ENSIGN GROUP, INC
Form 10-Q
August 06, 2009

Table of Contents

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

FORM 10-Q

þ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**
For the quarterly period ended June 30, 2009.

o **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**
For the transition period from _____ to _____.
Commission file number: 001-33757

THE ENSIGN GROUP, INC.
(Exact Name of Registrant as Specified in Its Charter)

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

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

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. þ 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). o Yes o No
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer , accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

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

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). o Yes þ No
As of July 31, 2009, 20,593,281 shares of the registrant s common stock were outstanding

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND SIX MONTHS ENDED JUNE 30, 2009
TABLE OF CONTENTS

Part I. Financial Information

Part II. Other Information

Table of Contents

Part I. Financial Information

Item 1. *Financial Statements*

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

	June 30, 2009	December 31, 2008
Assets		
Current assets:		
Cash and cash equivalents	$ 33,687	$ 41,326
Accounts receivable less allowance for doubtful accounts of $6,948 and $7,266 at June 30, 2009 and December 31, 2008, respectively	53,544	49,188
Prepaid expenses and other current assets	5,789	4,692
Deferred tax asset current	9,690	9,242
Total current assets	102,710	104,448
Property and equipment, net	180,274	157,029
Insurance subsidiary deposits and investments	12,797	11,745
Escrow deposits		10,090
Deferred tax asset	3,229	2,565
Restricted and other assets	5,431	5,131
Intangible assets, net	4,472	3,011
Goodwill	5,769	2,882
Total assets	$ 314,682	$ 296,901
Liabilities and stockholders equity		
Current liabilities:		
Accounts payable	$ 14,339	$ 12,682
Accrued wages and related liabilities	23,631	25,389
Accrued self-insurance liabilities current	8,413	7,454
Other accrued liabilities	11,448	11,050
Current maturities of long-term debt	1,064	1,062
Total current liabilities	58,895	57,637
Long-term debt less current maturities	58,953	59,489
Accrued self-insurance liabilities less current portion	20,693	18,864
Deferred rent and other long-term liabilities	4,674	4,890
Commitments and contingencies (Note 14)		
Stockholders equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 21,255 and 20,590 shares issued and outstanding at June 30, 2009, respectively, and 21,236 and 20,564 shares issued and outstanding at December 31, 2008, respectively	21	21
Additional paid-in capital	65,262	64,110
Retained earnings	110,491	96,237
	(4,307)	(4,347)

Common stock in treasury, at cost, 665 and 672 shares at June 30, 2009 and December 31, 2008, respectively		
Total stockholders equity	171,467	156,021
Total liabilities and stockholders equity	$ 314,682	$ 296,901

See accompanying notes to condensed consolidated financial statements.

Table of Contents

THE ENSIGN GROUP, INC.
CONDENSED CONSOLIDATED STATEMENTS OF INCOME
(In thousands, except per share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Revenue	$ 132,178	$ 115,318	$ 262,463	$ 229,097
Expense:				
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	105,290	92,633	209,489	184,067
Facility rent cost of services	3,724	3,948	7,425	7,947
General and administrative expense	5,417	4,971	10,378	10,063
Depreciation and amortization	3,209	2,173	6,174	4,163
Total expenses	117,640	103,725	233,466	206,240
Income from operations	14,538	11,593	28,997	22,857
Other income (expense):				
Interest expense	(1,141)	(1,169)	(2,469)	(2,370)
Interest income	69	372	139	855
Other expense, net	(1,072)	(797)	(2,330)	(1,515)
Income before provision for income taxes	13,466	10,796	26,667	21,342
Provision for income taxes	5,282	4,277	10,560	8,489
Net income	$ 8,184	$ 6,519	$ 16,107	$ 12,853
Net income per share:				
Basic	$ 0.40	$ 0.32	$ 0.78	$ 0.63
Diluted	$ 0.39	$ 0.32	$ 0.77	$ 0.62
Weighted average common shares outstanding:				
Basic	20,586	20,508	20,579	20,502
Diluted	20,874	20,636	20,883	20,637

See accompanying notes to condensed consolidated financial statements.

Table of Contents

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

	Six Months Ended June 30,	
	2009	**2008**
Cash flows from operating activities:		
Net income	$ 16,107	$ 12,853
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	6,174	4,171
Amortization of deferred financing fees	58	28
Deferred income taxes	(1,242)	(440)
Provision for doubtful accounts	2,030	2,050
Stock-based compensation	992	752
Excess tax benefit from share based compensation	(65)	(121)
Loss on disposition of property and equipment	64	157
Change in operating assets and liabilities		
Accounts receivable	(6,386)	3,610
Prepaid income taxes		4,528
Prepaid expenses and other current assets	(1,097)	(135)
Insurance subsidiary deposits	(1,052)	(1,525)
Accounts payable	1,657	(2,109)
Accrued wages and related liabilities	(1,758)	(69)
Other accrued liabilities	597	(747)
Accrued self-insurance	2,788	1,856
Deferred rent liability	(167)	(274)
Net cash provided by operating activities	18,700	24,585
Cash flows from investing activities:		
Purchase of property and equipment	(11,671)	(19,153)
Cash payment for business acquisitions	(22,133)	(2,005)
Escrow deposits used to fund business acquisitions	10,090	
Restricted and other assets	(358)	(216)
Net cash used in investing activities	(24,072)	(21,374)
Cash flows from financing activities:		
Payments on long term debt	(534)	(2,515)
Issuance of treasury stock upon exercise of options	40	210
Issuance of common stock upon exercise of options	104	113
Dividends paid	(1,852)	(1,646)
Principal payments on capital lease obligations	(13)	
Excess tax benefit from share based compensation	65	121
Payments of deferred financing costs	(77)	(292)
Net cash used in financing activities	(2,267)	(4,009)

Net decrease in cash and cash equivalents	(7,639)	(798)
Cash and cash equivalents beginning of period	41,326	51,732
Cash and cash equivalents end of period	$ 33,687	$ 50,934
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$ 2,557	$ 2,400
Income taxes	$ 12,200	$ 4,414

See accompanying notes to condensed consolidated financial statements.

Table of Contents

THE ENSIGN GROUP, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Dollars and shares in thousands, except per share data)
(Unaudited)

1. DESCRIPTION OF BUSINESS

The Company The Ensign Group, Inc., through its subsidiaries (collectively, Ensign or the Company), provides skilled nursing and rehabilitative care services through the operation of 70 facilities as of June 30, 2009, located in California, Arizona, Texas, Washington, Utah, Colorado and Idaho. All of these facilities are skilled nursing facilities, other than four stand-alone assisted living facilities in Arizona, Texas and Colorado and five campuses that offer both skilled nursing and assisted living services located in California, Arizona and Utah. The Company s facilities, each of which strives to be the facility of choice in the community it serves, provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. The Company s facilities have a collective capacity of approximately 8,000 operational skilled nursing, assisted living and independent living beds. As of June 30, 2009, the Company owned 38 of its 70 facilities and operated an additional 32 facilities through long-term lease arrangements, and had options to purchase 9 of those 32 facilities.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenue. All of the Company s facilities are operated by separate, wholly-owned, independent subsidiaries, each of which has its own management, employees and assets. One of the Company s wholly-owned subsidiaries, referred to as the Service Center, provides centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. The Company also has a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to the Company s operating subsidiaries for general and professional liability, as well as coverage for certain workers compensation insurance liabilities.

Like the Company s facilities, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated Company and its assets and activities, as well as the use of the terms we, us, our and similar verbia this quarterly report is not meant to imply that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the facilities, the Service Center or the Captive are operated by the same entity.

Other Information The accompanying condensed consolidated financial statements as of June 30, 2009 and for the three and six month periods ended June 30, 2009 and 2008 (collectively, the Interim Financial Statements), are unaudited. Certain information and footnote disclosures normally included in annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company s audited consolidated statements and notes thereto for the year ended December 31, 2008 which are included in the Company s annual report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (the SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company s financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation The accompanying condensed consolidated financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America. The Company is the sole member or shareholder of various consolidated limited liability companies and corporations; each established to operate various acquired skilled nursing and assisted living facilities. All intercompany transactions and balances have been eliminated in consolidation. Certain prior year amounts in the accompanying condensed consolidated financial statements have been reclassified to conform to current year presentation. Debt issuance costs, net of $1,363 have been reclassified from intangible assets, net to restricted and other assets on the condensed consolidated balance sheets as of December 31, 2008.

As described in detail below, in June 2009, the Financial Accounting Standards Board (FASB) introduced a new Codification of authoritative nongovernmental U.S. Generally Accepted Accounting Principles (GAAP), which will become effective in the quarter ending September 30, 2009. The Company has presented dual references to the new Codification and pre-Codification GAAP throughout the current period financial statements.

Table of Contents

Estimates and Assumptions The preparation of condensed consolidated financial statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company s condensed consolidated financial statements relate to revenue, allowance for doubtful accounts, intangible assets and goodwill, impairment of long-lived assets, patient liability, general and professional liability, worker s compensation, and healthcare claims included in accrued self-insurance liabilities, stock-based compensation and income taxes. Actual results could differ from those estimates.

Business Segments The Company has a single reportable segment long-term care services, which includes the operation of skilled nursing and assisted living facilities, and related ancillary services at the facilities. The Company s single reporting segment is made up of several individual operating segments grouped together principally based on their geographical locations within the United States. Based on the similar economic and other characteristics of each of the operating segments, management believes the Company meets the criteria for aggregating its operations into a single reporting segment.

Fair Value of Financial Instruments The Company s financial instruments consist principally of cash and cash equivalents, debt security investments, accounts receivable, insurance subsidiary deposits, accounts payable and borrowings. The Company believes all of the financial instruments recorded values approximate fair values because of their nature and respective short durations. The Company s fixed-rate debt instruments do not actively trade in an established market. The fair values of this debt are estimated by discounting the principal and interest payments at rates available to the Company for debt with similar terms and maturities. See further discussion of debt security investments at Note 4.

Revenue Recognition The Company recognizes revenue when the following four conditions have been met: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii) the price is fixed or determinable; and (iv) collection is reasonably assured.

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

Revenue from the Medicare and Medicaid programs accounted for approximately 75% of the Company s revenue for both periods during the three and six months ended June 30, 2009 and 74% and 75% for the three and six months ended June 30, 2008, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company s revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlements. The Company recorded retroactive adjustments that increased revenue by $57 and $465 for the three and six months ended June 30, 2009, respectively, and $12 and $348 for the three and six months ended June 30, 2008, respectively. The Company records revenue from private pay patients as services are performed.

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

In evaluating the collectibility of accounts receivable, the Company considers a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type and the status of ongoing disputes with third-party payors. The percentages applied to the aged receivable balances are based on the Company s historical experience and time limits, if any, for managed care, Medicare and Medicaid. The Company periodically refines its procedures for estimating the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances.

Impairment of Long-Lived Assets The Company reviews the carrying value of long-lived assets that are held and used in the Company s operations for impairment whenever events or changes in circumstances indicate that the

carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operations to which the assets relate, utilizing management s best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has not identified any impairment during the six months ended June 30, 2009 or 2008.

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

Table of Contents

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. The Company defines reporting units as the individual facilities. The Company performs its annual test for impairment during the fourth quarter of each year. The Company did not record any impairment charges during the six months ended June 30, 2009 or 2008.

Self-Insurance The Company is partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per occurrence, per location and on an aggregate basis for the Company. For claims made after April 1, 2009, the self-insured retention was $500 per claim with a $1,500 deductible. As of April 1, 2009, for all facilities except those located in Colorado, the third-party coverage above these limits was $1,000 per occurrence, $3,000 per facility with a $10,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1,000 per occurrence and $3,000 per facility, which is independent of the $10,000 blanket aggregate applicable to our other 66 facilities.

The self-insured retention and deductible limits for general and professional liability and worker s compensation are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying condensed consolidated financial statements. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. The Company s policy is to accrue amounts equal to the actuarially estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. Accrued general liability and professional malpractice liabilities recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets were $19,251 and $17,938 as of June 30, 2009 and December 31, 2008, respectively.

The Company s operating subsidiaries are self-insured for workers compensation liability in California. To protect itself against loss exposure in California, with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $500 for each claim. In Texas, the operating subsidiaries have elected non-subscriber status for workers compensation claims. The Company s operating subsidiaries in other states have third party guaranteed cost coverage. In California and Texas, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $7,605 and $6,511 as of June 30, 2009 and December 31, 2008, respectively.

The Company provides self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $250 for each covered person, which resets every plan year or a lifetime maximum of $5,000 per each covered person s lifetime on the PPO and EPO plans. The aforementioned coverage only applies to claims paid during the plan year. The Company s accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $2,250 and $1,869 at June 30, 2009 and December 31, 2008, respectively.

