ENSIGN GROUP, INC
Form 10-K
February 08, 2018
Table of Contents

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

x ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.
For the fiscal year ended December 31, 2017.

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)

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

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

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

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

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, 2017, was approximately $780,000,000. Shares of Common Stock held by each executive officer, director and each person owning more than 10% of the outstanding Common Stock of the registrant have been excluded in that such persons may be deemed to be affiliates of the registrant. This determination of affiliate status is not necessarily a conclusive determination for other purposes.
As of February 5, 2018, 51,484,963 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 2017 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.
INDEX TO ANNUAL REPORT ON FORM 10-K
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2017
TABLE OF CONTENTS

CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K contains forward-looking statements, which include, but are not limited to our 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 expressions, and variations negatives of these words. These statements are subject to the safe harbors created under the Securities Act of 1933 (Security Act) and the Securities Exchange Act of 1934 (Exchange Act). 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 Annual 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, "Ensign," Company," “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our operating subsidiaries, 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. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar terms in this Annual Report is not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. In addition, certain of our wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. In addition, our wholly-owned captive insurance subsidiary, which we refer to as the Captive, provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as for certain workers' compensation insurance liabilities.

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

Company Overview

We are a provider of health care services across the post-acute care continuum, as well as other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oklahoma, Oregon, South Carolina, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the service of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted and independent living, home health and hospice and other ancillary services. As of December 31, 2017, we offered skilled nursing, assisted and independent living and rehabilitative care services through 230 skilled nursing and assisted and independent living facilities across 13 states. Of the 230 facilities, we owned 63 and operated an additional 167 facilities under long-term lease arrangements, and had options to purchase 11 of those 167 facilities. Our home health and hospice business provides home health, hospice and home care services from 46 agencies across eleven states.

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 leaders are highly dedicated individuals who are responsible for key operational decisions at their operations. Leaders and staff are trained and motivated to pursue superior clinical outcomes, high patient and family satisfaction, operating efficiencies and financial performance at their operations.

We encourage and empower our leaders and staff to make their operation the “operation of choice” in the community it serves. This means that our leaders and staff are generally authorized 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 for, and reputation in, that particular community or market. We believe that our localized approach encourages prospective customers and referral sources to choose or recommend the operation. 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 order to improve clinical care, enhance 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 operation to focus on clinical excellence, and promote their operation independently within their local community.

Much of our historical growth can be attributed to our expertise in acquiring real estate or leasing both under-performing and performing post-acute care operations and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. We have also invested in new business lines that are complementary to our existing businesses, such as ancillary services. 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 patients;

•focusing on organic growth and internal operating efficiencies;

•continuing to acquire additional operations in existing and new markets;

•expanding and renovating our existing operations, and

•strategically investing in and integrating other post-acute care healthcare businesses.

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 in our industry are measured. We believe that through our efforts and leadership, we can foster a new level of patient care and professional competence at our operating subsidiaries, and set a new industry standard for quality skilled nursing and rehabilitative care services.

We organize our operating subsidiaries into portfolio companies, which we believe has enabled us to maintain a local, field-driven organizational structure, 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 operational 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 organizational structure has improved the quality of our recruiting and will continue to facilitate successful acquisitions.

We have three reportable segments: (1) transitional and skilled services, which includes the operation of skilled nursing facilities; (2) assisted and independent living services, which includes the operation of assisted and independent living facilities; and (3) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level. We also report an “all other” category that includes revenue from our mobile diagnostics and other ancillary operations. Our mobile diagnostics and other ancillary operations businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. For more information about our operating segments, as well as financial information, see Part II Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations and Note 7, Business Segments of the Notes to Consolidated Financial Statements.

Segments

Transitional and Skilled Services
As of December 31, 2017, our skilled nursing companies provided skilled nursing care at 181 operations, with 18,870 operational beds, in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. Through our skilled nursing operations, we provide short stay patients and long stay patients with a full range of medical, nursing, rehabilitative, pharmacy and routine services, including daily dietary, social and recreational services. We generate our revenue from Medicaid, private pay, managed care and Medicare payors. During the year ended December 31, 2017, approximately 45.7% and 27.0% of our transitional and skilled services revenue was derived from Medicaid and Medicare programs, respectively.

Assisted and Independent Living Services
We provide assisted and independent living services at 70 operations, of which 21 are located on the same site location as our skilled nursing care operations. As of December 31, 2017, we had 5,011 assisted and independent living units. Our assisted living companies located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Texas, Utah, Washington and Wisconsin, provide residential accommodations, activities, meals, security, housekeeping and assistance in the activities of daily living to seniors who are independent or who require some support, but not the level of nursing care provided in a skilled nursing operation. Our independent living units are non-licensed independent living apartments in which residents are independent and require no support with the activities of daily living. We generate revenue at these units primarily from private pay sources, with a portion earned from Medicaid or other state-specific programs. During the year ended December 31, 2017, approximately 77.7% of our assisted and independent living revenue was derived from private pay sources.

Home Health and Hospice Services

Home Health
As of December 31, 2017, we provided home health care services in Arizona, California, Colorado, Idaho, Iowa, Oklahoma, Oregon, Texas, Utah and Washington. Our home health care services generally consist of providing some

combination of nursing, speech, occupational and physical therapists, medical social workers and certified home health aide services. 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. We derive the majority of our home health revenue from Medicare and managed care organizations. During the year ended December 31, 2017, approximately 50.1% of our home health revenue was derived from Medicare.

Hospice

As of December 31, 2017, we provided hospice care services in Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah and Washington. Hospice services focus on the physical, spiritual and psychosocial needs of terminally ill individuals and their families, and consists primarily of palliative and clinical care, education and counseling. We derive the majority of our hospice revenue from Medicare reimbursement. During the year ended December 31, 2017, approximately 88.6% of our hospice revenue was derived from Medicare.

Other

As of December 31, 2017, we held a majority membership interest of ancillary operations located in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. We have invested in and are exploring new business lines that are complementary to our existing transitional and skilled services; assisted and independent living services and home health and hospice businesses. These new business lines consist of mobile ancillary services, including digital x-ray, ultrasound, electrocardiograms, sub-acute services and patient transportation to people in their homes or at long-term care facilities. To date these businesses are not meaningful contributors to our operating results.

Growth

We have an established track record of successful acquisitions. Much of our historical growth can be attributed to our expertise in acquiring real estate or leasing both under-performing and performing post-acute care operations and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. With each acquisition, we apply our core operating expertise to improve these operations, both clinically and financially. In years where pricing has been high, we have focused on the integration and improvement of our existing operating subsidiaries while limiting our acquisitions to strategically situated properties.

Over the last several years, our acquisition activity accelerated, allowing us to add 128 facilities between January 1, 2012 and December 31, 2017. From January 1, 2008 through December 31, 2017, we acquired 169 facilities, which added 12,434 operational skilled nursing beds and 4,433 assisted and independent living units to our operating subsidiaries. The following table summarizes our growth through December 31, 2017:

	December 31,										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Cumulative number of skilled nursing, assisted and independent living operations	61	63	77	82	102	108	119 (1)	136	186 (2)	210	230
Cumulative number of operational skilled nursing beds	6,436	6,635	8,250	8,548	9,787	10,215	10,949	12,379	14,925	17,724	18,870
Cumulative number of assisted living and independent living units	578	578	578	791	1,509	1,677	1,968 (1)	2,285	4,298 (2)	4,450	5,011
Number of home health, hospice and home care agencies	—	—	1	3	7	10	16	25	32	39	46

(1) Included in 2013 operational units are operational units of the three independent living facilities we transferred to CareTrust REIT, Inc. (CareTrust) as part of the spin-off transaction (the Spin-Off). Prior to the Spin-Off, the Company separated the healthcare operations from the independent living operations at two locations, resulting in two separate facilities and transferred the two separate facilities and one stand-alone independent facility to CareTrust.
(2) Included in 2010-2015 operational beds and number of operations are operational beds and operation of facilities we discontinued in 2016 and 2017. In the current and prior year, the number of operations and operational beds do not include the closed facilities.

