ENSIGN GROUP, INC
Form 10-K
February 13, 2014
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

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

For the fiscal year ended December 31, 2013

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

For the transition period from to .
Commission file number: 001-33757

THE ENSIGN GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

Delaware	33-0861263
(State or Other Jurisdiction of Incorporation or Organization)	(I.R.S. Employer Identification No.)

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	NASDAQ Global Select Market

Securities registered pursuant to Section 12(g) of the Act:
None

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. o Yes x No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. o Yes x No

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. x Yes o No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes o No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of the registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. o

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant, computed by reference to the closing price as of the last business day of the registrant's most recently completed second fiscal quarter, June 30, 2013, was approximately $687,300,000.

As of February 10, 2014, 22,163,855 shares of the registrant’s common stock were outstanding.

DOCUMENTS INCORPORATED BY REFERENCE:

Part III of this Form 10-K incorporates information by reference from the Registrant's definitive proxy statement for the Registrant's 2014 Annual Meeting of Stockholders to be filed within 120 days after the close of the fiscal year covered by this annual report.

THE ENSIGN GROUP, INC.
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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements, which include, but are not limited to the Company's expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities and plans and objectives of management. Forward-looking statements can often be identified by words such as “anticipates,” “expects,” “intends,” “plans,” “predicts,” “believes,” “seeks,” “estimates,” “may,” “will,” “should,” “would,” “could,” “potential,” “continue,” “ongoing,” similar expres variations or negatives of these words. These statements are subject to the safe harbors created under the Securities Act of 1933 and the Securities and Exchange Act of 1934. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Therefore, our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section “Risk Factors” in Part I, Item 1A of this Annual Report on Form 10-K. Accordingly, you should not rely upon forward-looking statements as predictions of future events. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management's beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law. As used in this Annual Report on Form 10-K, the words, “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our facilities, operations, the Service Center (defined below) and our wholly-owned captive insurance subsidiary (the Captive) are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of “we”, “us”, “our” and similar verbiage in this annual report is not meant to imply that any of our facilities, business operations, the Service Center or the Captive are operated by the same entity.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. All of our skilled nursing and assisted living facilities, home health and hospice operations, urgent care centers and majority owned subsidiaries are operated by separate, wholly-owned, independent subsidiaries, each of which have their own management, employees and assets. In addition, one of our wholly-owned independent subsidiaries, referred to as the Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. In addition, we have the Captive that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as for certain workers' compensation insurance liabilities.

Like our operations, the Service Center and Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. Reference herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar verbiage in this annual report is not meant to imply that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by the same entity. We were incorporated in 1999 in Delaware. The Service Center address is 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691, and our telephone number is (949) 487-9500. Our corporate website is located at www.ensigngroup.net. The information contained in, or that can be accessed through, our website does not constitute a part of this annual report.

Ensign™ is our United States trademark. All other trademarks and trade names appearing in this annual report are the property of their respective owners.

PART I.

Item 1. Business

Overview

We, through our subsidiaries, provide skilled nursing and rehabilitative care services through the operation of 119 facilities, nine home health and seven hospice operations, seven urgent care centers and a mobile x-ray and diagnostic company as of December 31, 2013, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. Our operations, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of healthcare services including skilled nursing, assisted living, home health and hospice, mobile ancillary, and urgent care services. Our facilities have a collective capacity of approximately 13,200 operational skilled nursing, assisted living and independent living beds. As of December 31, 2013, we owned 96 of our 119 facilities and operated an additional 23 facilities through long-term lease arrangements, and had options to purchase two of those 23 facilities.

We encourage and empower our leaders and staff to make their facility the “facility of choice” in the community it serves. This means that our leaders and staff are generally free to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then work to create a superior service offering and reputation for that particular community or market to encourage prospective customers and referral sources to choose or recommend the facility.

Our organizational structure is centered upon local leadership. We believe our organizational structure, which empowers leaders and staff at the local level, is unique within the healthcare services industry. Each of our operations is led by highly dedicated individuals who are responsible for key operational decisions at their facilities.

Leaders and staff are trained and motivated to pursue superior clinical outcomes, high patient and family satisfaction, operating efficiencies and financial performance at their facilities. In addition, our leaders are enabled and motivated to share real-time operating data and otherwise benchmark clinical and operational performance against their peers in other facilities in order to improve clinical care, maximize patient satisfaction and augment operational efficiencies, promoting the sharing of best practices.

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

Much of our historical growth can be attributed to our expertise in acquiring under-performing facilities and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. We plan to continue to grow our revenue and earnings by:

- continuing to grow our talent base and develop future leaders;

- increasing the overall percentage or “mix” of higher-acuity residents;

- focusing on organic growth and internal operating efficiencies;

- continuing to acquire additional facilities in existing and new markets; and

•expanding and renovating our existing facilities, and potentially constructing new facilities.

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Company History

Our company was formed in 1999 with the goal of establishing a new level of quality care within the skilled nursing industry. The name “Ensign” is synonymous with a “flag” or a “standard,” and refers to our goal of setting the standard by which all others are measured. We believe that through our efforts and leadership, we can foster a new level of patient care and professional competence at our operations, and set a new industry standard for quality skilled nursing and rehabilitative care services.

We organize our operations into portfolio companies, which we believe has enabled us to maintain a local, field-driven organizational structure and attract additional qualified leadership talent, and to identify, acquire, and improve operations at a generally faster rate. Each of our portfolio companies has its own president. These presidents, who are experienced and proven leaders that are generally taken from the ranks of facility CEOs, serve as leadership resources within their own portfolio companies, and have the primary responsibility for recruiting qualified talent, finding potential acquisition targets, and identifying other internal and external growth opportunities. We believe this organization has improved the quality of our recruiting and will continue to facilitate successful acquisitions.

Cumulative Facility Growth

We have an established track record of successful acquisitions. Many of our earliest acquisitions were completed at a time when the skilled nursing industry was undergoing a major restructuring. From 2001 to 2003, we acquired a number of underperforming facilities, as several long-term care providers disposed of troubled facilities from their portfolios. We then applied our core operating expertise to turn these facilities around, both clinically and financially. In 2004 and 2005, we focused on the integration and improvement of our existing operations while limiting our acquisitions to strategically situated properties, acquiring five facilities over that period.

With the introduction in early 2006 of the portfolio companies and our New Market CEO program, described below, our acquisition activity accelerated, allowing us to add 15 facilities between January 1, 2006 and July 31, 2007. We then effectively suspended our acquisition program while we effected our initial public offering, which was completed in November 2007. From January 1, 2008 through December 31, 2013, we acquired 58 facilities which added 6,099 operational beds to our operations.

During the year ended December 31, 2013, the Company acquired seven stand alone skilled nursing facilities, three stand alone assisted living campuses, three home health operations, three hospice operations and one urgent care center. The following table summarizes our growth through December 31, 2013:

	December 31,								
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Cumulative number of facilities	46	57	61	63	77	82	102	108	119
Cumulative number of operational skilled nursing, assisted living and independent living beds	5,585	6,667	7,105	7,324	8,948	9,539	11,702	12,198	13,204

New Market CEO and New Ventures Programs. In order to broaden our reach to new markets, and in an effort to provide existing leaders in our company with the entrepreneurial opportunity and challenge of entering a new market and starting a new business, we established our New Market CEO program in 2006. Supported by our Service Center and other resources, a New Market CEO evaluates a target market, develops a comprehensive business plan, and relocates to the target market to find talent and connect with other providers, regulators and the healthcare community in that market, with the goal of ultimately acquiring facilities and establishing an operating platform for future growth. In addition, this program was expanded to broaden our reach to other lines of business closely related to the skilled nursing industry through our New Ventures program. For example, we entered into home health as part of this

program. The New Ventures program encourages facility CEOs to evaluate service offerings with the goal of establishing an operating platform in new markets. We believe that this program will not only continue to drive growth, but will also provide a valuable training ground for our next generation of leaders, who will have experienced the challenges of growing and operating a new business.

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Recent Developments

Real Estate Investment Trust (REIT) Spin-Off — On November 7, 2013, we announced a plan to separate our healthcare business and real estate business into two separate, publicly traded companies:

- Ensign, which will continue to provide healthcare services through its existing operations; and
- CareTrust REIT, Inc. (CareTrust), which will own, acquire and lease real estate serving the healthcare industry.

We intend to accomplish the proposed separation by distributing all of the outstanding shares of CareTrust common stock to our stockholders on a pro rata basis (the Spin-Off). At the time of the Spin-Off, CareTrust, which is currently a wholly-owned subsidiary of ours, will hold substantially all of the real property owned by us, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for three independent living facilities that CareTrust will operate) will be leased to us on a triple-net basis, under which we will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

The proposed Spin-Off is conditioned on, among other things, final approval by our board of directors, the receipt of a ruling from the IRS that, among other things, the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes, the receipt of an opinion of counsel as to the satisfaction of certain requirements for such tax-free treatment, and the receipt of an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014. CareTrust has been organized in conformity with the requirements for qualification as a REIT under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

U.S. Government Inquiry Settlement — In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of $33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to $48.0 million (the Reserve Amount).

In October 2013, we completed and executed a settlement agreement (the Settlement Agreement) with the Department of Justice (DOJ) and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. 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 with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of our current compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. Our participation in federal healthcare programs is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in federal healthcare programs and/or subject to prosecution. See further details of the CIA at Note 19, Commitments and Contingencies of Notes to Consolidated Financial Statements.

Urgent Care Franchising — On March 25, 2013 we announced that our urgent care subsidiary, Immediate Clinic Healthcare, Inc., agreed to terms to sell Doctors Express, a national urgent care franchise system. The sale of specific assets and liabilities of Doctors Express was finalized on April 15, 2013. In accordance with the authoritative guidance for the disposal of long-lived assets, the sale of Doctors Express has been accounted for as discontinued

operations. Accordingly, the results of operations of this business for all periods presented and the loss or impairment related to this divesture have been classified as discontinued operations in the accompanying consolidated statements of income. As the sale was effective April 15, 2013, all assets and liabilities included in the sale were recorded as held for sale on our accompanying consolidated balance sheets as of December 31, 2012. See Note 4, Discontinued Operations in Notes to consolidated Financial Statements.

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Facility Acquisition History

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of December 31, 2013:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	Total
Number of facilities	36	13	27	12	6	6	6	3	5	5	119
Operational skilled nursing, assisted living and independent living beds	3,973	1,902	3,353	1,413	505	555	477	304	366	356	13,204

During the third quarter of 2013, we acquired a skilled nursing facility in Washington and an existing leased urgent care center in two separate transactions for an aggregate purchase price of approximately $6.1 million, which was paid in cash. The skilled nursing facility acquisition added 82 operational skilled nursing beds, while the urgent care center acquisition did not have an impact on our operational bed count.

During the second quarter of 2013, we acquired five nursing facilities in Texas, Washington, and Nebraska, and three assisted living facilities in Washington, California and Utah in five separate transaction for an aggregate purchase price of approximately $28.7 million, which was paid in cash. The skilled nursing facilities acquisitions added 460 operational skilled nursing beds, while the assisted living facilities acquisitions added 281 operational assisted living units.

During the first quarter of 2013, we acquired two home health operations in Washington and Texas, two hospice operations in Arizona and California, one home health and hospice with operations in Washington, and one skilled nursing facility in Texas, in five separate transactions for an aggregate purchase price of approximately $10.6 million, which was paid in cash. The home health and hospice acquisitions did not have an impact on our operational bed count, while the skilled nursing facility acquisition added 150 operational skilled nursing beds to our operations.

We also entered into a separate operations transfer agreement with the prior tenant as part of each transaction noted above. See further discussion of facility acquisitions in Note 8, Acquisitions in Notes to consolidated Financial Statements.

Quality of Care Measures

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. Generally we acquire facilities with a 1 or 2-Star rating. We believe compliance and quality outcomes are precursors to outstanding financial performance. The table below summarizes the improvements we have made in these quality measures since 2009:

	As of December 31,				
	2009	2010	2011	2012	2013
Cumulative number of facilities	77	82	102	108	119
4 and 5-Star Quality Rated facilities	14	21	38	45	60
Percent of 4 and 5-Star Quality Rated facilities	18.2 %	25.6 %	37.3 %	41.7 %	50.4 %

Industry Trends

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

- Shift of Patient Care to Lower Cost Alternatives. The growth of the senior population in the United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of

patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs

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are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.

- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

Effects of Changing Prices

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

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

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

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

0.1% decrease in payments to home health agencies.

On November 22, 2013, CMS issued its final ruling regarding Medicare payment rates for home health agencies effective January 1, 2014. As required by the PPACA, this rule includes rebasing adjustments, with a four-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. Under the ruling, CMS projects that Medicare payments to home health agencies in calendar year 2014 will be reduced by 1.05%, or $200 million, reflecting the combined effects of the 2.3% increase in the home health national payment update percentage; offset by a 2.7% decrease due to rebasing adjustments to the national, standardized 60-day episode payment rate, mandated by the Affordable Care Act; and a 0.6% decrease due to the effects of Home Health Prospective Payment Systems Grouper refinements. This final rule also updates the home health wage index for calendar year 2014. The ruling also established home health quality reporting

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requirements for 2014 payment and subsequent years to specify that Medicaid responsibilities for home health surveys be explicitly recognized in the State Medicaid Plan, which is similar to the current regulations for surveys of skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

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

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

On August 2, 2011, the President signed into law the Budget Control Act of 2011 (Budget Control Act), which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act created a Congressional Joint Select Committee on Deficit Reduction (the Committee) that was tasked with proposing additional deficit reduction of at least $1.5 trillion over ten years. As the Committee was unable to achieve its targeted savings, this regulation triggered automatic reductions in discretionary and mandatory spending starting in 2013, including reductions of not more than 2% to payments to Medicare providers. The Budget Control Act also requires Congress to vote on an amendment to the Constitution that would require a balanced budget.

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

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

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

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

Medicare Part B Therapy Cap — Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including

deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The Deficit Reduction Act of 2005 (DRA) added Sec. 1833(g)(5) of the Social Security Act and directed the Centers for Medicare and Medicaid Services to develop a process that allows exceptions for Medicare beneficiaries to therapy caps when continued therapy is deemed medically necessary.

The therapy cap exception has been reauthorized in a number of subsequent laws, most recently in the Pathway for SGR Reform Act of 2014, which extends the cap and exception process through March 31, 2014. That statute implements a two-tiered exception process, with an automatic exception process and a manual medical review exception process. The automatic

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exception process applies for patients who reach a $1,920 threshold. The manual medical review exception process applies at the $3,700 threshold.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond March 31, 2014, which could also have an adverse effect on our revenue after that date.

In addition, the Multiple Procedure Payment Reduction (MPPR) was increased from a 25% to 50% reduction applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies are provided on the same day. The implementation of MPPR includes 1) facilities that provide Medicare Part B speech-language pathology, occupational therapy, and physical therapy services and bill under the same provider number; and 2) providers in private practice, including speech-language pathologists, who perform and bill for multiple services in a single day. The change from 25% of the practice expense to a 50% reduction went into effect for Medicare Part B services provided on or after April 1, 2013.
Medicare Coverage Settlement Agreement — A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved on January 24, 2013, which tasked CMS with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve. At the conclusion of the CMS education campaign, the members of the class will have the opportunity for re-review of their claims, and a two- or three-year monitoring period will commence. Implementation of the provisions of this settlement agreement could favorably impact Medicare coverage reimbursement for our services.

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates see Risk Factors - Risks Related to Our Business and Industry - “Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare,” “Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending,” “We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations” and “Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements." The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. We are not able to predict the outcome of the legislative process. We also cannot predict the extent to which proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and existing new legislation will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue and could adversely affect our business, financial condition and results of operations.

Payor Sources

Total Revenue by Payor Sources. We derive revenue primarily from the Medicaid and Medicare programs, private pay patients and managed care payors. Medicaid typically covers patients that require standard room and board services, and provides reimbursement rates that are generally lower than rates earned from other sources. We monitor our quality mix, which is the percentage of non-Medicaid revenue from each of our facilities, to measure the level received from each payor across each of our business units. We intend to continue to focus on enhancing our care

offerings to accommodate more high acuity patients.

Medicaid. Medicaid is a state-administered program financed by state funds and matching federal funds. Medicaid programs are administered by the states and their political subdivisions, and often go by state-specific names, such as Medi-Cal in California and the Arizona Healthcare Cost Containment System in Arizona. Medicaid programs generally provide health benefits for qualifying individuals, and may supplement Medicare benefits for financially needy persons aged 65 and older. Medicaid reimbursement formulas are established by each state with the approval of the federal government in accordance with federal guidelines. Seniors who enter skilled nursing facilities as private pay clients can become eligible for Medicaid once they have substantially depleted their assets. Medicaid is the largest source of funding for nursing home facilities.

Private and Other Payors. Private and other payors consist primarily of individuals, family members or other third parties who directly pay for the services we provide.

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Medicare. Medicare is a federal program that provides healthcare benefits to individuals who are 65 years of age or older or are disabled. To achieve and maintain Medicare certification, a skilled nursing facility must meet the CMS, “Conditions of Participation”, on an ongoing basis, as determined in periodic facility inspections or “surveys” conducted primarily by the state licensing agency in the state where the facility is located. Medicare pays for inpatient skilled nursing facility services under the prospective payment system. The prospective payment for each beneficiary is based upon the medical condition of and care needed by the beneficiary. Medicare skilled nursing facility coverage is limited to 100 days per episode of illness for those beneficiaries who require daily care following discharge from an acute care hospital.

Managed Care and Private Insurance. Managed care patients consist of individuals who are insured by a third-party entity, typically a senior HMO plan, or who are Medicare beneficiaries who have assigned their Medicare benefits to a senior HMO plan. Another type of insurance, long-term care insurance, is also becoming more widely available to consumers, but is not expected to contribute significantly to industry revenues in the near term.

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

We take seriously our responsibility to act appropriately under applicable laws and regulations, including Medicare and Medicaid billing and reimbursement laws and regulations. Accordingly, we employ accounting, reimbursement and compliance specialists who train, mentor and assist our clerical, clinical and rehabilitation staffs in the preparation of claims and supporting documentation, regularly monitor billing and reimbursement practices within our operations, and assist with the appeal of overpayment and recoupment claims generated by governmental, fiscal intermediary and other auditors and reviewers. In addition, due to the potentially serious consequences that could arise from any impropriety in our billing and reimbursement processes, we investigate all allegations of impropriety or irregularity relative thereto, and sometimes do so with the aid of outside auditors, other than our independent registered public accounting firm, attorneys and other professionals.

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

Years Ended December 31,		
2013	2012	2011

	$	%	$	%	$	%
	(Dollars in thousands)					
Revenue:						
Medicaid	$323,803	35.8 %	$302,046	36.7 %	$277,736	36.6 %
Medicare	292,917	32.4	278,578	33.8	272,283	35.9
Medicaid-skilled	36,085	4.0	25,418	3.1	20,290	2.7
Total	652,805	72.2	606,042	73.6	570,309	75.2
Managed Care	118,168	13.1	106,268	12.9	94,266	12.4
Private and Other(1)	133,583	14.7	110,845	13.5	93,702	12.4
Total revenue	$904,556	100.0 %	$823,155	100.0 %	$758,277	100.0 %

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

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

	Years Ended December 31,					
	2013		2012		2011	
Percentage of Skilled Nursing Days:						
Medicare	14.8	%	15.3	%	15.2	%
Managed care	8.9		9.0		8.9	
Other skilled	2.7		1.6		1.4	
Skilled mix	26.4		25.9		25.5	
Private and other payors	13.7		13.2		12.6	
Quality mix	40.1		39.1		38.1	
Medicaid	59.9		60.9		61.9	
Total skilled nursing	100.0	%	100.0	%	100.0	%

Reimbursement for Specific Services

Reimbursement for Skilled Nursing Services. Skilled nursing facility revenue is primarily derived from Medicaid, private pay, managed care and Medicare payors. Our skilled nursing facilities provide Medicaid-covered services to eligible individuals consisting of nursing care, room and board and social services. In addition, states may, at their option, cover other services such as physical, occupational and speech therapies.

Reimbursement for Rehabilitation Therapy Services. Rehabilitation therapy revenue is primarily received from private pay and Medicare for services provided at skilled nursing facilities and assisted living facilities. The payments are based on negotiated patient per diem rates or a negotiated fee schedule based on the type of service rendered.

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

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

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

Second, overall payments made by Medicare to us on a per hospice program basis are also subject to a cap amount calculated by the Medicare fiscal intermediary at the end of the hospice cap period. The Medicare revenue paid to a hospice program from November 1 to October 31 may not exceed the annual aggregate cap amounts. For cap years

ending on or after October 31, 2012, and all subsequent cap years, the hospice aggregate cap is calculated using the proportional method. Under the proportional method, the hospice shall include in its number of Medicare beneficiaries only that fraction which represents the portion of a patient's total days of care in all hospices and all years that were spent in that hospice in that cap year, using the best data available at the time of the calculation. The whole and fractional shares of Medicare beneficiaries' time in a given cap year are then summed to compute the total number of Medicare beneficiaries served by that hospice in that cap year. The hospice's total Medicare beneficiaries in a given cap year is multiplied by the Medicare per beneficiary cap amount, resulting in that hospice's aggregate cap, which is the allowable amount of total Medicare payments that hospice can receive for that cap year. If a hospice exceeds its aggregate cap, then the hospice must repay the excess back to Medicare. The Medicare cap amount is reduced proportionately for patients who transferred in and out of our hospice services.

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

Competition

The skilled nursing industry is highly competitive, and we expect that the industry will become increasingly competitive in the future. The industry is highly fragmented and characterized by numerous local and regional providers, in addition to large national providers that have achieved geographic diversity and economies of scale. We also compete with inpatient rehabilitation facilities and long-term acute care hospitals. Competitiveness may vary significantly from location to location, depending upon factors such as the number of competing facilities, availability of services, expertise of staff, and the physical appearance and amenities of each location. We believe that the primary competitive factors in the skilled nursing industry are:

- ability to attract and to retain qualified management and caregivers;
- reputation and commitment to quality;
- attractiveness and location of facilities;
- the expertise and commitment of the facility management team and employees;
- community value, including amenities and ancillary services; and
- for private pay and HMO patients, price of services.

We seek to compete effectively in each market by establishing a reputation within the local community as the “facility of choice.” This means that the facility leaders are generally free to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then create a superior service offering and reputation for that particular community or market that is calculated to encourage prospective customers and referral sources to choose or recommend the facility.

Increased competition could limit our ability to attract and retain patients, maintain or increase rates or to expand our business. Some of our competitors have greater financial and other resources than we have, may have greater brand recognition and may be more established in their respective communities than we are. Competing companies may also offer newer facilities or different programs or services than we offer, and may therefore attract individuals who are currently residents of our facilities, potential residents of our facilities, or who are otherwise receiving our healthcare services. Other competitors may have lower expenses or other competitive advantages than us and, therefore, provide services at lower prices than we offer.

Our Competitive Strengths

We believe that we are well positioned to benefit from the ongoing changes within our industry. We believe that our ability to acquire, integrate and improve our facilities is a direct result of the following key competitive strengths:

Experienced and Dedicated Employees. We believe that our employees are among the best in their respective industry. We believe each of our operations is led by an experienced and caring leadership team, including dedicated front-line care staff, who participates daily in the clinical and operational improvement of their individual operations. We have been successful in attracting, training, incentivizing and retaining a core group of outstanding business and clinical leaders to lead our operations. These leaders operate as separate local businesses. With broad local control, these talented leaders and their care staffs are able to quickly meet the needs of their patients and residents, employees and local communities, without waiting for permission to act or being bound to a "one-size-fits-all" corporate strategy.

Unique Incentive Programs. We believe that our employee compensation programs are unique within the industry. Employee stock options and performance bonuses, based on achieving target clinical quality and financial benchmarks, represent a significant component of total compensation for our operational leaders. We believe that these compensation programs assist us in encouraging our leaders and key employees to act with a shared ownership mentality. Furthermore, our leaders are motivated to help local

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operations within a defined “cluster,” which is a group of geographically-proximate operations that share clinical best practices, real-time financial data and other resources and information.

Staff and Leadership Development. We have a company-wide commitment to ongoing education, training and professional development. Accordingly, our operational leaders participate in regular training. Most participate in training sessions at Ensign University, our in-house educational system. Other training opportunities are generally offered on a monthly basis. Training and educational topics include leadership development, our values, updates on Medicaid and Medicare billing requirements, updates on new regulations or legislation, emerging healthcare service alternatives and other relevant clinical, business and industry specific coursework. Additionally, we encourage and provide ongoing education classes for our clinical staff to maintain licensing and increase the breadth of their knowledge and expertise. We believe that our commitment to, and substantial investment in, ongoing education will further strengthen the quality of our operational leaders and staff, and the quality of the care they provide to our patients and residents.

Innovative Service Center Approach. We do not maintain a corporate headquarters; rather, we operate a Service Center to support the efforts of each operation. Our Service Center is a dedicated service organization that acts as a resource and provides centralized information technology, human resources, accounting, payroll, legal, risk management, educational and other key services, so that local leaders can focus on delivering top-quality care and efficient business operations. Our Service Center approach allows individual operations to function with the strength, synergies and economies of scale found in larger organizations, but without what we believe are the disadvantages of a top-down management structure or corporate hierarchy. We believe our Service Center approach is unique within the industry, and allows us to preserve the “one-facility-at-a-time” focus and culture that has contributed to our success.

Proven Track Record of Successful Acquisitions. We have established a disciplined acquisition strategy that is focused on selectively acquiring operations within our target markets. Our acquisition strategy is highly operations driven. Prospective leaders are included in the decision making process and compensated as these acquired operations reach pre-established clinical quality and financial benchmarks, helping to ensure that we only undertake acquisitions that key leaders believe can become clinically sound and contribute to our financial performance.

Since April 1999, we have acquired 119 facilities with 13,204 operational beds, including 1,603 assisted living beds and 477 independent living units, through both long-term leases and purchases. We believe our experience in acquiring these facilities and our demonstrated success in significantly improving their operations enables us to consider a broad range of acquisition targets. In addition, we believe we have developed expertise in transitioning newly-acquired facilities to our unique organizational culture and operating systems, which enables us to acquire facilities with limited disruption to patients, residents and facility operating staff, while significantly improving quality of care. We also intend to consider the construction of new facilities as we determine that market conditions justify the cost of new construction in some of our markets.

Reputation for Quality Care. We believe that we have achieved a reputation for high-quality and cost-effective care and services to our patients and residents within the communities we serve. We believe that our reputation for quality, coupled with the integrated skilled nursing and rehabilitation services that we offer, allows us to attract patients that require more intensive and medically complex care and generally result in higher reimbursement rates than lower acuity patients.

Community Focused Approach. We view skilled nursing care primarily as a local, community-based business. Our local leadership-centered management culture enables each facility's nursing and support staff and leaders to meet the

unique needs of their residents and local communities. We believe that our commitment to this “one-facility-at-a-time” philosophy helps to ensure that each facility, its residents, their family members and the community will receive the individualized attention they need. By serving our residents, their families, the community and our fellow healthcare professionals, we strive to make each individual facility the facility of choice in its local community.

We further believe that when choosing a healthcare provider, consumers usually choose a person or people they know and trust, rather than a corporation or business. Therefore, rather than pursuing a traditional organization-wide branding strategy, we actively seek to develop the facility brand at the local level, serving and marketing one-on-one to caregivers, our residents, their families, the community and our fellow healthcare professionals in the local market.

Attractive Asset Base. We believe that our facilities are among the best-operated in their respective markets. As of December 31, 2013, we owned 96 of the 119 facilities that we operated, and had purchase agreements or options to purchase two of the 23 facilities that we operated under long-term lease arrangements. We will consider exercising these purchase options as they become exercisable. Assuming we eventually exercise all purchase options we currently hold and we don't dispose of any of our current

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facilities, we would own approximately 82% of the facilities we currently operate. We plan to continue to invest in our facilities, both owned and leased, to keep them physically attractive and clinically sound.

Investment in Information Technology. We have acquired information technology that enables our facility leaders to access, and to share with their peers, both clinical and financial performance data in real time. Armed with relevant and current information, our facility leaders and their management teams are able to share best practices and latest information, adjust to challenges and opportunities on a timely basis, improve quality of care, mitigate risk and improve both clinical outcomes and financial performance. We have also invested in specialized healthcare technology systems to assist our nursing and support staff. We have installed automated software and touch-screen interface systems in each facility to enable our clinical staff to more efficiently monitor and deliver patient care and record patient information. We believe these systems have improved the quality of our medical and billing records, while improving the productivity of our staff.

Our Growth Strategy

We believe that the following strategies are primarily responsible for our growth to date, and will continue to drive the growth of our business:

Grow Talent Base and Develop Future Leaders. Our primary growth strategy is to expand our talent base and develop future leaders. A key component of our organizational culture is our belief that strong local leadership is a primary key to the success of each operation. While we believe that significant acquisition opportunities exist, we have generally followed a disciplined approach to growth that permits us to acquire an operation only when we believe, among other things, that we will have qualified leadership for that operation. To develop these leaders, we have a rigorous “CEO-in-Training Program” that attracts proven business leaders from various industries and backgrounds, and provides them the knowledge and hands-on training they need to successfully lead one of our operations. We generally have between five and twenty prospective administrators progressing through the various stages of this training program, which is generally much more rigorous, hands-on and intensive than the minimum 1,000 hours of training mandated by the licensing requirements of most states where we do business. Once administrators are licensed and assigned to an operation, they continue to learn and develop in our facility Chief Executive Officer Program, which facilitates the continued development of these talented business leaders into outstanding facility CEOs, through regular peer review, our Ensign University and on-the-job training.

In addition, our Chief Operating Officer Program recruits and trains highly-qualified Directors of Nursing to lead the clinical programs in our skilled nursing facilities. Working together with their facility CEO and/or administrator, other key facility leaders and front-line staff, these experienced nurses manage delivery of care and other clinical personnel and programs to optimize both clinical outcomes and employee and patient satisfaction.

Increase Mix of High Acuity Patients. Many skilled nursing facilities are serving an increasingly larger population of patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, as a result of government and other payors seeking lower-cost alternatives to traditional acute-care hospitals. We generally receive higher reimbursement rates for providing care for these patients. In addition, many of these patients require therapy and other rehabilitative services, which we are able to provide as part of our integrated service offerings. Where therapy services are prescribed by a patient's physician or other healthcare professional, we generally receive additional revenue in connection with the provision of those services. By making these integrated services

available to such patients, and maintaining established clinical standards in the delivery of those services, we are able to increase our overall revenues. We believe that we can continue to attract high acuity patients and therapy patients to our facilities by maintaining and enhancing our reputation for quality care, continuing our community focused approach, and strengthening our referral networks.