The Company believes that adequate provision has been made in the condensed consolidated financial statements for liabilities that may arise out of patient care, workers compensation, healthcare benefits and related services provided to date. The amount of the Company s reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires the Company to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and the Company s assumptions about emerging trends, the Company, with the assistance of an independent actuary, develops

information about the size of ultimate claims based on the Company s historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damage awards with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed the Company s estimate of loss. The self-insured liabilities are based upon estimates, and while management believes that the estimates of loss are reasonable, the ultimate liability may be in excess of or less than the recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that the Company could experience changes in estimated losses that could be material to net income. If the Company s actual liability exceeds its estimate of loss, its future earnings and financial condition would be adversely affected.

Income Taxes Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company s assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The temporary differences are primarily attributable to compensation accruals, straight line rent adjustments and reserves for doubtful accounts and insurance liabilities. When necessary, the Company records a valuation allowance to reduce its net deferred tax assets to the amount that is more likely than not to be realized. In considering the need for a valuation allowance against some portion or all of its deferred tax assets, the Company must make certain estimates and assumptions regarding future taxable income, the feasibility of tax planning strategies and other factors.

Table of Contents

Estimates and judgments regarding deferred tax assets and the associated valuation allowance, if any, are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. However, due to the nature of certain assets and liabilities, there are risks and uncertainties associated with some of the Company s estimates and judgments. Actual results could differ from these estimates under different assumptions or conditions. The net deferred tax assets as of June 30, 2009 and December 31, 2008 were $12,919 and $11,807, respectively. The Company expects to fully utilize these deferred tax assets; however, their ultimate realization is dependent upon the amount of future taxable income during the periods in which the temporary differences become deductible.

As of January 1, 2007, the Company maintains a liability for underpayment of income taxes and related interest and penalties, if any, for uncertain income tax positions. In considering the need for and magnitude of a liability for uncertain income tax positions, the Company must make certain estimates and assumptions regarding the amount of income tax benefit that will ultimately be realized. The ultimate resolution of an uncertain tax position may not be known for a number of years, during which time the Company may be required to adjust these reserves, in light of changing facts and circumstances.

The Company used an estimate of its annual income tax rate to recognize a provision for income taxes in financial statements for interim periods. However, changes in facts and circumstances could result in adjustments to the Company s effective tax rate in future quarterly or annual periods.

Stock-Based Compensation The Company measures and recognizes compensation expense for all share-based payment awards made to employees and directors including employee stock options based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the fair value of all stock options issued on and subsequent to January 1, 2006, the amount of which is contingent upon the number of future options granted and other variables. The Company recognized $476 and $992 in compensation expense during the three and six months ended June 30, 2009, respectively, and $291 and $752 during the three and six months ended June 30, 2008, respectively.

New Accounting Pronouncements In June 2009, the FASB issued SFAS 168, *The FASB Accounting Standard Codification and the Heirarchy of Generally Accepted Accounting Principles a Replacement of FASB Statement No. 162* (the Codification) as a single source of authoritative nongovernmental U.S. Generally Accepted Accounting Principles (GAAP) to be launched July 1, 2009. The Codification does not change current U.S. GAAP, but is intended to simplify user access to all authoritative U.S. GAAP by providing all the authoritative literature related to a particular topic in one place. The Codification is effective for interim and annual periods ending after September 15, 2009. The Codification is effective for the Company in the interim period ending September 30, 2009, and at that time all references made to U.S. GAAP will use the new Codification numbering system prescribed by the FASB. However, as the Codification is not intended to change existing GAAP, it is not expected to have any impact on the Company s financial position or cash flows.

Adoption of New Accounting Pronouncements In May 2009, the FASB issued SFAS No. 165, *Subsequent Events* (SFAS 165) (or ASC section 855-10), which establishes general standards of accounting for and disclosure of events that occur after the balance sheet date but before financial statements are issued or are available to be issued. SFAS 165 is effective prospectively for interim or annual financial periods ending after June 15, 2009. The Company s adoption of SFAS 165 during the second quarter of fiscal year 2009 had no impact on its consolidated financial statements. The Company has evaluated subsequent events through August 6, 2009, the date of its issuance of the condensed consolidated financial statements.

In April 2009, the FASB issued FASB Staff Position (FSP) FAS 107-1 and APB 28-1 (ASC 825-10-50), which expands the fair value disclosures required for all financial instruments within the scope of Statement 107 (ASC825-10-50) to interim periods for publicly traded entities. The FSP also requires entities to disclose the method(s) and significant assumptions used to estimate the fair value of financial instruments in financial statements on an interim basis and to highlight any changes of the methods and significant assumptions from prior periods. It does not require interim disclosures of credit or market risks also discussed in Statement 107. The Company s adoption of FSP FAS 107-1 and APB 28-1 had no impact on its consolidated financial statements.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements* (SFAS 157) (or ASC section 820-10) , which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and requires enhanced disclosures about fair value measurements. SFAS 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007. In February 2008 the FASB issued FASB Staff Position (FSP) 157-2, *Effective Date of FASB Statement No. 157*, (FSP 157-2) which delayed the effective date of SFAS 157 for non-financial assets and liabilities, other than those that are recognized or disclosed at fair value on a recurring basis, to fiscal years beginning after November 15, 2008. In addition, in October 2008, the FASB issued FSP FAS 157-3, *Determining the Fair Value of a Financial Assets When the Market for That Asset is Not Active* (FSP FAS 157-3), which clarifies the application of SFAS 157 in an inactive market and to illustrate how an entity would determine fair value in an inactive market. The Company s adoption of SFAS 157 and related FSPs for non-financial assets and liabilities had no impact on its consolidated financial statements.

Table of Contents

In December 2007, the FASB issued SFAS No. 141(R), *Business Combinations* (SFAS 141(R)) (or ASC section 805), which replaces SFAS 141. The provisions of SFAS 141(R) are similar to those of SFAS 141; however, SFAS 141(R) requires companies to record most identifiable assets, liabilities, noncontrolling interests, and goodwill acquired in a business combination at full fair value. SFAS 141(R) also requires companies to record fair value estimates of contingent consideration and certain other potential liabilities during the original purchase price allocation and to expense acquisition costs as incurred. This statement applies to all business combinations, including combinations by contract alone. Further, under SFAS 141(R), all business combinations will be accounted for by applying the acquisition method. SFAS 141(R) is effective for fiscal years beginning on or after December 15, 2008. The Company adopted SFAS No. 141(R) at the beginning of fiscal year 2009. See Note 6 for a description of the impact of this adoption on the Company s consolidated financial position and results of operations.

In December 2007, the FASB issued SFAS No. 160, *Noncontrolling Interests in Consolidated Financial Statements* (SFAS 160) (or ASC section 810-10), which requires noncontrolling interests (previously referred to as minority interests) to be treated as a separate component of equity, not as a liability or other item outside of permanent equity. This Statement applies to the accounting for noncontrolling interests and transactions with non-controlling interest holders in consolidated financial statements. SFAS 160 is to be applied prospectively to all noncontrolling interests, including any that arose before the effective date except that comparative period information must be recast to classify noncontrolling interests in equity, attribute net income and other comprehensive income to noncontrolling interests, and provide other disclosures required by Statement 160. The Company s adoption of SFAS 160 at the beginning of fiscal year 2009 had no impact on its consolidated financial statements.

In September 2008, the FASB finalized FSP No. EITF 03-6-1, *Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities* (FSP 03-6-1) (or ASC section 260-10). The FASB concluded that all outstanding unvested share-based payment awards that contain rights to nonforfeitable dividends participate in undistributed earnings with common shareholders and therefore the issuing entity is required to apply the two-class method of computing basic and diluted earnings per share. The FSP is effective for fiscal years beginning after December 15, 2008, and interim periods within those fiscal years. The Company s adoption of FSP 03-6-1 at the beginning of fiscal year 2009 did not have a significant impact on its consolidated financial statements.

3. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing net income attributable to common shares by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share except that the denominator is increased to include contingently returnable shares and the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued. In addition, in computing the dilutive effect of convertible securities, the numerator is adjusted to add back (a) any convertible preferred dividends and (b) the after-tax amount of interest, if any, recognized in the period associated with any convertible debt.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Numerator:				
Net income	$ 8,184	$ 6,519	$ 16,107	$ 12,853
Denominator:				
Weighted average shares outstanding for basic net income per share(1)	20,586	20,508	20,579	20,502
Basic net income per common share	$ 0.40	$ 0.32	$ 0.78	$ 0.63

Table of Contents

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Numerator:				
Net income	$ 8,184	$ 6,519	$ 16,107	$ 12,853
Denominator:				
Weighted average common shares outstanding	20,586	20,508	20,579	20,502
Plus: incremental shares from assumed conversions(1)	288	128	304	135
Adjusted weighted average common shares outstanding	20,874	20,636	20,883	20,637
Diluted net income per common share	$ 0.39	$ 0.32	$ 0.77	$ 0.62

(1) In addition, as of June 30, 2009, the Company had 507 options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above.

4. INSURANCE SUBSIDIARY DEPOSITS AND INVESTMENTS

On February 10, 2009, the Company purchased three separate AAA rated debt security investments for an aggregate purchase price of $12,183 with insurance subsidiary deposits and cash from the Captive. The debt securities mature in December 2010, July 2011 and December 2011 and are guaranteed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program upon maturity. The Company has the intent and ability to hold these debt securities to maturity.

At June 30, 2009, the Company had approximately $12,122 in debt security investments, which are held to maturity and carried at amortized cost. The fair value of the investments is determined based on Level 1 inputs, which consist of unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets. The carrying value of the debt securities approximates fair value.

5. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and six months ended June 30, 2009 and 2008, respectively, is summarized in the following tables:

	Three Months Ended June 30,

	2009		2008	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid custodial	$ 53,603	40.6%	$ 45,004	39.1%
Medicare	43,156	32.7	38,877	33.7
Medicaid skilled	2,705	2.0	1,873	1.6
Total Medicaid and Medicare	99,464	75.3	85,754	74.4
Managed care	17,182	13.0	15,923	13.8
Private and other payors	15,532	11.7	13,641	11.8
Revenue	$ 132,178	100.0%	$ 115,318	100.0%

	Six Months Ended June 30,			
	2009		2008	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid custodial	$ 105,839	40.3%	$ 90,321	39.4%
Medicare	86,362	32.9	76,795	33.5
Medicaid skilled	4,988	1.9	4,082	1.8
Total Medicaid and Medicare	197,189	75.1	171,198	74.7
Managed care	34,679	13.2	31,179	13.6
Private and other payors	30,595	11.7	26,720	11.7
Revenue	$ 262,463	100.0%	$ 229,097	100.0%

Table of Contents

Accounts receivable consisted of the following:

	June 30, 2009	December 31, 2008
Medicaid	$ 21,921	$ 20,736
Managed care	15,509	15,321
Medicare	14,727	12,818
Private and other payors	8,335	7,579
	60,492	56,454
Less allowance for doubtful accounts	(6,948)	(7,266)
Accounts receivable	$ 53,544	$ 49,188

6. ACQUISITIONS

The Company s acquisition policy is generally to purchase or lease facilities to complement the Company s existing portfolio of long-term care facilities. The operations of all the Company s facilities are included in the accompanying condensed consolidated financial statements subsequent to the date of acquisition. Acquisitions are typically paid for in cash and are accounted for using the acquisition method of accounting. Where the Company enters into facility lease agreements, the Company typically does not pay any material amount to the prior facility operator nor does the Company acquire any assets or assume any liabilities, other than rights and obligations under the lease and operations transfer agreement, as part of the transaction. Some leases include options to purchase the facilities. As a result, from time to time, the Company will acquire facilities that the Company has been operating under third-party leases. During the six months ended June 30, 2009, the Company acquired seven facilities. The aggregate purchase price of six of the seven acquisitions was approximately $20,507, which was paid in cash. The Company acquired the remaining facility pursuant to a long-term lease arrangement between the Company and the real property owner of the facility. In this transaction, the Company assumed ownership of the skilled nursing operating business at this facility for approximately $1,626, which was paid in cash. The facilities acquired during the six months ended June 30, 2009 are as follows:

On January 1, 2009, the Company assumed an existing lease for a 149 operational bed skilled nursing facility in San Luis Obispo, California. The Company purchased the tenant s rights under the lease agreement from the prior tenant and operator for approximately $1,626. The Company did not acquire any material assets or assume any liabilities other than the prior tenant s post-assumption rights and obligations under the lease. Consistent with its acquisition practices, the Company also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

On January 1, 2009, the Company purchased a skilled nursing facility in Lufkin, Texas for approximately $7,955, which was paid in cash. This facility added 150 operational beds to the Company s operations. Consistent with its acquisition practices, the Company also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

On January 15, 2009, the Company assumed the operations of a skilled nursing facility which also has the capacity to provide assisted living and independent living services in Riverside, California. On March 27, 2009, the Company purchased this facility for approximately $1,752, which was paid in cash. This acquisition added 38 operational skilled nursing, 54 operational assisted living and 24 independent living beds to the Company s operations. Consistent with its acquisition practices, the Company also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

On February 1, 2009, the Company purchased three skilled nursing facilities and one assisted living facility in Colorado for approximately $10,800, which was paid in cash. These acquisitions added 217 operational skilled nursing and 38 operational assisted living beds to the Company s operations. Consistent with its acquisition practices, the Company also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

Goodwill recognized in these transactions amounted to $2,887, which is expected to be fully deductible for tax purposes. In addition, the Company recognized other intangible assets in the form of favorable lease assets and patient base of $1,597 and $388, respectively. In addition, the Company expensed $101 in acquisition related costs which were previously capitalizable.