New Market CEO and New Ventures Programs. In order to broaden our reach into 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 businesses and establishing an operating platform for future growth. In addition, this program includes other lines of business that are closely related to the skilled nursing industry. For example, we entered into home health and hospice as part of this program. The New Ventures program encourages our local leaders to evaluate service offerings with the goal of establishing an operating platform in new markets and new businesses. 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.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds and units located at our facilities as of December 31, 2017:

	TX	CA	AZ	WI	UT	CO	WA	ID	NE	KS	IA	SC	NV	Total
Number of facilities														
Skilled nursing operations	43	39	23	2	16	9	9	6	4	—	4	4	1	160
Assisted and independent living services	4	6	6	19	1	5	1	3	1	—	—	—	3	49
Campuses(1)	4	3	1	—	1	1	—	1	2	6	2	—	—	21
Number of operational beds/units														
Operational skilled nursing beds	5,634	4,163	3,180	138	1,763	766	841	544	413	542	368	426	92	18,870
Assisted and independent living units	387	735	1,250	758	106	618	98	274	301	142	31	—	311	5,011

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

As of December 31, 2017, we provided home health and hospice services through our 46 agencies in Arizona, California, Colorado, Idaho, Iowa, Nevada, Oklahoma, Oregon, Texas, Utah and Washington.

During the year ended December 31, 2017, we continued to expand our operations through a combination of long-term leases and purchases, with the addition of eight stand-alone skilled nursing operations, nine stand-alone assisted and independent living operations, one campus operation, three home health agencies, three hospice agencies and one home care agency. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term leases. We have also invested in ancillary services that are complementary to our existing transitional and skilled services, assisted and independent living services, and home health and hospice businesses. The aggregate purchase price for these acquisitions for the year ended December 31, 2017 was $89.7 million. The addition of these operations added 905 operational skilled nursing beds and 594 assisted living units operated by our operating subsidiaries. We entered into a separate operations transfer agreement with the prior operator as part of each transaction.

Our operating subsidiaries also opened four newly constructed stand-alone skilled nursing operations under long-term lease agreements, which added 455 operational skilled nursing beds.

Subsequent to December 31, 2017, we acquired two stand-alone assisted and independent living operations for an aggregate purchase price of $4.3 million. The addition of these operations added 74 assisted living units operated by our Company's operating subsidiaries.

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

Quality of Care Measures

Skilled Nursing

In December 2008, the Centers for Medicare and Medicaid Services (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 skilled nursing operation 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 at the time we acquire them, which impacts our overall Five-Star Quality rating as a percentage of all our skilled nursing operations. We believe compliance and quality outcomes are precursors to outstanding financial performance.

Our star ratings starting in 2015 were impacted by changes in the CMS Five Star Quality Rating System requirements that were established on February 20, 2015. These changes include the use of antipsychotics in calculating the star ratings, modified calculations for staffing levels and reflect higher standards for nursing homes to achieve a high rating on the quality measure dimension. In 2016, CMS added six new quality measures to the Nursing Home Five-Star Quality Ratings, including the rate of hospitalization, emergency room use, community discharge, improvements in function, independently worsened and anxiety or

4

hypnotic medication among nursing home residents. Since the revised standards for performance are more difficult to achieve, many nursing homes experienced a lower quality measure rating based on new measurement standards rather than a change in the quality of care. In 2017, CMS issued a temporary freeze of the Health Inspection Five Star Ratings beginning in 2018 that will last approximately 12 months. The health inspection star rating for recertification surveys and complaints conducted on or after November 28, 2017 will be frozen. This freeze could impact have a negative impact on our star rating in 2018. Because of these changes, we believe that it is not appropriate to compare our 2017, 2016 and 2015 star ratings with those that appeared in earlier years. In addition, our percentage of 4 and 5-Star Quality Rated skilled nursing facilities is also impacted by the number of newly acquired facilities. As mentioned above, generally we acquire facilities with a 1 or 2-Star rating.

The table below summarizes the improvements we have made in these quality measures since 2012:

	As of December 31,					
	2012	2013	2014	2015	2016	2017
Cumulative number of skilled nursing facilities(1)	98	106	121	146	170	181
4 and 5-Star Quality Rated skilled nursing facilities	45	60	77	72	86	100
Percentage of 4 and 5-Star Quality Rated skilled nursing facilities	45.9%	56.6%	63.6%	49.3%	50.6%	55.2%

(1) Cumulative number includes only skilled nursing facilities as of the end of the respective period as star rating reports are only applicable to skilled nursing facilities.

Home Health

On July 17, 2015, CMS announced Home Health Star Ratings for home health agencies (HHAs). All Medicare-certified HHAs are potentially eligible to receive a Quality of Patient Care Star Rating. The Star Ratings include assessments of quality of patient care based on Medicare claims data and patient experience of care. Currently, HHAs must have at least 20 complete episodes of data for each measure and have reported data for five of the nine measures used in the calculation to have a Quality of Patient Care Star Rating computed. On December 14, 2017, CMS announced the influenza vaccination measure would be removed from consideration in the Quality of Patient Care Star Rating beginning with the April 2018 Home Health Compare refresh, reducing the number of quality measures used from nine to eight. As of December 31, 2017, we had 15 agencies, or 65.2%, with a 4 or 5-Star rating and our average rating was 3.89, as compared to the industry average of 3.67.

Industry Trends

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

- Shift of Patient Care to Lower Cost Alternatives. The growth of the senior population in the United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.
- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. Due to the increasing demands from hospitals and insurance carriers to implement sophisticated and expensive reporting systems, we believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the

overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

- Accountable Care Organizations and Reimbursement Reforms. A significant goal of federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable

for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization (ACO) models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing demonstration and mandatory programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. On April 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018. In March 2016, CMS announced that its 30% target for 2016 was reached in January 2016. On December 1, 2017, CMS finalized changes to the Comprehensive Care for Joint Replacement (CJR) Model, as well as the cancellation of care coordination through mandatory Episode Payments and Cardiac Rehabilitation Incentive Payment Model, and rescinded the regulations governing these models. Through the final rule, CMS canceled the Episode Payment Models, which were scheduled to begin on January 1, 2018 and implemented certain revisions to CJR, including giving certain hospitals a one-time option to choose whether to continue participation. The changes in the final rule allow the agency to engage providers in future voluntary efforts, including additional voluntary episode-based payment models, but removes the mandatory episode payment models.
We believe the post-acute industry has been and will continue to be impacted by several other trends. The use of long-term care insurance is increasing among seniors as a means of planning for the costs of skilled nursing services. In addition, as a result of increased mobility in society, reduction of average family size, and the increased number of two-wage earner couples, more seniors are looking for alternatives outside the family for their care.

Effects of Changing Prices

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

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

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

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

On October 4, 2016, CMS released a final rule that reforms the requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in the Medicare and Medicaid programs. The regulations have not been updated since 1991 and have been revised to improve quality of life, care and services in LTC facilities, optimize

resident safety, reflect current professional standards and improve the logical flow of the regulations. The regulations became effective November 28, 2016 and are being implemented in three phases. The first phase was effective November 28, 2016, the second phase was effective November 28, 2017 and the third phase becomes effective November 28, 2019.

A few highlights from the new regulation include the following:

- investigate and report all allegations of abusive conduct, and refrain from employing individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property;
- document a transfer or discharge in the medical record and exchange certain information to a receiving provider or facility when a resident is transferred;
- develop and implement a baseline care plan for each resident within 48 hours of their admission that includes instructions to provide effective and person-centered care that meets professional standards of quality care;
- develop and implement a discharge planning process that prepares residents to be active partners in post-discharge care;
- provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being;
- add a competency requirement for determining the sufficiency of nursing staff;
- require that a pharmacist reviews a resident’s medical chart during each monthly drug regiment review;
- refrain from charging a Medicare resident for loss or damage of dentures;
- provide each resident with a nourishing, palatable and well-balanced diet;
- conduct, document and annually review a facility-wide assessment to determine what resources are necessary to care for its residents;
- refrain from entering into a binding arbitration agreement until after a dispute arises between the parties;
- develop, implement and maintain an effective comprehensive, data-driven quality assurance and performance improvement program;
- develop an Infection Prevention and Control Program; and
- require their operating organization have in effect a compliance and ethics program.