Focus on Organic Growth and Internal Operating Efficiencies. We plan to continue to grow organically by focusing on increasing patient occupancy within our existing facilities. Although some of the facilities we have acquired were in good physical and operating condition, the majority have been clinically and financially troubled, with some facilities having had occupancy rates as low as 30% at the time of acquisition. Additionally, we believe that incremental operating margins on the last 20% of our beds are significantly higher than on the first 80%, offering real opportunities to improve financial performance within our existing facilities. Our overall occupancy is impacted significantly by the number of facilities acquired and the operational occupancy on the acquisition date. Therefore, consolidated occupancy will vary significantly based on these factors. Our average occupancy rates for the years ended December 31, 2013, 2012 and 2011 were 77.5%, 79.0% and 79.2%, respectively.

We also believe we can generate organic growth by improving operating efficiencies and the quality of care at the patient level. By focusing on staff development, clinical systems and the efficient delivery of quality patient care, we believe we are able to deliver higher quality care at lower costs than many of our competitors.

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We also have achieved incremental occupancy and revenue growth by creating or expanding outpatient therapy programs in existing facilities. Physical, occupational and speech therapy services account for a significant portion of revenue in most of our skilled nursing facilities. By expanding therapy programs to provide outpatient services in many markets, we are able to increase revenue while spreading the fixed costs of maintaining these programs over a larger patient base. Outpatient therapy has also proven to be an effective marketing tool, raising the visibility of our facilities in their local communities and enhancing the reputation of our facilities with short-stay rehabilitation patients.

Add New Facilities and Expand Existing Facilities. A key element of our growth strategy includes the acquisition of new and existing facilities from third parties, the expansion and upgrade of current facilities, and the potential construction of new facilities. In the near term, we plan to take advantage of the fragmented skilled nursing industry by acquiring facilities within select geographic markets and may consider the construction of new facilities or by partnering with a construction company to build out new facilities. In addition, historically we have targeted facilities that we believed were underperforming, and where we believed we could improve service delivery, occupancy rates and cash flow. With experienced leaders in place at the community level, and demonstrated success in significantly improving operating conditions at acquired facilities, we believe that we are well positioned for continued growth. While the integration of underperforming facilities generally has a negative short-term effect on overall operating margins, these facilities are typically accretive to earnings within 12 to 18 months following their acquisition. For the 92 facilities that we acquired from 2001 through 2012, the aggregate EBITDAR (defined below) as a percentage of revenue improved from 11.3% during the first full three months of operations to 14.5% during the thirteenth through fifteenth months of operations.

Labor

The operation of our skilled nursing and assisted living facilities, home health and hospice operations and urgent care centers requires a large number of highly skilled healthcare professionals and support staff. At December 31, 2013, we had approximately 11,372 full-time equivalent employees, employed by our Service Center and our operating subsidiaries. For the year ended December 31, 2013, approximately 60.0% of our total expenses were payroll related. Periodically, market forces, which vary by region, require that we increase wages in excess of general inflation or in excess of increases in reimbursement rates we receive. We believe that we staff appropriately, focusing primarily on the acuity level and day-to-day needs of our patients and residents. In most of the states where we operate, our skilled nursing facilities are subject to state mandated minimum staffing ratios, so our ability to reduce costs by decreasing staff, notwithstanding decreases in acuity or need, is limited. We seek to manage our labor costs by improving staff retention, improving operating efficiencies, maintaining competitive wage rates and benefits and reducing reliance on overtime compensation and temporary nursing agency services.

The healthcare industry as a whole has been experiencing shortages of qualified professional clinical staff. We believe that our ability to attract and retain qualified professional clinical staff stems from our ability to offer attractive wage and benefits packages, a high level of employee training, an empowered culture that provides incentives for individual efforts and a quality work environment.

Government Regulations

The regulatory environment within the skilled nursing industry continues to intensify in the amount and type of laws and regulations affecting it. In addition to this changing regulatory environment, federal, state and local officials are increasingly focusing their efforts on the enforcement of these laws. In order to operate our businesses we must

comply with federal, state and local laws relating to licensure, delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate-setting, billing and reimbursement, building codes and environmental protection. Additionally, we must also adhere to anti-kickback laws, physician referral laws, and safety and health standards set by the Occupational Safety and Health Administration (OSHA). Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

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

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

Federal Health Care Reform — On August 2, 2011, the President signed into law the Budget Control Act of 2011 (Budget Control Act), which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act created a Congressional Joint Select Committee on Deficit Reduction (the Committee) that was tasked with proposing additional deficit reduction of at least $1.5 trillion over ten years. As the Committee was unable to achieve its targeted savings, this regulation triggered automatic reductions in discretionary and mandatory spending, or budget sequestration, starting in 2013, including reductions of not more than 2% to payments to Medicare providers. The Budget Control Act also requires Congress to vote on an amendment to the Constitution that would require a balanced budget.

Legislation to delay a significant cut in reimbursement for physician services under Medicare has been enacted repeatedly, most recently in the Pathway for SGR Reform Act of 2014, which implements a 0.5% update for physician services through March 31, 2014. On February 12, 2014, the Senate passed legislation previously passed by the House of Representatives to provide $2.3 billion in funds to supplement Medicare physician payment rates in 2017 if those rates are less than 2013 rates. The President is expected to sign this legislation. In addition, key House and Senate committees have agreed on proposed legislation to permanently stabilize Medicare payment to physicians, but the full House and Senate have not yet taken action on this legislation

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

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

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

- Nursing Home Transparency Requirements — In addition to expanded CMP provisions, PPACA imposed substantial new transparency requirements for Medicare-participating nursing facilities. Existing law required Medicare providers to disclose to CMS: (1) any person or entity that owns directly or indirectly an ownership interest of five percent or more in a provider; (2) officers and directors (if a corporation) and partners (if a partnership); and (3) holders of a mortgage, deed of trust, note or other obligation secured by the entity or the property of the entity. PPACA expanded the information required to be disclosed to include: (4) the facility's organizational structure; (5) additional information on officers, directors, trustees, and "managing employees" of the facility (including their names, titles, and start dates of services); and (6) information on any "additional disclosable party" of the facility. CMS has not yet

promulgated final regulations to implement these provisions.

- Face-to-Face Encounter Requirements — PPACA imposed new patient face-to-face encounter requirements on home health agencies and hospices to establish a patient's ongoing eligibility for Medicare home health services or hospice services, as applicable. Effective for patients with home health starts of care on or after January 1, 2011 and for hospice patients with a third or later benefit period on or after January 1, 2011, a certifying physician or other designated health care professional must conduct and properly document the face-to-face encounters with the Medicare beneficiary within a specified timeframe, and failure of the face-to-face encounter to occur and be properly documented during the applicable timeframe could render the patient's care ineligible for reimbursement under Medicare.

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

- Overpayment Reporting and Repayment; Expanded False Claims Act Liability — PPACA also enacted several important changes that expand potential liability under the federal False Claims Act. PPACA provided that overpayments related to services provided to both Medicare and Medicaid beneficiaries must be reported and returned to the applicable payor within the later of sixty days of identification of the overpayment, or the date the corresponding cost report (if applicable) is due. Any overpayment retained after the deadline is considered an “obligation” for purposes of the federal False Claims Act.

- Skilled Nursing Facility Value-Based Purchasing Program — PPACA required the U.S. Department of Health and Human Services (HHS) to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities. 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 December 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.

- Voluntary Pilot Program — Bundled Payments — To support the policies of making all providers responsible during an episode of care and rewarding value over volume, HHS will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 days following discharge. The bundled payment will cover the costs of acute care inpatient services; physicians’ services delivered in and outside of an acute care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. As with Medicare’s shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.

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

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

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

Regulations Protecting Against Fraud. Various complex federal and state laws exist which govern a wide array of referrals, relationships and arrangements, and prohibit fraud by healthcare providers. Governmental agencies are devoting increasing attention and resources to such anti-fraud efforts. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Balanced Budget Act of 1997 (BBA) expanded the penalties for healthcare fraud. Additionally, in connection with our involvement with federal healthcare reimbursement programs, the government or those acting on its behalf may bring an action under the False Claims Act, alleging that a healthcare provider has defrauded the government. These claimants may seek treble damages for false claims and payment of additional civil monetary penalties. The False Claims Act allows a private individual with knowledge of fraud to bring a claim on behalf of the federal government and earn a percentage of the federal government's recovery. Due to these “whistleblower” incentives, suits have become more frequent.

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

In July 2010, Congress passed the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The Dodd-Frank Act establishes rigorous standards and supervision to protect the economy and American consumers, investors and businesses. Included under Section 922 of the Dodd-Frank Act, the Securities and Exchange

Commission (SEC) will be required to pay a reward to individuals who provide original information to the SEC resulting in monetary sanctions exceeding $1.0 million in civil or criminal proceedings. The award will range from 10 to 30 percent of the amount recouped and the amount of the award shall be at the discretion of the SEC. The purpose of this reward program is to “motivate those with inside knowledge to come forward and assist the Government to identify and prosecute persons who have violated securities laws and recover money for victims of financial fraud.”
On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute lengthened the retrospective time period for which CMS can recover overpayments from health care providers, from three years following the year in which payment was made, to five years following the year in which payment was made.

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

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

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

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

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

Antitrust Laws. We are also subject to federal and state antitrust laws. Enforcement of the antitrust laws against healthcare providers is common, and antitrust liability may arise in a wide variety of circumstances, including third party contracting, physician relations, joint venture, merger, affiliation and acquisition activities. In some respects, the application of federal and state antitrust laws to healthcare is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, healthcare providers and insurance and managed care organizations may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

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Environmental Matters

Our business is subject to a variety of federal, state and local environmental laws and regulations. As a healthcare provider, we face regulatory requirements in areas of air and water quality control, medical and low-level radioactive waste management and disposal, asbestos management, response to mold and lead-based paint in our facilities and employee safety.

As an owner or operator of our facilities, we also may be required to investigate and remediate hazardous substances that are located on and/or under the property, including any such substances that may have migrated off, or may have been discharged or transported from the property. Part of our operations involves the handling, use, storage, transportation, disposal and discharge of medical, biological, infectious, toxic, flammable and other hazardous materials, wastes, pollutants or contaminants. In addition, we are sometimes unable to determine with certainty whether prior uses of our facilities and properties or surrounding properties may have produced continuing environmental contamination or noncompliance, particularly where the timing or cost of making such determinations is not deemed cost-effective. These activities, as well as the possible presence of such materials in, on and under our properties, may result in damage to individuals, property or the environment; may interrupt operations or increase costs; may result in legal liability, damages, injunctions or fines; may result in investigations, administrative proceedings, penalties or other governmental agency actions; and may not be covered by insurance.

We believe that we are in material compliance with applicable environmental and occupational health and safety requirements. However, we cannot assure you that we will not encounter environmental liabilities in the future, and such liabilities may result in material adverse consequences to our operations or financial condition.

Available Information

We are subject to the reporting requirements under the Securities and Exchange Act of 1934, as amended (Exchange Act). Consequently, we are required to file reports and information with the Securities and Exchange Commission (SEC), including reports on the following forms: annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934. These reports and other information concerning the Company may be accessed through the SEC's website at http://www.sec.gov.

You may also find on our website at http://www.ensigngroup.net, electronic copies of our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and amendments to those reports filed or furnished pursuant to Section 13(a) or 15(d) of the Exchange Act. Such filings are placed on our website as soon as reasonably possible after they are filed with the SEC. All such filings are available free of charge. Information contained in our website is not deemed to be a part of this Annual Report.

Item 1A. Risk Factors

Set forth below are certain risk factors that could harm our business, results of operations and financial condition. You should carefully read the following risk factors, together with the financial statements, related notes and other information contained in this Annual Report on Form 10-K. This Annual Report on Form 10-K contains forward-looking statements that contain risks and uncertainties. Please refer to the section entitled "Cautionary Note Regarding Forward-Looking Statements" on page 1 of this Annual Report on Form 10-K in connection with your

consideration of the risk factors and other important factors that may affect future results described below.
Risks Related to Our Business and Industry
Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare.

We derived 39.8% of our revenue from the Medicaid program for the years ended December 31, 2013 and 2012. We derived 32.4% and 33.8% of our revenue from the Medicare program for the years ended December 31, 2013 and 2012, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our residents.

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

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

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

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

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

On November 22, 2013, CMS issued its final ruling regarding Medicare payment rates for home health agencies effective January 1, 2014. As required by the PPACA, this rule includes rebasing adjustments, with a four-year

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

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

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On August 2, 2013, CMS issued its final rule that would update fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices will see an estimated 1.0% ($160 million) increase in their payments for fiscal year 2014. The hospice payment increase is the net result of a hospice payment update percentage of 1.7% (a 2.5% hospital market basket increase minus a 0.8% reduction mandated by law), and a 0.7% decrease in payments to hospices due to updated wage data and the fifth year of the CMS's seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). As finalized in this rule, CMS will update the hospice per diem rates for fiscal year 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years. The fiscal year 2014 hospice payment rates and wage index became effective on October 1, 2013.
On August 2, 2011, the President signed into law the Budget Control Act of 2011 (Budget Control Act), which raised the debt ceiling and put into effect a series of actions for deficit reduction. The Budget Control Act created a Congressional Joint Select Committee on Deficit Reduction (the Committee) that was tasked with proposing additional deficit reduction of at least $1.5 trillion over ten years. As the Committee was unable to achieve its targeted savings, this regulation triggered automatic reductions in discretionary and mandatory spending starting in 2013, including reductions of not more than 2% to payments to Medicare providers. The Budget Control Act also requires Congress to vote on an amendment to the Constitution that would require a balanced budget.
On February 22, 2012, the President signed into law H.R. 3630, which among other things, delayed a cut in physician and Part B services. In establishing the funding for the law, payments to nursing facilities for residents' unpaid Medicare A co-insurance was reduced. The Deficit Reduction Act of 2005 had previously limited reimbursement of bad debt to 70% on privately responsibility co-insurance. However, under H.R. 3630, this reimbursement will be reduced to 65%.
Further, prior to the introduction of H.R. 3630, we were reimbursed for 100% of bad debt related to dual-eligible Medicare residents' co-insurance. H.R. 3630 will phase down the dual-eligible reimbursement over three years. Effective October 1, 2012, Medicare dual-eligible co-insurance reimbursement decreased from 100% to 88%, with further reductions to 77% and 65% as of October 1, 2013 and 2014, respectively. Any reductions in Medicare or Medicaid reimbursement could materially adversely affect our profitability.
On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute delays significant cuts in Medicare rates for physician services until December 31, 2013. The statute also creates a Commission on Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term care services and supports for individuals in need of such services and supports. Any implementation of recommendations from this commission may have an impact on coverage and payment for our services.
Should future changes in PPS, similar to those described above, include further reduced rates or increased standards for reaching certain reimbursement levels, our Medicare revenues derived from our skilled nursing facilities (including rehabilitation therapy services provided at our skilled nursing facilities) could be reduced, with a corresponding adverse impact on our financial condition or results of operations.

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. Some of the spending cuts were triggered only if an inadequate amount of federal funding is received from the American Recovery and Reinvestment Act of 2009. 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.

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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. On January 10, 2011, the California Governor proposed a budget for 2011-2012 which proposes to reduce Medi-Cal provider payments by 10%, including payments to long-term care facilities.

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 operations 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.

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 on or before December 31, 2012.

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

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

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

consolidated billing, which could adversely affect our revenue, financial condition and results of operations.

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

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) were enacted as law. These laws include sweeping changes to how health care is paid for and furnished in the United States.

PPACA, as modified by the Reconciliation Act, is projected to expand access to Medicaid for approximately 16 million additional people. It also reduces the projected growth of Medicare by $500 billion over ten years 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 will be disclosed on a website for comparison by members of the public.

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

Under PPACA, the U.S. Department of Health and Human Services (HHS) will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 days following discharge. The bundled payment will cover the costs of acute care inpatient services; physicians’ services delivered in and outside of an acute care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services; inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. As with Medicare’s shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.

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

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

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

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

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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 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 skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Texas, Utah and Washington. 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 our patients. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility. An increase in costs associated with, or a shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

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

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

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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.

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In 2004, one of our Medicare fiscal intermediaries began to conduct selected reviews of claims previously submitted by and paid to some of our facilities. While we have always been subject to post-payment audits and reviews, more intensive “probe reviews” appear to be a permanent procedure with our fiscal intermediary. Although some of these probe reviews identified patient miscoding, documentation deficiencies and other errors in our recordkeeping and Medicare billing, these errors resulted in no Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments. As of December 31, 2013, we had one facility under probe review.

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

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

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

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

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

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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 facilities have been in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of the revenue associated with the Medicare and Medicaid patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, these sanctions, entailing various remedies up to and including decertification, would further negatively affect our financial condition and results of operations. From time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements.

Facilities with otherwise acceptable regulatory histories generally are given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within nine months, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility's existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously-certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators. In addition, CMS has increased its focus on facilities with a history of serious quality of care problems through the special focus facility initiative. A facility's administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility's compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility “graduates” from the program once it demonstrates significant improvements in quality of care that are continued over time.

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 facilities. We have had several facilities placed on special focus facility status, due largely or entirely to their respective regulatory histories prior to our acquisition of the operations, and have successfully graduated four facilities from the program to date. CMS currently has not included any of our facilities on its special focus facilities listing, however, facilities may be identified for such status in the future.

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

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

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

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

In addition, the Multiple Procedure Payment Reduction (MPPR) was increased from a 25% to 50% reduction applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies are provided on the same day. The implementation of MPPR includes 1) facilities that provide Medicare Part B speech-language pathology, occupational therapy, and physical therapy services and bill under the same provider number; and 2) providers in private practice, including speech-language pathologists, who perform and bill for multiple services in a single day. The change from 25% of the practice expense to a 50% reduction went into effect for Medicare Part B services provided on or after April 1, 2013.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond March 31, 2014, which could also have an adverse effect on our revenue after that date.

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

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

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

- facility and professional licensure, certificates of need, permits and other government approvals;
- adequacy and quality of healthcare services;
- qualifications of healthcare and support personnel;
- quality of medical equipment;
- confidentiality, maintenance and security issues associated with medical records and claims processing;
- relationships with physicians and other referral sources and recipients;

- constraints on protective contractual provisions with patients and third-party payors;
- operating policies and procedures;
- certification of additional facilities by the Medicare program; and
- payment for services.

The laws and regulations governing our operations, along with the terms of participation in various government programs, regulate how we do business, the services we offer, and our interactions with patients and other healthcare providers. These laws and regulations are subject to frequent change. We believe that such regulations may increase in the future and we cannot predict the ultimate content, timing or impact on us of any healthcare reform legislation. Changes in existing laws or regulations, or the enactment of new laws or regulations, could negatively impact our business. If we fail to comply with these applicable laws and regulations, we could suffer civil or criminal penalties and other detrimental consequences, including denial of reimbursement, imposition of fines, temporary suspension of admission of new patients, suspension or decertification from the Medicaid and Medicare programs, restrictions on our ability to acquire new facilities or expand or operate existing facilities, the loss of our licenses to operate and the loss of our ability to participate in federal and state reimbursement programs.

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

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

We are also required to comply with state and federal laws governing the transmission, privacy and security of health information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires us to comply with

certain standards for the use of individually identifiable health information within our company, and the disclosure and electronic transmission of such information to third parties, such as payors, business associates and patients. These include standards for common electronic healthcare transactions and information, such as claim submission, plan eligibility determination, payment information submission and the use of electronic signatures; unique identifiers for providers, employers and health plans; and the security and privacy of individually identifiable health information. In addition, some states have enacted comparable or, in some cases, more stringent 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.

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

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

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

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

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

If any of our 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 facilities could harm our reputation for quality care and lead to a reduction in our patient referrals and ultimately a reduction in occupancy at these facilities. Also, responding to enforcement efforts would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings, regardless of whether we prevail on the underlying claim.

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

- medical necessity of services provided;
- conviction related to fraud;
- conviction relating to obstruction of an investigation;

- conviction relating to a controlled substance;
- licensure revocation or suspension;
- exclusion or suspension from state or other federal healthcare programs;
- filing claims for excessive charges or unnecessary services or failure to furnish medically necessary services;

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

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

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

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

The Office of the Inspector General or other organizations may choose to more closely scrutinize the billing practices of for-profit skilled nursing facilities, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.

In December 2010, the OIG released a report entitled “Questionable Billing by Skilled Nursing Facilities.” The report examined the billing practices of skilled nursing facilities based on Medicare Part A claims from 2006 to 2008 and found, among other things, that for-profit skilled nursing facilities were more likely to bill for higher paying therapy RUGs, particularly in the ultra high therapy categories, than government and not-for-profit operators. It also found that for-profit skilled nursing facilities showed a higher incidence of patients using RUGs with higher activities of daily living (ADL) scores, and had a “long” average length of stay among Part A beneficiaries, compared to their government and not-for-profit counterparts. The OIG recommended that CMS vigilantly monitor overall payments to skilled nursing facilities, adjust RUG rates annually, change the method for determining how much therapy is needed to ensure appropriate payments and conduct additional reviews for skilled nursing operators that exceed certain thresholds for higher paying therapy RUGs. CMS concurred with and agreed to take action on three of the four recommendations, declining only to change the methodology for assessing a patient's therapy needs. The OIG issued a separate memorandum to CMS listing 384 specific facilities that the OIG had identified as being in the top one percent for use of ultra high therapy, RUGs with high ADL scores, or “long” average lengths of stay, and CMS agreed to forward the list to the appropriate fiscal intermediaries or other contractors for follow up. Although we believe our therapy assessment and billing practices are consistent with applicable law and CMS requirements, we cannot predict the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. Two of our 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. Efforts by officials and others to make or advocate for any increase in regulatory monitoring and oversight, adversely change RUG rates, revise methodologies for assessing and treating patients, or conduct more frequent or intense reviews of our treatment and billing practices, could reduce our reimbursement, increase our costs of doing business and otherwise adversely affect our business, financial condition and results of operations.

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

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

- the purchase, construction or expansion of healthcare facilities;

- capital expenditures exceeding a prescribed amount; or

- changes in services or bed capacity.

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

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(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 facilities as well as payor mix and payment methodologies.

Our revenue is affected by the percentage of our patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. For the year ended December 31, 2013, 72.2% of our revenue was provided by government payors that reimburse us at predetermined rates. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of our patients 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 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 our patients and residents 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 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 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 our personnel 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

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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 the Company's competitors. The Company expects the plaintiff's bar to become increasingly aggressive in their pursuit of these staffing and similar claims.
A class action staffing suit was previously filed against the Company in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act at certain of the Company's California facilities. In 2007, the Company settled this class action suit, and the settlement was approved by the affected class and the Court. The Company has been defending a second such staffing class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, are projected to be approximately $6.5 million, of which, approximately $1.5 million of this amount was recorded in the fiscal year ended December 31, 2013, with the balance having been expensed in prior periods. We believe that the settlement will not have a material ongoing adverse effect on the Company’s business, financial condition or results of operations.

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

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

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

could increase, our liability insurance premiums could increase, and our business may be adversely affected.

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

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

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In connection with the settlement and effective as of October 1, 2013, we entered into a five-year corporate integrity agreement with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of our current compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. We are also required to maintain several elements of our existing program during the term of the CIA, including maintaining a compliance officer, a compliance committee of the board of directors, and a code of conduct. The CIA requires that we conduct certain additional compliance-related activities during the term of the CIA, including various training and monitoring procedures, and maintaining a disciplinary process for compliance obligations. Pursuant to the CIA, we are required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that we have committed a crime or have engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by Federal health care programs. We are also subject to periodic reporting and certification requirements attesting that the provisions of the CIA are being implemented and followed, as well as certain document and record retention mandates.

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

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

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

As an operator of healthcare facilities, we have a program to help us comply with various requirements of federal and private healthcare programs. Our compliance program includes, among other things, (1) policies and procedures modeled after applicable laws, regulations, government manuals and industry practices and customs that govern the clinical, reimbursement and operational aspects of our subsidiaries, (2) training about our compliance process for all of our employees, 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 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 skilled nursing facilities in these areas. We continue to monitor the measures implemented for effectiveness, and perform follow-up reviews to ensure compliance. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

If additional reviews result in identification and quantification of additional amounts to be refunded, we would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

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

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

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

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

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

We may not be able to successfully or efficiently integrate new acquisitions with our existing operations, culture and systems. The process of integrating acquired facilities 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 facilities 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 facilities into our existing operations. We may not be able to recover the costs incurred to reposition or renovate newly acquired facilities. 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 facilities 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 facilities we acquire, we will not realize the anticipated benefits and we may experience lower than anticipated profits, or even losses.

During the year ended December 31, 2013, we acquired seven stand-alone skilled nursing facilities, three stand-alone assisted living facilities, three home health operations, three hospice operations and one urgent care center with a total of 652 operational skilled nursing beds and 281 operational assisted living units. During the year ended December 31, 2012, we acquired six facilities and three businesses with a total of 441 operational beds. 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 operations and patient care at 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

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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 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 facility was surveyed by the local state survey agency during the third quarter of 2008 and passed the heightened survey requirements of the special focus facility program. Both facilities have successfully graduated from the Centers for Medicare and Medicaid Services' Special Focus program. We currently have no facilities on special focus facility status.

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 facilities could cause revenue at our facilities to decline.

Most state regulations governing skilled nursing and assisted living facilities require written patient admission agreements with each patient. Several of these regulations also require that each patient have the right to terminate the patient agreement for any reason and without prior notice. Consistent with these regulations, all of our skilled nursing patient agreements allow patients to terminate their agreements without notice, and all of our assisted living resident agreements allow residents to terminate their agreements upon thirty days' notice. Patients and residents terminate their agreements from time to time for a variety of reasons, causing some fluctuations in our overall occupancy as patients and residents are admitted and discharged in normal course. If an unusual number of patients or residents

elected to terminate their agreements within a short time, occupancy levels at our 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 facilities.

The skilled nursing, assisted living, home health and hospice fields are highly competitive, and we expect that these fields may become increasingly competitive in the future. Our 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.

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

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

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

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.

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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 California, and elected non-subscriber status for workers' compensation in Texas. If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, or if the coverage levels we can economically obtain decline, our business may be adversely affected.

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

We have maintained general and professional liability insurance since 2002 and workers' compensation insurance since 2005 through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our SIR and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted.

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

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

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

Our facilities located in California, Texas and Arizona account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since approximately 30% of our 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 facilities in Texas, Nebraska and Iowa are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, tornadoes and flooding. These acts of nature may cause disruption to us, our employees and our facilities, which could have an adverse impact on our patients and our business. In order to

provide care for our patients, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our facilities, and the availability of employees to provide services at our facilities. If the delivery of goods or the ability of employees to reach our facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our 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 our patients and employees, severely damage or destroy one or more of our facilities, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

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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 our employees 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 facilities that have been approached to unionize have uniformly rejected union organizing efforts. If employees decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

The unwillingness on the part of both our management and staff to accede to union demands for “neutrality” and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union actively prosecuted a negative retaliatory publicity action, also known as a “corporate campaign,” against us and filed, promoted or participated in multiple legal actions against us. The union's campaign asserted, among other allegations, poor treatment of patients, inferior medical services provided by our employees, poor treatment of our employees, and health code violations by us. In addition, the union has publicly mischaracterized actions taken by the DHS against us and our 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 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 operations. We continue to anticipate similar criticisms, charges and other negative publicity from such sources on a regular basis, particularly in the current political environment and following the recent December 2010 OIG report entitled “Questionable Billing by Skilled Nursing Facilities," described above in "The Office of the Inspector General or other organizations may choose to more closely scrutinize the billing practices of for-profit skilled nursing facilities, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations." Two of our facilities have been listed on the report. Such reports provide unions and their allies with additional opportunities to make negative statements about, and to encourage regulators to seek investigatory and enforcement actions against, the industry in general and non-union operators like us specifically. Although we believe that our operations and business practices substantially conform to applicable laws and regulations, we cannot predict the extent to which we might be subject to adverse publicity or calls for increased regulatory scrutiny from union and union ally sources, or what effect, if any, such negative publicity would have on us, but to the extent they are successful, our revenue may be reduced, our costs may be increased and our profitability and business could be adversely affected.

This union has also attempted to pressure hospitals, doctors, insurers and other healthcare providers and professionals to cease doing business with or referring patients to us. If this union or another union is successful in convincing our patients, 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 facilities. If proponents of these and similar laws are successful in facilitating unionization procedures or hindering employer responses thereto, our ability to oppose unionization efforts could be hindered, and our business could be negatively affected.

A number of our facilities are operated under master lease arrangements or leases that contain cross-default provisions, and in some cases the breach of a single facility lease could subject multiple facilities to the same risk.

We currently occupy approximately 6% of our facilities under agreements that are structured as master leases. Under a master lease, we may lease a large number of geographically dispersed properties through an indivisible lease. 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. Failure to comply with Medicare or Medicaid provider requirements is a default under several of our master lease 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, which would have a negative impact on our capital structure and our ability to generate future revenue, and could interfere with our ability to pursue our growth strategy.

In addition, we occupy approximately 7% of our facilities under individual facility leases that are held by the same or related landlords, the largest of which covers five of our facilities. These leases typically contain cross-default provisions that could cause a default at one facility to trigger a technical default with respect to one or more other locations, potentially subjecting us to the various remedies available to the landlords under each of the related leases.

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 operations and cause us to lose facilities or experience foreclosures.

At December 31, 2013, we had $260.0 million of outstanding indebtedness under the Senior Credit Facility, Ten Project Note, promissory notes, bonds and mortgage notes, plus $139.6 million of operating lease obligations. We intend to continue financing our facilities through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

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

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 operations, many of which are beyond our control. If we are unable to generate sufficient cash flow from operations in the future to service our debt or to make lease payments on our operating leases, we may be required, among other things, to seek additional financing in the debt or equity markets, refinance or restructure all or a portion of our indebtedness, sell selected assets, reduce or delay planned capital

expenditures or delay or abandon desirable acquisitions. Such measures might not be sufficient to enable us to service our debt or to make lease payments on our operating leases. The failure to make required payments on our debt or operating leases or the delay or abandonment of our planned growth strategy could result in an adverse effect on our future ability to generate revenue and sustain profitability. In addition, any such financing, refinancing or sale of assets might not be available on terms that are economically favorable to us, or at all.

