost of services as a percentage of total revenue decreased by 0.3% due to operational improvements.

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Home Health and Hospice Services

	Six Months Ended June 30,			
	2018	2017	Change	% Change
	(Dollars in thousands)			
Cost of service	$67,066	$56,094	10,972	19.6 %
Cost of service (Pro Forma (1))	68,200	56,094	12,106	21.6 %
Revenue percentage	82.8 %	84.0 %		(1.2)%
Revenue percentage (Pro Forma (1))	83.0 %	84.0 %		(1.0)%

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

Cost of services related to our home health and hospice services segment increased $11.0 million, or 19.6%, due to newly acquired operations and organic operational growth. Cost of services as a percentage of total revenue decreased by 1.2% primarily due to stronger collections, which resulted in higher revenue under the new revenue accounting guidance. In the prior year, this adjustment was classified as bad debt expense.

(Return of unclaimed class action settlement)/charges related to class action lawsuit. We funded the settlement of a class action lawsuit in December 2017 in the amount of $11.0 million, and the funds were distributed to the class members in the first quarter of 2018. During the six months ended June 30, 2018, we recorded recoveries of $1.7 million related to settlement funds that class members declined to claim during the settlement process.

(Gain)/losses related to divestitures. During the six months ended June 30, 2017, we recorded a loss of $4.0 million related to the closure of operations and lease terminations, which was partially offset by $1.3 million of loss recovery from a closure in 2016 which was recorded as a gain. These charges did not recur during the six months ended June 30, 2018.

Rent — cost of services. Our rent — cost of services as a percentage of total revenue decreased by 0.4% to 6.9% primarily due to more of our acquisitions including real estate assets as compared to leased properties in prior periods.
General and administrative expense. Our general and administrative expense rate increased by 0.5% to 4.8%, mainly due to wages to support growth and an increase in incentives due to operational improvements.
Depreciation and amortization. Depreciation and amortization expense increased $2.0 million, or 9.3%, to $23.2 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations. Depreciation and amortization expense as a percentage of revenue remained consistent at 2.4%.
Other expense, net. Other expense, net remained consistent as a percentage of revenue at 0.7%, or $6.5 million. Other expense mainly includes interest expense related to borrowings under our credit facility and HUD mortgages.
Provision for income taxes. Our effective tax rate was 21.7% for the six months ended June 30, 2018 compared to 35.2% for the same period in 2017. The lower effective tax rate reflects the lower corporate tax rate of The Tax Act and additional tax benefit from share-based payment awards. The lower effective tax rate was partially offset by increases in certain non-taxable and non-deductible items including the impact of non-deductible compensation. See Note 13, Income Taxes, in the Notes to Condensed Consolidated Financial Statements for further discussion.

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

Historically, we have financed the majority of our acquisitions primarily by financing our operating subsidiaries through mortgages, our revolving credit facility, and cash generated from operations. Cash paid to fund acquisitions was $58.0 million and $64.3 million for the six months ended June 30, 2018 and 2017, respectively. Total capital expenditures for property and equipment were $24.3 million and $23.0 million for the six months ended June 30, 2018 and 2017, respectively. We currently have approximately $60.0 million budgeted for renovation projects for 2018. We believe our current cash balances, our cash flow

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from operations and the amounts available under our credit facility will be sufficient to cover our operating needs for at least the next 12 months.

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

Our cash and cash equivalents as of June 30, 2018 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2018, we held debt security investments of approximately $44.3 million, which were split between AA, A and BBB+ rated securities. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

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

	Six Months Ended June 30,	
	2018	2017
	(In thousands)	
Net cash provided by operating activities	$101,240	$24,920
Net cash used in investing activities	(81,244)	(48,626)
Net cash used in financing activities	(35,149)	(524)
Net decrease in cash and cash equivalents	(15,153)	(24,230)
Cash and cash equivalents at beginning of period	42,337	57,706
Cash and cash equivalents at end of period	$27,184	$33,476

Our net cash provided by operating activities for the six months ended June 30, 2018 increased by $76.3 million. The increase was primarily due to an increase in net income as a result of operational improvements, reduced corporate tax rate and income tax refund of $11.0 million related to the Tax Act, combined with improvements in accounts receivable collections and timing of payments of taxes, and operating assets and liabilities.

Our net cash used in investing activities for the six months ended June 30, 2018 increased by $32.6 million. The change was primarily due to the lack of cash proceeds received from the sale-leaseback transaction of $38.0 million during the six months ended June 30, 2017, which did not recur in the first half of 2018.

Our net cash used in financing activities increased by $34.6 million. This increase was primarily due to the increase in net long-term debt re-payments of $43.9 million, offset by an increase in cash received from options exercised of $2.5 million. In addition, we repurchased common stock of $7.3 million during the six months ended June 30, 2017, which did not recur in the first half of 2018.

Principal Debt Obligations and Capital Expenditures

Credit Facility with a Lending Consortium Arranged by SunTrust

We maintain a credit facility with a lending consortium arranged by SunTrust (as amended to date, the Credit Facility). We originally entered into the Credit Facility in an aggregate principal amount of $150.0 million in May 2014. Under the Credit Facility, we could seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $75.0 million. Loans made under the Credit Facility are not subject to interim amortization. We are 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, we amended our existing revolving credit facility to increase our aggregate principal amount available to $250.0 million (the Amended Credit Facility). Under the Amended Credit Facility, we may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $150.0 million. The interest rates applicable to loans under the Amended Credit Facility are, at our option, equal to either a base rate plus a margin 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

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(as defined in the agreement). In addition, we will pay a commitment fee on the unused portion of the commitments under the Amended Credit Facility that will range from 0.3% to 0.5% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and our subsidiaries. We are permitted to prepay all or any portion of the loans under the Amended Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders.

On July 19, 2016, we 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 $450.0 million. The Second Amended Credit Facility comprised of a $300.0 million revolving credit facility and a $150.0 million term loan. Borrowings under the term loan portion of the Second Amended Credit Facility will 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 our wholly owned subsidiaries, and is secured by a pledge of stock of our material operating subsidiaries as well as a first lien on substantially all of our personal property. The Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and our operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the Credit Facility, we must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum Consolidated Total Net Debt to Consolidated EBITDA ratio (which shall be increased to 3.50:1.00 for the 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 we and our operating subsidiaries mortgage certain of our real property assets to secure the credit facility if an event of default occurs, the Consolidated Total Net Debt to Consolidated EBITDA ratio is above 2.75:1.00 for two consecutive fiscal quarters, or our liquidity is equal or less than 10% of the Aggregate Revolving Commitment Amount (as defined in the agreement) for ten consecutive business days, provided that such mortgages will no longer be required if the event of default is cured, the Consolidated Total Net Debt to Consolidated EBITDA ratio is below 2.75:1.00 for two consecutive fiscal quarters, or our liquidity is above 10% of the Aggregate Revolving Commitment Amount (as defined in the agreement) or ninety consecutive days, as applicable. As of June 30, 2018, our operating subsidiaries had $156.9 million outstanding under the Credit Facility. The outstanding balance on the on the term loan was $136.9 million, of which $7.5 million is classified as short-term and the remaining $129.4 million is classified as long-term. The outstanding balance on the revolving Credit Facility was $20.0 million, which is classified as long-term. We were in compliance with all loan covenants as of June 30, 2018.

As of July 30, 2018, there was approximately $156.9 million outstanding under the Credit Facility.

Mortgage Loans and Promissory Note

During the fourth quarter of 2017, seventeen of our subsidiaries entered into mortgage loans in the aggregate amount of $112.0 million. 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 term 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 our revolving line of credit. In addition to refinancing existing borrowings, the

proceeds of the HUD-insured debt helped used to 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, we have outstanding indebtedness under mortgage loans insured with HUD and 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 terms of the mortgage loans and note are between 12 and 33 years. The mortgage loans and note are secured by the real property comprising the facilities and the rents, issues and profits thereof, as well as all personal property used in the operation of the facilities.

As of June 30, 2018, our operating subsidiaries had $124.2 million outstanding under the mortgage loans and note, of which $2.6 million is classified as short-term and the remaining $121.6 million is classified as long-term.

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Contractual Obligations, Commitments and Contingencies

We lease from CareTrust REIT, Inc. (CareTrust) real property associated with 92 affiliated skilled nursing, assisted living and independent living facilities used in our operations under the Master Leases as a result of the tax free spin-off (Spin-Off). The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%.

We do 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, we may be liable for damages and incur charges such as continued payment of rent through the end of the lease term and as well as maintenance and repair costs for the leased property.