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

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

On September 16, 2016, CMS issued its final rule concerning emergency preparedness requirements for Medicare and Medicaid participating providers, specifically skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). The rule is designed to ensure providers and suppliers have comprehensive and integrated emergency policies and procedures in place, in particular during natural and man-made disasters. Under the rule, facilities are required to 1) document risk assessment and emergency planning; 2) develop and implement policies and procedures based on that risk assessment; 3) develop and maintain an emergency preparedness communication plan in compliance with both federal and state law; and 4) develop and maintain an emergency preparedness training and testing program. The regulations outlined in the final rule must be implemented by November 15, 2017.

On July 29, 2016, CMS issued its final rule laying out the performance standards relating to preventable hospital readmissions from skilled nursing facilities. The final rule includes the SNF 30-day All Cause Readmission Measure which assesses the risk-standardized rate of all-cause, all condition, unplanned inpatient hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from admission to an inpatient prospective payment system hospital, CAH or psychiatric hospital. The final rule includes the SNF 30-Day Potentially Preventable Readmission Measure as the SNF all condition risk adjusted potentially preventable hospital readmission measure. This measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital. Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable. This measure is claims-based, requiring no additional data collection or submission burden for SNFs.

On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for a new Cardiac Rehabilitation Incentive (CR) model, which includes mandatory bundled payment programs for an acute myocardial infarction (AMI) episode of care or a coronary artery bypass graft (CABG) episode of care, and modifications to the existing Comprehensive Care for Joint Replacement (CJR) model to include surgical hip/femur fracture treatment episodes. The new mandatory cardiac programs mirror the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models in that actual episode payments will be retrospectively compared against a target price. Similar to CJR, participating hospitals will be at risk for Medicare Part A and B payments in the inpatient admission and 90 days post-discharge. BPCI episodes would continue to take precedence over episodes in the CJR program and in the new cardiac bundled payment program. The cardiac model will be mandatory in 98 randomly selected geographic areas and the hip/femur procedure model will be mandatory in the same 67 geographic areas that were selected for CJR. CMS is also providing “Cardiac Rehabilitation Incentive Payments”, which can be used by hospitals to facilitate cardiac rehabilitation plans and adherence. The incentive will be provided to hospitals in 45 of the 98 geographic areas included in the mandatory bundled payment program and 45 geographic areas outside of the program. On May 19, 2017, CMS issued a final rule which delayed the effective date until May 20, 2017 and the start date was scheduled for January 1, 2018, and the final rule will continue for five performance years.

On August 15, 2017, CMS proposed changes to the Comprehensive Care for Joint Replacement (CJR) Model, which included the cancellation of care coordination through mandatory Episode Payments and Cardiac Rehabilitation Incentive Payment Model. On December 1, 2017, CMS issued a final rule which officially canceled the Episode Payment Models and Cardiac Rehabilitation Incentive Payment Model, rescinding the regulations governing these models. Additionally, the final rule implemented certain revisions to the CJR program, including making participation voluntary for approximately half of the geographic areas, along with other technical refinements. These regulation changes are effective January 1, 2018.

On January 9, 2018, CMS launched a new voluntary bundled payment called Bundled Payments for Care Improvement Advanced (BCPI Advanced). The Model Performance Period for BCPI Advanced commences on October 1, 2018 and runs through December 31, 2023. Under this bundled payment model, participants can earn additional payment if all expenditures for a beneficiary’s episode of care are under a spending target that factors in quality. BPCI Advanced Participants may receive payments for performance on 32 different clinical episodes, such as major joint replacement of the lower extremity (inpatient) and percutaneous coronary intervention (inpatient or outpatient). Participants bear financial risk, have payments under the model tied to quality performance, and are

required to use Certified Electronic Health Record Technology. An episode model such as BPCI Advanced supports healthcare providers who invest in practice innovation and care redesign to improve quality and reduce expenditures. Of note, BPCI Advanced will qualify as the first Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program. In 2015, Congress passed the Medicare Access and Chip Reauthorization Act or MACRA. MACRA requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid who participate in Medicare. QPP creates two tracks for physician payment - the Merit-Based Incentive Payment System or MIPS track and the Advanced APM track. Under MIPS, providers have to report a range of performance metrics and their payment amount is adjusted based on their performance. Under Advanced APMs, providers take on financial risk to earn the Advanced APM incentive payment that they are participating in.

Skilled Nursing

CMS Payment Rules. In 2017, CMS proposed an alternative case-mix classification system for fiscal year 2018, named Resident Classification System, Version I (RCS-I). RCS-I would case-mix adjust for the following major cost categories: Physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP) services, nursing services and non-therapy ancillaries (NTAs). Thus, where RUG-IV consists of two case-mix adjusted components (therapy and nursing), RCS-I would create four (PT/OT, SLP, nursing, and NTA) for a more resident-centered case-mix adjustment. RCS-I would also maintain the existing non-case-mix component to cover utilization of SNF resources that do not vary according to resident characteristics. For two of the case-mix-adjusted components, PT/OT and NTA, RCS-I includes variable per-diem payment adjustments that modify payment based on changes in utilization of these services over the course of a stay. The proposed model will compensate SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries and addresses concerns about current incentives for SNFs to delivery therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries. The proposed RCS-I classification model could improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care. The proposed rule is expected to reduce payments associated with residents in the highest therapy RUG (RU) and increase payments associated with residents who receive extensive services or have high NTA costs. The proposed rule also simplifies the MDS structure and reduces labor needs. Additionally, it is estimated that RCS-I would result in higher payments associated with the following resident types: dual enrollment in Medicare and Medicaid, end-stage renal disease (ESRD), having a longer qualifying inpatient stay, diabetes, wound infections, and use of IV medication.

On July 31, 2017, CMS issued its final rule outlining fiscal year 2018 Medicare payment rates for skilled nursing facilities. Under the final rule, the market basket index is revised and rebased by updating the base year from 2010 to 2014 and adding a new cost category for Installation, Maintenance, and Repair Services. The rule also includes revisions to the SNF Quality Reporting Program, including measure and standardized patient assessment data policies, as well as policies related to public display. In addition, it finalized policies for the Skilled Nursing Facility Value-Based Purchasing Program that will affect Medicare payment to SNFs beginning in fiscal year 2019 and clarification of the requirements regarding the composition of professionals for the survey team. The final rule uses a market basket percentage of 1% to update the federal rates, but if a SNF fails to submit quality reporting program requirements there will be a 2% reduction to the market basket update for the fiscal year involved. Thus, the increase in the proposed federal rates may increase the amount of our reimbursements for SNF services so long as we meet the reporting requirements.

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

The Value-Based Purchasing Program rewards skilled nursing facilities with incentive payments for the quality of care they give to people with Medicare. The final rule specifies the skilled nursing facility 30-day potentially preventable readmission measure, which assesses the facility-level risk standardized rate of unplanned, potentially preventable hospital readmissions for skilled nursing facility patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital. There is also finalized additional policies related to the Value-Based Purchasing Program including: establishing performance standards; establishing baseline and performance periods; adopting a performance

scoring methodology; and providing confidential feedback reports to the skilled nursing facilities. This SNF Value-Based Purchasing Program will start in fiscal year 2019.

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

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

Home Health

On November 1, 2017, CMS issued a final rule that became effective on January 1, 2018 and updated the calendar year 2018 Medicare payment rates and the wage index for home health agencies serving Medicare beneficiaries. The rule also finalized proposals for the Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP). Under the final rule. Medicare payments will be reduced by 0.4%. This decrease reflects the effects of a 1.0% home health payment update percentage; a -0.97% adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9%; and the sunset of the rural add-on provision.

On January 13, 2017, CMS issued a final rule that modernized the Home Health Conditions of Participation (CoPs). This rule is a continuation of CMS's effort to improve quality of care while streamlining provider requirements to reduce unnecessary procedural requirements. The rule makes significant revisions to the conditions currently in place, including (1) adding new conditions of participation related to quality assurance and performance improvement programs (QAPI) and infection control; and (2) expanding or revising requirements related to patient rights, comprehensive evaluations, coordination and care planning, home health aide training and supervision, and discharge and transfer summary and time frames. The new CoPs became effective on January 13, 2018.

