ADCARE HEALTH SYSTEMS INC
Form 10-K
March 19, 2012

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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION

Washington, D.C. 20549

FORM 10-K

(Mark One)

ý **ANNUAL REPORT UNDER SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the fiscal year ended December 31, 2011

o **TRANSITION REPORT UNDER SECTION 13 OR 15(d) OF THE EXCHANGE ACT**

For the transition period from to
Commission file number 001-33135

AdCare Health Systems, Inc.

(Exact name of registrant as specified in its charter)

Ohio	**31-1332119**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
5057 Troy Rd, Springfield, OH	**45502-9032**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number including area code **(937) 964-8974**

Securities registered pursuant to Section 12(b) of the Exchange Act:

Title of each class	**Name of each exchange on which registered**
Common Stock, no par value	NYSE Amex

Securities registered under Section 12(g) of the Exchange Act: **None**

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

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

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. Yes ý No o

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). Yes ý No o

Indicate by check mark if disclosure of delinquent filers in response to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of 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, a non-accelerated filer or a smaller reporting company. See definition 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 o	Non-accelerated filer o (Do not check if a smaller reporting company)	Smaller reporting company ý

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

The aggregate market value of AdCare Health Systems, Inc., common stock held by non-affiliates as of June 30, 2011, the last business day of the registrant's most recently completed second fiscal quarter, was $44,208,356. The number of shares of AdCare Health Systems, Inc., common stock, no par value, outstanding as of March 14, 2012 was 12,202,042.

DOCUMENTS INCORPORATED BY REFERENCE: **NONE**.

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Special Note Regarding Forward Looking Statements

Certain statements contained in this Annual Report on Form 10-K (this "Annual Report") under the caption "Management's Discussion and Analysis of Financial Condition and Results of Operations," and elsewhere, including information incorporated herein by reference to other documents, are "forward-looking statements" within the meaning of, and subject to the protections of, Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act").

Forward-looking statements include statements with respect to our beliefs, plans, objectives, goals, expectations, anticipations, assumptions, estimates, intentions and future performance and involve known and unknown risks, uncertainties and other factors, many of which may be beyond our control and which may cause the actual results, performance, or achievements of AdCare Health Systems, Inc. to be materially different from future results, performance or achievements expressed or implied by such forward-looking statements.

All statements other than statements of historical fact are statements that could be forward-looking statements. You can identify these forward-looking statements through our use of words such as "may," "will," "anticipate," "assume," "should," "indicate," "would," "believe," "contemplate," "expect," "estimate," "continue," "plan," "point to," "project," "predict," "could," "intend," "target," "potential" and other similar words and expressions of the future. These forward-looking statements may not be realized due to a variety of factors, including, without limitation, those described in Part I, Item 1A., "Risk Factors," and elsewhere in this Annual Report and those described from time to time in our future reports filed with the Securities and Exchange Commission (the "SEC") under the Exchange Act.

All written or oral forward-looking statements that are made by or are attributable to us are expressly qualified in their entirety by this cautionary notice. Our forward-looking statements apply only as of the date of this Annual Report or the respective date of the document from which they are incorporated herein by reference. We have no obligation and do not undertake to update, revise or correct any of the forward-looking statements after the date of this Annual Report, or after the respective dates on which such statements otherwise are made, whether as a result of new information, future events or otherwise.

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PART I.

Item 1. Business

Overview

AdCare Health Systems, Inc. ("AdCare") through its subsidiaries (together, the "Company" or "we"), own and operate retirement communities, skilled nursing facilities and assisted living facilities in the states of Arkansas, Alabama, Georgia, Missouri, North Carolina, Ohio, and Oklahoma. AdCare, through its wholly owned separate operating subsidiaries, owns, leases and manages 42 facilities consisting of 33 skilled nursing facilities, eight assisted living facilities and one independent living/senior housing facility which total approximately 3,700 units. Our facilities provide a range of health care services to patients and residents, including, but not limited to, skilled nursing and assisted living services, social services, various therapy services, and other rehabilitative and healthcare services for both long-term residents and short-stay patients. As of December 31, 2011, of the total 42 facilities, we managed four facilities, owned 20 facilities and operated 18 facilities (including six variable interest entities ("VIE's") and 12 long-term lease arrangements).