The Master Leases arrangement is commonly known as a triple-net lease. Accordingly, in addition to rent, we are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor), (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties, (3) all insurance required in connection with the leased properties and the business conducted on the leased properties, (4) all facility maintenance and repair costs and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Total rent expense under the Master Leases was approximately $14.5 million and $29.0 million for the three and six months ended June 30, 2018, respectively, and $14.2 million and $28.3 million for the three and six months ended June 30, 2017, respectively.

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

Among other things, under the Master Leases, we must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. As of June 30, 2018, we were in compliance with the Master Leases' covenants.

We also lease certain affiliated facilities and our administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. We have entered into multiple lease agreements with various landlords to operate newly constructed state-of-the-art, full-service healthcare resorts upon completion of construction. The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, we lease certain of our equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $34.5 million and $68.6 million for the three and six months ended June 30, 2018, respectively, and $32.9 million and $64.8 million for the three and six months ended June 30, 2017, respectively.

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

Class Action Lawsuit

Since 2011, we have been involved in a class action litigation claim alleging violations of state and federal wage and hour laws. In January 2017, we participated in an initial mediation session with plaintiffs' counsel.
In March 2017, we were invited to engage in further mediation discussions to determine whether settlement in advance of a determination on class certification was possible. In April 2017, we 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 recent change in case status, we recorded an accrual for estimated probable losses of $11.0 million in the first quarter of 2017. In

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June 2017, the settlement of the class action lawsuit and the settlement was approved by the Court. We made a lump-sum payment 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.

U.S. Government Inquiry and Corporate Integrity Agreement

In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. We resolved and settled the matter for $48.0 million in 2013. In October 2013, we and the government executed a final settlement agreement in accordance with the April 2013 agreement and we remitted full payment of $48.0 million. In addition, we executed a five-year corporate integrity agreement with the Office of Inspector General HHS as part of the resolution.

See additional description of our contingencies in Note 14, Debt, Note 16, Leases and Note 17, Commitments and Contingencies in Notes to Condensed Consolidated Financial Statements.

U.S. Department of Justice Civil Investigative Demand

On May 31, 2018, we received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating the Company to determine whether we have violated the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of our 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 our Southern California skilled nursing facilities. As a general matter, our operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. We are fully cooperating with the U.S. Department of Justice to promptly respond to the CID. However, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company.

Inflation

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

Labor and supply expenses make up a substantial portion of our cost of services. Those expenses can be subject to increase in periods of rising inflation and when labor shortages occur in the marketplace. To date, we have generally been able to implement cost control measures or obtain increases in reimbursement sufficient to offset increases in these expenses. We may not be successful in offsetting future cost increases.

Recent Accounting Pronouncements

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

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

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earnings as of the date of adoption (modified retrospective method). We 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 us in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on our consolidated financial statements.

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 us in the first quarter of fiscal year 2018. Our 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 combination prior to the adoption of the ASU.

In March 2018, we adopted FASB 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 Cuts and Jobs Act (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 us in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on our 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 us in the first quarter of fiscal year 2018. The adoption of this standard did not have a material impact on our 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 our fiscal year 2020, with early adoption permitted. The adoption of this standard is not expected to have a material impact on our consolidated financial statements.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For

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short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2018, which will be our fiscal year 2019, with early adoption permitted. We are currently evaluating the impact this guidance will have on our consolidated financial statements and disclosures and we expect that this adoption will result in a material increase in the assets and liabilities on our consolidated balance sheets, primarily related to leases of facilities. We are in the process of cataloging our existing lease contracts and implementing changes to our systems, related processes and controls. We are planning to elect the 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.

Off-Balance Sheet Arrangements

As of June 30, 2018, we had approximately $6.4 million on our credit facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

Item 3. Quantitative and Qualitative Disclosures about Market Risk

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

Our mortgages generally contain provisions that allow us to make repayments earlier than the stated maturity date. In some cases, we are not allowed to make early repayment prior to a cutoff date. Where prepayment is permitted, we are generally allowed to make prepayments only at a premium which is often designed to preserve a stated yield to the note holder. These prepayment rights may afford us opportunities to mitigate the risk of refinancing our debts at maturity at higher rates by refinancing prior to maturity.
On July 19, 2016, we entered into the Second Amended Credit Facility with a lending consortium arranged by SunTrust to make available a credit facility consisting of a $300.0 million revolving line of credit and a $150.0 million term loan component. Borrowings under the term loan portion of the 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, at our option, are equal to either a base rate plus a premium or LIBOR plus a premium. In addition, we are subject to pay a commitment fee on the unused portion of the commitments under the credit facility discussed in Item 2 of this Quarterly Report under the heading “Liquidity and Capital Resources.” Our exposure to fluctuations in interest rates may increase or decrease in the future with increases or decreases in the outstanding amount under the credit facility. As of June 30, 2018, our operating subsidiaries had $156.9 million outstanding under the credit facility. The outstanding balance on the on the term loan was $136.9 million, of which $7.5 million is classified as short-term and the remaining $129.4 million is classified as long-term. The outstanding balance on the revolving credit facility was $20.0 million, which is classified as long-term.

We have outstanding indebtedness under mortgage loans insured with Department of Housing and Urban Development (HUD) and promissory note. The mortgage loans and note bear fixed interest rates and amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of the principal balance on the date of prepayment. The outstanding balance under the mortgage loans and note was $124.2 million, of which $2.6 million is classified as short-term and the remaining $121.6 million is classified as long-term.

Our cash and cash equivalents as of June 30, 2018 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2018, we held debt security investments of approximately

$44.3 million, which were split between AA, A, and BBB+ rated securities. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of June 30, 2018 and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

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Item 4. Controls and Procedures

Disclosure Controls and Procedures

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

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended June 30, 2018, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

PART II.

Item 1. Legal Proceedings

Certain legal proceedings in which we are involved are discussed in Part I, Item 3. Legal Proceedings, of our Annual Report on Form 10-K for the year ended December 31, 2017. In addition, for more information regarding our legal proceedings, please see Note 17, Commitments and Contingencies included in Part 1, Item 1 of this Form 10-Q.

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 and failure to comply can result in 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, we learned of a potential issue at one of our independent operating entities in Arizona which involved the limited and inadvertent disclosure of certain confidential information. The issue has been fully investigated, addressed and disclosed as required by law. We believe that we are 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 us.

Indemnities — From time to time, we enter into certain types of contracts that contingently require us to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which we may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from our use of the applicable premises, (ii) operations transfer agreements, in which we agree to indemnify past operators of facilities we acquire against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer by the Company's operating subsidiary, (iii) certain lending agreements, under which we may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with our officers, directors and employees, under which we may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, 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 our balance sheets for any of the periods presented.

U.S. Department of Justice Civil Investigative Demand - On May 31, 2018, we received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating the Company to determine whether we have violated the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of our

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 our Southern California skilled nursing facilities. As a general matter, our operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. We are fully cooperating with the U.S. Department of Justice to promptly respond to the CID. However, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company.

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

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

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

We and our 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, we were named as a Defendant in a class action litigation alleging violations of state and federal wage and hour law. In January of 2017, we participated in an initial mediation session with plaintiffs' counsel.

In March of 2017, we were 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 2017, we 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, we recorded an accrual for estimated probable losses of $11.0 million, exclusive of legal fees, in

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the first quarter of 2017. In June 2017, the settlement of the class action lawsuit was approved by the Court. We funded the settlement amount of $11.0 million in December of 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.
A class action staffing suit was previously filed against us and certain of our California independent operating entities, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act. In 2007, we settled this class action suit, and the settlement was approved by the affected class and the Court. A second such class action staffing suit was filed in Los Angeles in 2010 and was resolved in a settlement and Court approval in 2012. Neither of the referenced lawsuits or settlements had a material ongoing adverse effect on our business, financial condition or results of operations.

Other claims and suits, including class actions, continue to be filed against us and other companies in the industry. For example, we and our independent operating entities have been subjected to, and are currently involved in, class action litigation alleging violations of state and federal wage and hour law. 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 our business, financial condition, results of operations and cash flows.

We have in the past been subject to class action litigation involving claims of violations of various regulatory requirements. While we have been able to settle these claims without a material ongoing adverse effect on our business, future claims could be brought that may materially affect our business, financial condition and results of operations. Other claims and suits continue to be filed against us and other companies in the industry. By way of example, we defended a general/premise liability claim, on behalf of one of our independent operating entities, involving an injury to a non-employee/contractor. Further, another one of our independent operating entities was sued on allegations of professional negligence.
Medicare Revenue Recoupments — We are subject to regulatory reviews relating to Medicare services, billings and potential overpayments resulting from RAC, ZPIC, PSC and MIC. As of June 30, 2018, four of our operating subsidiaries had probe reviews scheduled and in process, both pre- and post-payment. We anticipate 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 our 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 our hospice subsidiaries, and the results from the audit are currently under appeal.