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

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

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

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

We may need additional capital to fund our operations 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 facilities and equipment in a suitable condition to meet regulatory standards, operate efficiently and remain competitive in our markets requires us to commit substantial resources to continued investment in our 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.

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

Delays in reimbursement may cause liquidity problems.

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

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

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

Two of our facilities are currently subject to regulatory agreements with the Department of Housing and Urban Development (HUD) that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection. The re-inspection occurred in the fourth quarter of 2009 and the facility passed its HUD re-inspection. Compliance with HUD's requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state

agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

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

Our operations 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.

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Our facilities generate infectious or other hazardous medical waste due to the illness or physical condition of the patients. Each of our 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 operations 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 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 facilities we lease, own or may acquire may lead to the incurrence of costs for remediation, mitigation or the implementation of an operations and maintenance plan and may result in third party litigation for personal injury or property damage. Furthermore, in some circumstances, areas affected by mold may be unusable for periods of time for repairs, and even after successful remediation, the known prior presence of extensive mold could adversely affect the ability of a facility to retain or attract patients and staff and could adversely affect a facility's market value and ultimately could lead to the temporary or permanent closure of the facility.

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

In addition, because environmental laws vary from state to state, expansion of our operations to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our 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 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. In 2005 we became aware of two separate and unrelated instances of employees misappropriating an aggregate of approximately $0.4 million in patient trust funds, some of which was recovered from the employees and some of which we were required to reimburse from our funds. 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 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.

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

We are subject to both state and federal income taxes. Our effective tax rate could be adversely affected by changes in the mix of earnings in states with different statutory tax rates, changes in the valuation of deferred tax assets and liabilities, changes in tax laws and regulations, changes in our interpretations of tax laws, including pending tax law changes. In addition, in certain cases more than one state in which we operate has indicated an intent to attempt to tax the same assets and activities, which could result in double taxation if successful. Unanticipated changes in our tax rates or exposure to additional income tax liabilities could affect our profitability.
We are subject to the continuous examination of our income tax returns by the Internal Revenue Service and other local, state and foreign tax authorities. We regularly assess the likelihood of outcomes resulting from these examinations to determine the adequacy of our estimated income tax liabilities. The outcomes from these continuous examinations could adversely affect our provision for income taxes and estimated income tax liabilities.
The proposed Spin-Off transaction may not be completed on the terms contemplated, or at all, may not result in the benefits expected, will result in costs whether or not completed, or distract our management.

On November 7, 2013, we announced a proposed plan to separate our healthcare business and our real estate business into two separate, publicly traded companies through the proposed Spin-Off. The Spin-Off is a complex transaction, and its completion will require significant time, effort and expense. This could distract management from the day-to-day operations of our business, which could adversely affect our operations. The completion of the Spin-Off is subject to a number of conditions, and there is no assurance that the conditions will be satisfied and that the Spin-Off will be completed. In addition, we reserve the right to abandon, defer or modify the Spin-off at any time if our board of directors so determines. If the Spin-Off is completed, it is possible that, due to unforeseen changes in market or economic conditions, or other events or circumstances, the two resulting companies may not achieve the full strategic and operational benefits expected from the Spin-Off, which could result in the combined market value of the stock of both companies being less than the market value of our common stock if the Spin-Off had not occurred. If the Spin-Off is not completed for any reason, the market price of our common stock may decline to the extent that the market price at that time reflects a market assumption that the Spin-Off will be completed. Whether or not the Spin-Off is completed, we will incur costs related to the transaction, including legal and accounting fees and certain fees payable to our financial advisors.

Risks Related to Ownership of our Common Stock

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

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

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

Our current executive officers, directors and their affiliates, if they act together, will have substantial influence over the outcome of corporate actions requiring stockholder approval, including the election of directors, any merger,

consolidation or sale of all or substantially all of our assets or any other significant corporate transactions. The significant concentration of stock ownership may adversely affect the trading price of our common stock due to investors' perception that conflicts of interest may exist or arise.

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

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

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

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

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

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

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

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

Testing and maintaining internal controls can divert our management's attention from other matters that are important to our business. We may not be able to conclude on an ongoing basis that we have effective internal controls over financial reporting in accordance with Section 404 or our independent registered public accounting firm may not be able or willing to issue an unqualified report if we conclude that our internal controls over financial reporting are not

effective. If either we are unable to conclude that we have effective internal controls over financial reporting or our independent registered public accounting firm is unable to provide us with an unqualified report as required by Section 404, investors could lose confidence in our reported financial information and our company, which could result in a decline in the market price of our common stock, and cause us to fail to meet our reporting obligations in the future, which in turn could impact our ability to raise additional financing if needed in the future.

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

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

- our board of directors are authorized, without prior stockholder approval, to create and issue preferred stock, commonly referred to as “blank check” preferred stock, with rights senior to those of common stock;
- advance notice requirements for stockholders to nominate individuals to serve on our board of directors or to submit proposals that can be acted upon at stockholder meetings;
- our board of directors are classified so not all members of our board are elected at one time, which may make it more difficult for a person who acquires control of a majority of our outstanding voting stock to replace our directors;
- stockholder action by written consent is limited;
- 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.

On November 7, 2013, we adopted a stockholder rights plan, which could make it more difficult for a third party to acquire, or could discourage a third party from acquiring, 9.8% or more of our outstanding common stock. A third party that acquires 9.8% or more of our common stock could suffer substantial dilution of its ownership interest under the terms of the stockholder rights plan through the issuance of our common stock or other securities to all stockholders other than the acquiring person.

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

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

We may experience cyber attacks, and as a result, unauthorized parties may obtain access to our computer systems and networks. Such cyber attacks could result in the misappropriation of our proprietary information and technology or interrupt our business. The reliability and security of our information technology infrastructure is critical to our business. To the extent that any disruptions or security breaches result in significant loss or damage to our data, or inappropriate disclosure of significant proprietary information, it could cause damage to our reputation and affect our relationships with our residents and ultimately harm our business.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

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

Facilities. As of December 31, 2013, we operated 119 facilities in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington, with the operational capacity to serve approximately 13,000 residents. Of the 119 facilities that we operated, we owned 96 facilities and leased 23 facilities pursuant to operating leases, two of which contain purchase options that provide us with the right to purchase or agreements to purchase the facility in the future. We currently do not manage any facilities for third parties, except on a short-term basis pending receipt of new operating licenses by our operating subsidiaries.

The following table provides summary information regarding the number of operational beds at our facilities at December 31, 2013:

State	Leased without a Purchase Option	Purchase Agreement or Leased with a Purchase Option	Owned	Total Operational Beds
California	1,510	414	2,049	3,973
Arizona	575	—	1,327	1,902
Texas	112	—	3,241	3,353
Utah	108	—	1,305	1,413
Colorado	42	—	463	505
Washington	—	—	555	555
Idaho	—	—	477	477
Nevada	—	—	304	304
Nebraska	—	—	366	366
Iowa	—	—	356	356
Total	2,347	414	10,443	13,204
Skilled nursing	2,347	344	8,433	11,124
Assisted living	—	70	1,533	1,603
Independent living	—	—	477	477
Total	2,347	414	10,443	13,204

Item 3. Legal Proceedings

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

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

Cost-Containment Measures — Both government and private pay sources have instituted cost-containment measures designed to limit payments made to providers of healthcare services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect us.

Income Tax Examinations — During the first quarter of 2012, the State of California initiated an examination of our income tax returns for the 2008 and 2009 income tax years. The examination is primarily focused on the Captive and the treatment of related insurance matters. To date, California has not proposed any adjustments. We are not currently under examination by any other major income tax jurisdiction. During 2013, the statute of limitations has lapsed on our 2009 Federal tax year and will lapse on certain 2008 and 2009 state tax years during the fourth quarter. The lapse of the Federal statute had no significant impact on

the balance of unrecognized tax benefits. We do not believe the state statute lapses, the California examination, or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. See Note 14, Income Taxes.

Indemnities — From time to time, we enter into certain types of contracts that contingently requires us to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which we may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from our use of the applicable premises, (ii) operations transfer agreements, in which we agree to indemnify past operators of facilities we acquire against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain lending agreements, under which we may be required to indemnify the lender against various claims and liabilities, (iv) agreements with certain lenders under which we may be required to indemnify such lenders against various claims and liabilities, and (v) certain agreements with our officers, directors and employees, under which we may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on our balance sheets for any of the periods presented.

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

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

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

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

A class action staffing suit was previously filed against us in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act at certain of our California facilities. In 2007, we settled this class action suit, and the settlement was approved by the affected class and the Court. We have been defending a second such staffing class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, are projected to be approximately $6.5 million, of which, approximately $1.5 million of this amount was recorded during the year ended December 31, 2013, with the balance having been expensed in prior periods. We believe that the settlement will not have a material ongoing adverse effect on our business, financial condition or results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect our business, financial condition, results of operations and cash flows.
We 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 care and treatment provided at our facilities as well as employment related claims. We do not believe that the ultimate resolution of these actions will have a material adverse effect on our business, cash flows, financial condition or results of operations. A significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, could materially adversely affect our business, financial condition, results of operations and cash flows.

We cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and we are subjected to, alleged to be liable for, or agrees to a settlement of, claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, our business, financial condition and results of operations and cash flows could be materially and adversely affected and 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.
Medicare Revenue Recoupments — We are subject to reviews relating to Medicare services, billings and potential overpayments. We have one operation subject to probe review during the year ended December 31, 2013. We anticipate that these probe reviews will increase in frequency in the future. Further, we currently have no facilities on prepayment review; however, others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. We have no facilities that are currently undergoing targeted review.

U.S. Government Inquiry — In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. We, through our outside counsel and a special committee of independent directors established by its board, worked cooperatively with the U.S. Attorney's office to produce information requested by the government as part of an ongoing dialogue designed to resolve the issue.

In December 2011, the DOJ notified us that it had closed its criminal investigation without action although, as is typical, it reserved the right to reopen the criminal case if new facts came to light. This left only the civil investigation to resolve, and we continued to supply requested information to the DOJ and the Office of the Inspector General of the United States Department of Health and Human Services (HHS), including specific patient records and documents from 2007 to 2011 from six Southern California skilled nursing facilities that had been the subject of previous requests.

In early 2013, discussions between government representatives and our special committee, its outside counsel and their experts had advanced sufficiently that we recorded an initial estimated liability in the amount of $15.0 million in the fourth quarter of 2012 for the resolution of claims connected to the investigation. In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of $33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to $48.0 million (the Reserve Amount).

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In October 2013, we completed and executed a settlement agreement (the Settlement Agreement) with the DOJ and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. 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 with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of our current compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. We are also required to maintain several elements of our existing program during the term of the CIA, including maintaining a compliance officer, a compliance committee of the board of directors, and a code of conduct. The CIA requires that we conduct certain additional compliance-related activities during the term of the CIA, including various training and monitoring procedures, and maintaining a disciplinary process for compliance obligations. Pursuant to the CIA, we are required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that we have committed a crime or have engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by Federal health care programs. We are also subject to periodic reporting and certification requirements attesting that the provisions of the CIA are being implemented and followed, as well as certain document and record retention mandates.

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

Item 4. Mine Safety Disclosures

None.

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PART II.

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

Market Information

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

	High	Low
Fiscal 2012		
First Quarter	$29.73	$24.01
Second Quarter	$28.71	$23.40
Third Quarter	$30.76	$26.53
Fourth Quarter	$31.25	$24.97
Fiscal 2013		
First Quarter	$33.70	$27.54
Second Quarter	$38.08	$31.57
Third Quarter	$42.26	$35.24
Fourth Quarter	$46.39	$39.60

During fiscal 2013, we declared aggregate cash dividends of $0.265 per share of common stock, for a total of approximately $5.9 million.

As of February 10, 2014, there were approximately 230 holders of record of our common stock.

The graph below shows the cumulative total stockholder return of an investment of $100 (and the reinvestment of any dividends thereafter) on December 31, 2008 in (i) our common stock, (ii) the Skilled Nursing Facilities Peer Group 1 and (iii) the NASDAQ Market Index. Our stock price performance shown in the graph below is not indicative of future stock price performance.

COMPARISON OF 60 MONTH CUMULATIVE TOTAL RETURN*
Among Ensign Group, the NASDAQ Composite Index
and a Peer Group
*$100 invested on 12/31/08 in stock in index, including reinvestment of dividends.
Fiscal year ending December 31.

Comparison of 60 month cumulative total return among The Ensign Group, Inc., NASDAQ Market Index, Skilled Nursing Facilities

	December 31,					
	2008	2009	2010	2011	2012	2013
The Ensign Group, Inc.	$100.00	$93.05	$152.25	$151.32	$169.20	$277.92
NASDAQ Market Index	$100.00	$145.34	$171.70	$170.34	$200.57	$281.14
Peer Group	$100.00	$90.13	$127.89	$105.17	$126.22	$156.74

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

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

Dividend Policy

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

	Dividend per Share	Aggregate Dividend Declared (in thousands)
2012		
First Quarter	$0.060	$1,292
Second Quarter	$0.060	$1,298
Third Quarter	$0.060	$1,306
Fourth Quarter	$0.065	$1,424
2013		
First Quarter	$0.065	$1,437
Second Quarter	$0.065	$1,438
Third Quarter	$0.065	$1,443
Fourth Quarter	$0.070	$1,564

We do not have a formal dividend policy but we currently intend to continue to pay regular quarterly dividends to the holders of our common stock. From 2002 to 2013, we paid aggregate annual dividends equal to approximately 5% to 15% of our net income, after adjusting for the charge related to the U.S. Government inquiry settlement of $33.0 million and $15.0 million in fiscal years ended December 31, 2013 and 2012, respectively. However, future dividends will continue to be at the discretion of our board of directors, and we may or may not continue to pay dividends at such rate. We expect that the payment of dividends will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. The senior credit facility agreement governing our revolving line of credit with a lending consortium arranged by SunTrust and Wells Fargo restricts our subsidiaries and our ability to pay dividends to stockholders in excess of 20% of consolidated net income, or at all if we receive notice that we are in default under this agreement. In addition, we are a holding company with no direct operating assets, employees or revenues. As a result, we are dependent upon distributions from our independent subsidiaries to generate the funds necessary to meet our financial obligations and pay dividends. It is possible that in certain quarters, we may pay dividends that exceed our net income for such period as calculated in accordance with U.S. generally accepted accounting principles.

Issuer Repurchases of Equity Securities

Common Stock Repurchase Program. In the fourth quarter of 2012, the board of directors authorized the renewal of our common stock repurchase program, authorizing the repurchase of up to $10.0 million of our common stock over the next 12 months. Under this program, we are authorized to repurchase our 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, including Rule 10b-18 promulgated under the Securities Exchange Act of 1934 as amended.

The number of shares repurchased will depend entirely upon the levels of cash available, the attractiveness of alternate investment and business opportunities either at hand or on the horizon, Management's perception of value relative to

market price and other legal, regulatory and contractual requirements. The repurchase program does not obligate us to repurchase any particular dollar amount or number of shares of common stock. The repurchase program expired on November 15, 2013. During the year ended December 31, 2013, we did not repurchase any shares of our common stock. During the year ended December 31, 2012, we repurchased 7,340 shares of our common stock for a total of $0.2 million.

Item 6. Selected Financial Data

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

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In thousands, except per share data)				
Revenue	$904,556	$823,155	$758,277	$649,532	$542,002
Expense:					
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	725,989	656,424	600,804	516,668	434,318
Charge related to U.S. Government inquiry	33,000	15,000	—	—	—
Facility rent - cost of services	13,613	13,281	13,725	14,478	14,703
General and administrative expense	40,103	31,819	29,766	26,099	20,767
Depreciation and amortization	33,909	28,358	23,286	16,633	13,276
Total expenses	846,614	744,882	667,581	573,878	483,064
Income from operations	57,942	78,273	90,696	75,654	58,938
Other income (expense):					
Interest expense	(12,787)	(12,229)	(13,778)	(9,123)	(5,691)
Interest income	506	255	249	248	279
Other expense, net	(12,281)	(11,974)	(13,529)	(8,875)	(5,412)
Income before provision for income taxes	45,661	66,299	77,167	66,779	53,526
Provision for income taxes	20,003	25,134	29,492	26,253	21,040
Income from continuing operations	25,658	41,165	47,675	40,526	32,486
Loss from discontinued operations	(1,804)	(1,357)	—	—	—
Net income	$23,854	$39,808	$47,675	$40,526	$32,486
Less: net loss attributable to noncontrolling interests	(186)	(783)	—	—	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675	$40,526	$32,486
Amounts attributable to The Ensign Group, Inc.:					
Income from continuing operations attributable to The Ensign Group, Inc.	$25,844	$41,948	$47,675	$40,526	$32,486
Loss from discontinued operations, net of income tax	(1,804)	(1,357)	—	—	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675	$40,526	$32,486
Net income per share[1]:					
Basic:					
Income from continuing operations attributable to The Ensign Group, Inc.	$1.18	$1.96	$2.27	$1.95	$1.58
Loss from discontinued operations [2]	(0.08)	(0.07)	—	—	—
Net income attributable to The Ensign Group, Inc.	$1.10	$1.89	$2.27	$1.95	$1.58
Diluted:					
Income from continuing operations attributable to The Ensign Group, Inc.	$1.16	$1.91	$2.21	$1.92	$1.55
Loss from discontinued operations [2]	(0.09)	(0.06)	—	—	—
Net income attributable to The Ensign Group, Inc.	$1.07	$1.85	$2.21	$1.92	$1.55
Weighted average common shares outstanding:					
Basic	21,900	21,429	20,967	20,744	20,603
Diluted	22,364	21,942	21,583	21,159	20,925

(1) See Note 5 of Notes to Consolidated Financial Statements.
(2) See Note 4 of Notes to Consolidated Financial Statements.

	Years Ended December 31,		
	2013	2012	2011
	(In thousands)		
Other Non-GAAP Financial Data:			
EBITDA[1]	$92,037	$107,414	$113,982
Adjusted EBITDA[1][2]	136,741	131,427	115,978
EBITDAR[1]	105,650	120,695	127,707
Adjusted EBITDAR[1][2]	149,345	143,848	129,703

(1) EBITDA, EBITDAR, Adjusted EBITDA and Adjusted EBITDAR are supplemental non-GAAP financial measures. Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Securities Exchange Act of 1934, as amended, define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income from continuing operations, adjusted for net losses attributable to noncontrolling interest, before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude facility rent—cost of services. These non-GAAP financial measures are used in addition to and in conjunction with results presented in accordance with GAAP. These non-GAAP financial measures should not be relied upon to the exclusion of GAAP financial measures. These non-GAAP financial measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

We believe EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR are useful to investors and other external users of our financial statements in evaluating our operating performance because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall operating performance of companies in our industry without regard to items such as interest expense, net and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets, capital structure and the method by which assets were acquired; and
- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our capital structure and asset base from our operating results.

We use EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR:

- as measurements of our operating performance to assist us in comparing our operating performance on a consistent basis;
- to allocate resources to enhance the financial performance of our business;
- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We typically use EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR to compare the operating performance of each operation. These measures are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, and, with respect to EBITDAR, facility rent — cost of services, which may vary from period-to-period depending upon various factors, including the method used to finance facilities, the amount of debt that we have incurred, whether a facility is owned or leased, the date of acquisition of a facility or business, and the tax law of the state in which a business unit operates. As a result, we believe that the use of these measures provide a meaningful and consistent comparison of our business between periods by eliminating certain items required by GAAP.

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

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

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;
- they do not reflect changes in, or cash requirements for, our working capital needs;
- they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- they do not reflect any income tax payments we may be required to make;
- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and EBITDA and EBITDAR do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

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

Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these non-GAAP financial measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. For information about our financial results as reported in accordance with GAAP, see our consolidated financial statements and related notes included elsewhere in this document.

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

- Charges related to the DOJ settlement;
- Expenses incurred in connection with the Company's proposed spin-off of real estate assets in a newly formed publicly traded real estate investment trust (REIT);
- Legal costs incurred in connection with the DOJ settlement;
- Settlement of a class action lawsuit regarding minimum staffing requirements in the State of California.
- Impairment charges
- Losses incurred by our newly opened urgent care centers;
- Losses incurred by one newly constructed skilled nursing facility;
- Acquisition-related costs; and
- Costs incurred to recognize income tax credits.

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

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

	Years Ended December 31,				
	2013	2012	2011	2010	2009
	(In thousands)				
Consolidated statements of income Data:					
Net income	$23,854	$39,808	$47,675	$40,526	$32,486
Net loss attributable to noncontrolling interests	186	783	—	—	—
Loss from discontinued operations	1,804	1,357	—	—	—
Interest expense, net	12,281	11,974	13,529	8,875	5,412
Provision for income taxes	20,003	25,134	29,492	26,253	21,040
Depreciation and amortization	33,909	28,358	23,286	16,633	13,276
EBITDA	$92,037	$107,414	$113,982	$92,287	$72,214
Facility rent—cost of services	13,613	13,281	13,725	14,478	14,703
EBITDAR	$105,650	$120,695	$127,707	$106,765	$86,917
EBITDA	$92,037	$107,414	$113,982	$92,287	$72,214
Charge related to the U.S. Government inquiry[(a)]	33,000	15,000	—	—	—
Expenses related to the Spin-Off[(b)]	4,050	—	—	—	—
Legal costs[(c)]	1,098	1,945	1,544	—	—
Settlement of class action lawsuit[(d)]	1,524	2,596	—	—	—
Impairment of goodwill and other indefinite-lived intangibles [(j)]	490	2,225	—	185	—
Urgent care center losses[(e)]	1,844	546	—	—	—
Losses at skilled nursing facility not at full operation[(f)]	1,256	—	—	—	—
Acquisition related costs[(g)]	288	250	452	150	349
Costs incurred to recognize income tax credits[(h)]	145	591	—	—	—
Rent related to items (e) and (f) above[(i)]	1,009	860	—	—	—
Adjusted EBITDA	$136,741	$131,427	$115,978	$92,622	$72,563
Facility rent—cost of services	13,613	13,281	13,725	14,478	14,703
Less: rent related to items (e) and (f) above(i)	(1,009)	(860)	—	—	—
Adjusted EBITDAR	$149,345	$143,848	$129,703	$107,100	$87,266

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

(b) Expenses incurred in connection with the Company's proposed spin-off of its real estate assets to a newly formed publicly traded real estate investment trust (REIT).

(c) Legal costs incurred in connection with the DOJ settlement.

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

(e) Losses incurred at newly opened urgent care centers, excluding rent, depreciation, interest and income taxes.

(f) Losses incurred through the second quarter at one newly constructed skilled nursing facility which began operations during the first quarter of 2013, excluding rent, depreciation, interest and income taxes. The facility began running at full capacity during the third quarter of 2013, and therefore, results for the third and fourth quarters were not included in the results above.

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

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

(i) Rent related to newly opened urgent care centers and one newly constructed skilled nursing facility which began operations during the first quarter of 2013, not included in items (e) and (f) above.

(j)

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

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Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations

The following discussion should be read in conjunction with the consolidated financial statements and accompanying notes, which appear elsewhere in this Annual Report. This discussion contains forward-looking statements that involve risks and uncertainties. Our actual results could differ materially from those anticipated in these forward-looking statements as a result of various factors, including those discussed below and elsewhere in this Annual Report. See Item 1A. - “Risk Factors” and "Cautionary Note Regarding Forward-Looking Statements."

Overview

We, through our subsidiaries, provide skilled nursing and rehabilitative care services through the operation of 119 facilities, nine home health and seven hospice operations, seven urgent care centers and a mobile x-ray and diagnostic company as of December 31, 2013, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. Our operations, each of which strives to be the operation of choice in the community it serves, provides a broad spectrum of healthcare services including skilled nursing, assisted living, home health and hospice, mobile ancillary, and urgent care services. Our facilities have a collective capacity of approximately 13,200 operational skilled nursing, assisted living and independent living beds. As of December 31, 2013, we owned 96 of its 119 facilities and operated an additional 23 facilities through long-term lease arrangements, and had options to purchase two of those 23 facilities.

The following table summarizes our facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of December 31, 2013:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	96	2	21	119
Percent of total	80.7 %	1.7 %	17.6 %	100.0 %
Operational skilled nursing, assisted living and independent living beds	10,443	414	2,347	13,204
Percent of total	79.1 %	3.1 %	17.8 %	100.0 %

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. All of our skilled nursing, assisted living and home health and hospice operations are operated by separate, wholly-owned, independent subsidiaries, which have their own management, employees and assets. In addition, one of our wholly-owned independent subsidiaries, which we call our Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other services to each operating subsidiary through contractual relationships between such subsidiaries. In addition, we have the Captive that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as for certain workers’ compensation insurance liabilities. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar verbiage in this annual report is not meant to imply that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by the same entity.

Recent Developments

Real Estate Investment Trust (REIT) Spin-Off — On November 7, 2013, we announced a plan to separate our healthcare business and real estate business into two separate, publicly traded companies:

- Ensign, which will continue to provide healthcare services through its existing operations; and
- CareTrust REIT, Inc. (CareTrust), which will own, acquire and lease real estate serving the healthcare industry.

We intend to accomplish the proposed separation by distributing all of the outstanding shares of CareTrust common stock to our stockholders on a pro rata basis (the Spin-Off). At the time of the Spin-Off, CareTrust, which is currently a wholly-owned subsidiary of ours, will hold substantially all of the real property owned by us, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for three independent living facilities that CareTrust will operate) will be leased to us on a triple-net basis, under which we will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

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The proposed Spin-Off is conditioned on, among other things, final approval by our board of directors, the receipt of a ruling from the IRS that, among other things, the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes, the receipt of an opinion of counsel as to the satisfaction of certain requirements for such tax-free treatment, and the receipt of an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014, CareTrust has been organized in conformity with the requirements for qualification as a REIT under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

U.S. Government Inquiry Settlement — In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of $33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to $48.0 million (the Reserve Amount).

In October 2013, we completed and executed a settlement agreement (the Settlement Agreement) with the DOJ and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. 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 with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of our current compliance program, and requires that we continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. Our participation in federal healthcare programs is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in federal healthcare programs and/or subject to prosecution. See further details of the CIA at Note 19, Commitments and Contingencies of Notes to Consolidated Financial Statements.

Urgent Care Franchising — On March 25, 2013 we announced that our urgent care subsidiary, Immediate Clinic Healthcare, Inc., agreed to terms to sell Doctors Express, a national urgent care franchise system. The sale of specific assets and liabilities of Doctors Express was finalized on April 15, 2013. In accordance with the authoritative guidance for the disposal of long-lived asset, the sale of Doctors Express has been accounted for as discontinued operations. Accordingly, the results of operations of this business for all periods presented and the loss or impairment related to this divesture have been classified as discontinued operations in the accompanying consolidated statements of income. As the sale was effective April 15, 2013, all assets and liabilities included in the sale were recorded as held for sale on our accompanying consolidated balance sheets as of December 31, 2012. See Note 4, Discontinued Operations in Notes to consolidated Financial Statements.

Facility Acquisition History

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of December 31, 2013:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	Total
Number of facilities	36	13	27	12	6	6	6	3	5	5	119
Operational skilled nursing, assisted living and independent living beds	3,973	1,902	3,353	1,413	505	555	477	304	366	356	13,204

During the first quarter of 2013, we acquired a three home health operations in Washington and Texas, three hospice operations in Arizona, California and Washington, respectively, and one skilled nursing facility in Texas, in six separate transactions, for an aggregate purchase price of approximately $10.6 million, which was paid in cash. The skilled nursing facility acquisition added 150 operational skilled nursing beds to our operations. The home health and hospice acquisitions did not have an impact on our operational bed count.
During the second quarter of 2013, we acquired five skilled nursing facilities in Texas, Nebraska and Washington and three assisted living facilities in Washington, California and Utah in five separate transactions for an aggregate purchase price of approximately $28.7 million, which was paid in cash. These acquisitions added 460 operational skilled nursing beds and 281 operational assisted living units to our operations.

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During the third quarter of 2013, we acquired a skilled nursing facility and an urgent care center in Washington for approximately $6.1 million, which was paid in cash. The skilled nursing acquisition added 82 operational skilled nursing beds to our operations. The urgent care center acquisition did not have an impact on our bed count.
We also entered into a separate operations transfer agreement with the prior tenant as part of each transaction noted above. See further discussion of facility acquisitions in Note 8, Acquisitions in Notes to Consolidated Financial Statements.

Key Performance Indicators

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

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

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

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

	Year Ended December 31,		
	2013	2012	2011
Skilled Mix:			
Days	26.4 %	25.9 %	25.5 %
Revenue	50.0 %	50.0 %	51.3 %
Quality Mix:			
Days	40.1 %	39.1 %	38.1 %
Revenue	59.5 %	59.5 %	60.1 %

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

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

	Year Ended December 31,		
	2013	2012	2011
Occupancy:			
Operational beds at end of period	13,204	12,198	11,702
Available patient days	4,710,768	4,371,034	3,945,511
Actual patient days	3,648,651	3,452,598	3,124,724
Occupancy percentage (based on operational beds)	77.5 %	79.0 %	79.2 %

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Revenue Sources

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

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

	Years Ended December 31,								
	2013			2012			2011		
	$	%		$	%		$	%	
	(Dollars in thousands)								
Revenue:									
Medicaid	$323,803	35.8	%	$302,046	36.7	%	$277,736	36.6	%
Medicare	292,917	32.4		278,578	33.8		272,283	35.9	
Medicaid-skilled	36,085	4.0		25,418	3.1		20,290	2.7	
Total	652,805	72.2		606,042	73.6		570,309	75.2	
Managed Care	118,168	13.1		106,268	12.9		94,266	12.4	
Private and Other(1)	133,583	14.7		110,845	13.5		93,702	12.4	
Total revenue	$904,556	100.0	%	$823,155	100.0	%	$758,277	100.0	%

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

Primary Components of Expense

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Our cost of services represents the costs of operating our facilities and primarily consists of payroll and related benefits, supplies, purchased services, and ancillary expenses such as the cost of pharmacy and therapy services provided to residents. Cost of services also includes the cost of general and professional liability insurance and other general cost of services with respect to our operations.

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

General and Administrative Expense. General and administrative expense consists primarily of payroll and related benefits and travel expenses for our Service Center personnel, including training and other operational support. General and administrative expense also includes professional fees (including accounting and legal fees), costs relating to our information systems, stock-based compensation and rent for our Service Center office.