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

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

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

Lastly, CMS implemented a standardized cross-setting measure for calendar year 2016. The CoPs require home health agencies to submit OASIS assessments, within 30 days of completing the assessment of the beneficiary, as a condition of payment and also for quality measurement purposes. Commencing on April 3, 2017, if the OASIS assessment is not found in the quality system upon receipt of a final claim for an HH episode and the receipt date of the claim is more than 30 days after the assessment completion date, Medicare systems will deny the HH claim. Home health agencies

that do not submit quality measure data to CMS incur a 2.0% reduction in their annual home health payment update percentage. Under the rule, all home health agencies are required to timely submit both Start of Care (initial assessment) or Resumption of Care OASIS assessment and a Transfer or Discharge OASIS assessment for a minimum of 70.0% of all patients with episodes of care occurring during the annual reporting period starting July 1, 2015 and ending June 30, 2016, 80% of all patients with episodes occurring during the reporting period starting July 1, 2016 and ending June 30, 2017, and 90% for all episodes beginning on or after July 1, 2017.

Hospice

On August 1, 2017, CMS issued its final rule outlining the fiscal year 2018 Medicare payment rates, wage index and cap amount for hospices serving Medicare beneficiaries. The final rule uses a net market basket percentage increase of 1.0% to update the federal rates, as mandated by section 411(d) of the MACRA. Although, if a hospice fails to comply with quality reporting program requirements, there will be a 2.0% reduction to the market basket update for the fiscal year involved. The hospice cap

amount for fiscal year 2018 is increased by 1.0% , which is equal to the 2017 cap amount updated by the fiscal year 2018 hospice payment update percentage of 1.0%. In addition, this rule discusses changes to the Hospice Quality Reporting Program (HQRP), including changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) hospice survey measures and plans for sharing HQRP data in fiscal year 2017.

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

On July 31, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, there was a net 1.1% increase in payments effective October 1, 2015. The hospice payment increase was the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.4% minus 0.3% for reductions required by law) and 1.2% decrease in payments to hospices due to updated wage data and the phase-out of its wage index budget neutrality adjustment factor (BNAF), offset by the newly announced Core Based Statistical Areas (CBSA) delineation impact of 0.2%. The rule also created two different payment rates for routine home care (RHC) that resulted in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for 61 or more days of hospice care and a Service Intensity Add-On (SIA) Payment for fiscal year 2016 and beyond in conjunction with the proposed RHC rates.

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

Annual limitations on beneficiary incurred expenses for outpatient therapy services under Medicare Part B are commonly referred to as “therapy caps.” All beneficiaries began a new cap year on January 1, 2017 since the therapy caps are determined on a calendar year basis. For physical therapy (PT) and speech-language pathology services (SLP) combined, the limit on incurred expenses was $1,980 in 2017 compared to $1,960 in 2016. For occupational therapy (OT) services, the limit was $1,980 for 2017 compared to $1,960 in 2016. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

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

The Medicare Access to Rehabilitation Services Act of 2017 (S. 253/H.R. 807), which repeals the therapy cap has been introduced to Congress. Congress has not yet addressed a permanent fix of the therapy cap nor has final legislation been put in place to extend the exceptions process beyond 2017 for Medicare beneficiaries to receive

medically necessary therapy above the cap. Therefore, there is a hard cap of $2010 for PT/SLP services and $2010 for OT services in effect since January 1, 2018.

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

Medicare Coverage Settlement Agreement. A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved on January 24, 2013, which tasked CMS

with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS was also required to develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve, after which the members of the class were given the opportunity for re-review of their claims. The major provisions of this settlement agreement have been implemented by CMS, which could favorably impact Medicare coverage reimbursement for our services. However, health care providers may be subject to liability in the event they fail to appropriately adapt to the newly clarified reimbursement rules and consequently overbill state Medicaid programs in connection with services rendered to dual-eligible Medicare patients (i.e., by not maximizing Medicare coverage before billing Medicaid).

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates, see Part II, Item 1A Risk Factors under the headings Risks Related to Our Business and Industry - “Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare,” “Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending,” “We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations” and “Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements.” The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. We are not able to predict the outcome of the legislative process. We also cannot predict the extent to which proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and existing new legislation will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue and could adversely affect our business, financial condition and results of operations.

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.

Medicaid reimburses home health and hospice providers, physicians, and certain other health care providers for care provided to certain low income patients. Reimbursement varies from state to state and is based upon a number of different systems, including cost-based, prospective payment and negotiated rate systems. Rates are subject to statutory and regulatory changes and interpretations and rulings by individual state agencies.

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 sign a Medicare provider agreement and 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.

The Medicare home health benefit is available both for patients who need care following discharge from a hospital and patients who suffer from chronic conditions that require ongoing but intermittent care. As a condition of participation under Medicare, beneficiaries must be homebound (meaning that the beneficiary is unable to leave his/her home without a considerable and taxing effort), require intermittent skilled nursing, physical therapy or speech therapy services, and receive treatment under a plan of care established and periodically reviewed by a physician. Medicare rates are based on the severity of the patient's

condition, his or her service needs and other factors relating to the cost of providing services and supplies, bundled into 60-day episodes of care. There is no limit to the number of episodes a patient may receive as long as he or she remains Medicare eligible.

The Medicare hospice benefit is also available to Medicare-eligible patients with terminal illnesses, certified by a physician, where life expectancy is six months or less. Medicare rates are based on standard prospective rates for delivering care over a base 90-day or 60-day period (90-day episodes of care for the first two episodes and 60-day episodes of care for any subsequent episodes). Payments are based on daily rates for each day a beneficiary is enrolled in the hospice benefit. Rates are set based on specific levels of care, are adjusted by a wage index to reflect health care labor costs across the country and are established annually through Federal legislation. Medicare payments are subject to two fixed annual caps, which are assessed on a provider number basis. The annual caps per patient, known as hospice caps, are calculated and published by the Medicare fiscal intermediary on an annual basis and cover the twelve month period from November 1 through October 31. The caps can be subject to annual and retroactive adjustments, which can cause providers to owe money back to Medicare if such caps are exceeded.

Managed Care and Private Insurance. Managed care patients consist of individuals who are insured by certain third-party entities, or who are Medicare beneficiaries who have assigned their Medicare benefits to a senior managed care organization 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.

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.

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, audits or 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 contractors 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 or 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 operating subsidiaries, and assist with the appeal of overpayment and recoupment claims generated by governmental, Medicare contractors 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 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 our total revenue by payor source generated by each of our reportable segments and our "All Other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Year Ended December 31, 2017							
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %	
			Home Health Services	Hospice Services				
Medicaid	$603,104	$ 30,469	$4,398	$6,832	$—	$644,803	34.9	%
Medicare	417,870	—	36,592	61,422	—	515,884	27.9	
Medicaid-skilled	102,875	—	—	—	—	102,875	5.6	
Subtotal	1,123,849	30,469	40,990	68,254	—	1,263,562	68.4	
Managed care	281,563	—	21,058	765	—	303,386	16.4	
Private and other	139,798	106,177	10,997	339	25,058 (1)	282,369	15.2	
Total revenue	$1,545,210	$ 136,646	$73,045	$69,358	$25,058	$1,849,317	100.0	%

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

	Year Ended December 31, 2016							
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %	
			Home Health Services	Hospice Services				
Medicaid	$521,063	$ 26,397	$4,131	$6,367	$—	$557,958	33.7	%
Medicare	396,519	—	32,376	48,124	—	477,019	28.8	
Medicaid-skilled	87,517	—	—	—	—	87,517	5.3	
Subtotal	1,005,099	26,397	36,507	54,491	—	1,122,494	67.8	
Managed care	247,844	—	16,913	751	—	265,508	16.0	
Private and other	121,860	97,239	6,906	245	40,612 (1)	266,862	16.2	
Total revenue	$1,374,803	$ 123,636	$60,326	$55,487	$40,612	$1,654,864	100.0	%