Table of Contents

The purchase prices in the above transactions were allocated to real property, equipment, intangible assets and goodwill based on the following valuation techniques:

The fair value of land, buildings and improvements and equipment, furniture and fixtures (or tangible assets) was determined utilizing a cost approach. In the cost approach, the subject property is valued based upon the fair value of the land, as if vacant, by comparing recent sales or asking prices for similar land, to which the depreciated replacement cost of the building and improvements and equipment is added. The replacement cost of the building and improvements and equipment is adjusted for accrued depreciation resulting from physical deterioration, functional obsolescence and external or economic obsolescence.

The patient base was valued under an income capitalization approach using an excess earnings method. Excess earnings are the earnings remaining after deducting the market rates of return on the estimated values of contributory assets including debt-free net working capital, tangible and intangible assets. The excess earnings are thereby calculated and discounted to a present value. The primary components of this method consist of the determination of excess earnings and an appropriate rate of return. To arrive at the excess earnings attributable to an intangible asset, earnings after taxes derived from that asset are projected. Thereafter, the returns on contributory debt-free net working capital, tangible and intangible assets are deducted from the earnings projections. After deducting returns on these contributory assets, the remaining earnings are attributable to the customer base. These remaining, or excess, earnings are then discounted to a present value utilizing an appropriate discount rate for the asset.

Goodwill is calculated as the value that remains after subtracting the net asset value and the value of identifiable tangible and intangible assets and liabilities for the respective business combination.

The table below presents the allocation of the purchase price for the facilities acquired in business combinations during the six months ended June 30, 2009 and the year ended December 31, 2008:

	June 30, 2009	December 31, 2008
Land	$ 3,485	$
Building and improvements	13,101	
Equipment, furniture, and fixtures	675	
Goodwill	2,887	
Other intangible assets	1,985	2,005
	$ 22,133	$ 2,005

The Company s acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return on invested capital. The facilities acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming facilities, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not meaningful and may be misleading as the information is not representative of the Company s current operating results or indicative of the integration potential of its newly acquired facilities.

The seven businesses acquired during the six months ended June 30, 2009 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the June 30, 2009 condensed consolidated balance sheet of the Company and the operating results have been included in the condensed consolidated statement of income of the Company since the dates the Company gained effective control.

13

Table of Contents

7. PROPERTY AND EQUIPMENT

Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from 3 to 30 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Property and equipment consist of the following:

	June 30, 2009	December 31, 2008
Land	$ 33,925	$ 30,440
Buildings and improvements	120,021	103,278
Equipment	29,529	22,790
Furniture and fixtures	8,306	8,198
Leasehold improvements	16,283	13,276
Construction in progress	2,735	3,922
	210,799	181,904
Less accumulated depreciation	(30,525)	(24,875)
Property and equipment, net	$ 180,274	$ 157,029

8. INTANGIBLE ASSETS Net

	Weighted Average Life	June 30, 2009			December 31, 2008		
Intangible Assets	(Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	15.5	$ 1,071	$ (661)	$ 410	$ 1,071	$ (629)	$ 442
Favorable lease	20.0	3,573	(171)	3,402	1,976	(67)	1,909
Customer base	0.3	630	(617)	13	242	(242)	
Trade name	30.0	733	(86)	647	733	(73)	660
Total		$ 6,007	$ (1,535)	$ 4,472	$ 4,022	$ (1,011)	$ 3,011

Amortization expense was $227 and $524 for the three and six months ended June 30, 2009 and $114 and $180 for the three and six months ended June 30, 2008, respectively. Estimated amortization expense for each of the years ending December 31 is as follows:

Year	Amount
2009	$ 684
2010	291
2011	291
2012	291
2013	290
Thereafter	3,148
	$ 4,995

Goodwill

The Company performed its annual goodwill impairment analysis during the fourth quarter of fiscal year 2008 for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment. The Company tests for impairment by comparing the net assets of each reporting unit to their respective fair values. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. In the event a unit s net assets exceed its fair value, an implied fair value of goodwill must be determined by assigning the unit s fair value to each asset and liability of the unit. The excess of the fair value of the reporting unit over the amounts assigned to its assets and liabilities is the implied fair value of goodwill. An impairment loss is measured by the difference between the goodwill carrying value and the implied fair value. The Company recorded no goodwill impairment for the six months ended June 30, 2009 or the year ended December 31, 2008.

Table of Contents

9. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist primarily of capital reserves and deposits. Capital reserves are maintained as part of the mortgage agreements of the Company and certain of its landlords with the U.S. Department of Housing and Urban Development. These capital reserves are restricted for capital improvements and repairs to the related facilities. Restricted and other assets consist of the following:

	June 30, 2009	December 31, 2008
Deposits with landlords	$ 903	$ 903
Capital improvement reserves with landlords and lenders	3,223	2,865
Debt issuance costs, net	1,305	1,363
Restricted and other assets	$ 5,431	$ 5,131

10. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2009	December 31, 2008
Quality assurance fee	$ 1,329	$ 1,422
Resident refunds payable	1,874	1,533
Deferred resident revenue	1,222	1,475
Cash held in trust for residents	1,373	1,082
Dividends payable	927	925
Income taxes payable	940	1,096
Property taxes	889	962
Other	2,894	2,555
Other accrued liabilities	$ 11,448	$ 11,050

Quality assurance fee represents amounts payable to the State of California in respect of a mandated fee based on resident days. Resident refunds payable includes amounts due to residents for overpayments and duplicate payments. Deferred resident revenue occurs when the Company receives payments in advance of services provided. Cash held in trust for residents reflects monies received from, or on behalf of, residents. Maintaining a trust account for residents is a regulatory requirement and, while the trust assets offset the liability, the Company assumes a fiduciary responsibility for these funds. The cash balance related to this liability is included in other current assets in the accompanying condensed consolidated balance sheets.

11. INCOME TAXES

The provision for income taxes for the three and six months ended June 30, 2009 and 2008 is summarized as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Current:				
Federal	$ 6,263	$ 3,719	$ 9,643	$ 7,330
State	1,161	752	2,030	1,475
	7,424	4,471	11,673	8,805

Deferred:				
Federal	(1,786)	(169)	(795)	(351)
State	(430)	(45)	(447)	(89)
	(2,216)	(214)	(1,242)	(440)
Expense for uncertain tax positions	70		70	
Other expense, net	4	20	59	124
Total	$ 5,282	$ 4,277	$ 10,560	$ 8,489

Table of Contents

The Company s deferred tax assets and liabilities as of June 30, 2009 and December 31, 2008 are summarized as follows:

	June 30, 2009	December 31, 2008
Deferred tax assets (liabilities):		
Accrued expenses	$ 12,232	$ 10,503
Allowance for doubtful accounts	2,925	3,059
State taxes		314
Tax credits	1,201	1,132
Total deferred tax assets	16,358	15,008
State taxes	(274)	
Depreciation and amortization	(1,932)	(2,106)
Prepaid expenses	(1,233)	(1,095)
Total deferred tax liabilities	(3,439)	(3,201)
Net deferred tax assets	$ 12,919	$ 11,807

12. Debt

The Company has a Second Amended and Restated Loan and Security Agreement (the Revolver) with General Electric Capital Corporation (the Lender) under which the Company may borrow up to the lesser of $50,000 or 85% of the eligible accounts receivable. The Revolver will expire on February 21, 2013. The Company was in compliance with all covenants as of June 30, 2009. At June 30, 2009 and December 31, 2008, there were no outstanding borrowings under the Revolver. As of June 30, 2009, the amount of borrowing capacity pledged to secure outstanding letters of credit was $2,133. In addition, the Revolver includes provisions that allow the Lender to establish reserves against collateral for actual and contingent liabilities, a right which the Lender exercised with the Company s cooperation in December 2008. This reserve restricts $6.0 million of the Company s borrowing capacity, and may be reduced or eliminated based upon developments with respect to the ongoing U.S. Attorney investigation. In addition, in the event of the Company s default under the Third Amended and Restated Loan Agreement (the Term Loan), the Lender has the right to take control of the Company s facilities encumbered by the loan to the extent necessary to make such payments and perform such acts that are required under the loan.

Long-term debt consists of the following:

	June 30, 2009	December 31, 2008
Term Loan with the Lender, multiple-advance term loan, principal and interest payable monthly; interest is fixed at time of draw at 10-year Treasury Note rate plus 2.25% (rates in effect at June 30, 2009 range from 6.95% to 7.50%), balance due June 2016, collateralized by deeds of trust on real property, assignments of rents, security agreements and fixture financing statements	$ 53,653	$ 54,102
Mortgage note, principal, and interest of $54 payable monthly and continuing through February 2027, interest at fixed rate of 7.5%, collateralized by deed of trust on real property, assignment of rents and security agreement	6,364	6,449
	60,017	60,551

Less current maturities	(1,064)	(1,062)
	$ 58,953	$ 59,489

Under the Term Loan, the Company is subject to standard reporting requirements and other typical covenants for a loan of this type. As of June 30, 2009 the Company was in compliance with such loan covenants.
The carrying value of the Company s long-term debt is considered to approximate the fair value of such debt for all periods presented based upon the interest rates that the Company believes it can currently obtain for similar debt.

Table of Contents

13. OPTIONS AND WARRANTS

Stock-based compensation expense consists of share-based payment awards made to employees and directors including employee stock options based on estimated fair values. Stock-based compensation expense recognized in the Company s condensed consolidated statements of income for the three and six months ended June 30, 2009 and 2008 does not include compensation expense for share-based payment awards granted prior to, but not yet vested as of January 1, 2006, but does include compensation expense for the share-based payment awards granted on or subsequent to January 1, 2006 based on the grant date fair value. As stock-based compensation expense recognized in the Company s condensed consolidated statements of income for the three and six months ended June 30, 2009 and 2008 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan) all of which have been approved by the stockholders. In the 2001 Plan and the 2005 Plan, options may be exercised for unvested shares of common stock, which have full stockholder rights including voting, dividend and liquidation rights. The Company retains the right to repurchase any or all unvested shares at the exercise price paid per share of any or all unvested shares should the optionee cease to remain in service while holding such unvested shares. The total number of shares available under all of the Company s stock incentive plans was 1,136 as of June 30, 2009.

2001 Stock Option, Deferred Stock and Restricted Stock Plan The 2001 Plan authorizes the sale of up to 1,980 shares of common stock to officers, employees, directors, and consultants of the Company. Granted non-employee director options vest and become exercisable immediately. Generally, all other granted options and restricted stock vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. The exercise price of the stock is determined by the board of directors, but shall not be less than 100% of the fair value on the date of grant. Shares issued upon early exercise of options granted prior to 2006 vested in full upon the consummation of the Company s IPO. At June 30, 2009 and December 31, 2008 there were 288 and 279, respectively, unissued shares of common stock available for issuance under this plan, including shares that have been forfeited and are available for reissue.

2005 Stock Incentive Plan The 2005 Plan authorizes the sale of up to 1,000 shares of treasury stock, of which only 800 shares were repurchased and therefore eligible for reissuance as of December 31, 2007 and 2006, to officers, employees, directors and consultants of the Company. Options granted to non-employee directors vest and become exercisable immediately. All other granted options vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. At June 30, 2009 and December 31, 2008 there were 117 unissued shares of common stock available for issuance under this plan, including shares that have been forfeited and are available for reissue.