U.S. Government Inquiry and Corporate Integrity Agreement — In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint and related primarily to claims submitted to the Medicare program for rehabilitation services provided at certain skilled nursing facilities in Southern California. We resolved and settled the matter for $48.0 million in 2013. In October 2013, we executed a final settlement agreement with the Government and remitted full payment of $48.0 million. In addition, we executed a corporate integrity agreement with the Office of Inspector General HHS as part of the resolution.

See additional description of our contingencies in Notes 14, Debt, 16, Leases and 17, Commitments and Contingencies in
Notes to Condensed Consolidated Financial Statements.

Item 1A. Risk Factors
Risks Related to Our Business and Industry
Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare.

We derived 40.6% and 40.1% of our revenue from the Medicaid program for the three and six months ended June 30, 2018, respectively, and 39.6% and 39.2% of our revenue from the Medicaid program for the three and six months ended June 30, 2017, respectively. We derived 27.6% and 27.9% our revenue from the Medicare program for the three and six months ended June 30, 2018, respectively, and 28.6% and 29.0% of our revenue from the Medicare program for the three and six months ended June 30, 2017, respectively. The percentages of revenue from Medicaid and Medicare programs include the estimates of variable consideration under ASC 606. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction

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Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our patients.

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

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.

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

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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. In 2015, Congress passed the Medicare Access and Chip Reauthorization Act or 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 or 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.

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

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. As discussed below under the heading “Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged”, any further amendments or revisions to the ACA or its implementing regulations could materially impact our business.

Skilled Nursing

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. Thus, the increase in the 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 increase reflected a 2.7% market basket increase, reduced by a 0.3% multi-factor productivity (MFP) adjustment required by ACA. This final rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports.

The Value-Based Purchasing Program final rule specifies the skilled nursing facility 30-day potentially preventable readmission measure, which assesses the facility-level risk standardized rate of unplanned, potentially preventable hospital

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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 in fiscal year 2019.

Home Health

On July 2, 2018, CMS issued 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 in 2019.

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

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 0.8% by a 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 percentage 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.

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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 net 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 the hospices' 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 hospice quality reporting program requirements, including care surveys and two new quality measures that will assess hospice staff visits to patients and caregivers in the last three and seven days of life and the percentage of hospice patients who received care processes consistent with guidelines.

Regulations

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

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

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

Effective January 1, 2018, CMS published a final rule with comment period on November 16, 2017, that reduces certain burdens on physicians for participation in Merit-Based Incentive Payment Systems (MIPs) and Alternative Payment Models (APMs), for 2018, another transition year. MACRA in general affects reimbursement for services of certain physicians who receive reimbursement under Medicare Part B through different payment models. The rule changes some of the qualifications for APMs and MIPs, such as quality and cost measures. The rule creates various new APMs for physicians to participate in lieu of MIPs. This rule may impact reimbursement to physicians who provide services at SNFs, HHAs and hospices, but the application of the rule to reimbursement for the Company’s

facilities is uncertain at this time.

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

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2017 for home health agencies. Failure to report such data when required would subject a facility to a two percent reduction in market basket prices then in effect.

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

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

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

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

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

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

California's Governor signed the budget trailer into law in October 2010. Despite its enactment, these changes in reimbursement to long-term care facilities were to be implemented retroactively to the beginning of the calendar quarter in which California submitted its request for federal approval of CMS. California’s Governor released a 2014-2015 budget that includes $1.2 billion in additional Medi-Cal funding. This proposal, however, would not eliminate retroactive rate cuts for hospital-based skilled nursing facilities.

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

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

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

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

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

ACA and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) include sweeping changes to how health care is paid for and furnished in the United States. As discussed below under the heading “-Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged”, any further amendments or revisions to ACA or its implementing regulations could materially impact our business. 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.

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

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

Under ACA, HHS will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care. The bundled payment will cover the costs of acute care inpatient services; physicians’ services delivered in and outside of an acute

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care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services; inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program was not implemented. As with Medicare's shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-Kickback Statue, the Stark Law and the Civil Monetary Penalties Law.

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

We routinely receive Requests for Information (RFIs) from active referral and managed care networks asking for quality, rating, performance and other information about our SNFs operating in the geographic areas that they are being serviced. The RFIs are used to evaluate which SNFs should be included in each network of preferred providers. For those SNFs included in the network, the ACO and its associated providers may then recommend the SNF as a "preferred provider" to patients in need of skilled care. In the past, after responding to such RFIs, our SNFs have in some instances been rewarded with inclusion in a network of preferred providers, and in other instances have not been included. While referrals to a SNF in a preferred provider network will always be subject to a patient's freedom of choice, as well as the patient's physician's medical judgment as to which facility will best serve the patient's needs, the inclusion as a preferred provider in a network will likely result in an increase in overall admissions to that SNF. On the other hand, the failure to be included could result in some volume of patient admissions being shifted to other facilities that have been designated instead as preferred providers. As a result, to the extent that one of our SNF is not included in a preferred provider network, our revenues and results of operations could be adversely affected.

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

On 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 are effective November 28, 2016 and will be 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;

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- 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;
- 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 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 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 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.

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

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

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

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

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

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

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

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

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

A significant goal of Federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals at lower cost. Other reimbursement methodology reforms include value-

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based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. Providers who respond successfully to these trends and are able to deliver quality care at lower cost are likely to benefit financially.

The Affordable Care Act and the programs implemented by the law may reduce reimbursements for our services and may impact the demand for the Company's products. In addition, various healthcare programs and regulations may be ultimately implemented at the federal or state level. Failure to respond successfully to these trends could negatively impact our business, results of operations and/or financial condition. As discussed below under the heading "Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged", any further amendments or revisions to ACA or its implementing regulations could materially impact our business.

Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged.

A number of lawsuits have been filed challenging various aspects of ACA and related regulations. In addition, the efficacy of ACA is the subject of much debate among members of Congress and the public. 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. In the event that legal challenges are successful or ACA is repealed or materially amended, particularly any elements of ACA that are beneficial to our business or that cause changes in the health insurance industry, including reimbursement and coverage by private, Medicare or Medicaid payers, our business, operating results and financial condition could be harmed. While it is not possible to predict whether and when any such changes will occur, specific proposals discussed during and after the election, including a repeal or material amendment of ACA, could harm our business, operating results and financial condition. In addition, even if ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS have a significant impact on the implementation of the provisions of ACA, and the new administration could make changes impacting the implementation and enforcement of ACA, which could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

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

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

We operate one or more affiliated skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities

operating in that state. Failure to comply with these requirements can, among other things, jeopardize a facility's compliance with the conditions of participation under relevant state and federal healthcare programs. In addition, if a facility is determined to be out of compliance with these requirements, it may be subject to a notice of deficiency, a citation, or a significant fine or litigation risk. Deficiencies (depending on the level) may also result in the suspension of patient admissions and/or the termination of Medicaid participation, or the suspension, revocation or nonrenewal of the skilled nursing facility's license. If the federal or state governments were to issue regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.

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

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shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. We are also subject to audits under various government programs, including Recovery Audit Contractors (RAC), Zone Program Integrity Contractors (ZPIC), Program Safeguard Contractors (PSC) and Medicaid Integrity Contributors (MIC) programs, in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare programs. Private pay sources also reserve the right to conduct audits. We believe that billing and reimbursement errors and disagreements are common in our industry. We are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the process related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce. An adverse review, audit or investigation could result in:

- an obligation to refund amounts previously paid to us pursuant to the Medicare or Medicaid programs or from private payors, in amounts that could be material to our business;
- state or federal agencies imposing fines, penalties and other sanctions on us;
- loss of our right to participate in the Medicare or Medicaid programs or one or more private payor networks;
- an increase in private litigation against us; and
- damage to our reputation in various markets.

In 2004, our Medicare fiscal intermediaries began to conduct selected reviews of claims previously submitted by and paid to some of our affiliated facilities. While we have always been subject to post-payment audits and reviews, more intensive “probe reviews” appear to be a permanent procedure with our fiscal intermediaries. All findings of overpayment from CMS contractors are eligible for appeal through the CMS defined continuum. With the exception of rare findings of overpayment related to objective errors in Medicare payment methodology or claims processing, the Organization utilizes all defenses at its disposal to demonstrate that the services provided meet all clinical and regulatory requirements for reimbursement.

If the government or court were to conclude that such errors and deficiencies constituted criminal violations, or were to conclude that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or if it were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable levels, we and certain of our officers might face potential criminal charges and/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we and/or some of the key personnel of our operating subsidiaries could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare. In any event, it is likely that a governmental investigation alone, regardless of its outcome, would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings.