Depreciation and Amortization. Property and equipment are recorded at their original historical cost. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets. The following is a summary of the depreciable lives of our depreciable assets:

Buildings and improvements	Minimum of three years to a maximum of 57 years, generally 45 years
Leasehold improvements	Shorter of the lease term or estimated useful life, generally 5 to 15 years
Furniture and equipment	3 to 10 years

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Critical Accounting Policies

Our discussion and analysis of our financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with accounting principles generally accepted in the United States. The preparation of these financial statements and related disclosures requires us to make judgments, estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. On an ongoing basis we review our judgments and estimates, including, but not limited to, those related to doubtful accounts, income taxes, stock compensation, intangible assets and loss contingencies. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty and actual results could differ materially from the amounts reported. The following summarizes our critical accounting policies, defined as those policies that we believe: (a) are the most important to the portrayal of our financial condition and results of operations; and (b) require management's most subjective or complex judgments, often as a result of the need to make estimates about the effects of matters that are inherently uncertain.

Revenue Recognition

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

Revenue from Medicare and Medicaid programs account for 72.2%, 73.6% and 75.2% of our revenue for the years ended December 31, 2013, 2012, and 2011, respectively. We record revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. Our revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. We recorded retroactive adjustments to revenue which were not material to our consolidated revenue for the years ended December 31, 2013, 2012 and 2011.

Our service specific revenue recognition policies are as follows:

Skilled Nursing Revenue

Our revenue is derived primarily from providing long-term healthcare services to residents and is recognized on the date services are provided at amounts billable to individual residents. For residents under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts on a per patient, daily basis. We record revenue from private pay patients, at the agreed-upon rate, as services are performed.

Home Health Revenue

Medicare Revenue

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

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

In addition to revenue recognized on completed episodes,we also recognize a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. Thereby, estimating revenue and recognizing it on a daily basis.

Non-Medicare Revenue

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

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

Hospice Revenue

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

Accounts Receivable and Allowance for Doubtful Accounts

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

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

Self-Insurance

We are partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for us. For claims made after January 1, 2013, the self-insured retention was $0.5 million per claim, subject to an additional one-time deductible of $1.0 million for California facilities and a separate, one-time deductible of $0.8 million for non-California facilities. For all facilities, except those located in Colorado, the third-party coverage above these amounts was $1.0 million per claim, $3.0 million per facility, with a $5.0 million blanket aggregate available to both California and non-California operations separately. In Colorado, the third-party coverage above these limits was $1.0 million per claim and $3.0 million per facility, which is independent of the aforementioned blanket aggregate applicable to our other 113 facilities.

The self-insured retention and deductible limits for general and professional liability and workers' compensation are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying consolidated balance sheets. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. Our policy is to accrue amounts equal to the actuarially estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. We develop information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis.

Our operating subsidiaries are self-insured for workers' compensation liability in California. To protect ourself against loss exposure in California with this policy, we purchased individual stop-loss insurance coverage that insures individual claims that exceed $0.5 million for each occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers' compensation claims and, effective February 1, 2011, we purchased individual stop-loss coverage that insures individual claims

that exceed $0.8 million for each occurrence. Our operating subsidiaries in other states have third party guaranteed cost coverage. In California and Texas, we accrue amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. We use actuarial valuations to estimate the liability based on historical experience and industry information.

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

We believe that adequate provision has been made in the consolidated balance sheets for liabilities that may arise out of patient care, workers' compensation, healthcare benefits and related services provided to date. The amount of our reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, with the assistance of an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damage awards with respect to unpaid claims. The self-insured liabilities are based upon estimates, and while management believes that the estimates of loss are reasonable, the ultimate liability may be in excess of or less than the recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that we could experience changes in estimated losses that could be material to net income. If our 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 our assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. We generally expect to fully utilize our deferred tax assets; however, when necessary, we record a valuation allowance to reduce our net deferred tax assets to the amount that is more likely than not to be realized.

When we take uncertain income tax positions that do not meet the recognition criteria, we record a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, we must consider the potential outcomes from a review of the positions by the taxing authorities.

In determining the need for a valuation allowance, the annual income tax rate, or the need for and magnitude of liabilities for uncertain tax positions, we make certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with our estimates and assumptions, actual results could differ.

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 our consolidated balance sheets. We present the noncontrolling interest and the amount of consolidated net income attributable to The Ensign Group, Inc. in our 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.

Derivatives and Hedging Activities

We evaluate variable and fixed interest rate risk exposure on a routine basis and to the extent we believe that it is appropriate, we will offset most of our variable risk exposure by entering into interest rate swap agreements. It is our policy to only utilize derivative instruments for hedging purposes (i.e. not for speculation). We formally designate our interest rate swap agreements as hedges and document all relationships between hedging instruments and hedged items. We formally assess the effectiveness of our hedging relationships, both at the hedge inception and on an ongoing basis, then measure and record ineffectiveness. We would discontinue hedge accounting prospectively (i) if it is determined that the derivative is no longer effective in offsetting change in the cash flows of a hedged item, (ii) when the derivative expires or is sold, terminated or exercised, (iii) if it is no longer probable that the forecasted transaction will occur, or (iv) if management determines that designation of the derivative as a hedge instrument is no longer appropriate. The Company’s derivative is recorded on the balance sheet at its fair value.

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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 FASB Accounting Standards Codification™ (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. The Company has reviewed the FASB issued Accounting Standards Update (ASU) accounting pronouncements and interpretations thereof that have effectiveness dates during the periods reported and in future periods. The Company has carefully considered the new pronouncements that alter previous generally accepted accounting principles and does not believe that 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.

Additionally, the FASB and the International Accounting Standards Board are working on joint convergence projects to address accounting differences between GAAP and International Financial Reporting Standards in order to support their commitment to achieve a single set of high-quality global accounting standards. One of the projects under deliberation includes accounting for leases. If enacted in its current draft form, we anticipate that the lease accounting proposal could have an impact on our consolidated financial statements; however the FASB's standard-setting process is ongoing and until new standards have been finalized and issued, we cannot quantify and determine the impact on our consolidated financial statements that may result from such future changes.

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Results of Operations

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

	Year Ended December 31,		
	2013	2012	2011
Revenue	100.0 %	100.0 %	100.0 %
Expenses:			
Cost of services (exclusive of facility rent, general and administrative expense and depreciation and amortization shown separately below)	80.3	79.7	79.2
U.S. Government inquiry settlement	3.6	1.8	—
Facility rent—cost of services	1.5	1.6	1.8
General and administrative expense	4.4	3.9	3.9
Depreciation and amortization	3.8	3.4	3.1
Total expenses	93.6	90.4	88.0
Income from operations	6.4	9.6	12.0
Other income (expense):			
Interest expense	(1.4)	(1.5)	(1.8)
Interest income	—	—	—
Other expense, net	(1.4)	(1.5)	(1.8)
Income before provision for income taxes	5.0	8.1	10.2
Provision for income taxes	2.2	3.1	3.9
Income from continuing operations	2.8	5.0	6.3
Loss from discontinued operations	(0.2)	(0.2)	—
Net income	2.6	4.8	6.3
Less: net loss attributable to the noncontrolling interests	(0.1)	(0.1)	—
Net income attributable to The Ensign Group, Inc.	2.7 %	4.9 %	6.3 %

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Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

	Years Ended December 31,			
	2013	2012		
	(Dollars in thousands)		Change	% Change
Total Facility Results:				
Revenue	$904,556	$823,155	$81,401	9.9 %
Number of facilities at period end	119	108	11	10.2 %
Actual patient days	3,648,651	3,452,598	196,053	5.7 %
Occupancy percentage — Operational beds	77.5 %	79.0 %		(1.5)%
Skilled mix by nursing days	26.4 %	25.9 %		0.5 %
Skilled mix by nursing revenue	50.0 %	50.0 %		— %

	Years Ended December 31,			
	2013	2012		
	(Dollars in thousands)		Change	% Change
Same Facility Results(1):				
Revenue	$679,610	$670,747	$8,863	1.3 %
Number of facilities at period end	77	77	—	— %
Actual patient days	2,618,541	2,638,029	(19,488)	(0.7)%
Occupancy percentage — Operational beds	80.8 %	81.2 %		(0.4)%
Skilled mix by nursing days	28.3 %	27.5 %		0.8 %
Skilled mix by nursing revenue	52.1 %	52.0 %		0.1 %

	Years Ended December 31,			
	2013	2012		
	(Dollars in thousands)		Change	% Change
Transitioning Facility Results(2):				
Revenue	$141,180	$135,639	$5,541	4.1 %
Number of facilities at period end	25	25	—	— %
Actual patient days	724,243	736,995	(12,752)	(1.7)%
Occupancy percentage — Operational beds	73.8 %	74.9 %		(1.1)%
Skilled mix by nursing days	20.2 %	18.2 %		2.0 %
Skilled mix by nursing revenue	42.0 %	39.2 %		2.8 %

	Years Ended December 31,			
	2013	2012		
	(Dollars in thousands)		Change	% Change
Recently Acquired Facility Results(3):				
Revenue	$83,766	$16,769	$66,997	NM
Number of facilities at period end	17	6	11	NM
Actual patient days	305,867	77,574	228,293	NM
Occupancy percentage — Operational beds	62.7 %	55.5 %		NM
Skilled mix by nursing days	18.0 %	11.2 %		NM
Skilled mix by nursing revenue	38.1 %	20.9 %		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2010.
(2)

Transitioning Facility results represents all facilities purchased from January 1, 2010 to December 31, 2011.

(3) Recently Acquired Facility (or “Acquisitions”) results represent all facilities purchased on or subsequent to January 1, 2012.

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Revenue. Revenue increased $81.4 million, or 9.9%, to $904.6 million for the year ended December 31, 2013 compared to $823.2 million for the year ended December 31, 2012. Of the $81.4 million increase, Medicare and managed care revenue increased $26.2 million, or 6.8%, Medicaid custodial revenue increased $21.8 million, or 7.2%, private and other revenue increased $22.7 million, or 20.5% and Medicaid skilled revenue increased $10.7 million, or 42.0%. Revenue generated by Recently Acquired Facilities increased by approximately $67.0 million. Since January 1, 2012, the Company has acquired seventeen facilities, five home health and four hospice operations in seven states.

Revenue generated by Same Facilities increased $8.9 million, or 1.3%, for the year ended December 31, 2013 compared to the year ended December 31, 2012. This increase was primarily due to an increase in skilled mix days of 0.8% to 28.3% as compared to 2012. This increase was primarily due to an increase in managed care days of 11.1% during the year ended December 31, 2013 as compared to the year ended December 31, 2012, partially offset by a decrease in Medicare days of 5.4% during the year ended December 31, 2013 as compared to the year ended December 31, 2012.

Revenue at Transitioning Facilities increased by $5.5 million, or 4.1% for the year ended December 31, 2013 as compared to the year ended December 31, 2012. This increase was due to a 2.0% increase in skilled mix days primarily attributable to increases in Medicare days of 5.6% and managed care days of 13.3% for the year ended December 31, 2013 as compared to the year ended December 31, 2012.

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:

	Years Ended December 31, Same Facility		Transitioning		Acquisitions		Total		% Change	
	2013	2012	2013	2012	2013	2012	2013	2012		
Skilled Nursing Average Daily Revenue Rates:										
Medicare	$564.45	$555.44	$474.16	$471.25	$461.98	$418.73	$544.51	$541.63	0.5	%
Managed care	398.86	391.08	378.70	395.32	458.55	427.52	400.44	391.32	2.3	%
Other skilled	455.88	457.58	708.32	529.85	253.00	—	460.76	458.67	0.5	%
Total skilled revenue	492.13	490.63	462.86	460.25	460.78	418.88	487.53	486.98	0.1	%
Medicaid	176.97	168.85	158.45	155.16	167.26	204.57	174.04	167.78	3.7	%
Private and other payors	188.44	189.62	167.45	165.93	154.87	168.26	179.40	181.52	(1.2	)%
Total skilled nursing revenue	$267.38	$259.48	$222.39	$213.93	$218.10	$223.11	$257.67	$252.18	2.2	%

The average Medicare daily rate increased by 0.5%. This rate was impacted by a 1.8% market basket increase, which went into effect in October 2012 and a market basket increase of 1.3%, which went into effect October 2013. These market basket increases were offset by a 2% sequestration payment reduction that went into effect on April 1, 2013. The average Medicaid daily rate increased 3.7% for the year ended December 31, 2013 relative to the same period in the prior year, primarily due to increases in rates in various states, including Arizona and California.

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

	Years Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2013	2012	2013	2012	2013	2012	2013	2012
Percentage of Skilled Nursing Revenue:								
Medicare	31.3 %	33.0 %	35.1 %	33.3 %	26.6 %	20.6 %	31.4 %	32.9 %
Managed care	15.2	13.7	5.7	5.3	11.5	0.3	13.9	12.4
Other skilled	5.6	5.3	1.2	0.6	—	—	4.7	4.7
Skilled mix	52.1	52.0	42.0	39.2	38.1	20.9	50.0	50.0
Private and other payors	7.5	7.6	21.4	22.6	12.1	11.2	9.5	9.5
Quality mix	59.6	59.6	63.4	61.8	50.2	32.1	59.5	59.5
Medicaid	40.4	40.4	36.6	38.2	49.8	67.9	40.5	40.5
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

	Years Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2013	2012	2013	2012	2013	2012	2013	2012
Percentage of Skilled Nursing Days:								
Medicare	14.8 %	15.4 %	16.5 %	15.1 %	12.6 %	11.0 %	14.8 %	15.3 %
Managed care	10.2	9.1	3.3	2.8	5.4	0.2	8.9	8.0
Other skilled	3.3	3.0	0.4	0.3	—	—	2.7	2.6
Skilled mix	28.3	27.5	20.2	18.2	18.0	11.2	26.4	25.9
Private and other payors	10.7	10.4	28.4	29.2	17.0	14.7	13.7	13.2
Quality mix	39.0	37.9	48.6	47.4	35.0	25.9	40.1	39.1
Medicaid	61.0	62.1	51.4	52.6	65.0	74.1	59.9	60.9
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $69.6 million, or 10.6%, to $726.0 million for the year ended December 31, 2013 compared to $656.4 million for the year ended December 31, 2012. Of the $69.6 million increase, Same Facilities increased $7.9 million, or 1.5%, and Recently Acquired Facilities increased $55.9 million. The increase at Same Facilities was primarily related to an increase in quality assurance fee of $3.7 million in certain states where related Medicaid rates were also increased. In addition, we recorded additional costs of $1.5 million related to the class action staffing lawsuit during the year ended December 31, 2013. Cost of services increased as a percent of total revenue to 80.3% for the year ended December 31, 2013 as compared to 79.7% for the year ended December 31, 2012.

Charge Related to U.S. Government Inquiry. The Company recorded an additional charge in the amount of $33.0 million during the year ended December 31, 2013 related to investigation into some of our subsidiaries conducted by the DOJ. During the year ended December 31, 2012, the Company accrued an estimated liability of $15.0 million. See further discussion of the DOJ investigation and related estimated settlement in Liquidity and Capital Resources.
Facility Rent — Cost of Services. Facility rent — cost of services increased $0.3 million, or 2.3%, to $13.6 million for the year ended December 31, 2013 as compared to $13.3 million for the year ended December 31, 2012. Facility rent-cost of services decreased as a percent of total revenue to 1.5% for the year ended December 31, 2013 as compared to 1.6% for the year ended December 31, 2012.

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General and Administrative Expense. General and administrative expense increased $8.3 million, or 26.1%, to $40.1 million for the year ended December 31, 2013 compared to $31.8 million for the year ended December 31, 2012. General and administrative expenses increased as a percent of total revenue to 4.4% for the year ended December 31, 2013 as compared to 3.9% for the year ended December 31, 2012. The $8.3 million increase was primarily due to costs incurred in connection with the Company's proposed spin-off of its real estate assets to a newly formed publicly traded real estate investment trust (REIT) and wages and benefits as a result of enhancements made to its internal compliance team.

Depreciation and Amortization. Depreciation and amortization expense increased $5.5 million, or 19.4%, to $33.9 million for the year ended December 31, 2013 compared to $28.4 million for the year ended December 31, 2012. Depreciation and amortization expense increased as a percent of total revenue to 3.8% for the year ended December 31, 2013 as compared to 3.4% for the year ended December 31, 2012. This increase was primarily related to the additional depreciation of $3.5 million at Recently Acquired Facilities, as well as an increase of $1.9 million at Same Facilities due to recent renovations and the purchase of the underlying assets of three of our skilled nursing facilities which we previously operated under long-term lease agreements during the year ended December 31, 2012. Of the $3.5 million increase at Recently Acquired Facilities, $0.7 million represented amortization expense of patient base intangible assets which are amortized over four to eight months.

Other Income (Expense). Other expense, net increased $0.3 million, or 2.6%, to $12.3 million for the year ended December 31, 2013 as compared to $12.0 million for the year ended December 31, 2012. Other expenses, net decreased as a percent of total revenue to 1.4% for the year ended December 31, 2013 as compared to 1.5% for the year ended December 31, 2012.

Provision for Income Taxes. Provision for income taxes decreased $5.1 million, or 20.3%, to $20.0 million for the year ended December 31, 2013 as compared to $25.1 million for the year ended December 31, 2012. This decrease resulted from the decrease in income before income taxes. Our effective tax rate was 43.8% for the year ended December 31, 2013 as compared to 37.9% for the year ended December 31, 2012.

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Year Ended December 31, 2012 Compared to the Year Ended December 31, 2011

	Years Ended December 31,			
	2012	2011		
	(Dollars in thousands)		Change	% Change
Total Facility Results:				
Revenue	$823,155	$758,277	$64,878	8.6 %
Number of facilities at period end	108	102	6	5.9 %
Actual patient days	3,452,598	3,124,724	327,874	10.5 %
Occupancy percentage — Operational beds	79.0 %	79.2 %		(0.2)%
Skilled mix by nursing days	25.9 %	25.5 %		0.4 %
Skilled mix by nursing revenue	50.0 %	51.3 %		(1.3)%

	Years Ended December 31,			
	2012	2011		
	(Dollars in thousands)		Change	% Change
Same Facility Results(1):				
Revenue	$563,719	$568,087	$(4,368)	(0.8)%
Number of facilities at period end	62	62	—	— %
Actual patient days	2,152,011	2,137,951	14,060	0.7 %
Occupancy percentage — Operational beds	82.7 %	82.2 %		0.5 %
Skilled mix by nursing days	29.5 %	29.0 %		0.5 %
Skilled mix by nursing revenue	54.2 %	55.4 %		(1.2)%

	Years Ended December 31,			
	2012	2011		
	(Dollars in thousands)		Change	% Change
Transitioning Facility Results(2):				
Revenue	$147,104	$138,521	$8,583	6.2 %
Number of facilities at period end	20	20	—	— %
Actual patient days	662,290	640,396	21,894	3.4 %
Occupancy percentage — Operational beds	75.0 %	72.7 %		2.3 %
Skilled mix by nursing days	18.3 %	16.3 %		2.0 %
Skilled mix by nursing revenue	39.0 %	37.3 %		1.7 %

	Years Ended December 31,			
	2012	2011		
	(Dollars in thousands)		Change	% Change
Recently Acquired Facility Results(3):				
Revenue	$112,332	$51,669	$60,663	NM
Number of facilities at period end	26	20	6	NM
Actual patient days	638,297	346,377	291,920	NM
Occupancy percentage — Operational beds	72.1 %	74.9 %		NM
Skilled mix by nursing days	17.5 %	14.2 %		NM
Skilled mix by nursing revenue	38.2 %	34.0 %		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2009.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2009 to December 31, 2010.

(3) Recently Acquired Facility (or "Acquisitions") results represent all facilities purchased on or subsequent to January 1, 2011.

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Revenue. Revenue increased $64.9 million, or 8.6%, to $823.2 million for the year ended December 31, 2012 compared to $758.3 million for the year ended December 31, 2011. Of the $64.9 million increase, Medicare and managed care revenue increased−$18.3 million, or 5.0%, Medicaid revenue increased $24.3 million, or 8.8%, private and other revenue increased $17.2 million, or 20.0% and other skilled revenue increased $5.1 million, or 25.3%. Revenue generated by Recently Acquired Facilities increased by approximately $60.7 million, due to the Company's acquisition of 26 facilities, five home health and two hospice operations in ten states since January 1, 2011.

Revenue generated by Same Facilities decreased $4.4 million, or 0.8%, for the year ended December 31, 2012 as compared to the year ended December 31, 2011. Medicare revenue per patient day at Same Facilities decreased 8.6% during the year ended December 31, 2012 as compared to the year ended December 31, 2011. This decrease was primarily due to the impact of the CMS-imposed 11.1% reduction in Medicare skilled nursing PPS payments and therapy changes, which were implemented on October 1, 2011. This reduction was partially offset by an increase in occupancy of 0.5% to 82.7%, as well as an increase in skilled mix by nursing days of 0.5%, to 29.5%, which was the result of an increase in other skilled patient days at Same Facilities of 9.8%, as well as increases in Medicare and managed care patient days as compared to the year ended December 31, 2011.

Revenue at Transitioning Facilities increased by $8.6 million, or 6.2%, for the year ended December 31, 2012 as compared to the year ended December 31, 2011. This increase was achieved despite a decrease in Medicare revenue per patient day of 7.1% at Transitioning Facilities for the year ended December 31, 2012. This increase in revenue was primarily due to an increase in occupancy of 2.3% to 75.0%, as well as an increase in skilled mix by nursing days of 2.0%, to 18.3%, which was the result of increases in managed care and Medicare patient days of 35.4% and 6.6%, respectively, as compared to the year ended December 31, 2011.

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:

	Years Ended December 31,								
	Same Facility		Transitioning		Acquisitions		Total		%
	2012	2011	2012	2011	2012	2011	2012	2011	Change
Skilled Nursing Average Daily Revenue Rates:									
Medicare	$564.94	$618.22	$485.07	$522.28	$471.49	$464.57	$541.63	$595.30	(9.0)%
Managed care	377.94	367.74	408.23	415.82	400.94	408.28	382.13	372.41	2.6 %
Other skilled	521.11	542.93	571.97	554.10	610.62	—	528.00	564.60	(6.5)%
Total skilled revenue	492.71	519.82	470.08	497.87	461.19	458.06	486.98	515.90	(5.6)%
Medicaid	170.76	168.36	164.91	161.43	154.04	138.48	167.78	165.11	1.6 %
Private and other payors	196.64	188.21	167.34	173.40	165.64	158.35	181.52	179.42	1.2 %
Total skilled nursing revenue	$268.24	$272.35	$221.20	$218.01	$211.56	$191.02	$252.18	$256.34	(1.6)%

The 2011 results include the impact of the implementation of RUGS IV on both revenue reimbursement and related cost structure changes included in MDS 3.0 and concurrent therapy in the first three quarters of 2011. Medicare daily rates decreased by 9.0%, due to the impact of the CMS imposed 11.1% reduction in Medicare skilled nursing PPS payments and therapy changes, which were implemented in October 2011. The average Medicaid rate increased 1.6% for the year ended December 31, 2012 relative to the same period in the prior year, primarily due to increases in rates in several states and increased acuity in case mix states where rates were cut, partially offset by decreases in rates in Arizona due to changes in base reimbursement rates.

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

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

	Years Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2012	2011	2012	2011	2012	2011	2012	2011
Percentage of Skilled Nursing Revenue:								
Medicare	34.4 %	37.1 %	26.3 %	28.3 %	33.3 %	30.5 %	32.9 %	35.3 %
Managed care	15.6	14.7	9.4	7.5	4.9	3.5	13.4	12.9
Other skilled	4.2	3.6	3.3	1.5	—	—	3.7	3.1
Skilled mix	54.2	55.4	39.0	37.3	38.2	34.0	50.0	51.3
Private and other payors	7.1	7.1	10.3	10.6	24.9	30.3	9.5	8.8
Quality mix	61.3	62.5	49.3	47.9	63.1	64.3	59.5	60.1
Medicaid	38.7	37.5	50.7	52.1	36.9	35.7	40.5	39.9
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

	Years Ended December 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2012	2011	2012	2011	2012	2011	2012	2011
Percentage of Skilled Nursing Days:								
Medicare	16.3 %	16.3 %	12.0 %	11.8 %	14.9 %	12.5 %	15.3 %	15.2 %
Managed care	11.2	10.9	5.1	3.9	2.6	1.7	9.0	8.9
Other skilled	2.0	1.8	1.2	0.6	—	—	1.6	1.4
Skilled mix	29.5	29.0	18.3	16.3	17.5	14.2	25.9	25.5
Private and other payors	9.7	10.3	13.6	13.4	31.9	36.6	13.2	12.6
Quality mix	39.2	39.3	31.9	29.7	49.4	50.8	39.1	38.1
Medicaid	60.8	60.7	68.1	70.3	50.6	49.2	60.9	61.9
Total skilled nursing	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $55.6 million, or 9.3%, to $656.4 million for the year ended December 31, 2012 compared to $600.8 million for the year ended December 31, 2011. Of the $55.6 million increase, Same Facilities increased $1.4 million, or 0.3% and Recently Acquired Facilities increased $49.0 million. The $1.4 million increase in Same Facility cost of services was primarily due to an increase in ancillary expenses, partially offset by decreases in wages and benefits. The increase in ancillary expenses was primarily due to increased therapy costs as was anticipated due to the change in therapy regulation implemented on October 1, 2011. The decrease in wages and benefits was primarily due to reduced performance during the year ended December 31, 2012 as compared to 2011. Included in the $49.0 million increase in cost of services at Recently Acquired Facilities were impairment charges to intangible assets of $2.2 million resulting from a decline in fair value of DRX. See further discussion of impairment charges at Note 11, Goodwill and Other Indefinite-Lived Intangibles in Notes to Consolidated Financial Statements. Cost of services increased as a percent of total revenue to 79.7% for the year ended December 31, 2012 as compared to 79.2% for the year ended December 31, 2011.

Charge Related to U.S. Government Inquiry. During the year ended December 31, 2012, the Company accrued an estimated liability of $15.0 million related to the ongoing investigation into some of our subsidiaries being conducted by the DOJ. See further discussion of the DOJ investigation and related estimated settlement in Liquidity and Capital Resources.

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Facility Rent — Cost of Services. Facility rent — cost of services decreased $0.4 million, or 2.9%, to $13.3 million for the year ended December 31, 2012 compared to $13.7 million for the year ended December 31, 2011. Facility rent-cost of services decreased as a percent of total revenue to 1.6% for the year ended December 31, 2012 as compared to 1.8% for the year ended December 31, 2011. The decrease in facility rent is due to our purchase of the underlying assets of eight of our skilled nursing facilities in California, Utah and Idaho which we previously operated under long-term lease agreements, partially offset by additional rent recognized for a facility for which the Company has begun construction activities, but has not commenced operations of a skilled nursing facility as of December 31, 2012, new leases related to our urgent care centers, and normal annual increases in rent at leased facilities.

General and Administrative Expense. General and administrative expense increased $2.0 million, or 6.7%, to $31.8 million for the year ended December 31, 2012 compared to $29.8 million for the year ended December 31, 2011. General and administrative expenses remained consistent as a percent of total revenue at 3.9% for the year ended December 31, 2012 and 2011. The $2.0 million increase was primarily due to increases in wages and benefits due to our growth and increased legal costs incurred in connection with the ongoing investigation into the billing and reimbursement process of some of our subsidiaries being conducted by the DOJ.

Depreciation and Amortization. Depreciation and amortization expense increased $5.1 million, or 21.9%, to $28.4 million for the year ended December 31, 2012 compared to $23.3 million for the year ended December 31, 2011. Depreciation and amortization expense increased as a percent of total revenue to 3.4% for the year ended December 31, 2012 as compared to 3.1% for the year ended December 31, 2011. This increase was primarily related to the additional depreciation of $1.9 million at Recently Acquired Facilities, as well as increases of $2.0 million and $1.2 million at Same and Transitioning Facilities, respectively, due to recent renovations and the purchase of the underlying assets of eight of our skilled nursing facilities which we previously operated under a long-term lease agreements. Of the $1.9 million increase at Recently Acquired Facilities, $0.5 million represented amortization expense of patient base intangible assets which are amortized over four to eight months.

Other Income (Expense). Other expense, net decreased $1.5 million, or 11.5%, to $12.0 million for the year ended December 31, 2012 compared to $13.5 million for the year ended December 31, 2011. The decrease in other expense, net was primarily the result of a one-time exit fee and related extinguishment fees of $2.5 million upon prepaying the Six Project Note and exiting our former revolving credit facility during the year ended December 31, 2011. This decrease was partially offset by increased interest expense due to the additional $21.5 million in long-term debt added with the promissory notes with RBS Asset Finance, Inc. (2012 RBS Loan) in February 2012.

Provision for Income Taxes. Provision for income taxes decreased $4.4 million, or 14.9%, to $25.1 million for the year ended December 31, 2012 compared to $29.5 million for the year ended December 31, 2011. This decrease resulted from the decrease in income before income taxes of $10.9 million, or 14.1%. In addition, our effective tax rate decreased 0.3% to 37.9% for the year ended December 31, 2012 as compared to 38.2% for the year ended December 31, 2011.

Liquidity and Capital Resources

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

Since 2004, we have financed the majority of our facility acquisitions primarily through refinancing of existing facilities, and cash generated from operations. Cash paid for business acquisitions was $45.4 million, $31.6 million and $106.7 million for the years ended December 31, 2013, 2012 and 2011, respectively. Cash paid for asset acquisitions was $0, $11.3 million and $23.4 million for the years ended December 31, 2013, 2012 and 2011, respectively. Where we enter into a facility lease agreement, we typically do not pay any material amount to the prior facility operator, nor do we acquire any assets or assume any liabilities, other than our rights and obligations under the new lease and operations transfer agreement, as part of the transaction. Total capital expenditures for property and equipment were $29.8 million, $38.9 million and $40.8 million for the years ended December 31, 2013, 2012 and 2011, respectively. We currently have a combined $30.0 million budgeted for renovation projects for 2014.

We believe our current cash balances, our cash flow from operations and the revolving credit facility portion of our senior credit facility with a six-bank lending consortium arranged by SunTrust and Wells Fargo (the Senior Credit Facility), which was increased from $75.0 million to $150.0 million on February 1, 2013, 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.

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Our cash and cash equivalents as of December 31, 2013 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of December 31, 2013, we held debt security investments of approximately $22.4 million, which were split between AA- and A-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.

In connection with the Spin-Off, we anticipate that CareTrust will assume the mortgage debt related to certain of the properties it acquires. CareTrust will also issue senior unsecured notes and mortgage indebtedness. A portion of those proceeds is expected to be transferred to us. We expect that we will use the proceeds to repay certain outstanding third-party bank debt and other indebtedness and, subject to the approval of and declaration by our board of directors, pay up to eight regular quarterly dividends. The Spin-Off and related transactions are subject to conditions, and their terms are subject to change in the sole discretion of our board of directors. Further details can be found at CareTrust's registration statement on Form 10 (File No. 001-36181) filed with the Securities and Exchange Commission on February 13, 2014.