2007 Omnibus Incentive Plan The 2007 Plan authorizes the sale of up to 1,000 shares of common stock to officers, employees, directors and consultants of the Company. In addition, the number of shares of common stock reserved under the 2007 Plan will automatically increase on the first day of each fiscal year, which began on January 1, 2008, in an amount equal to the lesser of (i) 1,000 shares of common stock, or (ii) 2% of the number of shares outstanding as of the last day of the immediately preceding fiscal year, or (iii) such lesser number as determined by the Company s board of directors. Granted non-employee director options vest and become exercisable in three equal annual installments, or the length of the term if less than three years, on the completion of each year of service measured from the grant date. All other granted options vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. At June 30, 2009 and December 31, 2008 there were 731 and 609, respectively, unissued shares of common stock available for issuance under this plan.

On July 23, 2009 the Company s board of directors adopted an amendment to the Company s 2007 Omnibus Incentive Plan, amending the equity compensation program for the Company s non-employee directors to phase out a program of automatic non-qualified stock option grants and phase in a program providing for automatic quarterly stock awards to non-employee directors for their service on the Company s board of directors.

17

Table of Contents

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for all share-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time. Approximately 306 options were granted during the six month period ended June 30, 2009. The Company used the following assumptions for stock options granted during the six months ended June 30, 2009 and the year ended December 31, 2008:

Grant Year	Plan	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2009	2007	306	2.17 2.39%	6.5 years	55%	1.08%
2008	2007	836	2.88 3.47%	6.5 years	45 50%	1.45%

For the six months ended June 30, 2009 and the year ended December 31, 2008, the following represents the Company s weighted average exercise price, grant date intrinsic value and fair value displayed at grant date:

Grant Year	Plan	Options Granted	Weighted Average Exercise Price and Fair Value of Common Stock	Weighted Average Fair Value of Options
2009	2007	306	$ 16.14	$ 8.05
2008	2007	836	$ 12.00	$ 5.33

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended June 30, 2009 and December 31, 2008, and therefore, the intrinsic value was $0.

The following table represents the employee stock option activity during the year ended December 31, 2008 and the six months ended June 30, 2009:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price
December 31, 2007	1,023	$ 6.19	316	$ 5.25
Granted	836	12.00		
Forfeited	(72)	8.21		
Exercised	(84)	5.21		
December 31, 2008	1,703	9.01	451	5.74
Granted	306	16.14		
Forfeitures	(25)	10.09		
Exercised	(27)	5.40		

June 30, 2009	1,957	$ 10.16	532	$ 6.74

The following summary information reflects stock options outstanding, vesting and related details as of June 30, 2009:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	**Exercise Price**	**Number Outstanding**	**Black-Scholes Fair Value**	**Remaining Contractual Life (Years)**	**Number Vested and Exercisable**
2003	$ 0.67 0.81	39	$ *	5	39
2004	$ 1.96 2.46	48	*	6	41
2005	$ 4.99 5.75	257	*	7	149
2006	$ 7.05 7.50	525	5,029	8	203
2008	$ 9.38 14.87	785	4,194	9	100
2009	$ 14.92 16.70	303	2,443	10	
Total		1,957	$ 11,666		532

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

Table of Contents

The Company recognized $476 and $992 in compensation expense during the three and six months ended June 30, 2009 and $291 and $752 during the three and six months ended June 30, 2008, respectively. In future periods, the Company expects to recognize approximately $8.1 million in stock-based compensation expense over the next 2.8 weighted average years for unvested options that were outstanding as of June 30, 2009. There were 1,425 unvested and outstanding options at June 30, 2009, of which 1,270 are expected to vest. The weighted average contractual life for options vested at June 30, 2009 was 6.8 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of June 30, 2009 and December 31, 2008 is as follows:

Options	June 30, 2009	December 31, 2008
Outstanding	$ 8,640	$ 13,778
Vested	3,979	7,513
Expected to vest	4,161	2,353
Exercised	271	996

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

14. COMMITMENTS AND CONTINGENCIES

Leases The Company leases certain facilities and its administrative offices under non-cancelable operating leases and one capital lease, most of which have initial lease terms ranging from five to 20 years. The Company also leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments, was $3,839 and $7,656 for the three and six months ended June 30, 2009, respectively, and $4,252 and $8,481 for the three and six months ended June 30, 2008, respectively.

On July 15, 2009, the Company entered into the fourth amendment to the lease for its Service Center. The amendment extended the lease for ten years from the end of the existing lease term. In addition, the lease amendment expands the amount of rentable space by 9,110 square feet. Estimated future minimum lease payments for each of the years ending December 31 are as follows:

Year	Amount
2009	$ 53
2010	195
2011	322
2012	574
2013	598
Thereafter	3.666
	$ 5,408

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

In addition, a number of the Company s individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the

landlords under separate but cross-defaulted leases. The Company is not aware of any defaults as of June 30, 2009.

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

A significant portion of the Company s revenue is derived from Medicaid and Medicare, for which reimbursement rates are subject to regulatory changes and government funding restrictions. Although the Company is not aware of any significant future rate changes, significant changes to the reimbursement rates could have a material effect on the Company s operations.

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

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

Table of Contents

Litigation The skilled nursing business involves a significant risk of liability given the age and health of the Company s patients and residents and the services the Company provides. The Company and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services have resulted in personal injury, elder abuse, wrongful death or other related claims. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

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

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

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

Medicare Revenue Recoupments The Company is subject to reviews relating to Medicare services, billings and potential overpayments. One facility was subject to probe review during the year ended December 31, 2008, which was subsequently concluded with a Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments of approximately $4, which was paid during the second quarter of 2008. The Company anticipates that these probe reviews will increase in frequency in the future. In addition, two of the Company s facilities are currently on prepayment review, and others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. The Company has no facilities that are currently undergoing targeted review.

Other Matters In March 2007, the Company and certain of its officers received a series of notices from its bank indicating that the United States Attorney for the Central District of California had issued an authorized investigative demand, a request for records similar to a subpoena, to our bank. The U.S. Attorney subsequently rescinded that demand. The rescinded demand requested documents from the Company s bank related to financial transactions involving the Company, ten of its operating subsidiaries, an outside investor group, and certain of the Company s current and former officers. Subsequently, in June of 2007, the U.S. Attorney sent a letter to one of the Company s current employees requesting a meeting. The letter indicated that the U.S. Attorney and the U.S. Department of Health and Human Services Office of Inspector General were conducting an investigation of claims submitted to the Medicare program for rehabilitation services provided at unspecified facilities. Although both the Company and the

employee offered to cooperate, the U.S. Attorney later withdrew its meeting request.

On December 17, 2007, the Company was informed by Deloitte & Touche LLP, its independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of its operating subsidiaries. The subpoena confirmed the Company s previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of the Company s operating subsidiaries. All together, the March 2007 authorized investigative demand and the December 2007 subpoena specifically covered information from a total of 18 of the Company s 70 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. Both the Company and the employees contacted have offered to cooperate and meet with the U.S. Attorney, however, to date, the U.S. Attorney has declined these offers. Based on these events, the Company believes that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group and one or more of its skilled nursing facilities.

Table of Contents

Pursuant to these investigations, on December 17, 2008, representatives from the U.S. Department of Justice (DOJ) served search warrants on the Company s Service Center and six of its Southern California skilled nursing facilities. Following the execution of the warrants on the six facilities, a subpoena was issued covering eight additional facilities. Among other things, the warrants covered specific patient records at the six facilities. On May 4, 2009, the U.S. Attorney served a second subpoena requesting additional patient records on the same patients who were covered by the original warrants. The Company has worked with the U.S. Attorney s office to produce information responsive to both subpoenas. The Company and its regulatory counsel continue to actively work with the U.S. Attorney s office to determine what additional information, if any, will be assistive.

The Company is cooperating with the U.S. Attorney s office and intends to continue working with them to the extent they will allow the Company to help move their inquiry forward. To the Company s knowledge, however, neither The Ensign Group, Inc. nor any of its operating subsidiaries or employees has been formally charged with any wrongdoing. The Company cannot predict or provide any assurance as to the possible outcome of the investigation or any possible related proceedings, or as to the possible outcome of any *qui tam* litigation that may follow, nor can the Company estimate the possible loss or range of loss that may result from any such proceedings and, therefore, the Company has not recorded any related accruals. To the extent the U.S. Attorney s office elects to pursue this matter, or if the investigation has been instigated by a *qui tam* relator who elects to pursue the matter, and the Company is subjected to or alleged to be liable for claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, the Company s business, financial condition and results of operations could be materially and adversely affected and its stock price could decline.

The Company initiated an internal investigation in November 2006 when it became aware of an allegation of possible reimbursement irregularities at one or more of the Company s facilities. This investigation focused on 12 facilities, and included all six of the facilities which were covered by the warrants served in December 2008. The Company retained outside counsel to assist in looking into these matters. The Company and its outside counsel concluded this investigation in February 2008 without identifying any systemic or patterns and practices of fraudulent or intentional misconduct. The Company made observations at certain facilities regarding areas of potential improvement in some of its recordkeeping and billing practices and has implemented measures, some of which were already underway before the investigation began, that the Company believes will strengthen its recordkeeping and billing processes. None of these additional findings or observations appears to be rooted in fraudulent or intentional misconduct. The Company continues to evaluate the measures it has implemented for effectiveness, and is continuing to seek ways to improve these processes.

As a byproduct of its investigation the Company identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. The Company, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, the Company treated the claims as overpayments. Consistent with healthcare industry accounting practices, the Company records any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the year ended December 31, 2007, the Company accrued a liability of approximately $224, plus interest, for selected Medicare claims for which documentation has not been located or for other billing deficiencies identified to date. These claims have been submitted for settlement with the Medicare Fiscal Intermediary. If additional reviews result in identification and quantification of additional amounts to be refunded, the Company would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require the Company to record significant additional provisions or remit payments, the Company s business, financial condition and results of operations could be materially and adversely affected and its stock price could decline.

Concentrations

Credit Risk The Company has significant accounts receivable balances, the collectibility of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there is significant credit risks associated with these governmental programs. The Company believes that an appropriate

allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company s receivables from Medicare and Medicaid payor programs accounted for approximately 61% and 59% of its total accounts receivable as of June 30, 2009 and December 31, 2008, respectively. Revenue from reimbursements under the Medicare and Medicaid programs accounted for approximately 75% of the Company s revenue for both periods during the three and six months ended June 30, 2009 and 74% and 75% for the three and six months ended June 30, 2008, respectively.

Cash in Excess of FDIC Limits The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S.

15. Subsequent Events

Subsequent to June 30, 2009, the Company entered into an agreement to purchase real property and assets, including approximately 260 operational skilled nursing facility beds, 39 independent living units and a hospice care operation for approximately $17,000. As of the date of this filing, this transaction is still in the preliminary stages and the Company cannot guarantee the purchase will occur.

Table of Contents

Item 2. ***Management s Discussion and Analysis of Financial Condition and Results of Operations***

You should read the following discussion and analysis in conjunction with our unaudited condensed consolidated financial statements and the related notes thereto contained in Part I, Item 1 of this Report. The information contained in this Quarterly Report on Form 10-Q is not a complete description of our business or the risks associated with an investment in our common stock. We urge you to carefully review and consider the various disclosures made by us in this Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Annual Report on Form 10-K (Annual Report), which discusses our business and related risks in greater detail, as well as subsequent reports we may file from time to time on Forms 10-Q and 8-K, for additional information. The section entitled Risk Factors contained in Part II, Item 1A of this Report, and similar discussions in our other SEC filings, also describe some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

This Report contains forward-looking statements, which include, but are not limited to the Company s expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities and plans and objectives of management. Forward-looking statements can often be identified by words such as anticipates, expects, intends, plans, predicts, believes, seeks, estimat should, would, could, potential, continue, ongoing, similar expressions, and variations or negatives of these w These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Therefore, our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section Risk Factors contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management s beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law. As used in this Management s Discussion and Analysis of Financial Condition and Results of Operations, the words, we, our and us refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our facilities, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of we , us , our and similar verbiage in this quarterly report is not meant to imply that any of our facilities or the Service Center are operated by the same entity. This Management s Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with our consolidated financial statements and related notes included in the Annual Report.