In cases where claim and documentation review by any CMS contractor results in repeated poor performance, a facility can be subjected to protracted oversight. This oversight may include repeat education and re-probe, extended pre-payment review, referral to recovery audit or integrity contractors, or extrapolation of an error rate to other reimbursement outside of specifically reviewed claims. Sustained failure to demonstrate improvement towards meeting all claim filing and documentation requirements could ultimately lead to Medicare decertification. As of June 30, 2018, we had four operating subsidiaries that had probe reviews scheduled or in process, both pre- and post-payment. In addition, a ZPIC review was recently concluded at one our hospice subsidiaries, and the results from the audit are currently under appeal.

Public and government calls for increased survey and enforcement efforts toward long-term care facilities could result in increased scrutiny by state and federal survey agencies. In addition, potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.

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CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to identify multi-facility providers with patterns of noncompliance. In addition, HHS has adopted a rule that requires CMS to charge user fees to healthcare facilities cited during regular certification, recertification or substantiated complaint surveys for deficiencies, which require a revisit to assure that corrections have been made. CMS is also increasing its oversight of state survey agencies and requiring state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified, to investigate complaints more promptly, and to survey facilities more consistently.

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other enforcement actions. The diversion of these resources, including our management team, clinical and compliance staff, and others take away from the time and energy that these individuals could otherwise spend on routine operations. As noted, from time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. The focus of these deficiency reports tends to vary from year to year. Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility, which could result in the imposition of fines, imposition of a provisional or conditional license, suspension or revocation of a license, suspension or denial of payment for new admissions, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including criminal penalties. In the past, we have experienced inspection deficiencies that have resulted in the imposition of a provisional license and could experience these results in the future. We currently have no affiliated facilities operating under provisional licenses which were the result of inspection deficiencies.

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

When a facility is found to be deficient under state licensing and Medicaid and Medicare standards, sanctions may be threatened or imposed such as denial of payment for new Medicaid and Medicare admissions, civil monetary penalties, focused state and federal oversight and even loss of eligibility for Medicaid and Medicare participation or state licensure. Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients' care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance. In the past, some of our affiliated facilities have been in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of the revenue associated with the Medicare and Medicaid patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, these sanctions, entailing various remedies up to and including decertification, would

further negatively affect our financial condition and results of operations. In 2016, we elected to voluntarily close one operating subsidiary as a result of multiple regulatory deficiencies in order to avoid continued strain on our staff and other resources and to avoid restrictions on our ability to acquire new facilities or expand or operate existing facilities. In addition, from time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements. If we elect to voluntary close any operations in the future or to opt to stop accepting new patients pending completion of a state or federal survey, it could negatively impact our financial condition and results of operation.

Facilities with otherwise acceptable regulatory histories generally are given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within nine months, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities

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with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility's existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously-certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators. In addition, CMS has increased its focus on facilities with a history of serious quality of care problems through the special focus facility initiative. A facility's administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility's compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility “graduates” from the program once it demonstrates significant improvements in quality of care that are continued over time.

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our affiliated facilities. We have had several affiliated facilities placed on special focus facility status, due largely or entirely to their respective regulatory histories prior to our acquisition of the operating subsidiaries, and have successfully graduated five operating subsidiaries from the program to date. We currently have one facility placed on special focus facility status. Other operating subsidiaries may be identified for such status in the future.

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

Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The Deficit Reduction Act of 2005 (DRA) added Section 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 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.

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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.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our revenue.

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

With respect to our hospice operating subsidiaries, overall payments made by Medicare to each provider number are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from October 1 through September 30. If payments received by any one of our hospice provider numbers exceeds either of these caps, we are required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows. During the six months ended June 30, 2018 we recorded $0.2 million of hospice cap expense.

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

We, along with other companies in the healthcare industry, are required to comply with extensive and complex laws and regulations at the federal, state and local government levels relating to, among other things:

- facility and professional licensure, certificates of need, permits and other government approvals;
- adequacy and quality of healthcare services;
- qualifications of healthcare and support personnel;
- quality of medical equipment;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources and recipients;
- constraints on protective contractual provisions with patients and third-party payors;
- operating policies and procedures;
- certification of additional facilities by the Medicare program; and
- payment for services.

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

Changes in existing laws or regulations, or the enactment of new laws or regulations, could negatively impact our business. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties and other detrimental consequences, including denial of reimbursement, imposition of fines, temporary suspension of admission of new patients, suspension or decertification from the Medicaid and Medicare programs, restrictions on our ability to acquire new facilities or expand or operate existing facilities, the loss of our licenses to operate and the loss of our ability to participate in federal and state reimbursement programs.

We are subject to federal and state laws, such as the federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, and the federal “Stark” laws, that

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

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by FERA, health care providers face significant penalties for known retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government can argue, therefore, that a FCA violation can occur without any affirmative fraudulent action or statement, as long as it is knowingly improper. The ACA supplements FERA by imposing an affirmative obligation on health care providers to return an overpayment to CMS within 60 days of “identification” or the date any corresponding cost report is due, whichever is later. On August 3, 2015, the U.S. District Court for the Southern District of New York held that the 60 day clock following “identification” of an overpayment begins to run when a provider is put on notice of a potential overpayment, rather than the moment when an overpayment is conclusively ascertained. On February 12, 2016, CMS published a final rule with respect to Medicare Parts A and B clarifying that providers have an obligation to proactively exercise “reasonable diligence,” and that the 60 day clock begins to run after the reasonable diligence period has concluded, which may take at most 6 months from the from receipt of credible information, absent extraordinary circumstances. Retention of any overpayment beyond this period may result in FCA liability. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, there is no need for an employment relationship in order to qualify for protection against retaliation for whistleblowing.

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

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

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

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

Both federal and state government agencies have heightened and coordinated civil and criminal enforcement efforts as part of numerous ongoing investigations of healthcare companies and, in particular, skilled nursing facilities. The focus of these investigations includes, among other things:

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

If any of our affiliated facilities is decertified or loses its licenses, our revenue, financial condition or results of operations would be adversely affected. In addition, the report of such issues at any of our affiliated facilities could harm our reputation for quality care and lead to a reduction in the patient referrals of our operating subsidiaries and ultimately a reduction in occupancy at these facilities. Also, responding to enforcement efforts would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings, regardless of whether we prevail on the underlying claim.

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

- medical necessity of services provided;
- conviction related to fraud;
- conviction relating to obstruction of an investigation;
- conviction relating to a controlled substance;
- licensure revocation or suspension;
- exclusion or suspension from state or other federal healthcare programs;
- filing claims for excessive charges or unnecessary services or failure to furnish medically necessary services;
- ownership or control of an entity by an individual who has been excluded from the Medicaid or Medicare programs, against whom a civil monetary penalty related to the Medicaid or Medicare programs has been assessed or who has been convicted of a criminal offense under federal healthcare programs; and
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the transfer of ownership or control interest in an entity to an immediate family or household member in anticipation of, or following, a conviction, assessment or exclusion from the Medicare or Medicaid programs.

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

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its guidelines in a manner inconsistent with our interpretation or the OIG may ultimately determine that our corporate compliance program is insufficient.

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

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

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

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

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

In August 2012, the OIG released a report entitled “Inappropriate and Questionable Billing for Medicare Home Health Agencies.” The report analyzed data from home health, inpatient hospital, and skilled nursing facilities claims from 2010 to identify inappropriate home health payments. The report found that in 2010, Medicare made overpayments largely in connection with three specific errors: overlapping with claims for inpatient hospital stays, overlapping with

claims for skilled nursing facility stays, or billing for services on dates after beneficiaries' deaths. The report also concluded that home health agencies with questionable billing were located mostly in Texas, Florida, California, and Michigan. The report recommended that CMS implement claims processing edits or improve existing edits to prevent inappropriate payments for the three specific errors referenced above, increase monitoring of billing for home health services, enforce and consider lowering the ten percent cap on the total outlier payments a home health agency may receive annually, consider imposing a temporary moratorium on new home health agency enrollments in Florida and Texas, and take appropriate action regarding the inappropriate payments identified and home health agencies with questionable billing. CMS concurred with all five recommendations. Moratoria were subsequently put in place, and effective January 29, 2016, extended on July 29, 2016, again on January 9, 2017, again on July 28, 2017 and then on January 29, 2018. A moratoria on enrollment of new home health agencies and home health agency sub-units were extended in various counties in Florida, Michigan, Texas, Illinois, Pennsylvania and New Jersey. Additionally, following recommendations made by the OIG in an April 2014 report entitled "Limited Compliance with Medicare's Home Health Face-to-Face Documentation Requirements," CMS committed to implement a plan for oversight of home health agencies through Supplemental Medical Review Contractor audits of every home health agency in the country.