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

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Net cash provided by operating activities	$37,424	$82,050	$72,687
Net cash used in investing activities	(65,235)	(84,496)	(156,052)
Net cash provided by financing activities	52,881	13,547	40,861
Net increase (decrease) in cash and cash equivalents	25,070	11,101	(42,504)
Cash and cash equivalents at beginning of period	40,685	29,584	72,088
Cash and cash equivalents at end of period	$65,755	$40,685	$29,584

Year Ended December 31, 2013 Compared to Year Ended December 31, 2012

Net cash provided by operations for the year ended December 31, 2013 was $37.4 million compared to $82.1 million for the year ended December 31, 2012, a decrease of $44.7 million. This decrease was primarily due to the payment of the U.S. Government investigation settlement of $15.0 million, an increase in accounts receivable of $11.1 million as compared to the year ended December 31, 2012 and an increase in prepaid income taxes of $8.2 million as compared to the year ended December 31, 2012, due to the timing of payments.

Net cash used in investing activities for the year ended December 31, 2013 was $65.2 million compared to $84.5 million for the year ended December 31, 2012, a decrease of $19.3 million. The decrease was primarily the result of $71.3 million in cash paid for business acquisitions, asset acquisitions and purchased property and equipment in the year ended December 31, 2013 compared to $86.2 million in the year ended December 31, 2012, a decrease of $14.9 million. The remainder of this difference is due to cash proceeds received on the sale of the Company's urgent care franchising business of $3.6 million and equity method investment of $1.6 million during the year ended December 31, 2013.

Net cash provided by financing activities for the year ended December 31, 2013 was $52.9 million as compared to $13.5 million for the year ended December 31, 2012, an increase of $39.4 million. This increase was primarily due to the receipt of $58.7 million in borrowing proceeds from our Senior Credit Facility during the year ended December 31, 2013 as compared to $36.5 million during the year ended December 31, 2012, an increase of $22.2 million, combined with a decrease in long-term debt repayments of $7.2 million for the year ended December 31, 2013 as compared to $16.8 million for the year ended December 31, 2012, a decrease of $9.6 million.

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Year Ended December 31, 2012 Compared to Year Ended December 31, 2011

Net cash provided by operating activities for the year ended December 31, 2012 was $82.1 million compared to $72.7 million for the year ended December 31, 2011, an increase of $9.4 million. The increase was primarily due to our improved operating results, which contributed $94.5 million in 2012 after adding back depreciation and amortization, the charge related to U.S. Government inquiry, impairment charges, deferred income taxes, provision for doubtful accounts, share-based compensation, excess tax benefits from share-based compensation and loss on disposition of property and equipment (non-cash charges), as compared to $85.3 million for 2011, an increase of $9.2 million.

Net cash used in investing activities for the year ended December 31, 2012 was $84.5 million compared to $156.1 million for the year ended December 31, 2011, a decrease of $71.8 million. The decrease was primarily the result of $86.2 million in cash paid for business acquisitions, asset acquisitions and purchased property and equipment in the year ended December 31, 2012 compared to $156.7 million in the year ended December 31, 2011.

Net cash provided by financing activities for the year ended December 31, 2012 was $13.5 million as compared to $40.9 million for the year ended December 31, 2011, a decrease of $27.4 million. This decrease was primarily due to the receipt of $75.0 million in proceeds from the term loan portion of the Senior Credit Facility during the year ended December 31, 2011 as compared to $21.5 million in proceeds received from the 2012 RBS Loan during the year ended December 31, 2012, a decrease of $53.5 million. The reduction in long-term debt proceeds received was partially offset by a decrease in long-term debt repayments from $46.3 million for the year ended December 31, 2011 to $16.8 million for the year ended December 31, 2012, a difference of $29.5 million. The remaining decrease is due to the use of long-term debt proceeds to repay existing debt in the prior year.

Principal Debt Obligations and Capital Expenditures

Total long-term debt obligations, net of debt discount, outstanding as of December 31, 2013, 2012, 2011, 2010 and 2009 were as follows:

	December 31,				
	2009	2010	2011	2012	2013
	(in thousands)				
Senior Credit Facility	$—	$—	$88,125	$89,375	$144,325
Ten Project Note	53,200	52,229	51,185	50,072	48,864
Six Project Loan	39,970	39,495	—	—	—
Mortgage Loan and Promissory Notes	15,064	49,744	48,560	68,245	66,117
Bond payable	1,232	1,038	—	—	—
Total	$109,466	$142,506	$187,870	$207,692	$259,306

The following table represents the Company’s cumulative facility growth from 2008 to the present:

	December 31,					
	2008	2009	2010	2011	2012	2013
Cumulative number of facilities	63	77	82	102	108	119

Senior Credit Facility with a Lending Consortium Arranged by SunTrust and Wells Fargo (the Senior Credit Facility)

On April 22, 2013, we entered into the fourth amendment to the Senior Credit Facility (the Fourth Amendment), which amended our existing Senior Credit Facility Agreement, dated as of July 15, 2011, to amend certain covenants, representations and other key provisions in the credit agreement to, among other things, (i) allow for the settlement relating to the previously disclosed federal civil investigation that has been conducted by the U.S. DOJ and related federal agencies in an amount up to $50.0 million and (ii) permit us to enter into a corporate integrity agreement with the Office of Inspector General-HHS. Except as set forth in the Fourth Amendment, all other terms and conditions of the Senior Credit Facility, as amended, remain in full force.

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On February 1, 2013, we entered into the third amendment to the Senior Credit Facility (the Third Amendment), which amended our existing Senior Credit Facility Agreement, dated as of July 15, 2011. The Third Amendment revised the Senior Credit Facility Agreement to, among other things, (i) increase the revolving credit portion of the Senior Credit Facility by $75.0 million to an aggregate principal amount of $150.0 million, of which $78.7 million was drawn as of December 31, 2013, and (ii) extend the maturity date of the Senior Credit Facility from July 15, 2016 to February 1, 2018. Except as set forth in the Third Amendment, all other terms and conditions of the Senior Credit Facility remained in full force and effect as described below.

On July 15, 2011, we entered into the Senior Credit Facility in an aggregate principal amount of up to $150.0 million comprised of a $75.0 million revolving credit facility and a $75.0 million term loan advanced in one drawing on July 15, 2011. Borrowings under the term loan portion of the Senior Credit Facility amortize in equal quarterly installments that commenced on September 30, 2011, in an aggregate annual amount equal to 5.0% per annum of the original principal amount. Interest rates per annum applicable to the Senior Facility will be, at our option, (i) LIBOR plus an initial margin of 2.5% or (ii) the Base Rate (as defined under the Senior Credit Facility) plus an initial margin of 1.5%. Under the terms of the Senior Credit Facility, the applicable margin adjusts based on our leverage ratio as set forth in further detail in the Senior Credit Facility agreement. Amounts borrowed pursuant to the Senior Credit Facility are guaranteed by certain of our wholly-owned subsidiaries and secured by substantially all of our personal property. To reduce the risk related to interest rate fluctuations, we, on behalf of the subsidiaries, entered into an interest rate swap agreement to effectively fix the interest rate on the term loan portion of the Senior Credit Facility. See further details of the interest rate swap at Note 6, Fair Value Measurements in Notes to Condensed Consolidated Financial Statements.

Among other things, under the Senior Credit Facility, we must maintain compliance with specified financial covenants measured on a quarterly basis, including a maximum net leverage ratio, minimum interest coverage ratio and minimum asset coverage ratio. The loan documents also include certain additional reporting, affirmative and negative covenants including limitations on the incurrence of additional indebtedness, liens, investments in other businesses, dividends declared in excess of 20% of consolidated net income, stock repurchases and capital expenditures. As of December 31, 2013, we were in compliance with all loan covenants. As of December 31, 2013, our subsidiaries had $144.3 million outstanding on the Senior Credit Facility.

Promissory Notes with RBS Asset Finance, Inc.

On February 22, 2012, two of our real estate holding subsidiaries as Borrowers executed a promissory note in favor of RBS Asset Finance, Inc. (RBS) as Lender for an aggregate of $21.5 million (the 2012 RBS Loan). The 2012 RBS Loan was secured by a Commercial Deed of Trust, Security Agreement, Assignment of Leases and Rents and Fixture Filings on the two properties owned by the two Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2012 RBS Loan bears interest at a fixed rate of 4.75%. Amounts borrowed under the 2012 RBS Loan may be prepaid starting after the second anniversary of the note subject to certain prepayment fees. The term of the RBS Loan is for seven years, with monthly principal and interest payments commencing on March 1, 2012 and the balance due on March 1, 2019.

Among other things, under the 2012 RBS Loan, we must maintain compliance with specified financial covenants measured on a quarterly basis, including a minimum debt service coverage ratio, an average occupancy rate and a minimum project yield. The Loan Documents also include certain additional affirmative and negative covenants, including limitations on the disposition of the Borrowers and the collateral and minimum average cash balance requirements. As of December 31, 2013, we were in compliance with all loan covenants. As of December 31, 2013, our subsidiaries had $20.3 million outstanding on the 2012 RBS Loan.

Promissory Notes with RBS Asset Finance, Inc.

On December 31, 2010, four of our real estate holding subsidiaries as Borrowers executed a promissory note with RBS as Lender for an aggregate of $35.0 million (RBS Loan). The 2010 RBS Loan was secured by Commercial Deeds of Trust, Security Agreements, Assignment of Leases and Rents and Fixture Fillings on the four properties owned by the four Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2010 RBS Loan bears interest at a fixed rate of 6.04%. Amounts borrowed under the 2010 RBS Loan may be prepaid starting after the second anniversary of the note subject to certain prepayment fees. The term of the 2010 RBS Loan is for seven years, with monthly principal and interest payments commencing on February 1, 2011 and the balance due on January 1, 2018.

Among other things, under the 2010 RBS Loan, we must maintain compliance with specified financial covenants measured on a quarterly basis, including a minimum debt service coverage ratio, an average occupancy rate and a minimum project yield. The Loan Documents also include certain additional affirmative and negative covenants, including limitations on the disposition of the Borrowers and the collateral and minimum average cash balance requirements. As of December 31, 2013, we were in compliance with all loan covenants. As of December 31, 2013, our subsidiaries had $32.1 million outstanding on the 2010 RBS Loan.

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of our independent real estate holding subsidiaries jointly entered into the Third Amended and Restated Loan Agreement, with GECC, which consists of an approximately $55.7 million multiple-advance term loan, further referred to as the Ten Project Note. The Ten Project Note matures in June 2016, and is currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries. The Ten Project Note was funded in advances, with each advance bearing interest at a separate rate. The interest rates range from 6.95% to 7.50% per annum.

Under the Ten Project Note, we are subject to standard reporting requirements and other typical covenants for a loan of this type. Effective October 1, 2006 and continuing each calendar quarter thereafter, we are subject to restrictive financial covenants, including average occupancy, Debt Service (as defined in the agreement) and Project Yield (as defined in the agreement). As of December 31, 2013, we were in compliance with all loan covenants. As of December 31, 2013, our subsidiaries had $48.9 million outstanding on the Ten Project Note.

Promissory Notes with Johnson Land Enterprises, Inc.

On October 1, 2009, four of our subsidiaries entered into four separate promissory notes with Johnson Land Enterprises, LLC, for an aggregate of $10.0 million, as a part of our acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these notes is due on September 30, 2019. The notes bear interest at a rate of 6.0% per annum. As a part of this transaction, the Company recorded a discount to the debt balance in the form of imputed interest of $1.2 million. This amount will be amortized over the term of the promissory notes, or 10 years. As of December 31, 2013, our subsidiaries had $8.9 million outstanding on the Promissory Notes.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with the U.S. Department of Housing and Urban Development, or HUD, which subjects our Southland facility to HUD oversight and periodic inspections. As of December 31, 2013, the balance outstanding on this mortgage loan was approximately $5.4 million. The unpaid balance of principal and accrued interest from this mortgage loan is due on February 1, 2027. The mortgage loan bears interest at the rate of 7.5% per annum.

This mortgage loan is secured by the real property comprising the Southland Care Center facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

Common Stock Repurchase Program

In the fourth quarter of 2012, the board of directors authorized the renewal of our common stock repurchase program, authorizing the repurchase of up to $10.0 million of our common stock over the next 12 months. Under this program, we are authorized to repurchase our 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, including Rule 10b-18 promulgated under the Securities Exchange Act of 1934 as amended.

The number of shares repurchased will depend entirely upon the levels of cash available, the attractiveness of alternate investment and business opportunities either at hand or on the horizon, Management's perception of value relative to market price and other legal, regulatory and contractual requirements. The repurchase program does not obligate us to repurchase any particular dollar amount or number of shares of common stock. The repurchase program expired on November 15, 2013. During the year ended December 31, 2013, we did not repurchase any shares of our common stock. During the year ended December 31, 2012, we repurchased 7,340 shares of our common stock for a total of

$0.2 million.

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Contractual Obligations, Commitments and Contingencies

Our principal contractual obligations and commitments as of December 31, 2013 were as follows:

	2014	2015	2016	2017	2018	Thereafter	Total
			(In thousands)				
Operating lease obligations	$13,693	$13,677	$13,686	$13,722	$13,764	$71,093	$139,635
Long-term debt obligations	7,411	7,672	52,589	6,584	157,790	27,960	260,006
Interest payments on long-term debt	11,674	11,117	9,486	7,333	2,166	1,900	43,676
Total	$32,778	$32,466	$75,761	$27,639	$173,720	$100,953	$443,317

Not included in the table above are our actuarially determined self-insured general and professional malpractice liability, worker's compensation and medical (including prescription drugs) and dental healthcare obligations which are broken out between current and long-term liabilities in our financial statements included in this annual report.
We lease certain facilities and our Service Center office under operating leases, most of which have initial lease terms ranging from five to 20 years. Most of these leases contain options to renew or extend the lease term, some of which involve rent increases. We also lease a majority of our equipment under operating leases with initial terms ranging from three to five years. Total rent expense, inclusive of straight-line rent adjustments, was $14.2 million, $13.8 million and $14.2 million during the years ended December 31, 2013, 2012 and 2011, respectively.

US Government Inquiry

In late 2006, we learned that we might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. We, through our outside counsel and a special committee of independent directors established by our board, worked cooperatively with the U.S. Attorney's office to produce information requested by the government as part of an ongoing dialogue designed to resolve the issue.

In December 2011, the DOJ notified us that it had closed its criminal investigation without action although, as is typical, it reserved the right to reopen the criminal case if new facts came to light. This left only the civil investigation to resolve, and we continued to supply requested information to the DOJ and the Office of the Inspector General of the United States Department of Health and Human Services (HHS), including specific patient records and documents from 2007 to 2011 from six Southern California skilled nursing facilities that had been the subject of previous requests.

In early 2013, discussions between government representatives and our special committee, our outside counsel and their experts had advanced sufficiently that we recorded an initial estimated liability in the amount of $15.0 million in the fourth quarter of 2012 for the resolution of claims connected to the investigation. In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of $33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to $48.0 million (the Reserve Amount).

In October 2013, we and the government executed a final settlement agreement in accordance with the April agreement and we remitted full payment of the Reserve Amount. In addition, we executed a corporate integrity agreement with the Office of Inspector General HHS as part of the resolution.
See additional description of our contingencies in Notes 15, 16, 17 and 19 in Notes to Condensed Consolidated Financial Statements.
Inflation

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

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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.

Off-Balance Sheet Arrangements

As of December 31, 2013 and 2012, we had approximately $2.0 million of borrowing capacity on the Revolver pledged as collateral to secure outstanding letters of credit, respectively.

Item 7A. Quantitative and Qualitative Disclosures about Market Risk

Interest Rate Risk.We are exposed to interest rate changes in connection with the revolving credit facility portion of the Senior Credit Facility, which is available but historically has not regularly been used to maintain liquidity and fund capital expenditures and operations. Our interest rate risk management objective is to balance the impact of interest rate changes on earnings and cash flows and maintain a lower interest rate. To achieve this objective, we have historically borrowed primarily at fixed rates, although the revolving credit facility portion of the Senior Credit Facility is available and could be used for short-term borrowing purposes. As of December 31, 2013, we had outstanding borrowings under the revolving credit facility portion of the Facility of $78.7 million.

The Senior Credit Facility agreement exposes us to variability in interest payments due to changes in LIBOR interest rates. We entered into an interest rate swap agreement to reduce risk from volatility in the income statement on the term loan portion of the Senior Credit Facility. The swap agreement, with a notional amount of $75.0 million, amortizing concurrently with the related term loan portion of the Senior Credit Facility, is five years in length and set to mature on February 1, 2018. Under the terms of this agreement, the net effect of the hedge was to record swap interest expense at a fixed rate of approximately 4.3%.

Our cash and cash equivalents as of December 31, 2013 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of December 31, 2013, we held debt security investments of approximately $22.4 million, which were split between AA- and A-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 December 31, 2013, 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 8. Financial Statements and Supplementary Data

Quarterly Financial Data (Unaudited)

The following table presents our unaudited quarterly consolidated results of operations for each of the eight quarters in the two-year period ended December 31, 2013. The unaudited quarterly consolidated information has been derived from our unaudited quarterly financial statements on Forms 10-Q, which were prepared on the same basis as our audited consolidated financial statements. You should read the following table presenting our quarterly consolidated results of operations in conjunction with our audited consolidated financial statements and the related notes included elsewhere in this Annual Report on Form 10-K. The operating results for any quarter are not necessarily indicative of the operating results for any future period

	Dec. 31, 2013	Sept. 30, 2013	June 30, 2013	Mar. 31, 2013	Dec. 31, 2012	Sept. 30, 2012	June 30, 2012	Mar. 31, 2012
	(In thousands, except per share data)							
Revenue	$237,008	$229,261	$220,086	$218,201	$210,505	$206,691	$203,919	$202,040
Cost of services (exclusive of facility rent and depreciation and amortization)	187,843	186,172	175,913	176,061	169,133	164,579	162,085	160,627
Charge related to U.S. Government inquiry	—	—	—	33,000	15,000	—	—	—
Total expenses	211,893	208,972	196,794	228,955	202,553	183,184	180,587	178,558
Income (loss) from operations	25,115	20,289	23,292	(10,754)	7,952	23,507	23,332	23,482
Income (loss) from continuing operations	$13,349	$10,642	$12,430	$(10,763)	$2,917	$12,956	$12,398	$12,894
(Loss) income from discontinued operations	$—	$(30)	$(26)	$(1,748)	$(1,252)	$80	$(119)	$(66)
Net income (loss)	$13,349	$10,612	$12,404	$(12,511)	$1,665	$13,036	$12,279	$12,828
Income (loss) attributable to noncontrolling interests	$(7)	$148	$37	$(364)	$(272)	$(258)	$(177)	$(76)
Net income (loss) attributable to The Ensign Group, Inc.	$13,356	$10,464	$12,367	$(12,147)	$1,937	$13,294	$12,456	$12,904
Income (loss) from continuing operations attributable to the Ensign Group, Inc.	$13,356	$10,494	$12,393	$(10,399)	$3,189	$13,214	$12,575	$12,970
(Loss) income from discontinued operations	$—	$(30)	$(26)	$(1,748)	$(1,252)	$80	$(119)	$(66)
Net income (loss) attributable to The Ensign Group, Inc.	$13,356	$10,464	$12,367	$(12,147)	$1,937	$13,294	$12,456	$12,904
Basic income (loss) per share:								
Income (loss) from continuing operations	$0.61	$0.48	$0.57	$(0.48)	$0.15	$0.61	$0.59	$0.61

attributable to The Ensign Group, Inc.								
(Loss) income from discontinued operations	$—	$—	$—	$(0.08)	$(0.06)	$0.01	$(0.01)	$—
Net income (loss) attributable to the Ensign Group, Inc.	$0.61	$0.48	$0.57	$(0.56)	$0.09	$0.62	$0.58	$0.61
Diluted income (loss) per share:								
Income (loss) from continuing operations attributable to The Ensign Group, Inc.	$0.59	$0.47	$0.55	$(0.48)	$0.14	$0.60	$0.57	$0.60
(Loss) income from discontinued operations	$—	$—	$—	$(0.08)	$(0.05)	$—	$—	$(0.01)
Net income (loss) attributable to the Ensign Group, Inc.	$0.59	$0.47	$0.55	$(0.56)	$0.09	$0.60	$0.57	$0.59
Weighted average common shares outstanding:								
Basic	22,028	21,941	21,859	21,768	21,605	21,488	21,368	21,251
Diluted	22,507	22,409	22,321	21,768	22,075	22,010	21,886	21,796

The additional information required by this Item 8 is incorporated herein by reference to the financial statements set forth in Item 15 of this report, Exhibits, Financial Statement and Schedules.

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Item 9. Changes in and Disagreements with Accountants on Accounting and Financial Disclosures

None.

Item 9A. Controls and Procedures

(a) Conclusion Regarding the Effectiveness of Disclosure Controls and Procedures

The Company maintains disclosure controls and procedures that are designed to ensure that information we are required to disclose in reports that we file or submit under the Securities Exchange Act of 1934, as amended (Exchange Act) is recorded, processed, summarized and reported within the time periods specified in Securities and Exchange Commission rules and forms. In designing and evaluating our disclosure controls and procedures, our management recognized that any system of controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving the desired control objectives, as ours are designed to do, and management necessarily was required to apply its judgment in evaluating the cost-benefit relationship of possible controls and procedures.

In connection with the preparation of this Annual Report on Form 10-K our management evaluated, with the participation of our Chief Executive Officer and our Chief Financial Officer, the effectiveness of our disclosure controls and procedures, as such term is defined under Rule 13a-15(e) promulgated under the Exchange Act, and to ensure that information required to be disclosed is accumulated and communicated to our management, including our principal executive and financial officers, as appropriate to allow timely decisions regarding required disclosure. Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures were effective as of the end of the period covered by this Annual Report on Form 10-K.

(b) Management's Report on Internal Control over Financial Reporting

Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as defined in Rule 13a-15(f) promulgated under the Exchange Act. Internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our management, with the participation of our Chief Executive Officer and our Chief Financial Officer, evaluated the effectiveness of our internal control over financial reporting using the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in Internal Control - Integrated Framework (1992). Based on our evaluation, our management concluded that our internal control over financial reporting was effective as of the end of the period covered by this Annual Report on Form 10-K.

Our independent registered public accounting firm, Deloitte & Touche LLP, has audited the consolidated financial statements included in this annual report on Form 10-K and, as part of their audit, has issued an audit report, included herein, on the effectiveness of our internal control over financial reporting. Their report is set forth below.

(c) Changes in Internal Control over Financial Reporting

There were no changes in our internal controls over financial reporting, as defined in Rule 13a-15(f) promulgated under the Exchange Act, that occurred during the fourth quarter of fiscal 2013 that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

(d) Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of
The Ensign Group, Inc.
Mission Viejo, California

We have audited the internal control over financial reporting of The Ensign Group, Inc. and subsidiaries (the "Company") as of December 31, 2013, based on criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission. The Company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

We conducted our audit in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

A company's internal control over financial reporting is a process designed by, or under the supervision of, the company's principal executive and principal financial officers, or persons performing similar functions, and effected by the company's board of directors, management, and other personnel to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of the inherent limitations of internal control over financial reporting, including the possibility of collusion or improper management override of controls, material misstatements due to error or fraud may not be prevented or detected on a timely basis. Also, projections of any evaluation of the effectiveness of the internal control over financial reporting to future periods are subject to the risk that the controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

In our opinion, the Company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2013, based on the criteria established in Internal Control - Integrated Framework (1992) issued by

the Committee of Sponsoring Organizations of the Treadway Commission.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated financial statements and financial statement schedule as of and for the year ended December 31, 2013 of the Company and our report dated February 13, 2014 expressed an unqualified opinion on those financial statements and financial statement schedule.

/s/ DELOITTE & TOUCHE LLP

Costa Mesa, California
February 13, 2014

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Item 9B. Other Information

None.

PART III.

Item 10. Directors, Executive Officers and Corporate Governance

There is incorporated herein by reference the information required by this Item in our definitive proxy statement for the 2014 Annual Meeting of Stockholders that will be filed with the SEC no later than 120 days after the close of the fiscal year ended December 31, 2013.

Item 11. Executive Compensation

There is incorporated herein by reference the information required by this Item in our definitive proxy statement for the 2014 Annual Meeting of Stockholders that will be filed with the SEC no later than 120 days after the close of the fiscal year ended December 31, 2013.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

There is incorporated herein by reference the information required by this Item in our definitive proxy statement for the 2014 Annual Meeting of Stockholders that will be filed with the SEC no later than 120 days after the close of the fiscal year ended December 31, 2013.

Item 13. Certain Relationships and Related Transactions and Director Independence

There is incorporated herein by reference the information required by this Item in our definitive proxy statement for the 2014 Annual Meeting of Stockholders that will be filed with the SEC no later than 120 days after the close of the fiscal year ended December 31, 2013.

Item 14. Principal Accountant Fees and Services

There is incorporated herein by reference the information required by this Item in our definitive proxy statement for the 2014 Annual Meeting of Stockholders that will be filed with the SEC no later than 120 days after the close of the fiscal year ended December 31, 2013.

PART IV.

Item 15. Exhibits, Financial Statements and Schedules

The following documents are filed as a part of this report:

(a) (1) Financial Statements:

The Financial Statements are included in Item 8 and are filed as part of this report.

(2) Financial Statement Schedule:

Schedule II: Valuation and Qualifying Accounts

(a) (3) Exhibits: An “Exhibit Index” has been filed as a part of this Annual Report on Form 10-K and is incorporated herein by reference.

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SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Act of 1934, the Registrant has duly caused this Report to be signed on its behalf by the undersigned, thereunto duly authorized.

Dated: February 13, 2014

The Ensign Group, Inc.

By: /s/ Christopher R. Christensen
Christopher R. Christensen
Chief Executive Officer and President

Pursuant to the requirements of the Securities Exchange Act of 1934, this Report has been signed below by the following persons on behalf of the Registrant in the capacities and on the dates indicated.

Signature	Title	Date
/s/ CHRISTOPHER R. CHRISTENSEN Christopher R. Christensen	Chief Executive Officer, President and Director (principal executive officer)	February 13, 2014
/s/ SUZANNE D. SNAPPER Suzanne D. Snapper	Chief Financial Officer (principal financial and accounting officer)	February 13, 2014
/s/ ROY E. CHRISTENSEN Roy E. Christensen	Chairman of the Board	February 13, 2014
/s/ ANTOINETTE T. HUBENETTE Antoinette T. Hubenette	Director	February 13, 2014
/s/ JOHN G. NACKEL John G. Nackel	Director	February 13, 2014
/s/ DAREN J. SHAW Daren J. Shaw	Director	February 13, 2014
Clayton M. Christensen	Director	February 13, 2014
/s/ LEE A. DANIELS Lee A. Daniels	Director	February 13, 2014

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THE ENSIGN GROUP, INC.

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

To the Board of Directors and Stockholders of
The Ensign Group, Inc.
Mission Viejo, California

We have audited the accompanying consolidated balance sheets of The Ensign Group, Inc. and subsidiaries (the "Company") as of December 31, 2013 and 2012, and the related consolidated statements of income, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2013. Our audits also included the financial statement schedule listed in the Index at Item 15. These financial statements and the financial statement schedule are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements and the financial statement schedule based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of The Ensign Group, Inc. and subsidiaries as of December 31, 2013 and 2012, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2013, in conformity with accounting principles generally accepted in the United States of America. Also, in our opinion, such financial statement schedule, when considered in relation to the basic consolidated financial statements taken as a whole, presents fairly, in all material respects, the information set forth therein.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the Company's internal control over financial reporting as of December 31, 2013, based on the criteria established in Internal Control - Integrated Framework (1992) issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 13, 2014 expressed an unqualified opinion on the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP

Costa Mesa, California
February 13, 2014

THE ENSIGN GROUP, INC.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2013	2012
	(In thousands, except par values)	
Assets		
Current assets:		
Cash and cash equivalents	$65,755	$40,685
Accounts receivable—less allowance for doubtful accounts of $16,540 and $13,811 at December 31, 2013 and 2012, respectively	111,370	94,187
Investments—current	5,511	5,195
Prepaid income taxes	9,915	3,787
Prepaid expenses and other current assets	9,213	8,606
Deferred tax asset—current	9,232	14,871
Assets held for sale—current (Note 4)	—	268
Total current assets	210,996	167,599
Property and equipment, net	479,770	447,855
Insurance subsidiary deposits and investments	16,888	17,315
Escrow deposits	1,000	4,635
Deferred tax asset	4,464	2,234
Restricted and other assets	9,804	8,640
Intangible assets, net	5,718	6,115
Long-term assets held for sale (Note 4)	—	11,324
Goodwill	23,935	21,557
Other indefinite-lived intangibles	7,740	3,588
Total assets	$760,315	$690,862
Liabilities and equity		
Current liabilities:		
Accounts payable	$23,793	$26,069
Accrued charge related to U.S. Government inquiry (Note 19)	—	15,000
Accrued wages and related liabilities	40,093	35,847
Accrued self-insurance liabilities—current	15,461	16,034
Liabilities held for sale—current (Note 4)	—	339
Other accrued liabilities	25,698	20,871
Current maturities of long-term debt	7,411	7,187
Total current liabilities	112,456	121,347
Long-term debt—less current maturities	251,895	200,505
Accrued self-insurance liabilities—less current portion	33,642	34,849
Fair value of interest rate swap	1,828	2,866
Long-term liabilities held for sale (Note 4)	—	130
Deferred rent and other long-term liabilities	3,237	3,281
Total liabilities	403,058	362,978
Commitments and contingencies (Notes 15, 17 and 19)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 22,580 and 22,113 shares issued and outstanding at December 31, 2013, respectively, and 22,244 and 21,719 shares issued and outstanding at December 31, 2012, respectively	22	22

Additional paid-in capital	101,364	90,949
Retained earnings	257,502	239,344
Common stock in treasury, at cost, 237 and 301 shares at December 31, 2013 and 2012, respectively	(1,680)	(2,099)
Accumulated other comprehensive loss	(1,112)	(1,745)
Total Ensign Group, Inc. stockholders' equity	356,096	326,471
Non-controlling interest	1,161	1,413
Total equity	357,257	327,884
Total liabilities and equity	$760,315	$690,862

See accompanying notes to consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2013	2012	2011
	(In thousands, except per share data)		
Revenue	$904,556	$823,155	$758,277
Expense:			
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	725,989	656,424	600,804
U.S. Government inquiry settlement (Note 19)	33,000	15,000	—
Facility rent—cost of services	13,613	13,281	13,725
General and administrative expense	40,103	31,819	29,766
Depreciation and amortization	33,909	28,358	23,286
Total expenses	846,614	744,882	667,581
Income from operations	57,942	78,273	90,696
Other income (expense):			
Interest expense	(12,787)	(12,229)	(13,778)
Interest income	506	255	249
Other expense, net	(12,281)	(11,974)	(13,529)
Income before provision for income taxes	45,661	66,299	77,167
Provision for income taxes	20,003	25,134	29,492
Income from continuing operations	25,658	41,165	47,675
Loss from discontinued operations, net of income tax benefit of $1,157, $869 and $0 for the years ended December 31, 2013, 2012 and 2011, respectively (Note 4)	(1,804)	(1,357)	—
Net income	23,854	39,808	47,675
Less: net loss attributable to noncontrolling interests	(186)	(783)	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675
Amounts attributable to The Ensign Group, Inc.:			
Income from continuing operations attributable to The Ensign Group, Inc.	$25,844	$41,948	$47,675
Loss from discontinued operations, net of income tax benefit	(1,804)	(1,357)	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675
Net income (loss) per share:			
Basic:			
Income from continuing operations attributable to The Ensign Group, Inc.	$1.18	$1.96	$2.27
Loss from discontinued operations	(0.08)	(0.07)	—
Net income attributable to The Ensign Group, Inc.	$1.10	$1.89	$2.27
Diluted:			
Income from continuing operations attributable to The Ensign Group, Inc.	$1.16	$1.91	$2.21
Loss from discontinued operations	(0.09)	(0.06)	—
Net income attributable to The Ensign Group, Inc.	$1.07	$1.85	$2.21
Weighted average common shares outstanding:			
Basic	21,900	21,429	20,967
Diluted	22,364	21,942	21,583
Dividends per share	$0.27	$0.25	$0.23

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See accompanying notes to consolidated financial statements.