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

	Year Ended December 31, 2015							
	Transitional and Skilled Services	Assisted and Independent Living Services	Home Health and Hospice Services		All Other	Total Revenue	Revenue %	
			Home Health Services	Hospice Services				
Medicaid	$430,368	$ 19,642	$3,598	$5,348	$—	$458,956	34.2	%
Medicare	332,429	—	26,828	36,246	—	395,503	29.5	
Medicaid-skilled	71,905	—	—	—	—	71,905	5.4	
Subtotal	834,702	19,642	30,426	41,594	—	926,364	69.1	
Managed care	194,743	—	11,391	636	—	206,770	15.4	
Private and other	96,943	68,487	6,138	171	36,953 (1)	208,692	15.5	
Total revenue	$1,126,388	$ 88,129	$47,955	$42,401	$36,953	$1,341,826	100.0	%

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

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 operations over various periods. The following

table sets forth our percentage of skilled nursing patient days by payor source:

	Year Ended December 31,		
	2017	2016	2015
Percentage of Skilled Nursing Days:			
Medicare	13.4 %	14.4 %	14.6 %
Managed care	12.2	12.0	11.4
Other skilled	4.7	4.5	4.4
Skilled mix	30.3	30.9	30.4
Private and other payors	12.5	12.5	12.1
Quality mix	42.8	43.4	42.5
Medicaid	57.2	56.6	57.5
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, Medicare, managed care and private payors. Our skilled nursing operations 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, managed care and Medicare for services provided at skilled nursing operations and assisted living operations. 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 patients 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 rate categories based on the level of care we furnish to the beneficiary. This payment is designed to include all of the services needed to manage the beneficiary's care. These rates are subject to annual adjustments based on inflation and geographic wage considerations. In its 2016 Final Rule, CMS established a two-tiered payment system for routine home care services. Effective January 1, 2016, hospices are reimbursed at a higher rate for routine home care services provided from days 1 through 60 of a hospice episode of care and a lower rate for all subsequent days of service. CMS also provided for a Service Intensity Add-On, which increases payments for certain routine home care services provided by registered nurses and social workers to hospice patients during the final seven days of life.

We are subject to two limitations on Medicare payments for hospice services. First, we are subject to an inpatient cap. This cap limits the number of days that can be reimbursed at an inpatient care rate (both respite and general) to 20% of the total number of days of hospice care (both inpatient and in the home) that we provide to Medicare beneficiaries. Payments for days in excess of this limit are paid at the routine home care rate, and we must reimburse the government for any amounts received in excess of that rate.

Second, hospices are subject to an aggregate payment cap. This cap amount is calculated annually by multiplying the number of beneficiaries electing hospice care during the year by a statutory amount that is indexed for inflation. For cap years ended 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.

Traditionally, the hospice inpatient and aggregate caps covered revenue received and services provided from November 1 to October 31. The 2017 cap year was an 11 month transition year with cap amounts calculated for the 11 month period from November 1, 2016 to September 30, 2017. Beginning October 1, 2017, CMS has changed the hospice inpatient and aggregate cap year to coincide with the fiscal year (October 1 to September 30).

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 post-acute care 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. Our operating subsidiaries 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 post-acute care industry are:

- ability to attract and to retain qualified management and caregivers;
- reputation and achievements of quality healthcare outcomes;
- attractiveness and location of facilities;
- the expertise and commitment of the facility management team and employees; and
- community value, including amenities and ancillary services.

We seek to compete effectively in each market by establishing a reputation within the local community as the "operation of choice." This means that the operation 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 operation.

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 patients of our facilities, potential patients 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.

There are few barriers to entry in the home health and hospice business in jurisdictions that do not require certificates of need or permits of approval. Our primary competition in these jurisdictions comes from local privately and publicly-owned and hospital-owned health care providers. We compete based on the availability of personnel, the quality of services, expertise of visiting staff, and, in certain instances, on the price of our services. In addition, we compete with a number of non-profit organizations that finance acquisitions and capital expenditures on a tax-exempt basis and charity-funded programs that may have strong ties to their local medical communities and receive charitable contributions that are unavailable to us.

Our other services, such as assisted living facilities and other ancillary services, also compete with local, regional, and national companies. The primary competitive factors in these businesses are similar to those for our skilled nursing facilities and include reputation, cost of services, quality of clinical services, responsiveness to patient/resident needs, location and the ability to provide support in other areas such as third-party reimbursement, information management and patient recordkeeping.

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 operating subsidiaries' employees are among the best in their respective industry. We believe each of our operating subsidiaries 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 operating subsidiaries. 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, cultural, compliance 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 operations within a defined “cluster” and "market," 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 centralized 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.

As of December 31, 2017, we have expanded to 230 facilities with 18,870 operational skilled nursing beds and 5,011 assisted and independent 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 have also constructed new facilities to target demand, which exists for high-end healthcare facilities when 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 achievement of quality outcomes enhances our reputation for quality, that when coupled with the integrated 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 our services primarily as a local, community-based business. Our local leadership-centered management culture enables each operation's nursing and support staff and leaders to meet the unique needs of their

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

Investment in Information Technology. We utilize 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 operation leaders and their management teams are able to share best practices and the 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 operating subsidiaries. We generally have between five and 30 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 medically complex 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 medically necessary and prescribed by a patient's physician or other appropriate 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 and continuing our community focused approach.

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 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 our skilled nursing facilities for the years ended December 31, 2017, 2016 and 2015 were 75.4%, 75.4% and 77.6%, respectively. Our average occupancy rates for our assisted and independent living facilities for the years ended December 31, 2017, 2016 and 2015 were 76.4%, 76.0%, and 75.3%, 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.

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 and the expansion and upgrade of current facilities. In the near term, we plan to take advantage of the fragmented skilled nursing industry by acquiring operations within select geographic markets and may consider the construction of new facilities. In addition, we have targeted facilities that we believed were performing and operations that 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 147 facilities that we acquired from 2001 through 2017, the aggregate EBITDAR (See Part II, Item 6 - Selected Financial Data) as a percentage of revenue improved from 12.0% during the first full three months of operations to 13.4% during the thirteenth through fifteenth months of operations.

Strategically Invest In and Integrate Other Post-Acute Care Healthcare Businesses. Another important element to our growth strategy includes acquiring new and existing home health, hospice and other post-acute care healthcare businesses. Since 2010, we have steadily expanded our home health and hospice businesses through the acquisition of smaller third-party providers. Our strategy is to provide a more seamless experience to manage the transition of care throughout the post-acute continuum. Our objective is to simultaneously improve patient outcomes and reduce costs to payers, ACOs and hospital systems. We believe that the same principles that have guided our skilled nursing and assisted living operations are transferable to these businesses, including reliance on experienced local leaders at the community level to focus on integrating these operations into the continuum of care services we provide. Between 2009 and February 2018, we have acquired 22 hospice agencies, 24 home health and home care agencies, and we are well positioned for continued growth in these and other healthcare businesses.

Labor

The operation of our skilled nursing and assisted and independent living facilities, home health and hospice operations requires a large number of highly skilled healthcare professionals and support staff. At December 31, 2017, we had approximately 21,301 full-time equivalent employees who were employed by our Service Center and our operating subsidiaries. For the year ended December 31, 2017, 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 and subject to government audits and penalties in some states. 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 Regulation

The types of laws and statutes affecting the regulatory landscape of the skilled nursing industry continue to expand. 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 statues, 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 operating subsidiaries 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.

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 April 16, 2015, the President signed MACRA into law. This law included a number of provisions, including (1) replacement of the Sustainable Growth Rate (SGR) formula used by Medicare to pay physicians with new systems for establishing annual payment rate updates for physicians' services, (2) an extension of the outpatient therapy cap exception process until December 31, 2017; and (3) payment updates for post-acute providers at 1% after other adjustments required by the ACA for 2018. In addition, it increased premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels and made numerous other changes to Medicare and Medicaid.