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In December 2010, the OIG released a report entitled “Questionable Billing by Skilled Nursing Facilities.” The report examined the billing practices of skilled nursing facilities based on Medicare Part A claims from 2006 to 2008 and found, among other things, that for-profit skilled nursing facilities were more likely to bill for higher paying therapy RUGs, particularly in the ultra high therapy categories, than government and not-for-profit operators. It also found that for-profit skilled nursing facilities showed a higher incidence of patients using RUGs with higher activities of daily living (ADL) scores, and had a “long” average length of stay among Part A beneficiaries, compared to their government and not-for-profit counterparts. The OIG recommended that CMS vigilantly monitor overall payments to skilled nursing facilities, adjust RUG rates annually, change the method for determining how much therapy is needed to ensure appropriate payments and conduct additional reviews for skilled nursing operators that exceed certain thresholds for higher paying therapy RUGs. CMS concurred with and agreed to take action on three of the four recommendations, declining only to change the methodology for assessing a patient's therapy needs. The OIG issued a separate memorandum to CMS listing 384 specific facilities that the OIG had identified as being in the top one percent for use of ultra high therapy, RUGs with high ADL scores, or “long” average lengths of stay, and CMS agreed to forward the list to the appropriate fiscal intermediaries or other contractors for follow up. Although we believe our therapy assessment and billing practices are consistent with applicable law and CMS requirements, we cannot predict the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. Two of our affiliated facilities have been listed on the report. Our business model, like those of some other for-profit operators, is based in part on seeking out higher-acuity patients whom we believe are generally more profitable, and over time our overall patient mix has consistently shifted to higher-acuity and higher-RUGs patients in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording ADL services in order to, among other things, increase reimbursement to levels appropriate for the care actually delivered. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others, as well as other government agencies, unions, advocacy groups and others who seek to pursue their own mandates and agendas. In its fiscal year 2014 work plan, OIG specifically stated that it will continue to study and report on questionable Part A and Part B billing practices amongst skilled nursing facilities.

In addition, in its 2017 Work Plan, the OIG indicated that it will review compliance with various aspects which impact reimbursement to skilled nursing (SNF), home health, or hospice providers, including the documentation in support of the claims paid by Medicare. According to the 2017 Work Plan, prior OIG reviews found that SNFs are billing for higher levels of therapy than were provided or were reasonable or necessary and also that Medicare payments were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of a SNF admission. The OIG’s 2017 Work Plan provides that the OIG will review documentation at selected SNFs to determine if it meets the requirements for each particular RUG, compliance with SNF prospective payment system requirements related to a 3-day qualifying inpatient hospital stay, and other billing documentation related to Medicare payments for hospice and home health services to ensure they were made in accordance with Medicare requirements.

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

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

Some states require healthcare providers, including skilled nursing facilities, to obtain prior approval, known as a certificate of need, for:

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

In addition, other states that do not require certificates of need have effectively barred the expansion of existing facilities and the development of new ones by placing partial or complete moratoria on the number of new Medicaid beds they will certify in certain areas or in the entire state. Other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. In addition, some states the acquisition of a facility being operated by a non-profit organization requires the approval of the state Attorney General.

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Our ability to acquire or construct new facilities or expand or provide new services at existing facilities would be adversely affected if we are unable to obtain the necessary approvals, if there are changes in the standards applicable to those approvals, or if we experience delays and increased expenses associated with obtaining those approvals. We may not be able to obtain licensure, certificate of need approval, Medicaid certification, Attorney General approval or other necessary approvals for future expansion projects. Conversely, the elimination or reduction of state regulations that limit the construction, expansion or renovation of new or existing facilities could result in increased competition to us or result in overbuilding of facilities in some of our markets. If overbuilding in the skilled nursing industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

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

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

The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our affiliated facilities are required to comply with the ADA. The ADA has separate compliance requirements for “public accommodations” and “commercial properties,” but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law. While we are insured for these types of claims, we could experience damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

Compliance with federal and state fair housing, fire, safety and other regulations may require us to make unanticipated expenditures, which could be costly to us.

We must comply with the federal Fair Housing Act and similar state laws, which prohibit us from discriminating against individuals if it would cause such individuals to face barriers in gaining residency in any of our affiliated facilities. Additionally, the Fair Housing Act and other similar state laws require that we advertise our services in such a way that we promote diversity and not limit it. We may be required, among other things, to change our marketing techniques to comply with these requirements.

In addition, we are required to operate our affiliated facilities in compliance with applicable fire and safety regulations, building codes and other land use regulations and food licensing or certification requirements as they may be adopted by governmental agencies and bodies from time to time. Like other healthcare facilities, our affiliated skilled nursing facilities are subject to periodic surveys or inspections by governmental authorities to assess and assure compliance with regulatory requirements. Surveys occur on a regular (often annual or biannual) schedule, and special surveys may result from a specific complaint filed by a patient, a family member or one of our competitors. We may

be required to make substantial capital expenditures to comply with these requirements.

We depend largely upon reimbursement from third-party payors, and our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our affiliated facilities as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of the patients of our operating subsidiaries who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. For the three and six months ended June 30, 2018, 68.2% and 68.0%, respectively, of our revenue was provided by government payors that reimburse us at predetermined rates, respectively. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to

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maintain our proportion of high acuity patients or if there is any significant increase in the percentage of the patients of our operating subsidiaries for whom we receive Medicaid reimbursement, our results of operations may be adversely affected.

Initiatives undertaken by major insurers and managed care companies to contain healthcare costs may adversely affect our business. Among other initiatives, these payors attempt to control healthcare costs by contracting with healthcare providers to obtain services on a discounted basis. We believe that this trend will continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services, we may lose patients if we choose not to renew our contracts with these insurers at lower rates.

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

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

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

We are subject to litigation that could result in significant legal costs and large settlement amounts or damage awards.

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

In addition, plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers and other long-term care companies, and have employed a wide variety of advertising and publicity strategies. Among other things, these strategies include establishing their own Internet websites, paying for premium advertising space on other websites, paying Internet search engines to optimize their plaintiff solicitation advertising so that it appears in advantageous positions on Internet search results, including results from searches for our company and affiliated facilities, using newspaper, magazine and television ads targeted at customers of the healthcare industry generally, as well as at customers of specific providers, including us. From time to time, law firms claiming to specialize in long-term care litigation have named us, our affiliated facilities and other specific healthcare providers and facilities in their advertising and solicitation materials. These advertising and solicitation activities could result in more claims and litigation, which could increase our liability exposure and legal expenses, divert the time and attention of the personnel of our operating subsidiaries from day-to-day business operations, and materially and adversely affect our financial condition and results of operations. Furthermore, to the

extent the frequency and/or severity of losses from such claims and suits increases, our liability insurance premiums could increase and/or available insurance coverage levels could decline, which could materially and adversely affect our financial condition and results of operations.

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

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

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brought that may materially affect our business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. For example, there has been an increase in the number of wage and hour class action claims filed in several of the jurisdictions where we are present. Allegations typically include claimed failures to permit or properly compensate for meal and rest periods, or failure to pay for time worked. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could have a material adverse effect to our business, financial condition, results of operations and cash flows. In addition, we contract with a variety of landlords, lenders, vendors, suppliers, consultants and other individuals and businesses. These contracts typically contain covenants and default provisions. If the other party to one or more of our contracts were to allege that we have violated the contract terms, we could be subject to civil liabilities which could have a material adverse effect on our financial condition and results of operations.

Were litigation to be instituted against one or more of our subsidiaries, a successful plaintiff might attempt to hold us or another subsidiary liable for the alleged wrongdoing of the subsidiary principally targeted by the litigation. If a court in such litigation decided to disregard the corporate form, the resulting judgment could increase our liability and adversely affect our financial condition and results of operations.

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

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

In October 2013, we entered into the Settlement Agreement with the DOJ pertaining to an investigation of certain of our operating subsidiaries. Pursuant to the Settlement Agreement, we made a single lump-sum remittance to the government in the amount of $48.0 million in October 2013. We have denied engaging in any illegal conduct, and have agreed to the settlement amount without any admission of wrongdoing in order to resolve the allegations and to avoid the uncertainty and expense of protracted litigation.

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

business unit or location related to items or services that may be reimbursed by Federal health care programs. We are also required to retain an Independent Review Organization (IRO) to review certain clinical documentation annually for the term of the CIA.

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

On May 31, 2018, we received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating the Company to determine whether we have violated the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of our 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 our Southern California skilled nursing facilities. As a general matter, our operating entities maintain policies

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and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. We are fully cooperating with the U.S. Department of Justice to promptly respond to the CID. However, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company.

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

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

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

From time to time our systems and controls highlight potential compliance issues, which we investigate as they arise. Historically, we have, and would continue to do so in the future, initiated internal inquiries into possible recordkeeping and related irregularities at our affiliated skilled nursing facilities, which were detected by our internal compliance team in the course of its ongoing reviews.