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THE ENSIGN GROUP, INC.

CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME

	Years Ended December 31,		
	2013	2012	2011
	(In thousands)		
Net income	$23,854	$39,808	$47,675
Other comprehensive income (loss), net of tax:			
Unrealized gain (loss) on interest rate swap, net of income tax provision (benefit) of ($405), $286, and $835 for the years ended December 31, 2013, 2012 and 2011, respectively.	633	(437)	(1,308)
Comprehensive income	24,487	39,371	46,367
Less: net loss attributable to noncontrolling interests	(186)	(783)	—
Comprehensive income attributable to The Ensign Group, Inc.	$24,673	$40,154	$46,367

See accompanying notes to consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands)

	Common Stock		Additional Paid-In Capital	Retained Earnings	Treasury Stock		Accumulated Other Comprehensive Loss	Non-Controlling Interest	Redeemable Noncontrolling Interest	Total
	Shares (In thousands)	Amount			Shares	Amount				
Balance - January 1, 2011	20,815	$21	$70,814	$161,168	582	$(3,800)	$ —	$ —	$ —	$228,203
Issuance of common stock to employees and directors resulting from the exercise of stock options and grant of stock awards	344	1	1,607	—	(186)	1,241	—	—	—	2,849
Issuance of restricted stock to employees	20	—	—	—	—	—	—	—	—	—
Dividends declared	—	—	—	(4,770)	—	—	—	—	—	(4,770)
Employee stock award compensation	—	—	3,356	—	—	—	—	—	—	3,356
Excess tax benefit from exercise of stock options	—	—	1,480	—	—	—	—	—	—	1,480
Net income	—	—	—	47,675	—	—	—	—	—	47,675
Other comprehensive loss	—	—	—	—	—	—	(1,308)	—	—	(1,308)
	21,179	$22	$77,257	$204,073	396	$(2,559)	$ (1,308)	$ —	$ —	$277,485

Balance - December 31, 2011										
Issuance of common stock to employees and directors resulting from the exercise of stock options and grant of stock awards	488	—	4,067	—	(102)	634	—	—	—	4,701
Issuance of restricted stock to employees	52	—	1,360	—	—	—	—	—	—	1,360
Repurchase of common stock	—	—	—	—	7	(174)	—	—	—	(174)
Dividends declared	—	—	—	(5,320)	—	—	—	—	—	(5,320)
Employee stock award compensation	—	—	3,379	—	—	—	—	—	—	3,379
Excess tax benefit from exercise of stock options	—	—	1,868	—	—	—	—	—	—	1,868
Noncontrolling interests assumed related to acquisitions	—	—	—	—	—	—	—	1,778	11,600	13,378
Acquisition of noncontrolling interests, net of tax	—	—	3,018	—	—	—	—	340	(11,522)	(8,164)
Net loss attributable	—	—	—	—	—	—	—	(705)	(78)	(783)

to noncontrolling interests										
Net income attributable to The Ensign Group, Inc.	—	—	—	40,591	—	—	—	—	—	40,591
Other comprehensive loss	—	—	—	—	—	—	(437)	—	—	(437)
Balance - December 31, 2012	21,719	$22	$90,949	$239,344	301	$(2,099)	$ (1,745)	$ 1,413	$ —	$327,884
Issuance of common stock to employees and directors resulting from the exercise of stock options and grant of stock awards	343	—	3,163	—	(64)	419	—	—	—	3,582
Issuance of restricted stock to employees	51	—	385	—	—	—	—	—	—	385
Dividends declared	—	—	—	(5,882)	—	—	—	—	—	(5,882)
Employee stock award compensation	—	—	4,013	—	—	—	—	—	—	4,013
Excess tax benefit from exercise of stock options	—	—	2,854	—	—	—	—	—	—	2,854
Net loss attributable to	—	—	—	—	—	—	—	(186)	—	(186)

noncontrolling interests										
Net income attributable to The Ensign Group, Inc.	—	—	—	24,040	—	—	—	—	—	24,040
Purchase price adjustment	—	—	—	—	—	—	—	(66)	—	(66)
Other comprehensive income	—	—	—	—	—	—	633	—	—	633
Balance - December 31, 2013	22,113	$ 22	$ 101,364	$ 257,502	237	$ (1,680)	$ (1,112)	$ 1,161	$ —	$ 357,257

See accompanying notes to consolidated financial statements.

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THE ENSIGN GROUP, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Cash flows from operating activities:			
Net income	$23,854	$39,808	$47,675
Adjustments to reconcile net income to net cash provided by operating activities:			
Loss from sale of discontinued operations (Note 4)	2,837	—	—
Depreciation and amortization	33,942	28,464	23,286
Goodwill impairment (Note 11)	490	2,225	—
Amortization of deferred financing fees and debt discount	821	826	717
Deferred income taxes	3,006	(2,111)	1,090
Provision for doubtful accounts	12,106	9,474	7,921
Share-based compensation	4,399	4,739	3,356
Excess tax benefit from share-based compensation	(2,854)	(1,868)	(1,480)
Deferred income tax effect of purchase of noncontrolling interest	—	(2,464)	—
Loss on extinguishment of debt	—	—	2,542
Gain on sale of equity method investment	(380)	—	—
Loss on disposition of property and equipment	1,379	412	190
Change in operating assets and liabilities			
Accounts receivable	(27,290)	(16,150)	(24,795)
Prepaid income taxes	(6,129)	2,095	(4,549)
Prepaid expenses and other current assets	(501)	(944)	(491)
Insurance subsidiary deposits and investments	110	(5,758)	(394)
Accounts payable	(2,236)	3,152	2,701
U.S. Government inquiry accrual (Note 19)	(15,000)	15,000	—
Accrued wages and related liabilities	4,246	(6,360)	4,581
Other accrued liabilities	6,645	4,908	6,367
Accrued self-insurance	(1,842)	6,205	4,059
Deferred rent liability	(179)	397	(89)
Net cash provided by operating activities	37,424	82,050	72,687
Cash flows from investing activities:			
Purchase of property and equipment	(29,759)	(38,853)	(40,773)
Cash payment for business acquisitions	(45,101)	(31,558)	(106,747)
Cash payment for asset acquisitions	—	(11,261)	(23,385)
Escrow deposits	(1,000)	(4,635)	(175)
Escrow deposits used to fund business acquisitions	4,635	175	14,422
Cash proceeds on sale of urgent care franchising business, net of note receivable	3,607	—	—
Cash proceeds on sale of equity method investment	1,600	—	—
Cash proceeds from the sale of property and equipment	929	155	766
Restricted assets and other	(146)	1,481	(160)
Net cash used in investing activities	(65,235)	(84,496)	(156,052)
Cash flows from financing activities:			
Proceeds from issuance of debt	58,700	36,525	90,000
Payments on long-term debt	(7,207)	(16,825)	(46,259)
Repurchase of shares of common stock	—	(174)	—

Issuance of treasury stock upon exercise of options	419	634	1,241
Issuance of common stock upon exercise of options	3,163	4,067	1,607
Dividends paid	(4,318)	(6,604)	(4,637)
Excess tax benefit from share-based compensation	2,854	1,868	1,480
Purchase of noncontrolling interest	—	(5,700)	—
Payments of deferred financing costs	(730)	(244)	(2,571)
Net cash provided by financing activities	52,881	13,547	40,861
Net increase (decrease) in cash and cash equivalents	25,070	11,101	(42,504)
Cash and cash equivalents beginning of period	40,685	29,584	72,088
Cash and cash equivalents end of period	$65,755	$40,685	$29,584

See accompanying notes to consolidated financial statements.

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

	Year Ended December 31,		
	2013	2012	2011
	(In thousands)		
Supplemental disclosures of cash flow information:			
Cash paid during the period for:			
Interest	$12,809	$12,394	$13,871
Income taxes	$19,323	$24,842	$31,602
Non-cash financing and investing activity:			
Acquisition of redeemable noncontrolling interest	$—	$11,600	$—
Accrued capital expenditures	$1,693	$1,734	$571
Note receivable on sale of urgent care franchising business	$4,000	$—	$—

See accompanying notes to consolidated financial statements.

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THE ENSIGN GROUP, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Dollars and shares in thousands, except per share data)
1. DESCRIPTION OF BUSINESS

The Company — The Ensign Group, Inc., through its subsidiaries (collectively, Ensign or the Company), provides skilled nursing and rehabilitative care services through the operation of 119 facilities, nine home health and seven hospice operations, seven urgent care centers and a mobile x-ray and diagnostic company as of December 31, 2013, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. The Company's operations, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of healthcare services including skilled nursing, assisted living, home health and hospice, mobile ancillary, and urgent care services. The Company's facilities have a collective capacity of approximately 13,200 operational skilled nursing, assisted living and independent living beds. As of December 31, 2013, the Company owned 96 of its 119 facilities and operated an additional 23 facilities through long-term lease arrangements, and had options to purchase two of those 23 facilities.
The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenue. All of the Company’s operations are operated by separate, independent subsidiaries, each of which has its own management, employees and assets. One of the Company’s wholly-owned subsidiaries, referred to as the Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. The Company also has a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to the Company’s operating subsidiaries for general and professional liability, as well as coverage for certain workers’ compensation insurance liabilities.
Like the Company’s facilities, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar verbiage in this annual report is not meant to imply that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by the same entity.

2. PROPOSED SPIN-OFF OF REAL ESTATE ASSETS THROUGH A REAL ESTATE INVESTMENT TRUST (REIT)

On November 7, 2013, the Company announced a plan to separate its healthcare business and its real estate business into two separate, publicly traded companies:

- Ensign, which will continue to provide healthcare services through its existing operations; and
- CareTrust REIT, Inc. (CareTrust), which will own, acquire and lease real estate serving the healthcare industry.

The Company intends to accomplish the proposed separation by distributing all of the outstanding shares of CareTrust common stock to the Company’s stockholders on a pro rata basis (the Spin-Off). At the time of the Spin-Off, CareTrust, which is currently a wholly owned subsidiary of the Company, will hold substantially all of the real property owned by the Company, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for three independent living facilities that CareTrust will operate) will be leased to the Company on a triple-net basis, under which the Company will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

In accordance with Accounting Standards Codification (ASC) 505-60, Equity-Spinoffs and Reverse Spinoffs, the accounting for the separation of the Company follows its legal form, with Ensign as the legal and accounting spinnor

and CareTrust as the legal and accounting spinnee, due to the relative significance of Ensign’s healthcare business, the relative fair values of the respective companies, the retention by Ensign of all senior management except Gregory K. Stapley by Ensign, and other relevant indicators.

As part of the proposed Spin-Off, CareTrust intends to elect to be taxed and intends to qualify as a real estate investment trust (REIT) for U.S. federal income tax purposes commencing with its taxable year ending December 31, 2014. As a REIT, CareTrust will have to satisfy certain requirements relating to diversity of ownership, including a requirement that not more than 50% of its stock may be owned by five or fewer individuals. In order to help CareTrust satisfy the REIT requirements, its charter will include “excess share” provisions typical for REITs that will prohibit ownership of more than 9.8% of its outstanding shares. On November 7, 2013, the board of directors of the Company adopted a stockholder rights plan to discourage any of the Company's stockholders from exceeding this ownership level prior to the Spin-Off. In connection with the adoption of the stockholder rights plan, the board of directors declared a dividend of one right (a Right) for each share of Company common stock held by stockholders of record at the close of business on November 18, 2013. The Company will also issue one Right with each new share of the

Company's common stock that is subsequently issued while the stockholder rights plan is in place. The Rights are issued pursuant to a Rights Agreement, dated as of November 7, 2013 (the Rights Agreement). Initially, the Rights will not be exercisable and will trade with the shares of Company common stock. The Rights will generally be exercisable only if a person or group becomes an "acquiring person" by (i) acquiring beneficial ownership of 9.8% or more of the Company's common stock or, in the case of any person (including such person's affiliates and associates) that beneficially owns 9.8% or more of the Company's common stock, upon the acquisition of additional shares by such person, or (ii) commencing a tender offer or exchange offer which, if consummated, could result in a person owning 9.8% or more of the Company's common stock.

If a person or group becomes an acquiring person, the Rights will generally entitle each holder, other than the acquiring person, to acquire, for the exercise price of $200 per Right (subject to adjustment), shares of the Company's common stock (or, in certain circumstances, other consideration) having a market value equal to twice the exercise price. The Rights will expire at 5:00 P.M., New York City time, on the earlier of (i) the first business day after consummation of the proposed Spin-Off, or (ii) November 6, 2014, unless redeemed or exchanged earlier or unless the board of directors extends the expiration date. The Rights will not prevent a takeover of the Company, but may cause substantial dilution to a person that acquires 9.8% or more of the Company's common stock.

The proposed Spin-Off is conditioned on, among other things, final approval by the Board of Directors of the Company, the receipt of a ruling from the IRS that, among other things the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes, the receipt of an opinion of counsel as to the satisfaction of certain requirements for such tax-free treatment and, the receipt of an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014, CareTrust has been organized in conformity with the requirements for qualification as a REIT under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying consolidated financial statements (Financial Statements) have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP). The Company is the sole member or shareholder of various consolidated limited liability companies and corporations; each established to operate various acquired healthcare service operations. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interest within the equity section of its consolidated balance sheets. The Company presents the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interest in its consolidated statements of income.

The consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest and the accounts of any variable interest entities (VIEs) where the Company is subject to a majority of the risk of loss from the VIE's activities, or entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impact" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. The Company's relationship with variable interest entities was not material at December 31, 2013.

On March 25, 2013, the Company agreed to terms to sell Doctors Express (DRX), a national urgent care franchise system. The asset sale was effective on April 15, 2013. The results of operations for DRX have been classified as discontinued operations for all periods presented in the accompanying Financial Statements (see Note 4, Discontinued Operations). Certain assets and liabilities included in the sale of DRX have been presented as held for sale in the

accompanying consolidated balance sheet as of December 31, 2012. In addition, the results of operations of DRX and the loss or impairment related to this divesture have been classified as discontinued operations in the accompanying consolidated statements of income for all periods presented.

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

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

Fair Value of Financial Instruments — The Company's financial instruments consist principally of cash and cash equivalents, debt security investments, interest rate swap agreements, 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. The interest rate swap is carried at fair value on the balance sheet. The Company's fixed-rate debt instruments do not actively trade in an established market. The fair values of this debt are estimated by discounting the principal and interest payments at rates available to the Company for debt with similar terms and maturities. See further discussion of debt security investments in Note 6, Fair Value Measurements.

Revenue Recognition — The Company recognizes revenue when the following four conditions have been met: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii) the price is fixed or determinable; and (iv) collection is reasonably assured. The Company's revenue is derived primarily from providing healthcare services to residents and is recognized on the date services are provided at amounts billable to the individual. For reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts on a per patient, daily basis.

Revenue from the Medicare and Medicaid programs accounted for 72.2%, 73.6% and 75.2% of the Company's revenue for the years ended December 31, 2013, 2012 and 2011, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. The Company recorded retroactive adjustments to revenue which were not material to the Company's consolidated revenue for the years ended December 31, 2013, 2012 and 2011.

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

Skilled Nursing Revenue

The Company's revenue is derived primarily from providing long-term healthcare services to residents and is recognized on the date services are provided at amounts billable to individual residents. For residents under reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts on a per patient, daily basis. The Company records revenue from private pay patients, at the agreed-upon rate, as services are performed.

Home Health Revenue

Medicare Revenue

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

overpayments.

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

In addition to revenue recognized on completed episodes, the Company also recognizes a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. Thereby, estimating revenue and recognizing it on a daily basis.

Non-Medicare Revenue

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

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

Hospice Revenue

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

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

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

Cash and cash equivalents — Cash and cash equivalents consist of bank term deposits, money market funds and treasury bill related investments with original maturities of three months or less at time of purchase and therefore approximate fair value. The fair value of money market funds is determined based on “Level 1” inputs, which consist of unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets. The Company places its cash and short-term investments with high credit quality financial institutions.

Insurance Subsidiary Deposits and Investments — The Company's captive insurance subsidiary cash and cash equivalents, deposits and investments are designated to support long-term insurance subsidiary liabilities and have been classified as long-term assets. The majority of these deposits and investments are currently held in AA- and A-rated debt security investments and the remainder is held in a bank account with a high credit quality financial institution. See further discussion at Note 6, Fair Value Measurements.

Equity Investment — As of December 31, 2012, one of the Company's subsidiaries had a non-marketable equity investment which was accounted for under the equity method. The investment was initially recorded at cost and the Company adjusted the carrying amount for its share of the earnings or losses of the investee after the date of investment. On April 23, 2013, the Company entered into a common unit redemption agreement with the investee where the non-marketable equity investment was repurchased. See further discussion at Note 12, Restricted and Other

Assets.

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

Impairment of Long-Lived Assets — The Company reviews the carrying value of long-lived assets that are held and used in the Company's operations 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 operations to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has not identified any asset impairment during the years ended December 31, 2013, 2012 or 2011.

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

The Company's indefinite-lived intangible assets consist of trade names and home health and hospice Medicare licenses. The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable. Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. The Company defines reporting units as the individual operations. The Company performs its annual test for impairment during the fourth quarter of each year. See further discussion at Note 11, Goodwill and Other Indefinite-Lived Intangible Assets.

Deferred Rent — Deferred rent represents rental expense (determined on a straight-line basis over the life of the related lease) in excess of actual rent payments.

Self-Insurance — The Company is partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. For claims made after January 1, 2013, the self-insured retention was $500 per claim, subject to an additional one-time deductible of $1,000 for California facilities and a separate, one-time deductible of $750 for non-California facilities. For all facilities, except those located in Colorado, the third-party coverage above these amounts was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate available to both California and non-California operations, separately. In Colorado, the third-party coverage above these limits was $1,000 per claim and $3,000 per facility, which is independent of the aforementioned blanket aggregate applicable to its other 113 facilities.

The self-insured retention and deductible limits for general and professional liability and California workers' compensation are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying 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, 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.

The Company’s operating subsidiaries are self-insured for workers’ compensation liability in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $500 for each occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers’ compensation claims and, effective February 1, 2011, the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 for each occurrence. The Company’s operating subsidiaries in other states have third party guaranteed cost coverage. In California and Texas, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information.

In addition, the Company has recorded an asset and equal liability of $3,280 and $3,219 at December 31, 2013 and December 31, 2012, 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 12, Restricted and Other Assets.

The Company provides self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 per each covered member, subject to an additional one-time deductible of $75.

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

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

When the Company takes uncertain income tax positions that do not meet the recognition criteria, it records a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, the Company must consider the potential outcomes from a review of the positions by the taxing authorities.

In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

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

Stock-Based Compensation — The Company measures and recognizes compensation expense for all share-based payment awards made to employees and directors including employee stock options based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the

fair value of all stock options and restricted stock awards issued, the amount of which is contingent upon the number of future grants and other variables.

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

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 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.

Accumulated Other Comprehensive Loss and Total Comprehensive Income — Accumulated other comprehensive loss refers to revenue, expenses, gains, and losses that are recorded as an element of stockholders' equity but are excluded from net income. The Company's other comprehensive loss consists of net deferred gains and losses on certain derivative instruments accounted for as cash flow hedges. As of December 31, 2013 accumulated other comprehensive loss was $1,828, recorded net of tax of $716, or $1,112. As of December 31, 2012, accumulated other comprehensive loss was $2,866, recorded net of tax of $1,121, or $1,745.

Recent Accounting Pronouncements — Except for rules and interpretive releases of the Securities and Exchange Commission (SEC) under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) ASC is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. The Company has reviewed the FASB issued Accounting Standards Update (ASU) accounting pronouncements and interpretations thereof that have effectiveness dates during the periods reported and in future periods. The Company has carefully considered the new pronouncements that alter previous generally accepted accounting principles and does not believe that 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.

Additionally, the FASB and the International Accounting Standards Board are working on joint convergence projects to address accounting differences between GAAP and International Financial Reporting Standards in order to support their commitment to achieve a single set of high-quality global accounting standards. One of the projects under deliberation includes accounting for leases. If enacted in its current draft form, the Company anticipates that the lease accounting proposal could impact its consolidated financial statements; however, the FASB's standard-setting process is ongoing and until new standards have been finalized and issued, the Company cannot quantify and determine the impact on its consolidated financial statements that may result from such future changes.

4. DISCONTINUED OPERATIONS

On March 25, 2013, the Company agreed to terms to sell DRX, a national urgent care franchise system for approximately $8,000, adjusted for certain assets and liabilities. The asset sale was effective on April 15, 2013. The assets acquired at the initial purchase of DRX, including noncontrolling interest, were recorded at fair value. The initial fair value was greater than total cash paid to acquire all interests in DRX and the subsequent sale price. The sale of DRX has been accounted for as discontinued operations. Accordingly, the results of operations of this business for all periods presented and the loss related to this divesture have been classified as discontinued operations in the accompanying consolidated statements of income. As the sale was effective April 15, 2013, all assets and liabilities included in the sale were recorded as held for sale on the Company's consolidated balance sheets as of December 31, 2012.

A summary of discontinued operations follows:

	Years Ended December 31,		
	2013	2012	2011
Revenue	$728	$1,564	$—
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	(807)	(3,646)	—
Charges to discontinued operations for the excess carrying amount of goodwill and other indefinite-lived intangible assets	(2,837)	—	—
Facility rent—cost of services	(12)	(38)	—
Depreciation and amortization	(33)	(106)	—
Loss from discontinued operations	(2,961)	(2,226)	—
Benefit from income taxes	(1,157)	(869)	—
Loss from discontinued operations, net of income tax benefit	$(1,804)	$(1,357)	$—

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A summary of the net assets held for sale are as follows:

	December 31,	
	2013	2012
Current assets	$—	$268
Long-term assets:		
Goodwill	—	1,099
Other identifiable intangible assets, net	—	10,200
Other long-term assets, net	—	25
Total assets held for sale	—	11,592
Current liabilities	—	(339)
Long-term liabilities	—	(130)
Total liabilities held for sale	—	(469)
Net assets held for sale	$—	$11,123

5. 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:

	Years Ended December 31,		
	2013	2012	2011
Numerator:			
Income from continuing operations	$25,658	$41,165	$47,675
Less: net loss attributable to noncontrolling interests	(186)	(783)	—
Income from continuing operations attributable to The Ensign Group, Inc.	25,844	41,948	47,675
Plus: loss from discontinued operations, net of income tax	(1,804)	(1,357)	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675
Denominator:			
Weighted average shares outstanding for basic net income per share	21,900	21,429	20,967
Basic net income (loss) per common share:			
Income from continuing operations attributable to The Ensign Group, Inc.	$1.18	$1.96	$2.27
Loss from discontinued operations	(0.08)	(0.07)	—
Net income attributable to The Ensign Group, Inc.	$1.10	$1.89	$2.27

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

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

	Years Ended December 31,		
	2013	2012	2011
Numerator:			
Income from continuing operations	$25,658	$41,165	$47,675
Less: net loss attributable to the noncontrolling interests	(186)	(783)	—
Income from continuing operations attributable to The Ensign Group, Inc.	25,844	41,948	47,675
Plus: loss from discontinued operations, net of income tax	(1,804)	(1,357)	—
Net income attributable to The Ensign Group, Inc.	$24,040	$40,591	$47,675
Denominator:			
Weighted average common shares outstanding	21,900	21,429	20,967
Plus: incremental shares from assumed conversion [1]	464	513	616
Adjusted weighted average common shares outstanding	22,364	21,942	21,583
Diluted net income (loss) per common share:			
Income from continuing operations attributable to The Ensign Group, Inc.	$1.16	$1.91	$2.21
Loss from discontinued operations	(0.09)	(0.06)	—
Net income attributable to The Ensign Group, Inc.	$1.07	$1.85	$2.21

[1] Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 402, 340 and 97 for the years ended December 31, 2013, 2012 and 2011, respectively.

6. FAIR VALUE MEASUREMENTS

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

The following table summarizes the financial assets and liabilities measured at fair value on a recurring basis as of December 31, 2013 and 2012:

	December 31,					
	2013			2012		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$65,755	$—	$—	$40,685	$—	$—
Fair value of interest rate swap	$—	$1,828	$—	$—	$2,866	$—

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

Investments - Held to Maturity

At December 31, 2013 and 2012, the Company had approximately $22,399 and $22,510, respectively, in insurance subsidiary debt security investments which were classified as held to maturity and carried at amortized cost. The carrying value of the debt securities approximates fair value. The Company has the intent and ability to hold these debt securities to maturity. Further, at December 31, 2013, $4,066 is held in AA-rated debt securities backed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program, and $18,333 is held in A-rated debt securities. These debt securities mature from February 2013 to October 2015. At December 31, 2012, $6,310 was held in AA-rated debt securities and $16,200 was held in A-rated debt securities.

Interest Rate Swap Agreement

In connection with the Senior Credit Facility with a lending consortium arranged by SunTrust and Wells Fargo (the Senior Credit Facility), in July 2011, the Company entered into an interest rate swap agreement in accordance with Company policy to reduce risk from volatility in the income statement due to changes in the LIBOR interest rate. The swap agreement, with a notional amount of $75,000, amortizing concurrently with the related term loan portion of the Senior Credit Facility, was five years in length and set to mature on July 15, 2016. The interest rate swap has been designated as a cash flow hedge and, as such, changes in fair value are reported in other comprehensive income in accordance with hedge accounting. Under the terms of this swap agreement, the net effect of the hedge was to record swap interest expense at a fixed rate of approximately 4.3%, exclusive of fees. Net interest paid under the swap was $1,047, $951 and $471 for the year ended December 31, 2013, 2012, and 2011, respectively. In addition, based on the December 31, 2013 interest rate swap valuation, the Company expects to record swap interest expense of approximately $1,100 during the year ended December 31, 2014.

The Company assesses hedge effectiveness at inception and on an ongoing basis by performing a regression analysis. The regression analysis compares the historical monthly changes in fair value of the interest rate swap to the historical monthly changes in the fair value of a hypothetically perfect interest rate swap over the trailing 30 months. The change in fair value of the hypothetical derivative is regarded as a proxy for the present value of the cumulative change in the expected future cash flows on the hedged transaction. The regression analysis serves as the Company's prospective and retrospective assessment of hedge effectiveness. Assuming the hedging relationship qualifies as highly effective, the actual swap will be recorded at fair value on the balance sheet and accumulated other comprehensive income (loss) will be adjusted to reflect the lesser of either the cumulative change in the fair value of the actual swap or the cumulative change in the fair value of the hypothetical derivative.

The interest rate swap agreement is recorded at fair value based upon valuation models which utilize relevant factors such as the contractual terms of the interest rate swap agreements, credit spreads for the contracting parties and interest rate curves. Based on this valuation method, the Company categorized the interest rate swap as Level 2 and recorded accumulated other comprehensive losses as of December 31, 2013 of $1,828, recorded net of tax of $716, or $1,112 in stockholders' equity, compared to $2,866, recorded net of tax of $1,121, or $1,745 as of December 31, 2012. There are no amounts attributable to hedge ineffectiveness that were required to be recognized in earnings.

7. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the years ended December 31, 2013, 2012 and 2011 is summarized in the following tables:

	December 31,								
	2013			2012			2011		
	$	%		$	%		$	%	
Medicaid	$323,803	35.8	%	$302,046	36.7	%	$277,736	36.6	%
Medicare	292,917	32.4		278,578	33.8		272,283	35.9	
Medicaid — skilled	36,085	4.0		25,418	3.1		20,290	2.7	
Total Medicaid and Medicare	652,805	72.2		606,042	73.6		570,309	75.2	
Managed care	118,168	13.1		106,268	12.9		94,266	12.4	

Private and other payors[1]	133,583	14.7		110,845	13.5		93,702	12.4	
Revenue	$904,556	100.0	%	$823,155	100.0	%	$758,277	100.0	%

[1] Private and other payors includes revenue from urgent care centers and other ancillary businesses.

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Accounts receivable as of December 31, 2013 and 2012 is summarized in the following table:

	December 31,	
	2013	2012
Medicaid	$38,068	$28,534
Managed care	30,911	26,707
Medicare	34,562	32,168
Private and other payors	24,369	20,589
	127,910	107,998
Less: allowance for doubtful accounts	(16,540)	(13,811)
Accounts receivable	$111,370	$94,187

8. ACQUISITIONS

The Company's acquisition policy is generally to purchase or lease operations to complement the Company's existing portfolio. The results of all the Company's operations are included in the accompanying Financial Statements subsequent to the date of acquisition. Acquisitions are typically paid for in cash and are accounted for using the acquisition method of accounting. Where the Company enters into facility lease agreements, the Company typically does not pay any material amount to the prior facility operator nor does the Company acquire any assets or assume any liabilities, other than rights and obligations under the lease and operations transfer agreement, as part of the transaction. Some leases include options to purchase the facilities. As a result, from time to time, the Company will acquire facilities that the Company has been operating under third-party leases.