On February 20, 2015, CMS updated the Five Star Quality Rating System for nursing homes to include the use of antipsychotics in calculating the star ratings, include modified calculations for staffing levels and the establishment of more exacting standards for nursing homes to achieve a high rating on the quality measure dimension. Since the standards for performance are more difficult to achieve, the number of our 4 and 5 star facilities could be reduced.

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

On February 2, 2016, CMS issued its final rule concerning face-to-face requirements for Medicaid home health services. Under the rule, the Medicaid home health service definition was revised to be consistent with applicable sections of the ACA and MACRA. The rule also requires that for the initial ordering of home health services, the

physician must document the occurrence of a face-to-face encounter related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule also requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician provider (NPP) must document a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment which occur no more than six months prior to the start of services.

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

On January 13, 2017, CMS issued a Final Rule revising the conditions of participation for home health agencies serving Medicare beneficiaries. The rule makes significant revisions to the conditions currently in place, including (1) adding new conditions of participation related to quality assurance and performance improvement programs; and (2) expanding or revising requirements related to patient rights, comprehensive evaluations, coordination and care planning, home health aide training and supervision, and discharge and transfer summary and time frames. Without any contrary action by the new administration, the new conditions were scheduled to be effective January 13, 2018.

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

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

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

On January 2, 2013, the President signed the American Taxpayer Relief Act of 2012 into law. This statute created 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 support 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.

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

Further, prior to the introduction of H.R. 3630, we were reimbursed for 100% of bad debt related to dual-eligible Medicare patients' co-insurance. H.R. 3630 will phase down the dual-eligible reimbursement over three years. Effective October 1, 2012, Medicare dual-eligible co-insurance reimbursement decreased from 100% to 88%, with further rate 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 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.

On March 23, 2010, President Obama signed the ACA or the Affordable Care Act into law, which contained several sweeping changes to America's health insurance system. Among other reforms contained in ACA, many Medicare providers received reductions in their market basket updates. But ACA made no reduction to the market basket update for skilled nursing facilities in fiscal years 2010 or 2011. However, under ACA, the skilled nursing facility market basket update became subject to a full productivity adjustment beginning in fiscal year 2012. In addition, ACA 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.

Some key provisions of ACA include (i) enhanced civil monetary penalties, (ii) substantial and onerous transparency requirements for Medicare-participating nursing facilities, (iii) face-to-face encounter requirements applicable to home health agencies and hospices, (iv) expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud, (v) a requirement that overpayments for services provided to Medicare and Medicaid beneficiaries be reported to the applicable payor within sixty days of identification of the overpayment or the date of the corresponding cost report, (vi) implementation of a value-based purchasing program for Medicare payments to skilled nursing facilities, (vii) implementation of a value-based purchasing program for home health services, (viii) implementation of a voluntary bundled payments pilot program (i.e., Bundled Payments for Care Improvement), and (ix) the creation of Accountable Care Organizations (ACOs).

On June 28, 2012, the United States Supreme Court ruled that the enactment of ACA did not violate the Constitution of the United States. On June 25, 2015, the United States Supreme Court ruled that the tax credits described in Section 36B of ACA are available to individuals who purchase health insurance on an exchange created by the federal government. These rulings, taken together, permit the implementation of most of the provisions of ACA to proceed in substantially the same form contemplated after ACA's enactment. The provisions of ACA discussed above are only examples of federal health reform provisions that we believe may have a material impact on the long-term care industry and on our business. However, the foregoing discussion is not intended to constitute, nor does it constitute, an exhaustive review and discussion of ACA. It is possible that these and other provisions of ACA may be interpreted, clarified, or applied to our affiliated facilities or operating subsidiaries in a way that could have a material adverse impact on the results of operations.

Regulations Regarding Our Facilities. Governmental agencies and other authorities periodically inspect our facilities to assess our compliance with various standards, rules and regulations. The robust regulatory and enforcement environment continues to impact healthcare providers, especially in connection with responses to any alleged noncompliance identified in periodic surveys and other inspections by governmental authorities. Unannounced surveys or inspections generally occur at least annually, and may also follow 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 substantially comply with applicable standards, rules or regulations. 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 (FCA), 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 FCA 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. Many states also have a false claim prohibition that mirrors or tracks the federal FCA.

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.
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 to five years following the year in which payment was made.

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, suppliers and non-healthcare providers. 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, HHS 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 and security requirements at our affiliated facilities and operating subsidiaries. We maintain a company-wide HIPAA compliance plan, which we believe complies with the HIPAA privacy and security regulations. The HIPAA privacy regulations and security regulations have and will continue to impose significant costs on our facilities in order to comply with these standards. There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our operations are also subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties for privacy and security breaches.

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.

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 liabilities with respect to these regulations 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 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 reports 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. These reports and other information concerning our 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 reports 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 40.5% and 39.0% of our revenue from the Medicaid program for the years ended December 31, 2017 and 2016, respectively. We derived 27.9% and 28.8% of our revenue from the Medicare program for the years ended December 31, 2017 and 2016, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if

Table of Contents

there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our patients.

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

In addition, on October 1, 2010, the next generation of the Minimum Data Set (MDS) 3.0 was implemented, creating significant changes in the methodology for calculating the resource utilization group (RUG) category under Medicare Part A, most notably eliminating Section T. Because therapy does not necessarily begin upon admission, MDS 2.0 and the RUGS-III system included a provision to capture therapy services that are scheduled to occur but have not yet been provided in order to calculate a RUG level that better reflects the level of care the recipient would actually receive. This is eliminated with MDS 3.0, which creates a new category of assessment called the Medicare Short Stay Assessment. This assessment provides for calculation of a rehabilitation RUG for patients discharged on or before day eight who received less than five days of therapy.
On December 20, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for a new Cardiac Rehabilitation Incentive (CR) model, which includes mandatory bundled payment programs for an acute myocardial infarction (AMI) episode of care or a coronary artery bypass graft (CABG) episode of care, and modifications to the existing Comprehensive Care for Joint Replacement (CJR) model to include surgical hip/femur fracture treatment episodes. The new mandatory cardiac programs mirror the Bundled Payments for Care Improvement (BPCI) and Comprehensive Care for Joint Replacement (CJR) models in that actual episode payments will be retrospectively compared against a target price. Similar to CJR, participating hospitals will be at risk for Medicare Part A and B payments in the inpatient admission and 90 days post-discharge. BPCI episodes would continue to take precedence over episodes in the CJR program and in the new cardiac bundled payment program. The cardiac model will be mandatory in 98 randomly selected geographic areas and the hip/femur procedure model will be mandatory in the same 67 geographic areas that were selected for CJR. CMS is also providing “Cardiac Rehabilitation Incentive Payments”, which can be used by hospitals to facilitate cardiac rehabilitation plans and adherence. The incentive will be provided to hospitals in 45 of the 98 geographic areas included in the mandatory bundled payment program and 45 geographic areas outside of the program. On May 19, 2017, CMS issued a final rule which delayed the effective date until May 20, 2017 and the start date was scheduled for January 1, 2018, and the final rule will continue for five performance years.

On November 16, 2015, the Centers for Medicare & Medicaid Services (CMS) issued the final rule for a new mandatory Comprehensive Care for Joint Replacement (CJR) model focusing on coordinated, patient-centered care. Under this model, the hospital in which the hip or knee replacement takes place is accountable for the costs and quality of care from the time of the surgery through 90 days after, or an “episode” of care. Depending on the hospital’s quality and cost performance during the episode, the hospital either earns a financial reward or is required to repay Medicare for a portion of the costs. This payment is intended to give hospitals an incentive to work with physicians, home health agencies and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. This model initially covers 67 geographic areas throughout the country and most hospitals in those regions are required to participate. Following the implementation of the CJR program on April 1, 2016, our Medicare revenues derived from our affiliated skilled nursing facilities and other post-acute services related to lower extremity joint replacement hospital discharges could be increased or decreased in those geographic areas identified by CMS for mandatory participation in the bundled payment program. On August 15, 2017, CMS proposed changes to the Comprehensive Care for Joint Replacement Model, which included the cancellation of care coordination through mandatory Episode Payments and Cardiac Rehabilitation Incentive Payment Model.