Through these internal inquiries, we have identified potential deficiencies in the assessment of and recordkeeping for small subsets of patients. We have also identified and, at the conclusion of such investigations, assisted in implementing, targeted improvements in the assessment and recordkeeping practices to make them consistent with the existing standards and policies applicable to our affiliated skilled nursing facilities in these areas. We continue to monitor the measures implemented for effectiveness, and perform follow-up reviews to ensure compliance. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

If additional reviews result in identification and quantification of additional amounts to be refunded, we would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. Furthermore, failure to refund overpayments within required time frames (as described in greater detail above) could result in Federal False Claims Act (FCA) liability. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

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

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

We face competition for the acquisition of facilities and businesses and expect this competition to increase. Based upon factors such as our ability to identify suitable acquisition candidates, the purchase price of the facilities, prevailing market conditions, the availability of leadership to manage new facilities and our own willingness to take on new operations, the rate at which we have historically acquired facilities has fluctuated significantly. In the future, we anticipate the rate at which we may acquire facilities will continue to fluctuate, which may affect our revenue.

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

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

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

During the 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 with a total of 428 operational skilled nursing beds and 218 assisted living units. During the year ended December 31, 2017, we added to our operations twelve stand-alone skilled nursing operations, nine stand-alone assisted and independent living operations, one campus operation, three home health agencies, three hospice agencies and one home care agency with a total of 1,360 operational skilled nursing beds and 594 assisted living units. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such facilities quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our facility acquisitions, and our business may suffer.

In undertaking acquisitions, we may be adversely impacted by costs, liabilities and regulatory issues that may adversely affect our operations.

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those facilities, against whom we may have little or no recourse. Many facilities we have historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved operating subsidiaries and patient care at affiliated facilities that we have acquired, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may

include, without limitation, payment recoupment related to our predecessors' prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant facilities into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable. For example, in July of 2006 we acquired a facility that had a history of intermittent noncompliance. Although the affiliated facility had already been surveyed once by the local state survey agency after being acquired by us, and that survey would have met the heightened requirements of the special focus facility program, based upon the facility's compliance history prior to our acquisition, in January 2008, state officials nevertheless recommended to CMS that the facility be placed on special focus facility status. In addition, in October of 2006, we acquired a facility which had a history of intermittent non-compliance. This affiliated facility was surveyed by the local state survey agency during the third quarter of 2008 and passed the

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heightened survey requirements of the special focus facility program. Both affiliated facilities have successfully graduated from the Centers for Medicare and Medicaid Services' Special Focus program. We've had other affiliated facilities that have successfully graduated from the program. Other affiliated facilities may be identified for special focus status in the future.

In addition, we might encounter unanticipated difficulties and expenditures relating to any of the acquired facilities, including contingent liabilities. For example, when we acquire a facility, we generally assume the facility's existing Medicare provider number for purposes of billing Medicare for services. If CMS later determined that the prior owner of the facility had received overpayments from Medicare for the period of time during which it operated the facility, or had incurred fines in connection with the operation of the facility, CMS could hold us liable for repayment of the overpayments or fines. If the prior operator is defunct or otherwise unable to reimburse us, we may be unable to recover these funds. We may be unable to improve every facility that we acquire. In addition, operation of these facilities may divert management time and attention from other operations and priorities, negatively impact cash flows, result in adverse or unanticipated accounting charges, or otherwise damage other areas of our company if they are not timely and adequately improved.

We also incur regulatory risk in acquiring certain facilities due to the licensing, certification and other regulatory requirements affecting our right to operate the acquired facilities. For example, in order to acquire facilities on a predictable schedule, or to acquire declining operations quickly to prevent further pre-acquisition declines, we frequently acquire such facilities prior to receiving license approval or provider certification. We operate such facilities as the interim manager for the outgoing licensee, assuming financial responsibility, among other obligations for the facility. To the extent that we may be unable or delayed in obtaining a license, we may need to operate the facility under a management agreement from the prior operator. Any inability in obtaining consent from the prior operator of a target acquisition to utilizing its license in this manner could impact our ability to acquire additional facilities. If we were subsequently denied licensure or certification for any reason, we might not realize the expected benefits of the acquisition and would likely incur unanticipated costs and other challenges which could cause our business to suffer.

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

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

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

The post-acute care industry is highly competitive, and we expect that our industry may become increasingly competitive in the future. Our affiliated skilled nursing facilities compete primarily on a local and regional basis with many long-term care providers, from national and regional multi-facility providers that have substantially greater financial resources to small providers who operate a single nursing facility. We also compete with other skilled

nursing and assisted living facilities, and with inpatient rehabilitation facilities, long-term acute care hospitals, home healthcare and other similar services and care alternatives. Increased competition could limit our ability to attract and retain patients, attract and retain skilled personnel, maintain or increase private pay and managed care rates or expand our business.

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

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

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

In December 2008, CMS introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each nursing home a rating of between one and five stars in various categories. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating. The prior operator's results will impact our rating until we have sufficient clinical measurements subsequent to the acquisition date. If we are unable to achieve quality of care ratings that are comparable or superior to those of our competitors, our ability to attract and retain patients could be adversely affected.

On February 20, 2015, CMS modified the Five Star Quality Rating System for nursing homes to include the use of antipsychotics in calculating the star ratings, modified calculations for staffing levels and reflect higher standards for nursing homes to achieve a high rating on the quality measure dimension. On July 1, 2016, CMS implemented its first mandatory reporting period that required Skilled Nursing Facilities to submit information annually on staffing and census data on the Payroll-Based Journal (PBJ) system. CMS has long identified staffing as one of the vital components of a skilled nursing facility’s ability to provide quality care. The PBJ system allows staffing and census information to be easily collected by CMS. The staffing information gathered is not consistent with the actual hours worked, but instead based upon an established set of regulations.

On August 10, 2016, CMS modified the Five Star Quality Rating System for nursing homes to include five of the six new quality measures added April 27, 2016 to its consumer-based Nursing Home Compare website as part of an initiative to broaden the quality of information available on that site. They include the rate of rehospitalization, emergency room use, community discharge, improvements in function, and independently worsened ability to move. In 2017, CMS issued a temporary freeze of the Health Inspection Five Star Ratings beginning in 2018 that will last approximately 12 months. The health inspection star rating for recertification surveys and complaints conducted on or after November 28, 2017 will be frozen. The freeze of the Health Inspection Five Star Ratings and the increase in the standards for performance on quality measures could reduce the number of our 4 and 5 star facilities.

On April 6, 2018, CMS announced that starting in April 2018, CMS will use PBJ data to calculate the staffing ratings used in the Nursing Home Five Star Quality Rating System. CMS will be 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.

In July 17, 2015, CMS announced Home Health Star Ratings for home health agencies. All Medicare-certified HHAs are potentially eligible to receive a Quality of Patient Care Star Rating. The Star Ratings include assessments of quality of patient care based on Medicare claims data and patient experience of care. The Star Rating may impact patient choice of home health agencies and reimbursement from home health agencies, as a higher Star rating indicates better patient care than a lower Star rating. A low Star rating may decrease the number of patients for Medicare reimbursement. On December 14, 2017, CMS announced that the influenza vaccination measure would be removed from consideration in the Quality of Patient Care Star Rating beginning with the April 2018 Home Health Compare refresh, reducing the number of quality measures used from nine to eight.

In addition, CMS announced proposals to adopt new standards that home health agencies must comply with in order to participate in the Medicare program, including the strengthening of patient rights and communication requirements that focus on patient well-being.

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If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected.

It may become more difficult and costly for us to obtain coverage for resident care liabilities and other risks, including property and casualty insurance. For example, the following circumstances may adversely affect our ability to obtain insurance at favorable rates:

- we experience higher-than-expected professional liability, property and casualty, or other types of claims or losses;
- we receive survey deficiencies or citations of higher-than-normal scope or severity;
- we acquire especially troubled operations or facilities that present unattractive risks to current or prospective insurers;
- insurers tighten underwriting standards applicable to us or our industry; or
- insurers or reinsurers are unable or unwilling to insure us or the industry at historical premiums and coverage levels.

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

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

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

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

We have maintained general and professional liability insurance since 2002 and workers' compensation insurance since 2005 through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our self-insurance reimbursements (SIR) and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred

but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted.

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

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

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

Our affiliated facilities located in Arizona, California, and Texas account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since over 20% of our affiliated facilities are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as fires, earthquakes or mudslides.