Table of Contents

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 70 facilities located in California, Arizona, Texas, Washington, Utah, Colorado and Idaho. All of these facilities are skilled nursing facilities, other than four stand-alone assisted living facilities in Arizona, Texas and Colorado and five campuses that offer both skilled nursing and assisted living services in California, Arizona and Utah. Our facilities provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. We encourage and empower our facility leaders and staff to make their facility the facility of choice in the community it serves. This means that our facility leaders and staff are generally free to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then work to create a superior service offering and reputation for that particular community or market to encourage prospective customers and referral sources to choose or recommend the facility. As of June 30, 2009, we owned 38 of our facilities and operated an additional 32 facilities under long-term lease arrangements, and had options to purchase 9 of those 32 facilities. The following table summarizes our facilities and licensed and independent living beds by ownership status as of June 30, 2009:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	38	9	23	70
Percent of total	54.2%	12.9%	32.9%	100%
Operational skilled nursing, assisted living and independent living beds	4,182	1,059	2,745	7,986
Percent of total	52.3%	13.3%	34.4%	100%

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

Recent Developments

On January 1, 2009, we assumed an existing lease for a 149 operational bed skilled nursing facility in San Luis Obispo, California. We purchased the tenant s rights under the lease agreement from the prior tenant and operator for approximately $1.6 million, which was paid in cash. We did not acquire any material assets or assume any liabilities other than the prior tenant s post-assumption rights and obligations under the lease. Consistent with our acquisition practices, we also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

On January 1, 2009, we acquired a 150 operational bed skilled nursing facility in Lufkin, Texas for approximately $8.0 million, which was paid in cash. Consistent with our acquisition practices, we also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

On January 15, 2009, we assumed the operations of a skilled nursing facility which also has the capacity to provide assisted living and independent living services in Riverside, California. On March 27, 2009, we purchased this facility for approximately $1.8 million, which was paid in cash. This acquisition added 38 operational skilled nursing, 54 operational assisted living and 24 independent living beds to our operations. Consistent with our acquisition practices,

we also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.
On February 1, 2009, we purchased three skilled nursing facilities and one assisted living facility in Colorado for approximately $10.8 million, which was paid in cash. This acquisition added 217 operational skilled nursing and 38 operational assisted living beds to our operations. Consistent with our acquisition practices, we also entered into a separate operations transfer agreement with the prior tenant as a part of this transaction.

Facility Acquisition History

	As of December 31,										As of June 30,
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
Cumulative number of facilities	5	13	19	24	41	43	46	57	61	63	70
Cumulative number of operational skilled nursing, assisted living and independent living beds	665	1,571	2,155	2,751	4,959	5,213	5,585	6,667	7,105	7,324	7,986

Table of Contents

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of June 30, 2009:

	CA	AZ	TX	UT	CO	WA	ID	Total
Number of facilities	33	12	11	6	4	3	1	70
Operational skilled nursing, assisted living and independent living beds	3,721	1,836	1,226	577	255	283	88	7,986

Key Performance Indicators

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

Routine revenue: Routine revenue is generated by the contracted daily rate charged for all contractually inclusive services. The inclusion of therapy and other ancillary treatments varies by payor source and by contract. Services provided outside of the routine contractual agreement are recorded separately as ancillary revenue, including Medicare Part B therapy services, and are not included in the routine revenue definition.

Skilled revenue: The amount of routine revenue generated from patients in our skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs. The other skilled residents that are included in this population represent very high acuity residents who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care Skilled revenue excludes any revenue generated from our assisted living services.

Skilled mix: The amount of our skilled revenue as a percentage of our total routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving services at our skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at our skilled nursing facilities for any given period.

Quality mix: The amount of routine non-Medicaid revenue as a percentage of our total routine revenue. Quality mix (in days) represents the number of days our non-Medicaid patients are receiving services at our skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at our skilled nursing facilities for any given period.

Average daily rates: The routine revenue by payor source for a period at our skilled nursing facilities divided by actual patient days for that revenue source for that given period.

Occupancy percentage (operational beds): The total number of residents occupying a bed in a skilled nursing, assisted living or independent living facility as a percentage of the beds in a facility which are available for occupancy during the measurement period.

Number of facilities and operational beds: The total number of skilled nursing, assisted living and independent living facilities that we own or operate and the total number of operational beds associated with these facilities.

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Skilled Mix:				
Days	24.3%	25.5%	24.8%	25.4%
Revenue	48.0%	49.4%	48.3%	49.2%
Quality Mix:				
Days	36.8%	38.6%	37.4%	38.2%
Revenue	57.5%	59.2%	57.8%	58.8%

Table of Contents

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Occupancy:				
Operational beds at end of period	7,986	7,219	7,986	7,219
Available patient days	726,636	653,509	1,436,636	1,300,064
Actual patient days	576,738	528,984	1,143,357	1,059,379
Occupancy percentage (based on operational beds)	79.4%	81.0%	79.6%	81.5%

Revenue Sources

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

	Three Months Ended June 30,				Six Months Ended June 30,			
	2009		2008		2009		2008	
	$	%	$	%	$	%	$	%
	(in thousands)							
Revenue:								
Medicare	$ 43,156	32.7%	$ 38,877	33.7%	$ 86,362	32.9%	$ 76,795	33.5%
Managed care	17,182	13.0	15,923	13.8	34,679	13.2	31,179	13.6
Other skilled	2,756	2.1	1,873	1.6	5,039	1.9	4,082	1.8
Private and other payors(1)	15,481	11.7	13,641	11.8	30,544	11.7	26,720	11.7
Medicaid	53,603	40.5	45,004	39.1	105,839	40.3	90,321	39.4
Total revenue	$ 132,178	100.0%	$ 115,318	100.0%	$ 262,463	100.0%	$ 229,097	100.0%

(1) Includes revenue from assisted living facilities.

Critical Accounting Policies Update

There have been no significant changes during the six month period ended June 30, 2009 to the items that we disclosed as our critical accounting policies and estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K filed with the SEC.

Table of Contents

Industry Trends

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

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

Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.

Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.

Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to U.S. Census Bureau Interim Projections, there were 38 million people in the United States in 2008 that were over 65 years old. The U.S. Census Bureau estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

Effects of Changing Prices. Medicare reimbursement rates and procedures are subject to change from time to time, which could materially impact our revenue. Medicare reimburses our skilled nursing facilities under a prospective payment system (PPS) for certain inpatient covered services. Under the PPS, facilities are paid a predetermined amount per patient, per day, based on the anticipated costs of treating patients. The amount to be paid is determined by classifying each patient into a resource utilization group (RUG) category that is based upon each patient s acuity level. As of January 1, 2006, the RUG categories were expanded from 44 to 53, with increased reimbursement rates for treating higher acuity patients. 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, with a corresponding adverse impact on our financial condition or results of operation.

The Deficit Reduction Act of 2005 (DRA) was expected to significantly reduce net Medicare and Medicaid spending. Prior to the DRA, caps on annual reimbursements for rehabilitation therapy became effective on January 1, 2006. The DRA provides for exceptions to those caps for patients with certain conditions or multiple complexities whose therapy is reimbursed under Medicare Part B and provided in 2006. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 extended the exceptions to these therapy caps until December 31, 2009.

On July 31, 2009, Centers for Medicare and Medicaid Services (CMS) released its final rule on the fiscal year 2010 PPS reimbursement rates for skilled nursing facilities, which resulted in a 2.2% market basket increase. The fiscal

year 2010 recalibration of the case mix index (CMI) is expected to correct a forecast error resulting in a 3.3% rate reduction.

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates see Risk Factors Risks Related to Our Business and Industry Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare, Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending, and If Medicare reimbursement rates decline, our revenue, financial condition and results of operations could be adversely affected. 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.

Table of Contents

Results of Operations

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
Revenue	100.0%	100.0%	100.0%	100.0%
Expenses:				
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	79.7	80.3	79.8	80.3
Facility rent cost of services	2.8	3.4	2.8	3.5
General and administrative expense	4.1	4.3	4.0	4.4
Depreciation and amortization	2.4	1.9	2.4	1.8
Total expenses	89.0	89.9	89.0	90.0
Income from operations	11.0	10.1	11.0	10.0
Other income (expense):				
Interest expense	(0.9)	(1.0)	(1.0)	(1.0)
Interest income	0.1	0.3	0.1	0.3
Other expense, net	(0.8)	(0.7)	(0.9)	(0.7)
Income before provision for income taxes	10.2	9.4	10.1	9.3
Provision for income taxes	4.0	3.7	4.0	3.7
Net income	6.2%	5.7%	6.1%	5.6%

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2009	2008	2009	2008
	(in thousands)			
Consolidated Statement of Income Data:				
Net income	$ 8,184	$ 6,519	$ 16,107	$ 12,853
Interest expense, net	1,072	797	2,330	1,515
Provision for income taxes	5,282	4,277	10,560	8,489
Depreciation and amortization	3,209	2,173	6,174	4,163
EBITDA(1)	$ 17,747	$ 13,766	$ 35,171	$ 27,020
Facility rent cost of services	3,724	3,948	7,425	7,947
EBITDAR(1)	$ 21,471	$ 17,714	$ 42,596	$ 34,967

(1)

EBITDA and EBITDAR are supplemental non-GAAP financial measures. Regulation G, *Conditions for Use of Non-GAAP Financial Measures*, and other provisions of the Securities Exchange Act of 1934, as amended, define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude facility rent cost of services. These non-GAAP financial measures are used in addition to and in conjunction with results presented in accordance with

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

Table of Contents

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

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

- they help investors evaluate and compare the results of our operations from period to period by removing the impact of our capital structure and asset base from our operating results.

We use EBITDA and EBITDAR:

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

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

- to evaluate the effectiveness of our operational strategies; and

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

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

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

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

- they do not reflect our current or future cash requirements for capital expenditures or contractual commitments;

- they do not reflect changes in, or cash requirements for, our working capital needs;

- they do not reflect the net interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;

- they do not reflect any income tax payments we may be required to make;

- although depreciation and amortization are non-cash charges, the assets being depreciated and amortized will often have to be replaced in the future, and EBITDA and EBITDAR do not reflect any cash requirements for such replacements; and

- other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

We compensate for these limitations by using them only to supplement net income on a basis prepared in accordance with GAAP in order to provide a more complete understanding of the factors and trends affecting our business. Management strongly encourages investors to review our condensed consolidated financial statements in their entirety and to not rely on any single financial measure. Because these non-GAAP financial measures are not standardized, it may not be possible to compare these financial measures with other companies non-GAAP financial measures having the same or similar names. For information about our financial results as reported in accordance with GAAP, see our condensed consolidated financial statements and related notes included elsewhere in this document.

Table of Contents

Three Months Ended June 30, 2009 Compared to Three Months Ended June 30, 2008

	Three Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Revenue	$ 132,178	$ 115,318	$ 16,860	14.6%
Number of facilities at period end	70	62	8	12.9%
Actual patient days	576,738	528,984	47,754	9.0%
Occupancy percentage Operational beds	79.4%	81.0%		(1.6)%
Skilled mix by nursing days	24.3%	25.5%		(1.2)%
Skilled mix by revenue	48.0%	49.4%		(1.4)%

	Three Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Revenue	$ 121,757	$ 114,255	$ 7,502	6.6%
Number of facilities at period end	61	61		%
Actual patient days	524,582	524,381	201	0.0%
Occupancy percentage Operational beds	81.0%	81.1%		(0.1)%
Skilled mix by nursing days	25.3%	25.5%		(0.2)%
Skilled mix by revenue	49.6%	49.5%		0.1%

	Three Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(2):				
Revenue	$ 10,421	$ 1,063	$ 9,358	NM %
Number of facilities at period end	9	1	8	NM %
Actual patient days	52,156	4,603	47,553	NM %
Occupancy percentage Operational beds	66.0%	66.2%		(0.2)%
Skilled mix by nursing days	13.5%	28.0%		(14.4)%
Skilled mix by revenue	29.2%	48.2%		(19.0)%

(1) Same Facility results represent all facilities operated for the entire comparable periods presented and excludes facilities

acquired subsequent to April 1, 2008.

(2) Recently Acquired Facility results include all facilities acquired subsequent to April 1, 2008.

Revenue. Revenue increased $16.9 million, or 14.6%, to $132.2 million for the three months ended June 30, 2009 compared to $115.3 million for the three months ended June 30, 2008. Of the $16.9 million increase, Medicare and managed care revenue increased $5.6 million, or 10.1%, other skilled revenue increased $0.9 million, or 47.1%, Medicaid custodial revenue increased $8.6 million, or 19.1%, and private and other revenue increased $1.8 million, or 13.5%. This growth occurred despite an overall census decrease of 3.4% at our assisted living facilities and a decline in occupancy rates at Recently Acquired Facilities. Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix in Recently Acquired Facilities, and in the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we anticipate that our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio.

Revenue generated by Same Facilities increased $7.5 million, or 6.6%, for the three months ended June 30, 2009 as compared to the three months ended June 30, 2008. This increase was primarily due to higher acuity levels and higher reimbursement rates resulting from statutory increases relative to the three months ended June 30, 2008. The occupancy rate remained stable despite the transitioning of skilled nursing beds at two of our facilities to include sub acute services and the continued inflow of residents to the additional 30 skilled nursing beds in our Walla Walla, WA facility.