The Company is organized into three main segments: skilled nursing facilities ("SNF"), assisted living facilities ("ALF") and Corporate & Other. The SNF and ALF segments provide services to individuals needing long-term care in a nursing home or assisted living setting and management of those facilities. The corporate & other segment engages in the management of facilities and accounting and IT services. Through our subsidiaries, we provide a full complement of administrative services as well as consultative services that permit our local facility leadership teams to better focus on the delivery of healthcare services. We also provide these services to unaffiliated third party long term care operators and/or owners with whom we enter into contracts. We currently provide these services to five unaffiliated facility owners. Each of our facilities is led by highly dedicated individuals who are responsible for key operational decisions at their facilities. Facility 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 facility 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.

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:

- focusing on efficiencies in our operations and internal growth;
- continuing to acquire additional facilities in existing and new markets;
- expanding our existing facilities; and
- targeting the acquisition of complementary businesses which provide services to skilled nursing facilities, including nurse and technician staffing and physical rehabilitation.

Our principal executive offices are located at 5057 Troy Road, Springfield, Ohio 45502, and our telephone number is (937) 964-8974. We maintain a website at www.adcarehealth.com.

Company History

AdCare is an Ohio corporation. We were incorporated on August 14, 1991 under the name Passport Retirement, Inc. In 1995, we acquired substantially all of the assets and liabilities of AdCare Health Systems, Inc. and changed our name to AdCare Health Systems, Inc.

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We have embarked on a strategy to grow our business through acquisitions and leases of skilled nursing facilities and businesses providing services to those facilities. During the year ended December 31, 2011, we acquired a total of 15 skilled nursing facilities, and one assisted living facility, and we completed a number of transactions to provide capital for our strategic growth initiatives. We are currently evaluating acquisition opportunities in addition to those described below and we continue to seek new opportunities to further implement our growth strategy. As part of our strategy to focus on the growth of skilled nursing facilities, we decided in the fourth quarter of 2011 to exit the home health business and, therefore, this segment is reported as discontinued operations in our audited financial statements for the year ended December 31, 2011, which are included elsewhere in this report.

Acquisitions and Dispositions

Acquisitions. On December 30, 2010, we completed the acquisition of Mountain Trace, a skilled nursing facility located in Sylva, North Carolina, for a purchase price of $6,171,000. We obtained control of the facility effective January 1, 2011.

On April 29, 2011, we acquired the Southland Care Center, a skilled nursing facility located in Dublin, Georgia; the Autumn Breeze Healthcare Center, a skilled nursing facility located in Marietta, Georgia; and College Park Healthcare Center, a skilled nursing facility located in College Park, Georgia. The total purchase price for all three facilities was $17,943,000. Operations of Autumn Breeze Healthcare and Southland Care Center began May 1, 2011. Operations of College Park Care Center began June 1, 2011.

On August 1, 2011, five skilled nursing facilities located in Oklahoma, were purchased for an aggregate purchase price of $11,218,555 by companies controlled by Christopher Brogdon, the Company's Vice Chairman and Chief Acquisition Officer ("Mr. Brogdon"), and others. These facilities are known as the Living Center, Kenwood Manor, Enid Senior Care, Betty Ann Nursing Center and Grand Lake Villa. Even though we do not have any equity interest in these facilities, we are providing management services and have a related party affiliation with Mr. Brogdon. Due to these factors, we determined that it is a variable interest entity as the ownership entity does not have sufficient equity at risk. We initially consolidated the Oklahoma VIE's on August 1, 2011, the date of acquisition and initial operations.

On September 1, 2011, we acquired the Homestead Manor Nursing Home, a skilled nursing facility located in Stamps, Arkansas; the River Valley Health & Rehabilitation Center, a skilled nursing facility located in Fort Smith, Arkansas; Bentonville Manor, a skilled nursing facility located in Bentonville, Arkansas; Heritage Park Nursing Center, a skilled nursing facility located in Rogers, Arkansas; and the Pinnacle Home Office, a parcel of improved real property containing office facilities located in Rogers, Arkansas for an aggregate adjusted purchase price of $19,449,000. We also became the tenant and operator of the Red Rose Facility, a skilled nursing facility located in Cassville, Missouri and in connection with the transaction paid $490,000 in lease acquisition costs and $13,500 as a security deposit under the lease. The term of the lease expires on September 30, 2014. Operations for the Arkansas facilities began September 1, 2011. Operations for the Missouri facility began December 1, 2011.