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

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

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

The unwillingness on the part of both our management and staff to accede to union demands for “neutrality” and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union actively prosecuted a negative retaliatory publicity action, also known as a “corporate campaign,” against us and filed, promoted or participated in multiple legal actions against us. The union's campaign asserted, among other allegations, poor treatment of patients, inferior clinical services provided by the employees of our operating subsidiaries, poor

treatment of the employees of our operating subsidiaries, and health code violations by our operating subsidiaries. In addition, the union has publicly mischaracterized actions taken by the DHS against us and our affiliated facilities. In numerous cases, the union's allegations created the false impression that violations and other events that occurred at facilities prior to our acquisition of those facilities were caused by us. Since a large component of our business involves acquiring underperforming and distressed facilities, and improving the quality of operations at these facilities, we may have been associated with the past poor performance of these facilities. To the extent this union or another elects to directly or indirectly prosecute a corporate campaign against us or any of our affiliated facilities, our business could be negatively affected.

The Service Employees International Union has issued in the past, and may again issue in the future, public statements alleging that we or other for-profit skilled nursing operators have engaged in unfair, questionable or illegal practices in various areas, including staffing, patient care, patient evaluation and treatment, billing and other areas and activities related to the industry and our operating subsidiaries. We continue to anticipate similar criticisms, charges and other negative publicity from such sources on a regular basis, particularly in the current political environment and following the December 2010 OIG report entitled

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“Questionable Billing by Skilled Nursing Facilities," described above in " The Office of the Inspector General or other organizations may choose to more closely scrutinize the billing practices of for-profit skilled nursing facilities, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations." Two of our affiliated facilities have been listed on the report. Such reports provide unions and their allies with additional opportunities to make negative statements about, and to encourage regulators to seek investigatory and enforcement actions against, the industry in general and non-union operators like us specifically. Although we believe that our operations and business practices substantially conform to applicable laws and regulations, we cannot predict the extent to which we might be subject to adverse publicity or calls for increased regulatory scrutiny from union and union ally sources, or what effect, if any, such negative publicity would have on us, but to the extent they are successful, our revenue may be reduced, our costs may be increased and our profitability and business could be adversely affected.

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

Our ability to respond to unions, however, may be limited by some state laws, which purport to make it illegal for any recipient of state funds to promote or deter union organizing. For example, such a state law passed by the California Legislature was successfully challenged on the grounds that it was preempted by the National Labor Relations Act, only to have the challenge overturned by the Ninth Circuit in 2006 before being ultimately upheld by the United States Supreme Court in 2008. In addition, proposed legislation making it more difficult for employees and their supervisors to educate co-workers and oppose unionization, such as the proposed Employee Free Choice Act which would allow organizing on a single “card check” and without a secret ballot and similar changes to federal law, regulation and labor practice being advocated by unions and considered by Congress and the National Labor Relations Board, could make it more difficult to maintain union-free workplaces in our affiliated facilities. Further, the expedited election rules adopted by the National Labor Relations Board took effect on April 14, 2015 and make it far easier for unions to organize employees. These and similar laws have the potential to facilitate unionization procedures or hinder employer responses thereto, which may hinder our ability to oppose unionization efforts and negatively affect our business.

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

As of June 30, 2018, we leased 168 of our 235 affiliated facilities. Most of our leases are triple-net leases, which means that, in addition to rent, we are required to pay for the costs related to the property (including property taxes, insurance, and maintenance and repair costs). We are responsible for paying these costs notwithstanding the fact that some of the benefits associated with paying these costs accrue to the landlords as owners of the associated facilities. Each lease provides that the landlord may terminate the lease for a number of reasons, including, subject to applicable cure periods, the default in any payment of rent, taxes or other payment obligations or the breach of any other covenant or agreement in the lease. Termination of a lease could result in a default under our debt agreements and could adversely affect our business, financial position or results of operations. There can be no assurance that we will be able to comply with all of our obligations under the leases in the future.

In 2017, we voluntarily discontinued operations at one of our skilled nursing facilities after determining that the facility could not competitively operate in the marketplace without substantial investment renovating the building. After careful consideration, we determined that the costs to renovate the facility would outweigh the future returns

from the operation. As part of the arrangement, we remain obligated for lease payments and other obligation under the lease agreement. We have in the past, and may in the future, continued to be obligated for lease payments and other obligations under the leases even if we decided to withdraw from those locations. We could incur special charges relating to the closing of such facilities including lease termination costs, impairment charges and other special charges that would reduce our net income and could adversely affect our business, financial condition and results of operations.

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

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We maintain a revolving credit facility with a lending consortium. As of June 30, 2018, our operating subsidiaries had $156.9 million outstanding under our credit facility. On February 5, 2016, we amended our existing revolving credit facility to increase our aggregate principal amount available to $250.0 million. On July 19, 2016, we entered into the Second Amended Credit Facility to increase the aggregate principal amount up to $450.0 million comprised of a $300.0 million revolving credit facility and a $150.0 million term loan. In December 2017, seventeen of our subsidiaries entered into mortgage loans in the aggregate amount of $112.0 million under Department of Housing and Urban Development (HUD) insured loans. The terms of the mortgage loans range from 30- or 35-years. We also had other outstanding indebtedness of approximately $13.1 million as of June 30, 2018 under other HUD-insured loans and promissory note issued in connection with various acquisitions with maturity dates ranging from 2027 through 2052. Because these mortgage loans are insured with HUD, our borrower subsidiaries under these loans are subject to HUD oversight and periodic inspections.

In addition, we had $1.7 billion of future operating lease obligations as of June 30, 2018. We intend to continue financing our operating subsidiaries through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, our outstanding credit facilities and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage, project yield, net leverage ratios, minimum interest coverage ratios and minimum asset coverage ratios. These restrictions may interfere with our ability to obtain additional advances under existing credit facilities or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue.

From time to time, the financial performance of one or more of our mortgaged facilities may not comply with the required operating covenants under the terms of the mortgage. Any non-payment, noncompliance or other default under our financing arrangements could, subject to cure provisions, cause the lender to foreclose upon the facility or facilities securing such indebtedness or, in the case of a lease, cause the lessor to terminate the lease, each with a consequent loss of revenue and asset value to us or a loss of property. Furthermore, in many cases, indebtedness is secured by both a mortgage on one or more facilities, and a guaranty by us. In the event of a default under one of these scenarios, the lender could avoid judicial procedures required to foreclose on real property by declaring all amounts outstanding under the guaranty immediately due and payable, and requiring us to fulfill our obligations to make such payments. If any of these scenarios were to occur, our financial condition would be adversely affected. For tax purposes, a foreclosure on any of our properties would be treated as a sale of the property for a price equal to the outstanding balance of the debt secured by the mortgage. If the outstanding balance of the debt secured by the mortgage exceeds our tax basis in the property, we would recognize taxable income on foreclosure, but would not receive any cash proceeds, which would negatively impact our earnings and cash position. Further, because our mortgages and operating leases generally contain cross-default and cross-collateralization provisions, a default by us related to one facility could affect a significant number of other facilities and their corresponding financing arrangements and operating leases.

Because our term loans, promissory notes, bonds, mortgages and lease obligations are fixed expenses and secured by specific assets, and because our revolving loan obligations are secured by virtually all of our assets, if reimbursement rates, patient acuity mix or occupancy levels decline, or if for any reason we are unable to meet our loan or lease obligations, we may not be able to cover our costs and some or all of our assets may become at risk. Our ability to make payments of principal and interest on our indebtedness and to make lease payments on our operating leases depends upon our future performance, which will be subject to general economic conditions, industry cycles and

financial, business and other factors affecting our operating subsidiaries, many of which are beyond our control. If we are unable to generate sufficient cash flow from operations in the future to service our debt or to make lease payments on our operating leases, we may be required, among other things, to seek additional financing in the debt or equity markets, refinance or restructure all or a portion of our indebtedness, sell selected assets, reduce or delay planned capital expenditures or delay or abandon desirable acquisitions. Such measures might not be sufficient to enable us to service our debt or to make lease payments on our operating leases. The failure to make required payments on our debt or operating leases or the delay or abandonment of our planned growth strategy could result in an adverse effect on our future ability to generate revenue and sustain profitability. In addition, any such financing, refinancing or sale of assets might not be available on terms that are economically favorable to us, or at all.

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

The majority of our affiliated facilities have historically been skilled nursing facilities. As we expand our presence in the assisted living, home health and hospice services or other relevant healthcare service, our existing overall business model will

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continue to change and expose our company to risks in a market in which we have limited experience. Although assisted living operating subsidiaries generally have lower costs and higher margins than skilled nursing, they typically generate lower overall revenue than skilled nursing operating subsidiaries. In addition, assisted living revenue is derived primarily from private payors as opposed to government reimbursement. In most states, skilled nursing, assisted living, home health and hospice care are regulated by different agencies, and we have less experience with the agencies that regulate assisted living, home health and hospice care. In general, we believe that assisted living is a more competitive industry than skilled nursing. As we expand our presence in the assisted living, home health and hospice services, and other ancillary services we expect that we will have to adjust certain elements of our existing business model, which could have an adverse effect on our business.