Approximately $9.4 million of the total revenue increase was due to revenue generated by Recently Acquired Facilities, which was primarily attributable to the operations for the three months ended June 30, 2009 at five skilled nursing facilities, one assisted living facility and one skilled nursing facility which also provides assisted living and independent living services acquired during the first quarter of 2009 and one skilled nursing facility acquired in December 2008.

Table of Contents

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

	Three Months Ended June 30,						
	Same Facility		Acquisitions		Total		
	2009	2008	2009	2008	2009	2008	% Change
Skilled Nursing Average Daily Revenue Rates:							
Medicare	$ 547.23	$ 496.80	$ 466.65	$ 400.64	$ 542.05	$ 495.57	9.4%
Managed care	341.32	330.08	396.32	376.40	342.94	330.41	3.8%
Other skilled	620.88	596.98			620.88	596.98	4.0%
Total skilled revenue	470.14	436.70	450.61	394.40	469.18	436.27	7.5%
Medicaid	159.78	149.89	164.21	180.68	160.16	150.11	6.7%
Private and other payors	179.67	169.55	185.32	137.31	180.64	168.95	6.9%
Total skilled nursing revenue	$ 240.27	$ 225.23	$ 207.69	$ 229.35	$ 237.40	$ 225.26	5.2%

The average Medicare daily rate increased by approximately 9.4% in the three months ended June 30, 2009 as compared to the three months ended June 30, 2008, as a result of higher acuity patient mix and an increase in the national average Medicare rate of approximately 3.4% as a result of the market basket increase beginning in the fourth quarter of fiscal year 2008. The average Medicaid rate increase of 6.7% in the three months ended June 30, 2009 relative to the same period in the prior year primarily resulted from increases in reimbursement rates in the state of Texas due to the state reimbursement system changing to a RUG based system.

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

	Three Months Ended June 30,					
	Same Facility		Acquisitions		Total	
	2009	2008	2009	2008	2009	2008
Percentage of Skilled Nursing Revenue:						
Medicare	33.3%	33.7%	23.3%	36.3%	32.5%	33.7%
Managed care	13.9	14.1	5.9	11.9	13.3	14.0
Other skilled	2.4	1.7			2.2	1.7
Skilled mix	49.6	49.5	29.2	48.2	48.0	49.4
Private and other payors	8.5	9.7	21.7	15.4	9.5	9.8
Quality mix	58.1	59.2	50.9	63.6	57.5	59.2
Medicaid	41.9	40.8	49.1	36.4	42.5	40.8
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended June 30,					
	Same Facility		Acquisitions		Total	
	2009	2008	2009	2008	2009	2008

Percentage of Skilled Nursing Days:						
Medicare	14.6%	15.3%	10.4%	20.8%	14.2%	15.3%
Managed care	9.8	9.6	3.1	7.2	9.2	9.6
Other skilled	0.9	0.6			0.9	0.6
Skilled mix	25.3	25.5	13.5	28.0	24.3	25.5
Private and other payors	11.5	12.9	24.3	25.8	12.5	13.1
Quality mix	36.8	38.4	37.8	53.8	36.8	38.6
Medicaid	63.2	61.6	62.2	46.2	63.2	61.4
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table of Contents

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $12.7 million, or 13.7%, to $105.3 million for the three months ended June 30, 2009 compared to $92.6 million for the three months ended June 30, 2008. Cost of services decreased as a percent of total revenue to 79.7% for the three months ended June 30, 2009 as compared to 80.3% for the three months ended June 30, 2008. Of the $12.7 million increase, $5.0 million was attributable to Same Facility increases and the remaining $7.7 million was attributable to Recently Acquired Facilities. The $5.0 million increase was primarily due to a $2.1 million increase in salaries and benefits, partially offset by a reduction in contract nursing services of $0.3 million, a $1.3 million increase in insurance costs and a $1.0 million increase in ancillary expenses. The increase in salaries and benefits was primarily due to increases in nursing wages and benefits, a portion of which is attributable to replacing contract nursing labor with full time employees. The increase in insurance costs was primarily a result of increased self-insured general and professional liability due to an increase in the level of self-insured deductible and higher actuarial projections for future claim settlements. The increase in ancillary expenses is primarily due to increased therapy expenses.

Facility Rent Cost of Services. Facility rent cost of services decreased $0.2 million, or 5.7%, to $3.7 million for the three months ended June 30, 2009 compared to $3.9 million for the three months ended June 30, 2008. Facility rent-cost of services decreased as a percent of total revenue to 2.8% for the three months ended June 30, 2009 as compared to 3.4% for the three months ended June 30, 2008. This decrease was primarily due to a $0.3 million decrease as a result of our purchases of six previously leased properties during 2008.

General and Administrative Expense. General and administrative expense increased $0.4 million, or 9.0%, to $5.4 million for the three months ended June 30, 2009 compared to $5.0 million for the three months ended June 30, 2008. General and administrative expense decreased as a percent of total revenue to 4.1% for the three months ended June 30, 2009 as compared to 4.3% for the three months ended June 30, 2008. The $0.4 million increase was primarily due to an increase in wages and benefits, largely due to increases in incentive compensation related to improved profitability and additional staffing in our accounting and legal departments.

We have, and will continue to experience higher stock-based compensation expense, which will impact cost of services and general and administrative expenses on a go forward basis, until 2011 when the adoption date will no longer impact the expense calculation.

Depreciation and Amortization. Depreciation and amortization expense increased $1.0 million, or 47.6%, to $3.2 million for the three months ended June 30, 2009 compared to $2.2 million for the three months ended June 30, 2008. Depreciation and amortization expense increased as a percent of total revenue to 2.4% for the three months ended June 30, 2009 as compared to 1.9% for the three months ended June 30, 2008. This increase was related to the additional depreciation of Recently Acquired Facilities, as well as an increase in Same Facility depreciation expense due to purchases of six previously leased properties during 2008. In addition, amortization expense increased $0.2 million as compared to the three months ended June 30, 2008, primarily related to the amortization of patient base intangible assets at Recently Acquired Facilities.

Other Income (Expense). Other expense, net increased $0.3 million, or 34.5%, to $1.1 million for the three months ended June 30, 2009 compared to $0.8 million for the three months ended June 30, 2008. Other expense, net increased as a percent of total revenue to 0.8% for the three months ended June 30, 2009 as compared to 0.7% for the three months ended June 30, 2008. This change was primarily due to a $0.3 million decrease in interest income received for the three months ended June 30, 2009 compared to the three months ended June 30, 2008.

Provision for Income Taxes. Provision for income taxes increased $1.0 million, or 23.5%, to $5.3 million for the three months ended June 30, 2009 compared to $4.3 million for the three months ended June 30, 2008. This increase resulted from the increase in income before income taxes of $2.7 million, or 24.7%. Our effective tax rate was 39.2% for the three months ended June 30, 2009 as compared to 39.6% for the three months ended June 30, 2008.

Table of Contents

Six Months Ended June 30, 2009 Compared to Six Months Ended June 30, 2008

	Six Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Revenue	$ 262,463	$ 229,097	$ 33,366	14.6%
Number of facilities at period end	70	62	8	12.9%
Actual patient days	1,143,357	1,059,379	83,978	7.9%
Occupancy percentage Operational beds	79.6%	81.5%		(1.9)%
Skilled mix by nursing days	24.8%	25.4%		(0.6)%
Skilled mix by revenue	48.3%	49.2%		(0.9)%

	Six Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Revenue	$ 243,696	$ 228,034	$ 15,662	6.9%
Number of facilities at period end	61	61		0.0%
Actual patient days	1,049,358	1,054,776	(5,418)	(0.5)%
Occupancy percentage Operational beds	81.3%	81.6%		(0.3)%
Skilled mix by nursing days	25.8%	25.4%		0.4%
Skilled mix by revenue	49.8%	49.2%		0.6%

	Six Months Ended June 30,			
	2009	2008	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(2):				
Revenue	$ 18,766	$ 1,063	$ 17,703	NM %
Number of facilities at period end	9	1	8	NM %
Actual patient days	93,999	4,603	89,396	NM %
Occupancy percentage Operational beds	64.4%	66.2%		(1.8)%
Skilled mix by nursing days	13.1%	28.0%		(14.9)%
Skilled mix by revenue	28.6%	48.2%		(19.5)%

(1) Same Facility results represent all facilities operated for the entire comparable periods presented and excludes facilities

acquired subsequent to January 1, 2008.

(2) Recently Acquired Facility results include all facilities acquired subsequent to January 1, 2008.

Revenue. Revenue increased $33.4 million, or 14.6%, to $262.5 million for the six months ended June 30, 2009 compared to $229.1 million for the six months ended June 30, 2008. Of the $33.4 million increase, Medicare and managed care revenue increased $13.1 million, or 12.1%, other skilled revenue increased $1.0 million, or 23.4%, Medicaid custodial revenue increased $15.5 million, or 17.2%, and private and other revenue increased $3.8 million, or 14.3%. This growth occurred despite an overall census decrease due to a reduction in the number of days in the year to 181 for the six months ended June 30, 2009 as compared to 182 for the six months ended June 30, 2008. The lower occupancy rate was primarily attributable to our Recently Acquired Facilities which had a combined occupancy rate of 64.4% and a decline in the occupancy rate of our assisted living facilities of 5.2%. Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix in Recently Acquired Facilities, and in the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. If this trend continues, we anticipate that our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio.

Revenue generated by Same Facilities increased $15.7 million, or 6.9%, for the six months ended June 30, 2009 as compared to the six months ended June 30, 2008. This increase was primarily due to an increase in skilled mix of 0.6% combined with higher acuity levels and higher reimbursement rates resulting from statutory increases relative to the six months ended June 30, 2008. The stable occupancy rate was negatively impacted by the unavailability of operational beds as we transition skilled nursing beds to include sub acute services and the continued inflow of residents to the additional 30 skilled nursing beds in our Walla Walla, WA facility.

Table of Contents

Approximately $17.7 million of the total revenue increase was due to revenue generated by Recently Acquired Facilities, which was primarily attributable to the current year operations at five skilled nursing facilities, one assisted living facility and one skilled nursing facility which also provides assisted living and independent living services acquired during the six months ended June 30, 2009 and one skilled nursing facility acquired in December 2008.

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

	Six Months Ended June 30,						
	Same Facility		Acquisitions		Total		
	2009	2008	2009	2008	2009	2008	% Change
Skilled Nursing Average Daily Revenue Rates:							
Medicare	$ 539.69	$ 495.09	$ 459.25	$ 400.64	$ 535.15	$ 494.48	8.2%
Managed care	336.60	322.87	419.62	376.40	338.73	323.06	4.9%
Other skilled	632.38	595.38			632.38	595.38	6.2%
Total skilled revenue	463.53	433.04	450.18	394.40	462.96	432.84	7.0%
Medicaid	160.24	149.59	163.52	180.68	160.51	149.70	7.2%
Private and other payors	178.96	166.88	182.00	137.31	179.43	166.60	7.7%
Total skilled nursing revenue	$ 240.27	$ 223.41	$ 205.36	$ 229.35	$ 237.43	$ 223.43	6.3%

The average Medicare daily rate increased by approximately 8.2% in the six months ended June 30, 2009 as compared to the six months ended June 30, 2008, as a result of higher acuity patient mix and an increase in the average Medicare rate of approximately 3.4% as a result of the market basket increase beginning in the fourth quarter of fiscal year 2008.

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

	Six Months Ended June 30,					
	Same Facility		Acquisitions		Total	
	2009	2008	2009	2008	2009	2008
Percentage of Skilled Nursing Revenue:						
Medicare	33.5%	33.5%	22.5%	36.4%	32.8%	33.5%
Managed care	14.1	13.8	6.1	11.8	13.5	13.8
Other skilled	2.2	1.9			2.0	1.9
Skilled mix	49.8	49.2	28.6	48.2	48.3	49.2
Private and other payors	8.6	9.6	21.4	15.4	9.5	9.6
Quality mix	58.4	58.8	50.0	63.6	57.8	58.8
Medicaid	41.6	41.2	50.0	36.4	42.2	41.2
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Six Months Ended June 30,		
	Same Facility	Acquisitions	Total

	2009	2008	2009	2008	2009	2008
Percentage of Skilled Nursing Days:						
Medicare	14.9%	15.1%	10.1%	20.8%	14.5%	15.2%
Managed care	10.1	9.6	3.0	7.2	9.5	9.5
Other skilled	0.8	0.7			0.8	0.7
Skilled mix	25.8	25.4	13.1	28.0	24.8	25.4
Private and other payors	11.6	12.8	24.1	25.8	12.6	12.8
Quality mix	37.4	38.2	37.2	53.8	37.4	38.2
Medicaid	62.6	61.8	62.8	46.2	62.6	61.8
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table of Contents

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $25.4 million, or 13.8%, to $209.5 million for the six months ended June 30, 2009 compared to $184.1 million for the six months ended June 30, 2008. Cost of services decreased as a percent of total revenue to 79.8% for the six months ended June 30, 2009 as compared to 80.3% for the six months ended June 30, 2008. Of the $25.4 million increase, $10.6 million was attributable to Same Facility increases and the remaining $14.8 million was attributable to Recently Acquired Facilities. The $10.6 million increase was primarily due to a $4.4 million increase in salaries and benefits, partially offset by a reduction in contract nursing services of $0.6 million, a $2.3 million increase in ancillary expenses, and a $2.2 million increase in insurance costs. The increase in salaries and benefits was primarily due to increases in nursing wages and benefits, a portion of which is attributable to replacing contract nursing labor with full time employees. The increase in ancillary expenses is primarily due to increased therapy expenses which correspond to increases in skilled mix. The increase in insurance costs was primarily a result of increased self-insured general and professional liability due to an increase in the level of self-insured deductible and higher actuarial projections for future claim settlements.