During the year ended December 31, 2013, the Company acquired seven stand-alone skilled nursing facilities, three stand-alone assisted living facilities, three home health operations, three hospice operations and one urgent care center. The aggregate purchase price of the 17 business acquisitions was approximately $45,364, which was paid in cash. The Company also entered into a separate operations transfer agreement with the prior tenant as part of each transaction. The operations acquired during the year ended December 31, 2013 are as follows:

- On January 1, 2013, the Company acquired a home health operation in Washington for approximately $2,801, which was paid in cash. The acquisition did not have an impact on the Company's operational bed count. The Company recognized $1,966 and $815 in goodwill and other indefinite-lived intangible assets, respectively, as part of this transaction.
- On January 1, 2013, the Company acquired two hospice operations in Arizona and California, respectively, for approximately $1,825, which was paid in cash. The acquisition did not have an impact on the Company's operational bed count. The Company recognized $1,825 in other indefinite-lived intangible assets as part of these transactions.
- On February 16, 2013, the Company acquired a home health operation in Texas for approximately $375, which was paid in cash. This acquisition did not have an impact on the Company's operational bed count. The Company recognized $375 in other indefinite-lived intangible assets as part of this transaction.
- On March 1, 2013, the Company acquired a home health and hospice operation in Washington for approximately $1,137, which was paid in cash. This acquisition did not have an impact on the Company's operational bed count. The Company recognized $1,137 in other indefinite-lived intangible assets as part of this transaction.
- In addition, on March 1, 2013, the Company purchased a skilled nursing facility in Texas for approximately $4,508, which was paid in cash. This acquisition added 150 operational skilled nursing beds to the Company's operations.
- On April 1, 2013, the Company acquired three skilled nursing facilities in Texas for an aggregate purchase price of approximately $7,114, which was paid in cash. These acquisitions added 280 operational skilled nursing beds to the Company's operations.
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On May 1, 2013, the Company acquired a skilled nursing facility and an assisted living facility in Washington for an aggregate purchase price of $11,585, which was paid in cash. These acquisitions added 102 operational assisted living units and 110 operational skilled nursing beds to the Company's operations.

- In addition, on May 1, 2013, the Company acquired a skilled nursing facility in Nebraska for approximately $2,846, which was paid in cash. This acquisition added 70 operational skilled nursing beds to the Company's operations.
- On June 1, 2013, the Company acquired an assisted living facility in California for approximately $4,263, which was paid in cash. This acquisition added 110 operational assisted living units to the Company's operations.
- In addition, on June 1, 2013, the Company acquired an assisted living facility in Utah for approximately $2,856, which was paid in cash. This acquisition added 69 operational assisted living units to the Company's operations.
- On July 1, 2013 the Company acquired a skilled nursing facility in Washington for approximately $4,499, which was paid in cash. This acquisition added 82 operational skilled nursing beds to the Company's operations.
- In addition, on September 16, 2013, the Company acquired an existing leased urgent care center for approximately $1,555, which was paid in cash. The Company assumed the existing lease that was in place at the time of acquisition. The urgent care center acquisition did not have an impact on the Company's bed count. As part of this acquisition, the Company recognized $1,231 in goodwill.

During the year ended December 31, 2012, the Company acquired five stand-alone skilled nursing facilities, one stand-alone assisted living facility, two home health operations and one hospice operation. The aggregate purchase price of the nine long-term care business acquisitions was approximately $31,558, which was paid in cash. The Company also entered into a separate operations transfer agreement with the prior tenant as part of each transaction.

In addition, during the year ended December 31, 2012, the Company purchased the underlying assets of three of its skilled nursing facilities in California which it previously operated under long-term lease agreements, which contained options to purchase, for $11,386, which was paid in cash. These acquisitions did not impact the Company's operational bed count.

In January 2012, the Company announced the formation of Immediate Clinic (IC) to develop and operate urgent care centers and related businesses. The first IC operated centers opened in the third quarter of 2012. As of the year ended December 31, 2013, the Company had seven IC operated centers open. On October 4, 2012, the Company invested an additional $6,000 to IC in exchange for senior preferred stock, which resulted in the Company holding approximately 96% of the outstanding interests in the joint venture on a fully-diluted basis. On December 20, 2012, the Company purchased the remaining outstanding interests in IC for approximately $400.

On March 1, 2012, DRX Urgent Care LLC (DRX), a newly formed subsidiary of IC, purchased substantially all of the assets and assumed certain liabilities of Doctors Express Franchising LLC, a national urgent care franchise system for $2,000, adjusted for certain items at the time of close and redeemable noncontrolling interest. The redeemable noncontrolling interest was fair valued at the acquisition date at $11,600. The Company recognized intangible assets of $7,900 in trade name, $3,000 in franchise relationships and $2,724 in goodwill. See additional details in Note 11, Goodwill and Other Indefinite-Lived Intangible Assets - Net. On December 31, 2012, IC purchased the remaining ownership interest in DRX for approximately $5,300.
On December 31, 2012, the Company purchased 80% of the membership interest of a mobile x-ray and diagnostic company for $5,800, plus preliminary net working capital of approximately $1,300 for total consideration of approximately $7,100, which was paid in cash. The Company recognized intangible assets of approximately $900 in trade name, $4,200 in customer relationship and $2,100 in goodwill. The Company believes that goodwill will be deductible for tax purposes. See additional details in Note 11 Goodwill and Other Indefinite-Lived Intangible Assets-Net to the Financial Statements.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The table below presents the allocation of the purchase price for the operations acquired in business combinations during the years ended December 31, 2013 and 2012:

	December 31,	
	2013	2012
Land	$9,312	$1,012
Building and improvements	26,593	17,615
Equipment, furniture, and fixtures	1,386	1,771
Assembled occupancy	724	289
Goodwill	3,197	7,105
Other indefinite-lived intangible assets	4,152	10,007
Definite-lived intangible assets	—	7,200
Other assets acquired, net of liabilities assumed	—	651
Total acquisitions	$45,364	$45,650
Less: redeemable noncontrolling interest	—	(11,600)
Less: noncontrolling interest in mobile diagnostic company acquired	—	(1,778)
Less: cash received at acquisition	—	(714)
Total cash paid for acquisitions	$45,364	$31,558

The Company’s acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return on invested capital. The operations acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not meaningful, representative of the Company’s current operating results or indicative of the integration potential of its newly acquired operations. The businesses acquired in each of the years ending December 31, 2013, and 2012 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the consolidated balance sheet of the Company, and the operating results have been included in the consolidated statement of income of the Company since the dates the Company gained effective control.

9. PROPERTY AND EQUIPMENT

Property and equipment consist of the following:

	December 31,	
	2013	2012
Land	$79,679	$70,487
Buildings and improvements	379,021	341,096
Equipment	97,984	80,860
Furniture and fixtures	8,851	8,790
Leasehold improvements	44,123	32,570
Construction in progress	2,081	14,185
	611,739	547,988
Less: accumulated depreciation	(131,969)	(100,133)
Property and equipment, net	$479,770	$447,855

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THE ENSIGN GROUP, INC.
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10. INTANGIBLE ASSETS — Net

Intangible Assets	Weighted Average Life (Years)	December 31, 2013 Gross Carrying Amount	Accumulated Amortization	Net	2012 Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	15.5	$684	$(589)	$95	$684	$(545)	$139
Favorable lease	15.0	1,596	(532)	1,064	1,596	(426)	1,170
Assembled occupancy	0.5	2,979	(2,948)	31	2,255	(2,211)	44
Facility trade name	30.0	733	(195)	538	733	(171)	562
Customer relationships	20.0	4,200	(210)	3,990	4,200	—	4,200
Total		$10,192	$(4,474)	$5,718	$9,468	$(3,353)	$6,115

Amortization expense was $1,121, $571 and $1,329 for the years ended December 31, 2013, 2012 and 2011, respectively. Of the $1,121 in amortization expense incurred during the year ended December 31, 2013, approximately $737 related to the amortization of patient base intangible assets at recently acquired facilities, which is typically amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date.

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

Year	Amount
2014	$416
2015	365
2016	345
2017	345
2018	345
Thereafter	3,902
	$5,718

11. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

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

On March 25, 2013, the Company agreed to terms to sell DRX, a national urgent care franchise system for approximately $8,000, adjusted for certain assets and liabilities. The asset sale was effective on April 15, 2013. The sale resulted in a pre-tax loss of $2,837 for the year ended December 31, 2013. The Company recognized charges to discontinued operations for the excess carrying amount of goodwill and other indefinite-lived intangible assets of $1,099 and $1,738, respectively, during the year ended December 31, 2013 as part of this transaction. See Note 4, Discontinued Operations for additional information.

The following table represents activity in goodwill as of and for the years ended December 31, 2013, 2012 and 2011:

	Goodwill
January 1, 2011	$10,339
Additions	6,838
Impairments	—
December 31, 2011	17,177
Additions	7,104
Impairments	(1,625)
December 31, 2012	22,656
Less: charge to discontinued operations for the excess carrying amount of goodwill	(1,099)
	21,557
Additions	3,197
Impairment	(490)
Purchase price adjustment	(329)
December 31, 2013	$23,935

The Company recorded an impairment charge to goodwill on one facility of $490 for the year ended December 31, 2013. The facility experienced a significant reduction in admissions due to extensive renovations, which occurred over a year, which resulted in declines in related forecasted cash flows, resulting in the impairment to goodwill. Prior to this, the Company had not recorded a goodwill impairment charge related to a facility since the year ended December 31, 2010. Since 1999, the Company has recognized cumulative goodwill impairment losses of $3,399. The purchase price adjustment of $329 relates to the finalization of net working capital for the Company's acquisition in a mobile x-ray and diagnostic company in fiscal year 2012.

The initial fair value of DRX assets and liabilities incorporated the fair value analysis of the noncontrolling interest. Therefore, the original carrying value was based on the fair value of the noncontrolling interest and cash paid. In the course of performing its impairment analysis for the year ended December 31, 2012, the Company performed an impairment test over the assets of DRX. As part of the impairment test, the Company calculated the fair value of certain assets, including trade name and franchise agreements. To determine the implied value of goodwill, fair values were allocated to the assets and liabilities of DRX as of December 31, 2012. The implied fair value of goodwill was measured as the excess of the fair value of DRX over the amounts assigned to its assets and liabilities. The impairment loss for DRX was measured by the amount the carrying value of goodwill exceeded the implied fair value of the goodwill. Based on this assessment, the Company recorded a charge to goodwill and trade name at DRX of $1,625 and $600, respectively, in the year ended December 31, 2012, which the Company attributed to a decline in the estimated fair value of redeemable noncontrolling interest. See Note 4, Discontinued Operations.

As of December 31, 2013, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes.

During the year ended December 31, 2013, the Company recorded $4,109 and $43 in home health and hospice Medicare license and trade name indefinite-lived intangible assets, respectively, as part of its acquisition of three home health and three hospice operations.

Other indefinite-lived intangible assets consists of the following:

	December 31,	
	2013	2012
Trade name	$1,033	$990

Home health and hospice Medicare license	6,707	2,598
	$7,740	$3,588

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12. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	December 31,	
	2013	2012
Note receivable	$2,000	$—
Debt issuance costs, net	2,801	2,769
Long-term insurance losses recoverable asset	3,280	3,219
Deposits with landlords	872	749
Capital improvement reserves with landlords and lenders	706	683
Equity method investment	—	1,220
Other long-term assets	145	—
Restricted and other assets	$9,804	$8,640

Included in other assets as of December 31, 2013 and 2012, are anticipated insurance recoveries related to the Company's general and professional liability claims that are recorded on a gross rather than net basis in accordance with an Accounting Standards Update issued by the FASB, capitalized debt issuance costs and the long-term portion of a note receivable from the sale of DRX. See Note 4, Discontinued Operations. Included in other assets as of December 31, 2012, was a non-marketable equity investment accounted for under the equity method. On April 23, 2013, the Company entered into a common unit redemption agreement with the investee where the non-marketable equity investment was repurchased for $1,600. The Company recognized a gain on the sale of its non-marketable equity investment of $380 in the second quarter of 2013.

13. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	December 31,	
	2013	2012
Quality assurance fee	$3,933	$2,010
Resident refunds payable	5,238	4,564
Deferred revenue	4,633	5,661
Cash held in trust for residents	1,780	1,520
Resident deposits	1,680	1,666
Dividends payable	1,564	—
Property taxes	2,894	2,264
Other	3,976	3,186
Other accrued liabilities	$25,698	$20,871

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

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THE ENSIGN GROUP, INC.
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14. INCOME TAXES

The provision for income taxes for the years ended December 31, 2013, 2012 and 2011 is summarized as follows:

	December 31,		
	2013	2012	2011
Current:			
Federal	$13,457	$24,434	$24,217
State	2,766	4,445	4,185
	16,223	28,879	28,402
Deferred:			
Federal	3,777	(2,433)	2,041
State	3	(1,312)	(951)
	3,780	(3,745)	1,090
Total	$20,003	$25,134	$29,492

A reconciliation of the federal statutory rate to the effective tax rate for the years ended December 31, 2013, 2012 and 2011, respectively, is comprised as follows:

	December 31,		
	2013	2012	2011
Income tax expense at statutory rate	35.0 %	35.0 %	35.0 %
State income taxes - net of federal benefit	4.0	3.0	2.9
Non-deductible settlement costs	5.0	—	—
Non-deductible expenses	0.6	0.5	0.3
Other adjustments	(0.8)	(0.6)	—
Total income tax provision	43.8 %	37.9 %	38.2 %

The Company's deferred tax assets and liabilities as of December 31, 2013 and 2012 are summarized as follows:

	December 31,	
	2013	2012
Deferred tax assets (liabilities):		
Accrued expenses	$12,814	$16,916
Allowance for doubtful accounts	6,836	5,705
Tax credits	2,898	2,400
Captive insurance	8,979	7,360
Total deferred tax assets	31,527	32,381
State taxes	(1,111)	(327)
Depreciation and amortization	(10,825)	(11,828)
Prepaid expenses	(5,895)	(3,121)
Total deferred tax liabilities	(17,831)	(15,276)
Net deferred tax assets	$13,696	$17,105

The Company had state credit carryforwards as of December 31, 2013 and 2012 of $2,898 and $2,400, respectively. These carryforwards almost entirely relate to state limitations on the application of Enterprise Zone employment-related tax credits. These Enterprise Zone credits are currently expected to carryforward until 2023 to offset future state income tax. The remainder of these carryforwards relate to credits against the Texas margin tax and is expected to carryforward until 2027.

The Company had Federal net operating loss carryforwards as of December 31, 2013 and 2012 of $1,243 and $932, respectively. These Federal net operating losses are expected to carry forward until 2032. The Company also had state net operating losses as of December 31, 2013 and 2012 of $559 and $1,134, respectively. These state net operating losses carry forward over various periods.

As of December 31, 2013, 2012 and 2011, the Company did not have any unrecognized tax benefits that would affect the Company's effective tax rate.

The Federal statutes of limitations on the Company's 2007, 2008, and 2009 income tax years lapsed during the third quarter of 2011, 2012 and 2013, respectively. During the fourth quarter of each year, various state statutes of limitations also lapsed. The lapses for the years ended December 31, 2013, 2012 and 2011 had no impact on the Company's unrecognized tax benefits.

During the first quarter of 2012, the State of California initiated an examination of the Company's income tax returns for the 2008 and 2009 income tax years. The examination was primarily focused on the Captive and the treatment of related insurance matters. To date, California has not proposed any adjustments. The Company is not currently under examination by any other major income tax jurisdiction. The Company does not believe the California examination or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months.

The Company classifies interest and/or penalties on income tax liabilities or refunds as additional income tax expense or income. Such amounts are not material.
The Company recorded total pre-tax charges related to the settlement with the U.S. Department of Justice (DOJ) and related expenses of $33,000 and $15,000 during the years ended December 31, 2013 and 2012, respectively, for a total charge of $48,000. The Company recorded estimated tax benefits of $10,383 and $5,865 during the year ended December 31, 2013 and three months ended December 31, 2012, respectively. See Note 19, Commitments and Contingencies.

15. LEASES

The Company leases certain facilities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company also 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, was $14,073, $13,779 and $14,185 for the years ended December 31, 2013, 2012 and 2011, respectively.

Future minimum lease payments for all leases as of December 31, 2013 are as follows:

Year	Amount
2014	$13,693
2015	13,677
2016	13,686
2017	13,722
2018	13,764
Thereafter	71,093
	$139,635

Six of the Company's facilities are operated under two separate three-facility master lease arrangements and a breach at a single facility could subject multiple facilities covered by the same master lease to the same default risk. Under a master lease, the Company may lease a large number of geographically dispersed properties through an indivisible lease. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in the Company's outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord. In addition, a number of the Company's individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the landlords under separate but cross-defaulted leases. The Company is not aware of any defaults as of December 31, 2013.

16. SELF INSURANCE RESERVES

The following table represents activity in our insurance reserves as of and for the years ended December 31, 2013 and 2012:

	General and Professional Liability	Worker's Compensation	Health	Total
Balance January 1, 2012	$32,010	$ 9,827	$2,436	$44,273
Current year provisions	13,226	7,186	14,302	34,714
Claims paid and direct expenses	(9,207)	(5,031)	(14,271)	(28,509)
Long-term insurance losses recoverable	(921)	1,326	—	405
Balance December 31, 2012	35,108	13,308	2,467	50,883
Current year provisions	7,879	6,656	17,170	31,705
Claims paid and direct expenses	(11,890)	(4,755)	(16,901)	(33,546)
Long-term insurance losses recoverable	(648)	709	—	61
Balance December 31, 2013	$30,449	$ 15,918	$2,736	$49,103

Included in long-term insurance losses recoverable as of December 31, 2013 and 2012, are anticipated insurance recoveries related to the Company's general and professional liability claims that are recorded on a gross rather than net basis in accordance with GAAP.

17. DEBT

Long-term debt consists of the following:

	December 31, 2013	2012
Promissory note with RBS, principal and interest payable monthly and continuing through March 2019, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	$20,347	$21,032
Senior Credit Facility with SunTrust and Wells Fargo, principal and interest payable quarterly, balance due at February 1, 2018, secured by substantially all of the Company’s personal property.	144,325	89,375
Ten Project Note with GECC, principal and interest payable monthly; interest is fixed, balance due June 2016, collateralized by deeds of trust on real property, assignment of rents, security agreements and fixture financing statements.	48,864	50,072
Promissory note with RBS, principal and interest payable monthly and continuing through January 2018, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	32,122	33,167
Promissory notes, principal, and interest payable monthly and continuing through October 2019, interest at fixed rate, collateralized by deed of trust on real property,	8,919	9,203

assignment of rents and security agreement.		
Mortgage note, principal, and interest payable monthly and continuing through February 2027, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	5,429	5,665
	260,006	208,514
Less current maturities	(7,411)	(7,187)
Less debt discount	(700)	(822)
	$251,895	$200,505

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Senior Credit Facility with a Lending Consortium Arranged by SunTrust and Wells Fargo (the Senior Credit Facility)

On April 22, 2013, the Company entered into the fourth amendment to the Senior Credit Facility (the Fourth Amendment), which amended the Company's existing Senior Credit Facility Agreement, dated as of July 15, 2011, to amend certain covenants, representations and other key provisions in the credit agreement to, among other things, (i) allow for the settlement relating to the previously disclosed federal civil investigation that has been conducted by the U.S. Department of Justice and related federal agencies in an amount up to $50,000 and (ii) permit the Company to enter into a corporate integrity agreement with the Office of Inspector General-HHS. Except as set forth in the Fourth Amendment, all other terms and conditions of the Senior Credit Facility, as amended, remained in full force.

On February 1, 2013, the Company entered into the third amendment to the Senior Credit Facility (the Third Amendment), which amended the Company's existing Senior Credit Facility Agreement, dated as of July 15, 2011. The Third Amendment revised the Senior Credit Facility Agreement to, among other things, (i) increase the revolving credit portion of the Senior Credit Facility by $75,000 to an aggregate principal amount of $150,000, of which $78,700 was drawn as of December 31, 2013, and (ii) extend the maturity date of the Senior Credit Facility from July 15, 2016 to February 1, 2018. Except as set forth in the Third Amendment, all other terms and conditions of the Senior Credit Facility remained in full force and effect as described below.

On July 15, 2011, the Company entered into the Senior Credit Facility in an aggregate principal amount of up to $150,000 comprised of a $75,000 revolving credit facility and a $75,000 term loan advanced in one drawing on July 15, 2011. Borrowings under the term loan portion of the Senior Credit Facility amortize in equal quarterly installments commencing on September 30, 2011, in an aggregate annual amount equal to 5% per annum of the original principal amount. Interest rates per annum applicable to the Senior Credit Facility are, at the option of the Company, (i) LIBOR plus an initial margin of 2.5% or (ii) the Base Rate (as defined by the agreement) plus an initial margin of 1.5%. Under the terms of the Senior Credit Facility, the applicable margin adjusts based on the Company’s leverage ratio as set forth in further detail in the Senior Credit Facility agreement. Amounts borrowed pursuant to the Senior Credit Facility are guaranteed by certain of the Company’s wholly-owned subsidiaries and secured by substantially all of their personal property. To reduce the risk related to interest rate fluctuations, the Company, on behalf of the subsidiaries, entered into an interest rate swap agreement to effectively fix the interest rate on the term loan portion of the Senior Credit Facility. See further details of the interest rate swap at Note 6, Fair Value Measurements.

Among other things, under the Senior Credit Facility, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a maximum net leverage ratio, minimum interest coverage ratio and minimum asset coverage ratio. The loan documents also include certain additional reporting, affirmative and negative covenants including limitations on the incurrence of additional indebtedness, liens, investments in other businesses, dividends declared in excess of 20% of consolidated net income and repurchases and capital expenditures. As of December 31, 2013, we were in compliance with all loan covenants.

Promissory Note with RBS Asset Finance, Inc.

On February 17, 2012, two of the Company's real estate holding subsidiaries as Borrowers executed a promissory note in favor of RBS Asset Finance, Inc. (RBS) as Lender for an aggregate of $21,525 (the 2012 RBS Loan). The 2012 RBS Loan was secured by Commercial Deed of Trust, Security Agreement, Assignment of Leases and Rents and Fixture Filings on the properties owned by the Borrowers, and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The 2012 RBS Loan bears interest at a fixed rate of 4.75%. Amounts borrowed under the 2012 RBS Loan may be prepaid starting after the second anniversary of the note subject to certain prepayment fees. The term of the RBS Loan is for seven years, with monthly principal and interest

payments commencing on April 1, 2012 and the balance due on March 1, 2019.

Among other things, under the RBS Loan the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a minimum debt service coverage ratio, an average occupancy rate and a minimum project yield. The Loan Documents also include certain additional affirmative and negative covenants, including limitations on the disposition of the Borrowers and the collateral and minimum average cash balance requirements. As of December 31, 2013, the Company was in compliance with all loan covenants.

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Promissory Notes with RBS Asset Finance, Inc.

On December 31, 2010, four of the Company's real estate holding subsidiaries executed a promissory note with RBS as Lender for an aggregate of $35,000 (RBS Loan). The RBS Loan was secured by Commercial Deeds of Trust, Security Agreements, Assignment of Leases and Rents and Fixture Fillings on the four properties and other related instruments and agreements, including without limitation a promissory note and a Company guaranty. The RBS Loan bears interest at a fixed rate of 6.04%. Amounts borrowed under the RBS Loan may be prepaid starting after the second anniversary of the note subject to prepayment fees of 5.0% of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% a year for years three through seven of the loan. The term of the RBS Loan is for seven years, with monthly principal and interest payments commencing on February 1, 2011 and the balance due on January 1, 2018.

Among other things, under the RBS Loan, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a minimum debt service coverage ratio, an average occupancy rate and a minimum project yield. The loan documents also include certain additional affirmative and negative covenants, including limitations on the disposition of the Borrowers and the collateral. As of December 31, 2013, the Company was in compliance with all loan covenants.

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of the Company's independent real estate holding subsidiaries jointly entered into the Third Amended and Restated Loan Agreement, with General Electric Capital Corporation (GECC), which consists of an approximately $55,700 multiple-advance term loan, further referred to as the Ten Project Note. The Ten Project Note matures in June 2016, and is currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries. The Ten Project Note was funded in advances, with each advance bearing interest at a separate rate. The interest rates range from 6.95% to 7.50% per annum.

Under the Ten Project Note, the Company is subject to standard reporting requirements and other typical covenants for a loan of this type. Effective October 1, 2006 and continuing each calendar quarter thereafter, we are subject to restrictive financial covenants, including average occupancy, Debt Service (as defined in the agreement) and Project Yield (as defined in the agreement). As of December 31, 2013, the Company was in compliance with all loan covenants.

Promissory Notes with Johnson Land Enterprises, Inc.

On October 1, 2009, four subsidiaries of The Ensign Group, Inc. entered into four separate promissory notes with Johnson Land Enterprises, LLC, for an aggregate of $10,000, as a part of the Company’s acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these notes is due on September 30, 2019. The notes bear interest at a rate of 6.0% per annum. As a part of this transaction, the Company recorded a discount to the debt balance in the form of imputed interest of $1,218. This amount will be amortized over the term of the promissory notes, or 10 years.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with the U.S. Department of Housing and Urban Development, or HUD, which subjects the Company's Southland facility to HUD oversight and periodic inspections. The unpaid balance of principal and accrued interest from this mortgage loan is due on February 1, 2027. The mortgage loan bears interest at the rate of 7.5% per annum.

This mortgage loan is secured by the real property comprising the Southland Care Center facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

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.

Future principal payments due under the long-term debt arrangements discussed above are as follows:

Years Ending December 31,	Amount
2014	$7,411
2015	7,672
2016	52,589
2017	6,584
2018	157,790
Thereafter	27,960
	$260,006

18. 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 consolidated statements of income for the years ended December 31, 2013, 2012 and 2011 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan), all of which have been approved by the stockholders. The total number of shares available under all of the Company's stock incentive plans was 1,780 as of December 31, 2013.

2001 Stock Option, Deferred Stock and Restricted Stock Plan - The 2001 Plan authorizes the sale of up to 1,980 shares of common stock to officers, employees, directors, and consultants of the Company. Granted non-employee director options vest and become exercisable immediately. Generally, all other granted options and restricted stock vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. The exercise price of the stock is determined by the board of directors, but shall not be less than 100% of the fair value on the date of grant. At December 31, 2013, 2012 and 2011, there were 319, 319 and 314, respectively, unissued shares of common stock available for issuance under this plan, including shares that have been forfeited and are available for reissue.

2005 Stock Incentive Plan - The 2005 Plan authorizes the sale of up to 1,000 shares of treasury stock of which only 800 shares were repurchased and therefore eligible for reissuance. Options granted to non-employee directors vest and become exercisable immediately. All other granted options vest over five years at 20% per year on the anniversary of the grant date. Options expire 10 years from the date of grant. There were 147 unissued shares of common stock available for issuance under this plan for each of the years ending December 31, 2013, 2012 and 2011, including shares that have been forfeited and are available for reissue.

2007 Omnibus Incentive Plan - The 2007 Plan authorizes the sale of up to 1,000 shares of common stock to officers, employees, directors and consultants of the Company. In addition, the number of shares of common stock reserved under the 2007 Plan will automatically increase on the first day of each fiscal year, beginning on January 1, 2008, in

an amount equal to the lesser of (i) 1,000 shares of common stock, or (ii) 2% of the number of shares outstanding as of the last day of the immediately preceding fiscal year, or (iii) such lesser number as determined by the Company's board of directors. Granted non-employee director options vest and become exercisable in three equal annual installments, or the length of the term if less than three years, on the completion of each year of service measured from the grant date. All other granted options vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. At December 31, 2013, 2012 and 2011, there were 1,314, 1,149 and 1,039 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 Black-Scholes model required the Company to make several key judgments including:

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- The expected option term reflects the application of the simplified method set out in Staff Accounting Bulletin (SAB) No. 107 Share-Based Payment (SAB 107), which was issued in March 2005. In December 2007, the Securities and Exchange Commission (SEC) released Staff Accounting Bulletin No. 110 (SAB 110), which extends the use of the "simplified" method, under certain circumstances, in developing an estimate of the expected term of "plain vanilla" share options. Accordingly, the Company has utilized the average of the contractual term of the options and the weighted average vesting period for all options to calculate the expected option term. The Company will utilize its own experience to calculate the expected option term in the future when it has sufficient history.

- Estimated volatility also reflects the application of SAB 107 interpretive guidance and, accordingly, incorporates historical volatility of similar public entities until sufficient information regarding the volatility of the Company's share price becomes available. The Company will utilize its own experience to calculate estimated volatility in the future when it has sufficient history.

- The dividend yield is based on the Company's historical pattern of dividends as well as expected dividend patterns.

- The risk-free rate is based on the implied yield of U.S. Treasury notes as of the grant date with a remaining term approximately equal to the expected term.

- Estimated forfeiture rate of approximately 8.45% per year is based on the Company's historical forfeiture activity of unvested stock options.

The Company used the following assumptions for stock options granted during the years ended December 31, 2013, 2012 and 2011:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2013	248	1.18 %-1.87%	6.5 years	55 %	0.64 %-0.93%
2012	246	0.84 %-1.18%	6.5 years	55 %	0.93%
2011	97	1.42 %-2.53%	6.5 years	55 %	0.93%

For the years ended December 31, 2013, 2012 and 2011, 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
2013	248	$35.47	$17.70
2012	246	$27.65	$13.47
2011	97	$24.79	$12.38

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 December 31, 2013, 2012 and 2011 and therefore, the intrinsic value was $0 at date of grant.