On November 30, 2011, we acquired the Stone County facilities from White River Health System, Inc. consisting of the Stone County Nursing and Rehabilitation Facility, a 97 bed skilled nursing, and the Stone County Residential Care Facility, a 32 bed skilled nursing facility/assisted living facility, both located in Mountain View, Arkansas, for an aggregate purchase price of $4,250,000.

On December 30, 2011, we acquired Woodland Manor (also known as Eaglewood Care Center), a 113 bed skilled nursing facility, and Eaglewood Village, an 80 bed assisted living facility, both located in Springfield, Ohio, for an aggregate purchase price of $12,500,000. Operations began on January 1, 2012.

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During 2011, we acquired 16 facilities (15 skilled nursing facilities and one assisted living facility), bringing our Company's total bed count to 3,737 at December 31, 2011. During 2010, we acquired 13 facilities (12 skilled nursing facilities and one assisted living facility), bringing our Company's total bed count to more than 2,400 units at December 31, 2010. The following tables provide summary information regarding our recent acquisitions and facility composition at December 31, 2011:

	December 31,		
	2011	**2010**	**2009**
Cumulative number of facilities	42	27	14
Cumulative number of operational beds	3,737	2,428	852

		Number of Facilities				
State	**Number of Operational Beds/Units**	**Owned**	**VIE**	**Leased**	**Managed for Third Parties**	**Total**
Arkansas	530	6				6
Alabama	408	2	1			3
Georgia	1,497	3		10		13
Missouri	80			1		1
North Carolina	106	1				1
Ohio	802	8		1	4	13
Oklahoma	314		5			5
Total	3,737	20	6	12	4	42
Facility Type						
Skilled Nursing	3,322	13	5	12	3	33
Assisted Living	332	7	1			8
Independent Living	83				1	1
Total	3,737	20	6	12	4	42

We are currently evaluating acquisition opportunities in addition to those described above and we continue to seek new opportunities to further implement our growth strategy. No assurances are made that we will be able to complete any such acquisitions on terms acceptable to us, if at all.

Discontinued Operations. As part of the Company's strategy to focus on the growth of skilled nursing facilities, the Company decided in the fourth quarter of 2011 to exit the home health business. At December 31, 2011, the home heath business was held for sale. The Company anticipates the sale or termination of the home health business to occur in 2012.

Growth Strategy

Our objective is to be the provider of choice for health care and related services to the elderly in the communities in which we operate. We intend to grow our business through numerous initiatives. We expect to continue to increase occupancy rates and revenue per occupied unit at our communities, and to continue our growth in the ancillary services that we offer through additional strategic acquisitions. We believe that our current operations serve as the foundation on which we can build a large fully-integrated senior living company. We will target attractive geographic markets by using our existing infrastructure and operating model, to provide a broad range of high quality care in a cost-efficient manner.

Organic Growth. We intend to focus on improving our operating margins within all of our communities. We continually seek to maintain and improve occupancy rates by:

retaining residents as they "age in place" by extended optional care and service programs;

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attracting new residents through the on-site marketing programs focused on residents and family members;

aggressively seeking referrals from professional community outreach sources, including area religious organizations, senior social service programs, civic and business networks, as well as the medical community; and

continually refurbishing and renovating our communities.

Pursue Strategic Acquisitions. We believe that our current infrastructure and extensive contacts within the industry will continue to provide us with the opportunity to evaluate numerous acquisition opportunities. We believe there is a significant opportunity for a private to public arbitrage, and to increase our operating margins by focusing on service companies to the senior marketplace versus the capital intensive ownership of facilities.

Fragmentation in the Industry Provides Acquisition and Consolidation Opportunities. The senior living industry is highly fragmented and we believe that this provides significant acquisition and consolidation opportunities. We believe that the limited capital resources available to many small, private operators impedes their growth and exit prospects. We believe that we are well positioned to approach strategic small private operators and offer to them exit strategies which are not currently available as well as the ability to grow in their business.

Emphasize Employee Training and Retention. We devote special attention to the hiring, screening, training, supervising and retention of our employees and caregivers. We have adopted comprehensive recruiting and screening programs for management positions that utilize corporate office team interviews and thorough background and reference checks. We believe our commitment to and emphasis on quality hiring practices, employee training and retention differentiates us from many of our competitors.