Facility Rent Cost of Services. Facility rent cost of services decreased $0.5 million, or 6.6%, to $7.4 million for the six months ended June 30, 2009 compared to $7.9 million for the six months ended June 30, 2008. Facility rent-cost of services decreased as a percent of total revenue to 2.8% for the six months ended June 30, 2009 as compared to 3.5% for the six months ended June 30, 2008. This decrease is due to a $0.8 million decrease as a result of our purchases of six previously leased properties during 2008. This decrease was partially offset by a $0.3 million increase in rent expense related to Recently Acquired Facilities and increases in rent at Same Facilities.

General and Administrative Expense. General and administrative expense increased $0.3 million, or 3.1%, to $10.4 million for the six months ended June 30, 2009 compared to $10.1 million for the six months ended June 30, 2008. General and administrative expense decreased as a percent of total revenue to 4.0% for the six months ended June 30, 2009 as compared to 4.4% for the six months ended June 30, 2008. The $0.3 million increase was primarily due to an increase in wages and benefits, largely due to increases in incentive compensation related to improved profitability and additional staffing in our accounting and legal departments.

We have, and will continue to experience higher stock-based compensation expense, which will impact cost of services and general and administrative expenses on a go forward basis until 2011, when the adoption date will no longer impact the expense calculation.

Depreciation and Amortization. Depreciation and amortization expense increased $2.0 million, or 48.3%, to $6.2 million for the six months ended June 30, 2009 compared to $4.2 million for the six months ended June 30, 2008. Depreciation and amortization expense increased as a percent of total revenue to 2.4% for the six months ended June 30, 2009 as compared to 1.8% for the six months ended June 30, 2008. This increase was related to the additional depreciation of Recently Acquired Facilities, as well as an increase in Same Facility depreciation expense due to purchases of six previously leased properties during 2008. In addition, amortization expense increased $0.4 million as compared to the six months ended June 30, 2008, related to the amortization of patient base intangible assets at Recently Acquired Facilities.

Other Income (Expense). Other expense, net increased $0.8 million, or 53.8%, to $2.3 million for the six months ended June 30, 2009 compared to $1.5 million for the six months ended June 30, 2008. Other expense, net increased as a percent of total revenue to 0.9% for the six months ended June 30, 2009 as compared to 0.7% for the six months ended June 30, 2008. This change was due to a $0.8 million decrease in interest income received for the six months ended June 30, 2009 compared to the six months ended June 30, 2008.

Provision for Income Taxes. Provision for income taxes increased $2.1 million, or 24.4%, to $10.6 million for the six months ended June 30, 2009 compared to $8.5 million for the six months ended June 30, 2008. This increase resulted from the increase in income before income taxes of $5.3 million, or 25.0%. Our effective tax rate was 39.6% for the six months ended June 30, 2009 as compared to 39.8% for the six months ended June 30, 2008.

Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flow from operations, long term debt secured by our real property and our Second Amended and Restated Loan and Security Agreement (the Revolver) with General Electric Capital Corporation (the Lender). As of June 30, 2009, the maximum available for borrowing

under the Revolver was approximately $50.0 million, subject to available collateral limits. During the six months ended June 30, 2009 and the year ended December 31, 2008, the amount of borrowing capacity pledged to secure outstanding letters of credit was $2.1 million. In addition, the Revolver includes provisions that allow the Lender to establish reserves against collateral for actual and contingent liabilities, a right which the Lender exercised with our cooperation in December 2008. This reserve restricts $6.0 million of our borrowing capacity, and may be reduced or eliminated based upon developments with respect to the ongoing U.S. Attorney investigation.

Since 2004, we have financed the majority of our facility acquisitions primarily through refinancing of existing facilities, and cash generated from operations or proceeds from our IPO. Cash paid for business acquisitions was $22.1 million and $9.4 million for the six months ended June 30, 2009 and 2008, respectively. Where we enter into a facility lease agreement, we typically do not pay any material amount to the prior facility operator, nor do we acquire any assets or assume any liabilities, other than our rights and obligations under the new lease and operations transfer agreement, as part of the transaction. Leases are included in the contractual obligations section below. Total capital expenditures for property and equipment were $11.7 million and $19.2 million for the six months ended June 30, 2009 and 2008, respectively. We currently have a combined $14.0 million budgeted for capital expenditure projects in 2009 and 2010.

Table of Contents

We believe our current cash balances, our cash flow from operations and the Revolver will be sufficient to cover our operating needs for at least the next 12 months. We may in the future seek to raise additional capital to fund growth, capital renovations, operations and other business activities, but such additional capital may not be available on acceptable terms, on a timely basis, or at all.

Our cash and cash equivalents as of June 30, 2009 consisted of bank term deposits, money market funds and treasury bill related investments. In addition, as of June 30, 2009, we held debt security investments of approximately $12.1 million, which are guaranteed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program upon maturity. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

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

	Six Months Ended June 30,	
	2009	2008
	(In thousands)	
Net cash provided by operating activities	$ 18,700	$ 24,585
Net cash used in investing activities	(24,072)	(21,374)
Net cash used in financing activities	(2,267)	(4,009)
Net increase (decrease) in cash and cash equivalents	(7,639)	(798)
Cash and cash equivalents at beginning of period	41,326	51,732
Cash and cash equivalents at end of period	$ 33,687	$ 50,934

Six Months Ended June 30, 2009 Compared to Six Months Ended June 30, 2008

Net cash provided by operations for the six months ended June 30, 2009 was $18.7 million compared to $24.6 million for the six months ended June 30, 2008, a decrease of $5.9 million. This decrease was primarily due to increases in outstanding accounts receivable balances and decreased cash disbursements related to prepaid income taxes in 2008 which did not recur in the current year. This increase was partially offset by our improved operating results, which contributed $24.3 million in 2009 after adding back depreciation and amortization, deferred income taxes, provision for doubtful accounts, stock-based compensation, excess tax benefit from share based compensation and loss on disposition of property and equipment (non-cash charges), as compared to $19.5 million for 2008, an increase of $4.8 million.

Net cash used in investing activities for the six months ended June 30, 2009 was $24.1 million compared to $21.4 million for the six months ended June 30, 2008, an increase of $2.7 million. The increase was the result of net $23.7 million in cash paid for business acquisitions and purchased property and equipment in the six months ended June 30, 2009 compared to $21.2 million in the six months ended June 30, 2008.

Net cash used in financing activities for the six months ended June 30, 2009 totaled $2.3 million compared to $4.0 million for the six months ended June 30, 2008, a decrease of $1.7 million. The decrease was primarily due to payment of the remaining principal balance on one mortgage note in April 2008, which did not recur in the current year. This decrease was partially offset by higher dividend payments during the six months ended June 30, 2009 as compared to the six months ended June 30, 2008.

35

Table of Contents

Principal Debt Obligations and Capital Expenditures

Revolving Credit Facility with General Electric Capital Corporation

On February 21, 2008, we amended our existing Revolver by extending the term to 2013, increasing the available credit thereunder up to the lesser of $50.0 million or 85% of the eligible accounts receivable, and changing the interest rate for all or any portion of the outstanding indebtedness thereunder to any of three options, as we may elect from time to time, (i) the 1, 2, 3 or 6 month LIBOR (at our option) plus 2.5%, or (ii) the greater of (a) prime plus 1.0% or (b) the federal funds rate plus 1.5% or (iii) a floating LIBOR rate plus 2.5%. In connection with the Revolver, we incurred financing costs of approximately $0.5 million. The Revolver contains typical representations and financial and non-financial covenants for a loan of this type, a violation of which could result in a default under the Revolver and could possibly cause all amounts owed by us to the Lender, including amounts due under the Third Amended and Restated Loan Agreement (the Term Loan), to be declared immediately due and payable. In addition, the Revolver includes provisions that allow the Lender to establish reserves against collateral for actual and contingent liabilities, a right which the Lender exercised with our cooperation in December 2008. This reserve restricts $6.0 million of our borrowing capacity, and may be reduced or eliminated based upon developments with respect to the ongoing U.S. Attorney investigation.

The proceeds of the loans under the Revolver have been and continue to be used for working capital and other expenses arising in our ordinary course of business.

The Revolver contains affirmative and negative covenants, including limitations on:

certain indebtedness;

certain investments, loans, advances and acquisitions;

certain sales or other dispositions of our assets;

certain liens and negative pledges;

financial covenants;

changes of control (as defined in the loan agreement);

certain mergers, consolidations, liquidations and dissolutions;

certain sale and leaseback transactions without the Lender s consent;

dividends and distributions during the existence of an event of default;

guarantees and other contingent liabilities;

affiliate transactions that are not in the ordinary course of business; and

certain changes in capital structure.

A violation of these or other representations or covenants of ours could result in a default under the Revolver and could possibly cause the entire amount outstanding under the Revolver and a cross-default of all amounts owed by us, including amounts due under the Term Loan, to be declared immediately due and payable.

In connection with the Revolver, the majority of our subsidiaries granted a first priority security interest to the Lender in, among other things: (1) all accounts, accounts receivable and rights to payment of every kind, contract rights, chattel paper, documents and instruments with respect thereto, and all of our rights, remedies, securities and liens in, to, and in respect of our accounts, (2) all moneys, securities, and other property and the proceeds thereof under the control of the Lender and its affiliates, (3) all right, title and interest in, to and in respect of all goods relating to or

resulting in accounts, (4) all deposit accounts into which our accounts are deposited, (5) general intangibles and other property of every kind relating to our accounts, (6) all other general intangibles, including, without limitation, proceeds from insurance policies, intellectual property rights, and goodwill, (7) inventory, machinery, equipment, tools, fixtures, goods, supplies, and all related attachments, accessions and replacements, and (8) proceeds, including insurance proceeds, of all of the foregoing. In the event of our default, the Lender has the right to take possession of the foregoing with or without judicial process.

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of our independent real estate holding subsidiaries jointly entered into the Term Loan with the Lender, which consists of an approximately $55.7 million multiple-advance term loan. The Term Loan matures on September 29, 2016, and is currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries.

The Term Loan has been funded in advances, with each advance bearing interest at a separate rate. The interest rates range from 6.95% to 7.50% per annum. The proceeds of the advances made under the Term Loan have been used to refinance an existing loan from the Lender secured by certain of the properties, and to purchase other additional properties that we were previously leasing.

Table of Contents

In connection with the Term Loan, we have guaranteed the payment and performance of all the obligations of our real estate holding subsidiaries under the loan documents for the Term Loan. In the event of our default under the Term Loan, all amounts owed by our subsidiaries, and guaranteed by us, under this loan agreement and any other loan with the Lender, including the Revolver discussed above, would become immediately due and payable. In addition, in the event of our default under the Term Loan, the Lender has the right to take control of our facilities encumbered by the loan to the extent necessary to make such payments and perform such acts required under the loan.

Under the Term Loan, we are subject to standard reporting requirements and other typical covenants for a loan of this type. Effective October 1, 2006 and continuing each calendar quarter thereafter, we are subject to restrictive financial covenants, including average occupancy, Debt Service (as defined in the agreement) and Project Yield (as defined in the agreement). As of June 30, 2009, we were in compliance with all loan covenants. As of June 30, 2009, our borrowing subsidiaries had $53.7 million outstanding on the Term Loan.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with the U.S. Department of Housing and Development, or HUD, which subjects our Southland facility to HUD oversight and periodic inspections. As of June 30, 2009, the balance outstanding on this mortgage loan was approximately $6.4 million. The unpaid balance of principal and accrued interest from this mortgage loan is due on February 1, 2027. The mortgage loan bears interest at the rate of 7.5% per annum.