If our referral sources fail to view us as an attractive skilled nursing provider, or if our referral sources otherwise refer fewer patients, our patient base may decrease.

We rely significantly on appropriate referrals from physicians, hospitals and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our affiliated facilities. Our referral sources are not obligated to refer business to us and may refer business to other healthcare providers. We believe many of our referral sources refer business to us as a result of the quality of our patient care and our efforts to establish and build a relationship with our referral sources. If we lose, or fail to maintain, existing relationships with our referral resources, fail to develop new relationships, or if we are perceived by our referral sources as not providing high quality patient care, our occupancy rate and the quality of our patient mix could suffer. In addition, if any of our referral sources have a reduction in patients whom they can refer due to a decrease in their business, our occupancy rate and the quality of our patient mix could suffer.

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

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

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

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

A cyber security attack or other incident that bypasses our information systems security could cause a security breach which may lead to a material disruption to our information systems infrastructure or business and may involve a

significant loss of business or patient health information. If a cyber security attack or other unauthorized attempt to access our systems or facilities were to be successful, it could result in the theft, destructions, loss, misappropriation or release of confidential information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cyber security attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties and could subject us to substantial penalties under HIPAA and other federal and state privacy laws, in addition to private litigation with those affected.

Failure to maintain the security and functionality of our information systems and related software, or a failure to defend a cyber security attack or other attempt to gain unauthorized access to our systems, facilities or patient health information could expose us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, the OIG or state attorneys general), fines, private litigation

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with those affected by the data breach, loss of customers, disputes with payors and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations and liquidity.

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

Our ability to maintain and enhance our operating subsidiaries and equipment in a suitable condition to meet regulatory standards, operate efficiently and remain competitive in our markets requires us to commit substantial resources to continued investment in our affiliated facilities and equipment. We are sometimes more aggressive than our competitors in capital spending to address issues that arise in connection with aging and obsolete facilities and equipment. In addition, continued expansion of our business through the acquisition of existing facilities, expansion of our existing facilities and construction of new facilities may require additional capital, particularly if we were to accelerate our acquisition and expansion plans. Financing may not be available to us or may be available to us only on terms that are not favorable. In addition, some of our outstanding indebtedness and long-term leases restrict, among other things, our ability to incur additional debt. If we are unable to raise additional funds or obtain additional funds on terms acceptable to us, we may have to delay or abandon some or all of our growth strategies. Further, if additional funds are raised through the issuance of additional equity securities, the percentage ownership of our stockholders would be diluted. Any newly issued equity securities may have rights, preferences or privileges senior to those of our common stock.

The condition of the financial markets, including volatility and deterioration in the capital and credit markets, could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business, as well as negatively impact or impair the value of our current portfolio of cash, cash equivalents and investments, including U.S. Treasury securities and U.S.-backed investments.

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

Further, our cash, cash equivalents and investments are held in a variety of interest-bearing instruments, including U.S. treasury securities. As a result of the uncertain domestic and global political, credit and financial market conditions, investments in these types of financial instruments pose risks arising from liquidity and credit concerns. Given that future deterioration in the U.S. and global credit and financial markets is a possibility, no assurance can be made that losses or significant deterioration in the fair value of our cash, cash equivalents, or investments will not occur. Uncertainty surrounding the trading market for U.S. government securities or impairment of the U.S. government's ability to satisfy its obligations under such treasury securities could impact the liquidity or valuation of our current portfolio of cash, cash equivalents, and investments, a substantial portion of which were invested in U.S. treasury securities. Further, unless and until the current U.S. and global political, credit and financial market crisis has been sufficiently resolved, it may be difficult for us to liquidate our investments prior to their maturity without incurring a loss, which would have a material adverse effect on our consolidated financial position, results of operations or cash flows.

Though we anticipate that the cash amounts generated internally, together with amounts available under the revolving credit facility portion of the Credit Facility, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if

unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available or available on terms favorable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our billing information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews. For example, in January 2009, the State of California announced expected cash shortages in February which impacted payments to Medi-Cal providers from late March through April. Medi-Cal had also delayed the release of the reimbursement rates which were announced in January 2010. These rate increases were put in place on a retrospective basis, effective August 1, 2009.

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

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

Nineteen of our affiliated facilities are currently subject to regulatory agreements with HUD that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection. The re-inspection occurred in the fourth quarter of 2009 and the facility passed its HUD re-inspection. Compliance with HUD's requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

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

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

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

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

personal injury or improper work exposure associated with asbestos-containing materials and potential asbestos-containing materials. The presence of asbestos-containing materials, or the failure to properly dispose of or remediate such materials, also may adversely affect our ability to attract and retain patients and staff, to borrow when using such property as collateral or to make improvements to such property.

The presence of mold, lead-based paint, underground storage tanks, contaminants in drinking water, radon and/or other substances at any of the affiliated facilities we lease, own or may acquire may lead to the incurrence of costs for remediation, mitigation or the implementation of an operations and maintenance plan and may result in third party litigation for personal injury or property damage. Furthermore, in some circumstances, areas affected by mold may be unusable for periods of time for repairs, and even after successful remediation, the known prior presence of extensive mold could adversely affect the ability of a facility to retain or attract patients and staff and could adversely affect a facility's market value and ultimately could lead to the temporary or permanent closure of the facility.

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If we fail to comply with applicable environmental laws, we would face increased expenditures in terms of fines and remediation of the underlying problems, potential litigation relating to exposure to such materials, and a potential decrease in value to our business and in the value of our underlying assets.

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

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

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

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

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

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

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

The Tax Cuts and Jobs Act of 2017 was approved by Congress and signed into law in December 2017. This legislation makes significant changes to the U.S. Internal Revenue Code. Such changes include a reduction in the corporate tax rate and limitations on certain corporate deductions and credits, among other changes. Certain of these changes could have a negative impact on our business. Moreover, further legislative and regulatory changes may be more likely in the current political environment, particularly to the extent that Congress and the U.S. presidency are controlled by the same political party and significant reform of the tax code has been described publicly as a legislative priority. Significant further changes to the tax code could have an impact on our business, financial

condition and results of operations.

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

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

We received a private letter ruling from the Internal Revenue Services (IRS), which provides substantially to the effect that, on the basis of certain facts presented and representations and assumptions set forth in the request submitted to the IRS, the Spin-

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Off will qualify as tax-free under Sections 368(a)(1)(D) and 355 of the Internal Revenue Code (the IRS Ruling). The IRS Ruling does not address certain requirements for tax-free treatment of the Spin-Off under Section 355 of the Code, and we received tax opinions from our tax advisor and counsel, substantially to the effect that, with respect to such requirements on which the IRS will not rule, such requirements have been satisfied. The IRS Ruling, and the tax opinions that we received from our tax advisor and counsel, rely on, among other things, certain facts, representations, assumptions and undertakings, including those relating to the past and future conduct of our and CareTrust's businesses, and the IRS Ruling and the tax opinions would not be valid if such facts, representations, assumptions and undertakings were incorrect in any material respect. Notwithstanding the IRS Ruling and the tax opinions, the IRS could determine the Spin-Off should be treated as a taxable transaction for U.S. federal income tax purposes if it determines any of the facts, representations, assumptions or undertakings that were included in the request for the IRS Ruling are false or have been violated or if it disagrees with the conclusions in the opinions that are not covered by the IRS Ruling.

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

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

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

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

Risks Related to Ownership of our Common Stock

We may not be able to pay or maintain dividends and the failure to do so would adversely affect our stock price.

Our ability to pay and maintain cash dividends is based on many factors, including our ability to make and finance acquisitions, our ability to negotiate favorable lease and other contractual terms, anticipated operating cost levels, the level of demand for our beds, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. In addition, the revolving credit facility portion of the Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement. The failure to pay or maintain dividends could adversely affect our stock price.

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

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

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common stock, we could incur substantial costs defending or settling the lawsuit. Such a lawsuit could also divert the time and attention of our management from our business.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

None.

Item 3. Defaults Upon Senior Securities

None.

Item 4. Mine Safety Disclosures

None.

Item 5. Other Information

None.

Item 6. Exhibits

EXHIBIT INDEX

Exhibit	Description
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
101	Interactive data file (furnished electronically herewith pursuant to Rule 406T of Regulation S-T)

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SIGNATURES

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

THE ENSIGN GROUP, INC.

August 2, 2018 BY: /s/ SUZANNE D. SNAPPER
Suzanne D. Snapper
Chief Financial Officer (Principal Financial Officer and Duly Authorized Officer)

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