Positioned for Growth. We believe that we are well-positioned to be a substantial independent senior living company. Our development/consulting practice for third-party owners provides a comprehensive turnkey package from project inception, through the development process, to the management of a facility. The consulting practice is strategic, providing additional development and management opportunities that support our core long-term care business without requiring large capital outlays. We believe our physical assets and human resources position us for internal growth and provide a platform for strategic acquisitions of complementary health care providers.

Pursue Management Contracts. We intend to pursue management opportunities for senior living communities. We believe that our management infrastructure and proven operating track record will allow us to take advantage of increased opportunities in the senior living market for new management contracts for third-party operators.

Operating Strategy

Our operating philosophy is to provide affordable, quality living communities and services to senior citizens and provide a continuum of care as their needs change over time. This continuum of care sustains residents' autonomy and independence based on their physical and mental abilities. As residents age, in many of our communities, they are able to obtain the additional needed services within the same community, avoiding the disruptive and often traumatic move to a different facility.

Provide a Broad Range of Cost-Effective Services. We provide a variety of services in a broad continuum of care which meet the ever changing needs of the elderly. Our expanded service offering currently includes assisted living, independent living and skilled nursing (including Alzheimer's and dementia care).

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Increase Revenues and Profitability at Existing Facilities. Our strategy includes increasing facility revenues and profitability levels through increasing occupancy levels, maximizing reimbursement rates as appropriate, providing additional services to our current residents, and containing costs. Ongoing initiatives to promote higher occupancy levels and appropriate payor and case mixes at our senior living facilities include corporate programs to improve customer service, develop safety programs to improve worker compensation insurance rates and programs for specialized care and therapy services at our facilities.

Offer Services Based on Level of Care. Our range of products and services is continually expanding to meet the evolving needs of our residents. We have developed a menu of products and service programs that may be further customized to serve both the moderate and upper income markets of a particular targeted geographic area.

Improve Operating Efficiencies. We actively monitor and manage our operating costs. By having an established portfolio of communities, we believe that we have a platform to achieve operating efficiencies through economies of scale in the purchase of bulk items, such as food, and in the spreading of fixed costs, such as corporate overhead, over a larger revenue base, and the ability to provide more effective management supervision and financial controls.

Increase Occupancy Through Emphasis on Marketing Efforts. We emphasize strong corporate support for the marketing of our various local facilities. At a local level, our sales and marketing efforts are designed to promote higher occupancy levels and optimal payor mix. Management believes that the long-term care industry is fundamentally a local industry in which both patients and residents and the referral sources for them are based in the immediate local geographic area of the facility.

Promote an Internally-Developed Marketing Program. We focus on the identification and provision of services needed by the community. We assist each facility administrator in analysis of local demographics and competition with a view toward complementary service development. Our belief is that this locally based marketing approach, coupled with strong corporate monitoring and support, provides an advantage over many smaller or larger regional competitors.

Operate the Community Based Management Model. We hire an administrator/manager for each of our communities and provide them with autonomy, responsibility and accountability. We believe this allows us to attract and retain a higher quality of administrator. This administrator manages the day-to-day operations at each senior living community, including oversight of the quality of care, delivery of resident services, and monitoring of the financial performance and marketing functions. We actively recruit personnel to maintain adequate staffing levels at our existing communities and provide financial and budgeting assistance for our managers and administrators.

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 growth of the senior population in the United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.

The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition

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and consolidation opportunities for us. Additionally, based on a decrease in the number of skilled nursing facilities over the past few 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.

We also anticipate that as life expectancy continues to increase in the United States, 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.

Medicare and Medicaid Reimbursement

Rising healthcare costs due to a variety of factors, including an aging population and increasing life expectancies, has generated growing demand for post-acute healthcare services in recent years. In an effort to mitigate the cost of providing healthcare benefits, third party payors including Medicare, Medicaid, managed care providers, insurance companies and others have increasingly encouraged the treatment of patients in lower-cost care settings. As a result, in recent years skilled nursing facilities, which typically have significantly lower cost structures than acute care hospitals and certain other post-acute care settings, have generally been serving larger populations of higher-acuity patients than in the past. However, Medicare and Medicaid reimbursement rates are subject to change from time to time and reduction in rates could materially and adversely impact our revenue.

Revenue derived directly or indirectly from Medicare reimbursement has historically comprised a substantial portion of our consolidated 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. In October 2010, the number of RUG categories was expanded from 53 to 66 as part of the implementation of the RUGs IV system and the introduction of a revised and substantially expanded patient assessment tool called the minimum data set (MDS) version 3.0.