The following table represents the employee stock option activity during the years ended December 31, 2013, 2012 and 2011:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2011	1,904	$11.55	921	$9.07
Granted	97	24.79		
Forfeited	(54)	13.57		
Exercised	(314)	7.90		
December 31, 2011	1,633	$12.97	936	$10.65
Granted	246	27.65		
Forfeited	(63)	15.80		
Exercised	(429)	10.95		
December 31, 2012	1,387	$16.06	739	$11.88
Granted	248	35.47		
Forfeited	(66)	24.71		
Exercised	(320)	11.19		
December 31, 2013	1,249	$20.71	681	$14.23

The following summary information reflects stock options outstanding, vested and related details as of December 31, 2013:

	Stock Options Outstanding					Stock Options Vested
Year of Grant	Exercise Price		Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2005	4.99	- 5.75	20	*	2	20
2006	7.05	- 7.50	96	923	3	96
2008	9.38	- 14.87	254	1,409	5	254
2009	14.88	- 16.70	280	2,221	6	208
2010	17.47	- 18.16	73	653	7	35
2011	21.61	- 29.30	80	993	8	29
2012	24.04	- 29.16	215	2,890	9	39
2013	29.25	- 42.13	231	4,116	10	—
Total			1,249	$ 13,205		681

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

In addition to the above, during the years ended December 31, 2013, 2012 and 2011, the Company granted 93, 71 and 143 restricted stock awards, respectively. All awards were granted at an exercise price of $0 and vest over five years. The fair value per share of restricted awards granted in 2013, 2012 and 2011 ranged from $27.98 to $42.13, $24.04 to $29.16 and $21.61 to $29.30, respectively.

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A summary of the status of the Company's nonvested restricted stock awards as of December 31, 2013, and changes during the years ended December 31, 2013, 2012 and 2011 is presented below:

	Nonvested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2011	102	$ 18.05
Granted	143	25.52
Vested	(31)	24.18
Forfeited	(4)	19.16
Nonvested at December 31, 2011	210	$ 22.32
Granted	71	27.78
Vested	(44)	27.53
Forfeited	(13)	21.98
Nonvested at December 31, 2012	224	$ 23.04
Granted	93	35.27
Vested	(51)	23.67
Forfeited	(36)	24.70
Nonvested at December 31, 2013	230	$ 28.68

In addition, during the year ended December 31, 2013, the Company granted 10 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 $27.98 to $41.91 based on the market price on the grant date. The Company also granted 11 executive incentive awards at a fair value per share of $32.85 based on the market price on the grant date.

Total share-based compensation expense recognized for the years ended December 31, 2013, 2012 and 2011 was as follows:

	Years Ended December 31,		
	2013	2012	2011
Share-based compensation expense related to stock options	$ 2,217	$ 1,903	$ 2,265
Share-based compensation expense related to restricted stock awards	1,387	1,084	1,091
Share-based compensation expense related to stock awards	795	1,752	—
Total	$ 4,399	$ 4,739	$ 3,356

For the year ended December 31, 2013, the Company expensed $410 in share-based compensation related to the quarterly stock awards to non-employee directors.
The Company recognized tax benefits related to share-based compensation expense of $1,723, $1,740, and $1,285 during the years ended December 31, 2013, 2012 and 2011, respectively. In future periods, the Company expects to recognize approximately $7,089 and $5,867 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of December 31, 2013. Future share-based compensation expense will be recognized over 3.8 and 3.5 weighted average years for unvested options and restricted stock awards, respectively. There were 568 unvested and outstanding options at December 31, 2013, of which 530 are expected to vest. The weighted average contractual life for options vested at December 31, 2013 was 6.3 years.

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The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of December 31, 2013, 2012, and 2011 is as follows:

	December 31,		
	2013	2012	2011
Outstanding	$29,431	$15,703	$18,942
Vested	20,465	11,285	12,960
Expected to vest	7,873	4,088	5,374
Exercised	8,709	7,123	5,651

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

19. COMMITMENTS AND CONTINGENCIES

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

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

Cost-Containment Measures — Both government and private pay sources have instituted cost-containment measures designed to limit payments made to providers of healthcare services, and there can be no assurance that future measures designed to limit payments made to providers will not adversely affect the Company.

Income Tax Examinations — During the first quarter of 2012, the State of California initiated an examination of the Company's income tax returns for the 2008 and 2009 income tax years. The examination is primarily focused on the Captive and the treatment of related insurance matters. To date, California has not proposed any adjustments. The Company is not currently under examination by any other major income tax jurisdiction. See Note 14, Income Taxes.

Indemnities — From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from the Company’s use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of facilities the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, (iv) agreements with certain lenders under which the Company may be required to indemnify such lenders against various claims and liabilities, and (v) certain agreements with the Company’s officers, directors and employees, under which the Company may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company’s balance sheets for any of the periods presented.

Litigation — The skilled nursing business involves a significant risk of liability given the age and health of the Company’s patients and residents and the services the Company provides. The Company and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services have resulted in personal injury, elder abuse, wrongful death or other related claims. The defense of these lawsuits

may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

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

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

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

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

A class action staffing suit was previously filed against the Company in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act at certain of the Company's California facilities. In 2007, the Company settled this class action suit, and the settlement was approved by the affected class and the Court. The Company has been defending a second such staffing class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, are projected to be approximately $6,500, of which, approximately $1,500 of this amount was recorded during the year ended December 31, 2013, with the balance having been expensed in prior periods. The Company believes that the settlement will not have a material ongoing adverse effect on the Company’s business, financial condition or results of operations.

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

The Company has been, and continues to be, subject to claims and legal actions that arise in the ordinary course of business, including potential claims related to care and treatment provided at its facilities as well as employment related claims. The Company does not believe that the ultimate resolution of these actions will have a material adverse effect on the Company’s business, cash flows, financial condition or results of operations. A significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, could materially adversely affect the Company’s business, financial condition, results of operations and cash flows.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company is subjected to, alleged to be liable for, or agrees to a settlement of, claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, its business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the Company's assumption of specific procedural and financial obligations going forward under a corporate integrity agreement and/or other arrangement with the government.
Medicare Revenue Recoupments — The Company is subject to reviews relating to Medicare services, billings and potential overpayments. The Company had one operation subject to probe review during the year ended December 31, 2013. The Company anticipates that these probe reviews will increase in frequency in the future. Further, the Company currently has no facilities on prepayment review; however, others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. The Company has no facilities that are currently undergoing targeted review.

U.S. Government Inquiry — In late 2006, the Company learned that it might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. The Company, through its outside counsel and a special committee of independent directors established by its board, worked cooperatively with the U.S. Attorney's office to produce information requested by the government as part of an ongoing dialogue designed to resolve the issue.

In December 2011, the DOJ notified the Company that it had closed its criminal investigation without action although, as is typical, it reserved the right to reopen the criminal case if new facts came to light. This left only the civil investigation to resolve, and the Company continued to supply requested information to the DOJ and the Office of the Inspector General of the United States Department of Health and Human Services (HHS), including specific patient records and documents from 2007 to 2011 from six Southern California skilled nursing facilities that had been the subject of previous requests.

In early 2013, discussions between government representatives and the Company's special committee, its outside counsel and their experts had advanced sufficiently that the Company recorded an initial estimated liability in the amount of $15,000 in the fourth quarter of 2012 for the resolution of claims connected to the investigation. In April 2013, the Company and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, the Company recorded and announced an additional charge in the amount of $33,000 in the first quarter of 2013, increasing the total reserve to resolve the matter to $48,000 (the Reserve Amount).

In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the Department of Justice and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. Pursuant to the settlement agreement, the Company made a single lump-sum remittance to the government in the amount of $48,000 in October 2013. The Company has denied engaging in any illegal conduct, and has agreed to the settlement amount without any admission of wrongdoing in order to resolve the allegations and to avoid the uncertainty and expense of protracted litigation.

In connection with the settlement and effective as of October 1, 2013, the Company entered into a five-year corporate integrity agreement with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of the Company's current compliance program, and requires that the Company continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. The Company is also required to maintain several elements of its existing program during the term of the CIA, including maintaining a compliance officer, a compliance committee of the board of directors, and a code of conduct. The CIA requires that the Company conduct certain additional compliance-related activities during the term of the CIA, including various training and monitoring procedures, and maintaining a disciplinary process for compliance obligations. Pursuant to the CIA, the Company is required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that the Company has committed a crime or has engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by Federal health care programs. The Company is also subject to periodic reporting and certification requirements attesting that the provisions of the CIA are being implemented and followed, as well as certain document and record retention mandates.

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

Concentrations

Credit Risk — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company’s receivables from Medicare and Medicaid payor programs accounted for approximately 56.8% and 56.2% of its total accounts receivable as of December 31, 2013 and 2012, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 72.2%, 73.6% and 75.2% of the Company’s revenue for the years ended December 31, 2013, 2012 and 2011, respectively.

Cash in Excess of FDIC Limits — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of February 11, 2014, the Company had approximately $1,001 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

20. DEFINED CONTRIBUTION PLAN

The Company has a 401(k) defined contribution plan (the 401(k) Plan), whereby eligible employees may contribute up to 15% of their annual basic earnings. Additionally, the 401(k) Plan provides for discretionary matching contributions (as defined in the 401(k) Plan) by the Company. The Company expensed matching contributions to the 401(k) Plan of $487, $444 and $369 during the years ended December 31, 2013, 2012 and 2011, respectively. Beginning in 2007, the Company's plan allowed eligible employees to contribute up to 90% of their eligible compensation, subject to applicable annual Internal Revenue Code limits.

(b) Financial Statement Schedules

THE ENSIGN GROUP, INC. and SUBSIDIARIES

Schedule II
Valuation and Qualifying Accounts

	Balance at Beginning of Year	Additions Charged to Costs and Expenses	Deductions	Balances at End of Year
		(In thousands)		
Year Ended December 31, 2011				
Allowance for doubtful accounts	$(9,793)	$(7,921)	$4,932	$(12,782)
Year Ended December 31, 2012				
Allowance for doubtful accounts	$(12,782)	$(9,474)	$8,445	$(13,811)
Year Ended December 31, 2013				
Allowance for doubtful accounts	$(13,811)	$(12,106)	$9,377	$(16,540)

All other schedules have been omitted because the information required to be set forth therein is not applicable or is shown in the consolidated financial statements or notes thereto.

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EXHIBIT INDEX
(c) Exhibit Index

Exhibit No.		Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
3.1		Fifth Amended and Restated Certificate of Incorporation of The Ensign Group, Inc., filed with the Delaware Secretary of State on November 15, 2007	10-Q	001-33757	3.1	12/21/2007	
3.3		Amended and Restated Bylaws of The Ensign Group, Inc.	10-Q	001-33757	3.2	12/21/2007	
3.4		Certificate of Designation, Preferences and Rights of Series A Junior Participating Preferred Stock, as filed with the Secretary of State of the State of Delaware on November 7, 2013	8-K	001-33757	3.1	11/7/2013	
4.1		Specimen common stock certificate	S-1	333-142897	4.1	10/5/2007	
4.2		Stock Position Management Agreement, dated October 16, 2008, between The Ensign Group, Inc. and Terri M. Christensen	10-K	001-33757	4.2	2/18/2009	
4.3		Rights Agreement, dated as of November 7, 2013, between The Ensign Group, Inc. and Registrar and Transfer Company, as Rights Agent.	8-K	001-33757	4.1	11/7/2013	
10.1	+	The Ensign Group, Inc. 2001 Stock Option, Deferred Stock and Restricted Stock Plan, form of Stock Option Grant Notice for Executive Officers and Directors, stock option agreement and form of restricted stock agreement for Executive Officers and Directors	S-1	333-142897	10.1	7/26/2007	
10.2	+	The Ensign Group, Inc. 2005 Stock Incentive Plan, form of Nonqualified Stock Option Award for Executive Officers and Directors, and form of restricted stock agreement for Executive Officers and Directors	S-1	333-142897	99.2	7/26/2007	
10.3	+	The Ensign Group, Inc. 2007 Omnibus Incentive Plan	S-1	333-142897	10.3	10/5/2007	
10.4	+	Amendment to The Ensign Group, Inc. 2007 Omnibus Incentive Plan	8-K	001-33757	10.2	7/28/2009	
10.5	+	Form of 2007 Omnibus Incentive Plan Notice of Grant of Stock Options; and form of Non-Incentive Stock Option Award Terms and Conditions	S-1	333-142797	10.4	10/5/2007	
10.6	+	Form of 2007 Omnibus Incentive Plan Restricted Stock Agreement	S-1	333-142897	10.5	10/5/2007	
10.7	+	Form of Indemnification Agreement entered into between The Ensign Group, Inc. and its directors, officers and certain key employees	S-1	333-142897	10.6	10/5/2007	
10.8		Fourth Amended and Restated Loan Agreement, dated as of November 10, 2009, by and among certain subsidiaries of The Ensign Group, Inc. as Borrowers, and General Electric Capital Corporation as Agent and Lender	8-K	001-33757	10.1	11/17/2009	
10.9			S-1	333-142897	10.8	7/26/2007	

	Consolidated, Amended and Restated Promissory Note, dated as of December 29, 2006, in the original principal amount of $64,692,111.67, by certain subsidiaries of The Ensign Group, Inc. in favor of General Electric Capital Corporation				
10.10	Third Amended and Restated Guaranty of Payment and Performance, dated as of December 29, 2006, by The Ensign Group, Inc. as Guarantor and General Electric Capital Corporation as Agent and Lender, under which Guarantor guarantees the payment and performance of the obligations of certain of Guarantor's subsidiaries under the Third Amended and Restated Loan Agreement	S-1	333-142897	10.9	7/26/2007

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.11	Form of Amended and Restated Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of June 30, 2006 (filed against Desert Terrace Nursing Center, Desert Sky Nursing Home, Highland Manor Health and Rehabilitation Center and North Mountain Medical and Rehabilitation Center), by and among Terrace Holdings AZ LLC, Sky Holdings AZ LLC, Ensign Highland LLC and Valley Health Holdings LLC as Grantors, Chicago Title Insurance Company as Trustee, and General Electric Capital Corporation as Beneficiary and Schedule of Material Differences therein	S-1	333-142897	10.10	7/26/2007	
10.12	Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of June 30, 2006 (filed against Park Manor), by and among Plaza Health Holdings LLC as Grantor, Chicago Title Insurance Company as Trustee, and General Electric Capital Corporation as Beneficiary	S-1	333-142897	10.11	7/26/2007	
10.13	Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of June 30, 2006 (filed against Catalina Care and Rehabilitation Center), by and among Rillito Holdings LLC as Grantor, Chicago Title Insurance Company as Trustee, and General Electric Capital Corporation as Beneficiary	S-1	333-142897	10.12	7/26/2007	
10.14	Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of October 16, 2006 (filed against Park View Gardens at Montgomery), by and among Mountainview Communitycare LLC as Grantor, Chicago Title Insurance Company as Trustee, and General Electric Capital Corporation as Beneficiary	S-1	333-142897	10.13	7/26/2007	
10.15	Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of October 16, 2006 (filed against Sabino Canyon Rehabilitation and Care Center), by and among Meadowbrook Health Associates LLC as Grantor, Chicago Title Insurance Company as Trustee and General Electric Capital Corporation as Beneficiary	S-1	333-142897	10.14	7/26/2007	
10.16	Form of Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of December 29, 2006 (filed against Upland Care and Rehabilitation Center and Camarillo Care Center), by and among Cedar Avenue Holdings LLC and Granada Investments LLC as Grantors, Chicago Title Insurance Company	S-1	333-142897	10.15	7/26/2007	

	as Trustee and General Electric Capital Corporation as Beneficiary and Schedule of Material Differences therein				
10.17	Form of First Amendment to (Amended and Restated) Deed of Trust, Assignment of Rents, Security Agreement and Fixture Financing Statement, dated as of December 29, 2006 (filed against Desert Terrace Nursing Center, Desert Sky Nursing Home, Highland Manor Health and Rehabilitation Center, North Mountain Medical and Rehabilitation Center, Catalina Care and Rehabilitation Center, Park Manor, Park View Gardens at Montgomery, Sabino Canyon Rehabilitation and Care Center), by and among Terrace Holdings AZ LLC, Sky Holdings AZ LLC, Ensign Highland LLC, Valley Health Holdings LLC, Rillito Holdings LLC, Plaza Health Holdings LLC, Mountainview Communitycare LLC and Meadowbrook Health Associates LLC as Grantors, Chicago Title Insurance Company as Trustee, and General Electric Capital Corporation as Beneficiary and Schedule of Material Differences therein	S-1	333-142897	10.16	7/26/2007
10.18	Amended and Restated Loan and Security Agreement, dated as of March 25, 2004, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrower, and General Electric Capital Corporation as Agent and Lender	S-1	333-142897	10.19	5/14/2007
10.19	Amendment No. 1, dated as of December 3, 2004, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrower, and General Electric Capital Corporation as Lender	S-1	333-142897	10.20	5/14/2007

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.20	Second Amended and Restated Revolving Credit Note, dated as of December 3, 2004, in the original principal amount of $20,000,000, by The Ensign Group, Inc. and certain of its subsidiaries in favor of General Electric Capital Corporation	S-1	333-142897	10.19	7/26/2007	
10.21	Amendment No. 2, dated as of March 25, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrower, and General Electric Capital Corporation as Lender	S-1	333-142897	10.22	5/14/2007	
10.22	Amendment No. 3, dated as of June 22, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrower and General Electric Capital Corporation as Lender	S-1	333-142897	10.21	7/26/2007	
10.23	Amendment No. 4, dated as of August 1, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrowers and General Electric Capital Corporation as Lender	S-1	333-142897	10.42	8/17/2007	
10.24	Amendment No. 5, dated September 13, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrowers and General Electric Capital Corporation as Lender	S-1	333-142897	10.43	10/5/2007	
10.25	Revolving Credit Note, dated as of September 13, 2007, in the original principal amount of $5,000,000 by The Ensign Group, Inc. and certain of its subsidiaries in favor of General Electric Capital Corporation	S-1	333-142897	10.44	10/5/2007	
10.26	Commitment Letter, dated October 3, 2007, from General Electric Capital Corporation to The Ensign Group, Inc., setting forth the general terms and conditions of the proposed amendment to the revolving credit facility, which will increase the available credit thereunder to $50.0 million	S-1	333-142897	10.46	10/5/2007	
10.27	Amendment No. 6, dated November 19, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrowers and General Electric Capital Corporation as Lender	8-K	001-33757	10.1	11/21/2007	
10.28	Amendment No. 7, dated December 21, 2007, to the Amended and Restated Loan and Security Agreement, by and among The Ensign Group, Inc. and certain of its subsidiaries as Borrowers and General Electric Capital Corporation as Lender	8-K	001-33757	10.1	12/27/2007	

10.29	Amendment No. 1 and Joinder Agreement to Second Amended and Restated Loan and Security Agreement, by certain subsidiaries of The Ensign Group, Inc. as Borrower and General Electric Capital Corporation as Lender	8-K	001-33757	10.1	2/9/2009
10.30	Second Amended and Restated Revolving Credit Note, dated February 4, 2009, by certain subsidiaries of The Ensign Group, Inc. as Borrowers for the benefit of General Electric Capital Corporation as Lender	8-K	001-33757	10.2	2/9/2009
10.31	Amended and Restated Revolving Credit Note, dated February 21, 2008, by certain subsidiaries of The Ensign Group, Inc. as Borrowers for the benefit of General Electric Capital Corporation as Lender	8-K	001-33757	10.2	2/27/2008
10.32	Ensign Guaranty, dated February 21, 2008, between The Ensign Group, Inc. as Guarantor and General Electric Capital Corporation as Lender	8-K	001-33757	10.3	2/27/2008

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.33	Holding Company Guaranty, dated February 21, 2008, by and among The Ensign Group, Inc. and certain of its subsidiaries as Guarantors and General Electric Capital Corporation as Lender	8-K	001-33757	10.4	2/27/2008	
10.34	Pacific Care Center Loan Agreement, dated as of August 6, 1998, by and between G&L Hoquiam, LLC as Borrower and GMAC Commercial Mortgage Corporation as Lender (later assumed by Cherry Health Holdings, Inc. as Borrower and Wells Fargo Bank, N.A. as Lender)	S-1	333-142897	10.23	5/14/2007	
10.35	Deed of Trust and Security Agreement, dated as of August 6, 1998, by and among G&L Hoquiam, LLC as Grantor, Ticor Title Insurance Company as Trustee and GMAC Commercial Mortgage Corporation as Beneficiary	S-1	333-142897	10.24	7/26/2007	
10.36	Promissory Note, dated as of August 6, 1998, in the original principal amount of $2,475,000, by G&L Hoquiam, LLC in favor of GMAC Commercial Mortgage Corporation	S-1	333-142897	10.25	7/26/2007	
10.37	Loan Assumption Agreement, by and among G&L Hoquiam, LLC as Prior Owner; G&L Realty Partnership, L.P. as Prior Guarantor; Cherry Health Holdings, Inc. as Borrower; and Wells Fargo Bank, N.A., the Trustee for GMAC Commercial Mortgage Securities, Inc., as Lender	S-1	333-142897	10.26	5/14/2007	
10.38	Exceptions to Nonrecourse Guaranty, dated as of October 2006, by The Ensign Group, Inc. as Guarantor and Wells Fargo Bank, N.A. as Trustee for GMAC Commercial Mortgage Securities, Inc., under which Guarantor guarantees full and prompt payment of all amounts due and owing by Cherry Health Holdings, Inc. under the Promissory Note	S-1	333-142897	10.22	7/26/2007	
10.39	Deed of Trust with Assignment of Rents, dated as of January 30, 2001, by and among Ensign Southland LLC as Trustor, Brian E. Callahan as Trustee and Continental Wingate Associates, Inc. as Beneficiary	S-1	333-142897	10.27	7/26/2007	
10.40	Deed of Trust Note, dated as of January 30, 2001, in the original principal amount of $7,455,100, by Ensign Southland, LLC in favor of Continental Wingate Associates, Inc.	S-1	333-142897	10.28	5/14/2007	
10.41	Security Agreement, dated as of January 30, 2001, by and between Ensign Southland, LLC and Continental Wingate Associates, Inc.	S-1	333-142897	10.29	5/14/2007	
10.42	Master Lease Agreement, dated July 3, 2003, between Adipiscor LLC as Lessee and LTC Partners VI, L.P., Coronado Corporation and Park	S-1	333-142897	10.30	5/14/2007	

	Villa Corporation collectively as Lessor				
10.43	Lease Guaranty, dated July 3, 2003, between The Ensign Group, Inc. as Guarantor and LTC Partners VI, L.P., Coronado Corporation and Park Villa Corporation collectively as Lessor, under which Guarantor guarantees the payment and performance of Adipiscor LLC's obligations under the Master Lease Agreement	S-1	333-142897	10.31	5/14/2007
10.44	Master Lease Agreement, dated September 30, 2003, between Permunitum LLC as Lessee, Vista Woods Health Associates LLC, City Heights Health Associates LLC, and Claremont Foothills Health Associates LLC as Sublessees, and OHI Asset (CA), LLC as Lessor	S-1	333-142897	10.32	5/14/2007
10.45	Lease Guaranty, dated September 30, 2003, between The Ensign Group, Inc. as Guarantor and OHI Asset (CA), LLC as Lessor, under which Guarantor guarantees the payment and performance of Permunitum LLC's obligations under the Master Lease Agreement	S-1	333-142897	10.33	5/14/2007

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.46	Lease Guaranty, dated September 30, 2003, between Vista Woods Health Associates LLC, City Heights Health Associates LLC and Claremont Foothills Health Associates LLC as Guarantors and OHI Asset (CA), LLC as Lessor, under which Guarantors guarantee the payment and performance of Permunitum LLC's obligations under the Master Lease Agreement	S-1	333-142897	10.34	5/14/2007	
10.47	Master Lease Agreement, dated January 31, 2003, between Moenium Holdings LLC as Lessee and Healthcare Property Investors, Inc., d/b/a in the State of Arizona as HC Properties, Inc., and Healthcare Investors III collectively as Lessor	S-1	333-142897	10.35	5/14/2007	
10.48	Lease Guaranty, between The Ensign Group, Inc. as Guarantor and Healthcare Property Investors, Inc. as Owner, under which Guarantor guarantees the payment and performance of Moenium Holdings LLC's obligations under the Master Lease Agreement	S-1	333-142897	10.36	5/14/2007	
10.49	First Amendment to Master Lease Agreement, dated May 27, 2003, between Moenium Holdings LLC as Lessee and Healthcare Property Investors, Inc., d/b/a in the State of Arizona as HC Properties, Inc., and Healthcare Investors III collectively as Lessor	S-1	333-142897	10.37	5/14/2007	
10.50	Second Amendment to Master Lease Agreement, dated October 31. 2004, between Moenium Holdings LLC as Lessee and Healthcare Property Investors, Inc., d/b/a in the State of Arizona as HC Properties, Inc., and Healthcare Investors III collectively as Lessor	S-1	333-142897	10.38	5/14/2007	
10.51	Lease Agreement, by and between Mission Ridge Associates LLC as Landlord and Ensign Facility Services, Inc. as Tenant; and Guaranty of Lease, dated August 2, 2003, by The Ensign Group, Inc. as Guarantor in favor of Landlord, under which Guarantor guarantees Tenant's obligations under the Lease Agreement	S-1	333-142897	10.39	5/14/2007	
10.52	First Amendment to Lease Agreement dated January 15, 2004, by and between Mission Ridge Associates LLC as Landlord and Ensign Facility Services, Inc. as Tenant	S-1	333-142897	10.40	5/14/2007	
10.53	Second Amendment to Lease Agreement dated December 13, 2007, by and between Mission Ridge Associates LLC as Landlord and Ensign Facility Services, Inc. as Tenant; and Reaffirmation of Guaranty of Lease, dated	10-K	001-33757	10.52	3/6/2008	

	December 13, 2007, by The Ensign Group, Inc. as Guarantor in favor of Landlord, under which Guarantor reaffirms its guaranty of Tenants obligations under the Lease Agreement				
10.54	Third Amendment to Lease Agreement dated February 21, 2008, by and between Mission Ridge Associates LLC as Landlord and Ensign Facility Services, Inc. as Tenant	10-K	001-33757	10.54	2/17/2010
10.55	Fourth Amendment to Lease Agreement dated July 15, 2009, by and between Mission Ridge Associates LLC as Landlord and Ensign Facility Services, Inc. as Tenant	10-K	001-33757	10.55	2/17/2010
10.56	Form of Independent Consulting and Centralized Services Agreement between Ensign Facility Services, Inc. and certain of its subsidiaries	S-1	333-142897	10.41	5/14/2007
10.57	Agreement of Purchase and Sale and Joint Escrow Instructions, dated August 31, 2007, as amended on September 6, 2007	S-1	333-142897	10.45	10/5/2007
10.58	Form of Health Insurance Benefit Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Medicare program	S-1	333-142897	10.48	10/19/2007
10.59	Form of Medi-Cal Provider Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the California Medicaid program	S-1	333-142897	10.49	10/19/2007

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.60	Form of Provider Participation Agreement pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Arizona Medicaid program	S-1	333-142897	10.50	10/19/2007	
10.61	Form of Contract to Provide Nursing Facility Services under the Texas Medical Assistance Program pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Texas Medicaid program	S-1	333-142897	10.51	10/19/2007	
10.62	Form of Client Service Contract pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Washington Medicaid program	S-1	333-142897	10.52	10/19/2007	
10.63	Form of Provider Agreement for Medicaid and UMAP pursuant to which certain subsidiaries of The Ensign Group, Inc. participate in the Utah Medicaid program	S-1	333-142897	10.53	10/19/2007	
10.64	Form of Medicaid Provider Agreement pursuant to which a subsidiary of The Ensign Group, Inc. participates in the Idaho Medicaid program	S-1	333-142897	10.54	10/19/2007	
10.65	Six Project Promissory Note dated as of November 10, 2009, in the original principal amount of $40,000,000, by certain subsidiaries of the Ensign Group, Inc. in favor of General Electric Capital Corporation	8-K	001-33757	10.2	11/17/2009	
10.66	Commercial Deeds of Trust, Security Agreement, Assignment of Leases and Rents and Fixture Filing, dated as of December 31, 2010, made by certain subsidiaries of the Company for the benefit of RBS Asset Finance, Inc.	8-K	001-33757	10.1	1/6/2011	
10.67	Note, dated December 31, 2010 by certain subsidiaries of the Company.	8-K	001-33757	10.1	1/6/2011	
10.68	Revolving Credit and Term Loan Agreement, dated as of July 15, 2011, among the Ensign Group, Inc. and the several banks and other financial institutions and lenders from time to time party thereto (the "Lenders") and SunTrust Bank, in its capacity as administrative agent for the Lenders, as issuing bank and as swingline lender.	8-K	001-33757	10.1	7/19/2011	
10.69	Commercial Deeds of Trust, Security Agreements, Assignment of Leases and Rents and Future Filing, dated as of February 17, 2012, made by certain subsidiaries of the Company for the benefit of RBS Asset Finance, Inc. 8-K.	8-K	001-33757	10.1	2/22/2012	
10.70	First Amendment to Revolving Credit and Term Loan Agreement, dated as of October 27, 2011, among The Ensign Group, Inc. and the several banks and other financial institutions and lenders	10-K	001-33757	10.70	2/13/2013	

	from time to time party thereto (the "Lenders") and SunTrust Bank, in its capacity as administrative agent for the Lenders, as issuing bank and as swingline lender.				
10.71	Second Amendment to Revolving Credit and Term Loan Agreement, dated as of April 30, 2012, among The Ensign Group, Inc. and the several banks and other financial institutions and lenders from time to time party thereto (the "Lenders") and SunTrust Bank, in its capacity as administrative agent for the Lenders, as issuing bank and as swingline lender.	10-K	001-33757	10.71	2/13/2013

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Exhibit No.	Exhibit Description	Form	File No.	Exhibit No.	Filing Date	Filed Herewith
10.72	Third Amendment to Revolving Credit and Term Loan Agreement, dated as of February 1, 2013, among The Ensign Group, Inc. and the several banks and other financial institutions and lenders from time to time party thereto (the "Lenders") and SunTrust Bank, in its capacity as administrative agent for the Lenders, as issuing bank and as swingline lender.	8-K	001-33757	10.1	2/6/2012	
10.73	Fourth Amendment to Revolving Credit and Term Loan Agreement, dated as of April 16, 2013, among the Ensign Group, Inc. and the several banks and other financial institutions and lenders from time to time party thereto(the "Lenders") and SunTrust Bank, in its capacity as administrative agent fort he Lenders, as issuing bank and as swingline lender.	8-K	001-33757	10.1	4/22/2013	
10.74	Corporate Integrity Agreement between the Office of Inspector General of the Department of Health and Human Services and The Ensign Group, Inc. dated October 1, 2013.					X
21.1	Subsidiaries of The Ensign Group, Inc., as amended					X
23.1	Consent of Deloitte & Touche LLP					X
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002					X
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002					X
101	Interactive data file (furnished electronically herewith pursuant to Rule 406T of Regulations S-T)					X
+	Indicates management contract or compensatory plan.					