Table of Contents

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

On January 9, 2018, CMS launched a new voluntary bundled payment called Bundled Payments for Care Improvement Advanced (BCPI Advanced). The Model Performance Period for BCPI Advanced commences on October 1, 2018 and runs through December 31, 2023. Under this bundled payment model, participants can earn additional payment if all expenditures for a beneficiary's episode of care are under a spending target that factors in quality. BPCI Advanced Participants may receive payments for performance on 32 different clinical episodes, such as major joint replacement of the lower extremity (inpatient) and percutaneous coronary intervention (inpatient or outpatient). Participants bear financial risk, have payments under the model tied to quality performance, and are required to use Certified Electronic Health Record Technology. An episode model such as BPCI Advanced supports healthcare providers who invest in practice innovation and care redesign to improve quality and reduce expenditures. Of note, BPCI Advanced will qualify as the first Advanced Alternative Payment Model (Advanced APM) under the Quality Payment Program. In 2015, Congress passed the Medicare Access and Chip Reauthorization Act or MACRA. MACRA requires CMS to implement a program called the Quality Payment Program or QPP, which changes the way physicians are paid who participate in Medicare. QPP creates two tracks for physician payment - the Merit-Based Incentive Payment System or MIPS track and the Advanced APM track. Under MIPS, providers have to report a range of performance metrics and their payment amount is adjusted based on their performance. Under Advanced APMs, providers take on financial risk to earn the Advanced APM incentive payment that they are participating in.

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

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, the ACA). The reforms contained in the ACA have affected our operating subsidiaries in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. These reforms include the possible modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. As discussed below under the heading "Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged", any further amendments or revisions to the ACA or its implementing regulations could materially impact our business.

Skilled Nursing

In 2017, CMS proposed an alternative case-mix classification system for fiscal year 2018, named Resident Classification System, Version I (RCS-I). RCS-I, would case-mix adjust for the following major cost categories: Physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP) services, nursing services and non-therapy ancillaries (NTAs). Thus, where RUG-IV consists of two case-mix adjusted components (therapy and nursing), RCS-I would create four (PT/OT, SLP, nursing, and NTA) for a more resident-centered case-mix adjustment. RCS-I would also maintain the existing non-case-mix component to cover utilization of SNF resources that do not vary according to resident characteristics. For two of the case-mix-adjusted components, PT/OT and NTA, RCS-I includes variable per-diem payment adjustments that modify payment based on changes in utilization of these services over the course of a stay. The proposed model will compensate SNFs accurately based on the complexity of the particular beneficiaries they serve and the resources necessary in caring for those beneficiaries and addresses concerns about current incentives for SNFs to delivery therapy to beneficiaries based on financial considerations, rather than the most effective course of treatment for beneficiaries. The proposed RCS-I classification model could

improve the SNF PPS by basing payments predominantly on clinical characteristics rather than service provision, thereby enhancing payment accuracy and strengthening incentives for appropriate care. The proposed rule is expected to reduce payments associated with residents in the highest therapy RUG (RU) and increase payments associated with residents who receive extensive services or have high NTA costs. The proposed rule also simplifies the MDS structure and reduces labor needs. Additionally, it is estimated that RCS-I would result in higher payments associated with the following resident types: dual enrollment in Medicare and Medicaid, end-stage renal disease (ESRD), having a longer qualifying inpatient stay, diabetes, wound infections, and use of IV medication.

Table of Contents

On July 31, 2017, CMS issued its final rule outlining fiscal year 2018 Medicare payment rates for skilled nursing facilities. Under the final rule, the market basket index is revised and rebased by updating the base year from 2010 to 2014 and adding a new cost category for Installation, Maintenance, and Repair Services. The rule also includes revisions to the SNF Quality Reporting Program, including measure and standardized patient assessment data policies, as well as policies related to public display. In addition, it finalized policies for the Skilled Nursing Facility Value-Based Purchasing Program that will affect Medicare payment to SNFs beginning in fiscal year 2019 and clarification of the requirements regarding the composition of professionals for the survey team. The final rule uses a market basket percentage of 1% to update the federal rates, but if a SNF fails to submit quality reporting program requirements there will be a 2% reduction to the market basket update. Thus, the increase in the federal rates may increase the amount of our reimbursements for SNF services so long as we meet the reporting requirements.
On July 29, 2016, CMS issued its final rule outlining fiscal year 2017 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the finalized rule continue to shift Medicare payments from volume to value. The aggregate payments to skilled nursing facilities increased by a net 2.4% for fiscal year 2017. This increase reflected a 2.7% market basket increase, reduced by a 0.3% multi-factor productivity (MFP) adjustment required by ACA. This final rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports.
The Value-Based Purchasing Program final rule specifies the skilled nursing facility 30-day potentially preventable readmission measure, which assesses the facility-level risk standardized rate of unplanned, potentially preventable hospital readmissions for skilled nursing facility patients within 30 days of discharge from a prior admission to a hospital paid under the Inpatient Prospective Payment System, a critical access hospital, or a psychiatric hospital. There is also finalized additional policies related to the Value-Based Purchasing Program including: establishing performance standards; establishing baseline and performance periods; adopting a performance scoring methodology; and providing confidential feedback reports to the skilled nursing facilities. This SNF Value-Based Purchasing Program will start in fiscal year 2019.

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

Home Health

On November 1, 2017, CMS issued a final rule that became effective on January 1, 2018 and updated the calendar year 2018 Medicare payment rates and the wage index for home health agencies serving Medicare beneficiaries. The rule also finalized proposals for the Home Health Value-Based Purchasing (HHVBP) Model and the Home Health Quality Reporting Program (HH QRP). Under the final rule. Medicare payments will be reduced by 0.4%. This decrease reflects the effects of a 1.0% home health payment update percentage; a -0.97% adjustment to the national, standardized 60-day episode payment rate to account for nominal case-mix growth for an impact of -0.9%; and the sunset of the rural add-on provision.

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

and transfer summary and time frames. The new CoPs became effective on January 13, 2018.

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

On November 5, 2015, CMS issued a final rule updating the Medicare HH PPS rates and wage index for calendar year 2016. In the final rule, CMS implemented the third year of the four year phase-in of rebasing adjustments to the HH PPS payment rates

Table of Contents

as required by ACA. In addition, CMS decreased the national, standardized 60-day episode payment amount by 0.97% in each year for calendar years 2016, 2017 and 2018.

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

Lastly, CMS implemented a standardized cross-setting measure for calendar year 2016. The CoPs require home health agencies to submit OASIS assessments as a condition of payment and also for quality measurement purposes. Home health agencies that do not submit quality measure data to CMS incur a 2.0% reduction in their annual home health payment update percentage. Under the rule, all home health agencies are required to timely submit both Start of Care (initial assessment) or Resumption of Care OASIS assessment and a Transfer or Discharge OASIS assessment for a minimum of 70.0% of all patients with episodes of care occurring during the annual reporting period starting July 1, 2015 and ending June 30, 2016, 80% of all patients with episodes occurring during the reporting period starting July 1, 2016 and ending June 30, 2017, and 90% for all episodes beginning on or after July 1, 2017.

Hospice

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

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

On July 31, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, there was a net 1.1% increase in payments effective October 1, 2015. The hospice payment increase was the net result of a hospice payment update to the hospice per diem rates of 2.1% (a “hospital market basket” increase of 2.4% minus 0.3% for reductions required by law) and a 1.2% decrease in payments to hospices due to updated wage data and the phase-out of its wage index budget neutrality adjustment factor (BNAF), offset by the newly announced Core Based Statistical Areas (CBSA) delineation impact of

0.2%. The rule also created two different payment rates for routine home care (RHC) that resulted in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for 61 or more days of hospice care and a Service Intensity Add-On (SIA) Payment for fiscal year 2016 and beyond in conjunction with the proposed RHC rates.