On July 29, 2011, the Centers for Medicare & Medicaid Services ("CMS") issued a final rule providing for, among other things, a net 11.1% reduction in PPS payments to skilled nursing facilities for CMS's fiscal year 2012 (which began October 1, 2011) as compared to PPS payments in CMS's fiscal year 2011 (which ended September 30, 2011). The 11.1% reduction is on a net basis, after the application of a 2.7% market basket increase, and reduced by a 1.0% multi-factor productivity adjustment required by the Patient Protection and Affordable Care Act of 2010 ("PPAC"). The final CMS rule also adjusted the method by which group therapy is counted for reimbursement purposes, and changed the timing in which patients who are receiving therapy must be reassessed for purposes of determining their RUG category.

Should future changes in PPS include further reduced rates or increased standards for reaching certain reimbursement levels (including as a result of automatic cuts tied to federal deficit cut efforts or otherwise), our Medicare revenues derived from our skilled nursing facilities) could be reduced, with a corresponding adverse impact on our financial condition or results of operation.

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We also derive a substantial portion of our consolidated revenue from Medicaid reimbursement, primarily through our skilled nursing business. Medicaid programs are administered by the applicable states and financed by both state and federal funds. Medicaid spending nationally has increased significantly in recent years, becoming an increasingly significant component of state budgets. This, combined with slower state revenue growth and other state budget demands, has led both the federal government to institute measures aimed at controlling the growth of Medicaid spending (and in some instances reducing it).

Historically, adjustments to reimbursement under Medicare and Medicaid have had a significant effect on our revenue and results of operations. Recently enacted, pending and proposed legislation and administrative rulemaking at the federal and state levels could have similar effects on our business. Efforts to impose reduced reimbursement rates, greater discounts and more stringent cost controls by government and other payors are expected to continue for the foreseeable future and could adversely affect our business, financial condition and results of operations. Additionally, any delay or default by the federal or state governments in making Medicare and/or Medicaid reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

Revenue 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 patient 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 our focus on enhanced care offerings for 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. 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.

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.

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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 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 facilities, 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.

Whether information about our billing and reimbursement processes is obtained from external sources or activities such as Medicare and Medicaid audits or probe reviews 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. We continually strive to improve the efficiency and accuracy of all of our operational and business functions, including our billing and reimbursement processes.

	December 31,		
Annual Revenue by Payor	**2011**	**2010**	**2009**
Amounts in (000s)			
Medicare	$ 43,842	$ 9,375	$ 2,744
Medicaid	78,690	22,957	6,467
Other	27,201	16,365	12,569
Total	$ 149,733	$ 48,697	$ 21,780

Competition

Our ability to compete successfully varies from location to location and depends on a number of factors, including the number of competing facilities in the local market, the types of services available, our local reputation for quality care of patients, the commitment and expertise of our staff and physicians, our local service offerings and treatment programs, the cost of care in each locality, and the physical appearance, location, age and condition of our facilities. We are in a competitive, yet fragmented, industry. While there are several national and regional companies that provide retirement living alternatives, we anticipate that our primary source of competition will be the smaller regional and local development and management companies. There is limited, if any, price competition with respect to Medicaid and Medicare patients, since revenues for services to such patients are strictly controlled and are based on fixed rates and cost reimbursement principles. Although the degree of success with which our facilities compete varies from location to location, management believes that its facilities generally compete effectively with respect to these factors. Our competitors include assisted living communities and other retirement facilities and communities, home health care agencies, nursing homes, and convalescent centers, some of which operate on a not-for-profit or charitable basis. Our nursing homes and assisted living facilities compete with both national and local competitors. We also compete with other health care companies for facility acquisitions and management contracts. There

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can be no assurance that additional facilities and management contracts can be acquired on favorable terms.

We seek to compete effectively in each market by establishing a reputation within the local community for quality of care, attractive and comfortable facilities, and providing specialized healthcare with an ability to care for high-acuity patients. We believe that the average cost to a third-party payor for the treatment of our typical high-acuity patient is lower if that patient is treated in one of our skilled nursing facilities than if that same patient were to be treated in an inpatient rehabilitation facility or long-term acute-care hospital. We face direct competition from alternative facilities in our markets for residents. The skilled nursing facilities operated by us compete with other facilities in their respective markets, including rehabilitation hospitals and oth