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

Table of Contents

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

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

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

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

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

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

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

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

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

Table of Contents

average Medi-Cal reimbursement rate paid to long-term care facilities shall not exceed the weighted average Medi-Cal reimbursement rate for the 2008-2009 rate year. In addition, the budget proposal increased the amounts that California nursing facilities will pay to Medi-Cal in quality assurance fees for the 2009-2010 and 2010-2011 rate years by including Medicare revenue in the calculation of the quality assurance fee that nursing facilities pay under A.B. 1629. Although overall reimbursement from Medi-Cal remained stable, individual facility rates varied.

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

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

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

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

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

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

ACA and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) include sweeping changes to how health care is paid for and furnished in the United States. As discussed below under the heading "-Our business may be materially impacted if certain aspects of the Affordable Care Act are amended, repealed, or successfully challenged", any further amendments or revisions to ACA or its implementing regulations could materially impact our business. The recent presidential and congressional elections in the United States could result in significant changes in, and uncertainty with respect to, legislation, regulation, implementation of Medicare and/or Medicaid, and government policy that could significantly impact our business and the health care industry. We continually monitor these developments in an effort to respond to the changing regulatory environment impacting our business.

Table of Contents

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

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

Under ACA, HHS will establish, test and evaluate alternative payment methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care. The bundled payment will cover the costs of acute care inpatient services; physicians’ services delivered in and outside of an acute care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services; inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program was not implemented. As with Medicare’s shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-Kickback Statue, the Stark Law and the Civil Monetary Penalties Law.

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

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

other facilities that have been designated instead as preferred providers. As a result, to the extent that one of our SNF is not included in a preferred provider network, our revenues and results of operations could be adversely affected.

In addition, ACA required HHS to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities. HHS delivered a report to Congress outlining its plans for implementing this value-based purchasing program. The value-based purchasing program would provide payment incentives for Medicare-participating skilled nursing facilities to improve the quality of care provided to Medicare beneficiaries. Among the most relevant factors in HHS' plans to implement value-based purchasing for skilled nursing facilities is the current Nursing Home Value-Based Purchasing Demonstration Project, which concluded in 2012. HHS provided Congress with an outline of plans to implement a value-based purchasing program, and any permanent value-based purchasing program for skilled nursing facilities will be implemented after that evaluation.
On October 4, 2016, CMS released a final rule that reforms the requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in the Medicare and Medicaid programs. The regulations

Table of Contents

have not been updated since 1991 and have been revised to improve quality of life, care and services in LTC facilities, optimize resident safety, reflect current professional standards and improve the logical flow of the regulations. The regulations are effective November 28, 2016 and will be implemented in three phases. The first phase was effective November 28, 2016, the second phase was effective November 28, 2017 and the third phase becomes effective November 28, 2019.

A few highlights from the new regulation include the following:

- investigate and report all allegations of abusive conduct, and refrain from employing individuals who have had a disciplinary action taken against their professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of residents or misappropriation of their property;
- document a transfer or discharge in the medical record and exchange certain information to a receiving provider or facility when a resident is transferred;
- develop and implement a baseline care plan for each resident within 48 hours of their admission that includes instructions to provide effective and person-centered care that meets professional standards of quality care;
- develop and implement a discharge planning process that prepares residents to be active partners in post-discharge care;
- provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being;
- add a competency requirement for determining the sufficiency of nursing staff;
- require that a pharmacist reviews a resident's medical chart during each monthly drug regiment review;
- refrain from charging a Medicare resident for loss or damage of dentures;
- provide each resident with a nourishing, palatable and well-balanced diet;
- conduct, document and annually review a facility-wide assessment to determine what resources are necessary to care for its residents;
- refrain from entering into a binding arbitration agreement until after a dispute arises between the parties;
- develop, implement and maintain an effective comprehensive, data-driven quality assurance and performance improvement program;
- develop an Infection Prevention and Control Program; and
- require their operating organization have in effect a compliance and ethics program.

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

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

32

Table of Contents

On September 16, 2016, CMS issued its final rule concerning emergency preparedness requirements for Medicare and Medicaid participating providers, specifically skilled nursing facilities (SNFs), nursing facilities (NFs), and intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs). The rule is designed to ensure providers and suppliers have comprehensive and integrated emergency policies and procedures in place, in particular during natural and man-made disasters. Under the rule, facilities are required to 1) document risk assessment and emergency planning; 2) develop and implement policies and procedures based on that risk assessment; 3) develop and maintain an emergency preparedness communication plan in compliance with both federal and state law; and 4) develop and maintain an emergency preparedness training and testing program. The regulations outlined in the final rule must be implemented by November 15, 2017.

On July 29, 2016, CMS issued its final rule laying out the performance standards relating to preventable hospital readmissions from skilled nursing facilities. The final rule includes the SNF 30-day All Cause Readmission Measure which assesses the risk-standardized rate of all-cause, all condition, unplanned inpatient hospital readmissions for Medicare fee-for-service SNF patients within 30 days of discharge from admission to an inpatient prospective payment system hospital, CAH or psychiatric hospital. The final rule includes the SNF 30-Day Potentially Preventable Readmission Measure as the SNF all condition risk adjusted potentially preventable hospital readmission measure. This measure assesses the facility-level risk-standardized rate of unplanned, potentially preventable hospital readmissions for SNF patients within 30 days of discharge from a prior admission to an IPPS hospital, CAH, or psychiatric hospital. Hospital readmissions include readmissions to a short-stay acute-care hospital or CAH, with a diagnosis considered to be unplanned and potentially preventable. This measure is claims-based, requiring no additional data collection or submission burden for SNFs.

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

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

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

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

On June 28, 2012, the United States Supreme Court ruled that the enactment of ACA did not violate the Constitution of the United States. This ruling permits the implementation of most of the provisions of ACA to proceed. The

provisions of ACA discussed above are only examples of federal health reform provisions that we believe may have a material impact on the long-term care industry and on our business. However, the foregoing discussion is not intended to constitute, nor does it constitute, an exhaustive review and discussion of ACA. It is possible that these and other provisions of ACA may be interpreted, clarified, or applied to our affiliated facilities or operating subsidiaries in a way that could have a material adverse impact on the results of operations.

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

Table of Contents

facilities and distribute this pool of payment to skilled nursing facilities as incentive payments for preventing readmissions to hospitals.

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

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

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

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

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

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

A number of lawsuits have been filed challenging various aspects of ACA and related regulations. In addition, the efficacy of ACA is the subject of much debate among members of Congress and the public. The recent presidential and congressional elections in the United States could result in significant changes in, and uncertainty with respect to, legislation, regulation, implementation of Medicare and/or Medicaid, and government policy that could significantly impact our business and the health care industry. In the event that legal challenges are successful or ACA is repealed or materially amended, particularly any elements of ACA that are beneficial to our business or that cause changes in the health insurance industry, including reimbursement and coverage by private, Medicare or Medicaid payers, our business, operating results and financial condition could be harmed. While it is not possible to predict whether and when any such changes will occur, specific proposals discussed during and after the election, including a repeal or material amendment of ACA, could harm our business, operating results and financial condition. In addition, even if ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS have a significant impact on the implementation of the provisions of ACA, and the new administration could

make changes impacting the implementation and enforcement of ACA, which could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

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

Our success depends upon our ability to retain and attract nurses, Certified Nurse Assistants (CNAs) and therapists. Our success also depends upon our ability to retain and attract skilled management personnel who are responsible for the day-to-day operations of each of our affiliated facilities. Each facility has a facility leader responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Depending upon the size of the facility, each facility leader is supported by facility staff that is directly responsible for day-to-day care of the patients and marketing and

Table of Contents

community outreach programs. Other key positions supporting each facility may include individuals responsible for physical, occupational and speech therapy, food service and maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

We operate one or more affiliated skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities operating in that state. Failure to comply with these requirements can, among other things, jeopardize a facility's compliance with the conditions of participation under relevant state and federal healthcare programs. In addition, if a facility is determined to be out of compliance with these requirements, it may be subject to a notice of deficiency, a citation, or a significant fine or litigation risk. Deficiencies (depending on the level) may also result in the suspension of patient admissions and/or the termination of Medicaid participation, or the suspension, revocation or nonrenewal of the skilled nursing facility's license. If the federal or state governments were to issue regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.