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

Contractual Obligations, Commitments and Contingencies

We lease certain facilities and our Service Center office under operating leases, most of which have initial lease terms ranging from five to 20 years. Most of these leases contain options to renew or extend the lease term, some of which involve rent increases. We also lease a majority of our equipment under operating leases with initial terms ranging from three to five years. Total rent expense, inclusive of straight-line rent adjustments, was $3.8 million and $7.7 million for the three and six months ended June 30, 2009, respectively, and $4.3 million and $8.5 million for the three and six months ended June 30, 2008, respectively. In addition to the above, we lease one facility under a capital lease agreement with an initial lease term of 15 years.

In March 2007, we and certain of our officers received a series of notices from our bank indicating that the United States Attorney for the Central District of California had issued an authorized investigative demand, a request for records similar to a subpoena, to our bank. The U.S. Attorney subsequently rescinded that demand. The rescinded demand requested documents from our bank related to financial transactions involving us, ten of our operating subsidiaries, an outside investor group, and certain of our current and former officers. Subsequently, in June of 2007, the U.S. Attorney sent a letter to one of our current employees requesting a meeting. The letter indicated that the U.S. Attorney and the U.S. Department of Health and Human Services Office of Inspector General were conducting an investigation of claims submitted to the Medicare program for rehabilitation services provided at unspecified facilities. Although both we and the employee offered to cooperate, the U.S. Attorney later withdrew its meeting request.

On December 17, 2007, we were informed by Deloitte & Touche LLP, our independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of our operating subsidiaries. The subpoena confirmed our previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of our operating subsidiaries. All together, the March 2007 authorized investigative demand and the December 2007 subpoena specifically covered information from a total of 18 of our 70 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. Both we and the employees contacted have offered to cooperate and meet with the U.S. Attorney, however, to date, the U.S. Attorney has declined these offers. Based on these events, we believe that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group and one or more of our skilled nursing facilities.

Pursuant to these investigations, on December 17, 2008, representatives from the U.S. Department of Justice (DOJ) served search warrants on our Service Center and six of our Southern California skilled nursing facilities.

Following the execution of the warrants on the six facilities, a subpoena was issued covering eight additional facilities. Among other things, the warrants covered specific patient records at the six facilities. On May 4, 2009, the U.S. Attorney served a second subpoena requesting additional patient records on the same patients who were covered by the original warrants. We have worked with the U.S. Attorney s office to produce information responsive to both subpoenas. We and our regulatory counsel continue to actively work with the U.S. Attorney s office to determine what additional information, if any, will be assistive.

Table of Contents

We are cooperating with the U.S. Attorney s office, and will continue working with them to the extent they will allow us to help move their inquiry forward. To our knowledge, however, neither The Ensign Group, Inc. nor any of our operating subsidiaries or employees has been formally charged with any wrongdoing. We cannot predict or provide any assurance as to the possible outcome of the investigation or any possible related proceedings, or as to the possible outcome of any *qui tam* litigation that may follow, nor can we estimate the possible loss or range of loss that may result from any such proceedings and, therefore, we have not recorded any related accruals. To the extent the U.S. Attorney s office elects to pursue this matter, or if the investigation has been instigated by a *qui tam* relator who elects to pursue the matter, and we are subjected to or alleged to be liable for claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

We initiated an internal investigation in November 2006 when we became aware of an allegation of possible reimbursement irregularities at one or more of our facilities. This investigation focused on 12 facilities, and included all six of the facilities which were covered by the warrants served in December 2008. We retained outside counsel to assist us in looking into these matters. We and our outside counsel concluded this investigation in February 2008 without identifying any systemic or patterns and practices of fraudulent or intentional misconduct. We made observations at certain facilities regarding areas of potential improvement in some of our recordkeeping and billing practices and have implemented measures, some of which were already underway before the investigation began, that we believe will strengthen our recordkeeping and billing processes. None of these additional findings or observations appears to be rooted in fraudulent or intentional misconduct. We continue to evaluate the measures we have implemented for effectiveness, and we are continuing to seek ways to improve these processes.

As a byproduct of our investigation we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. We, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, we treated the claims as overpayments. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the year ended December 31, 2007, we accrued a liability of approximately $0.2 million, plus interest, for selected Medicare claims for which documentation has not been located or for other billing deficiencies identified to date. These claims have been submitted for settlement with the Medicare Fiscal Intermediary. If additional reviews result in identification and quantification of additional amounts to be refunded, we would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

See additional description of our contingencies in Note 14 in Notes to Condensed Consolidated Financial Statements.

Inflation

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

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

New Accounting Pronouncements

In June 2009, the FASB issued SFAS 168, *The FASB Accounting Standard Codification and the Heirarchy of Generally Accepted Accounting Principles a Replacement of FASB Statement No. 162* (the Codification) as a single source of authoritative nongovernmental U.S. Generally Accepted Accounting Principles (GAAP) to be launched

July 1, 2009. The Codification does not change current U.S. GAAP, but is intended to simplify user access to all authoritative U.S. GAAP by providing all the authoritative literature related to a particular topic in one place. The Codification is effective for interim and annual periods ending after September 15, 2009. The Codification is effective for us in the interim period ending September 30, 2009, and at that time all references made to U.S. GAAP will use the new Codification numbering system prescribed by the FASB. However, as the Codification is not intended to change existing GAAP, it is not expected to have any impact on our financial position or cash flows.

Adoption of New Accounting Pronouncements

In May 2009, the FASB issued SFAS No. 165, *Subsequent Events* (SFAS 165) (or ASC section 855-10), which establishes general standards of accounting for and disclosure of events that occur after the balance sheet date, but before financial statements are issued or are available to be issued. SFAS 165 is effective prospectively for interim or annual financial periods ending after June 15, 2009. The Company s adoption of SFAS 165 during the second quarter of the fiscal year 2009 had no impact on its consolidated financial statements. We have evaluated subsequent events through August 6, 2009, the date of our issuance of the condensed consolidated financial statements.

Table of Contents

In April 2009, the FASB issued FASB Staff Position (FSP) FAS 107-1 and APB 28-1 (ASC 825-10-50), which expands the fair value disclosures required for all financial instruments within the scope of Statement 107 (ASC825-10-50) to interim periods for publicly traded entities. The FSP also requires entities to disclose the method(s) and significant assumptions used to estimate the fair value of financial instruments in financial statements on an interim basis and to highlight any changes of the methods and significant assumptions from prior periods. It does not require interim disclosures of credit or market risks also discussed in Statement 107. Our adoption of FSP FAS 107-1 and APB 28-1 had no impact on our consolidated financial statements.

In September 2006, the FASB issued SFAS No. 157, *Fair Value Measurements* (SFAS 157) (or ASC section 820-10), which defines fair value, establishes a framework for measuring fair value in accordance with GAAP, and requires enhanced disclosures about fair value measurements. SFAS 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007. In February 2008 the FASB issued FSP 157-2, *Effective Date of FASB Statement No. 157* , which delayed the effective date of SFAS 157 for non-financial assets and liabilities, other than those that are recognized or disclosed at fair value on a recurring basis, to fiscal years beginning after November 15, 2008. In addition, in October 2008, the FASB issued FSP FAS 157-3, *Determining the Fair Value of a Financial Assets When the Market for That Asset is Not Active* (FSP FAS 157-3) , which clarifies the application of SFAS 157 in an inactive market and to illustrate how an entity would determine fair value in an inactive market. Our adoption of SFAS 157 and related FSPs for non-financial assets and liabilities had no impact on our consolidated financial statements.

In December 2007, the FASB issued SFAS No. 141(R), *Business Combinations* (SFAS 141(R)) (or ASC section 805), which replaces SFAS 141. The provisions of SFAS 141(R) are similar to those of SFAS 141; however, SFAS 141(R) requires companies to record most identifiable assets, liabilities, noncontrolling interests, and goodwill acquired in a business combination at full fair value. SFAS 141(R) also requires companies to record fair value estimates of contingent consideration and certain other potential liabilities during the original purchase price allocation and to expense acquisition costs as incurred. This statement applies to all business combinations, including combinations by contract alone. Further, under SFAS 141(R), all business combinations will be accounted for by applying the acquisition method. SFAS 141(R) is effective for fiscal years beginning on or after December 15, 2008. We adopted SFAS No. 141(R) at the beginning of fiscal year 2009. See Note 6 in Notes to the Condensed Consolidated Financial Statements and Management Discussion and Analysis for a description of the impact of this adoption on our consolidated financial position and results of operations.

In December 2007, the FASB issued SFAS No. 160, *Noncontrolling Interests in Consolidated Financial Statements* (SFAS 160) (or ASC section 810-10), which will require noncontrolling interests (previously referred to as minority interests) to be treated as a separate component of equity, not as a liability or other item outside of permanent equity. This Statement applies to the accounting for noncontrolling interests and transactions with non-controlling interest holders in consolidated financial statements. SFAS 160 will be applied prospectively to all noncontrolling interests, including any that arose before the effective date except that comparative period information must be recast to classify noncontrolling interests in equity, attribute net income and other comprehensive income to noncontrolling interests, and provide other disclosures required by Statement 160. Our adoption of SFAS 160 at the beginning of fiscal year 2009 had no impact on our consolidated financial statements.

In September 2008, the FASB finalized Staff Position (FSP) No. EITF 03-6-1, *Determining Whether Instruments Granted in Share-Based Payment Transactions Are Participating Securities* (FSP 03-6-1) (or ASC section 260-10). The FSP affects entities that accrue cash dividends on share-based payment awards during the awards service period when the dividends do not need to be returned if the employees forfeit the awards. The FASB concluded that all outstanding unvested share-based payment awards that contain rights to nonforfeitable dividends participate in undistributed earnings with common shareholders and therefore the issuing entity is required to apply the two-class method of computing basic and diluted earnings per share. The FSP is effective for fiscal years beginning after December 15, 2008, and interim periods within those fiscal years. Our adoption of FSP 03-6-1 at the beginning of fiscal year 2009 did not have a significant impact on our consolidated financial statements.

Item 3. ***Quantitative and Qualitative Disclosures about Market Risk***

Interest Rate Risk. We are exposed to interest rate changes in connection with the Revolver, which is available but is not regularly used to maintain liquidity and fund capital expenditures and operations. Our interest rate risk management objective is to limit the impact of interest rate changes on earnings and cash flows and to provide more predictability to our overall borrowing costs. To achieve this objective, we borrow primarily at fixed rates, although the Revolver is available and could be used for short-term borrowing purposes. At June 30, 2009, we had no outstanding floating rate debt.

Our cash and cash equivalents as of June 30, 2009 consisted of bank term deposits, money market funds and treasury bill related investments. In addition, as of June 30, 2009, we held debt security investments of approximately $12.1 million which are guaranteed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program upon maturity. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that exist as of June 30, 2009, and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Table of Contents

Item 4. ***Controls and Procedures***

Disclosure Controls and Procedures

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

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended June 30, 2009, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Part II. Other Information

Item 1. ***Legal Proceedings***

Certain legal proceedings in which we are involved are discussed in Part I, Item 3, of our Annual Report on Form 10-K for the year ended December 31, 2008. In addition, for more information regarding our legal proceedings, please see Note 14 included in Part 1, Item 1.

We are party to various legal actions and administrative proceedings and are subject to various claims arising in the ordinary course of business, including claims that our services have resulted in injury or death to the residents of our facilities and claims related to employment and commercial matters. Although we intend to vigorously defend ourselves in these matters, there can be no assurance that the outcomes of these matters will not have a material adverse effect on our results or operations and financial condition. In most states in which we have operations, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law public policy prohibitions. As such, we do not carry insurance coverage for punitive damages. There can be no assurance that we will not be liable for punitive damages awarded in litigation or that such an award if rendered would not have a material and adverse impact on our earnings or prospects.

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

Item 1A. ***Risk Factors***

Our operations and financial results are subject to various risks and uncertainties, including those described below, that could adversely affect our business, financial condition, results of operations, cash flows, and trading price of our common stock. Please refer also to our Annual Report on Form 10-K (File No. 001-33757) for additional information concerning these and other uncertainties that could negatively impact the Company.

Table of Contents

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 approximately 42% of our revenue from the Medicaid program for both periods during the three and six months ended June 30, 2009 and approximately 41% for both periods during the three and six months ended June 30, 2008, respectively. We derived approximately 33% of our revenue from the Medicare program for both periods during the three and six months ended June 30, 2009 and approximately 33% and 34% for the three and six months ended June 30, 2008, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our residents.

The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting base rates or basis of payment, retroactive rate adjustments, 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. The presidential budget submitted for federal fiscal year 2009 included proposed reforms of the Medicaid program to cut a total of $18 billion in Medicaid expenditures over the next five years. In addition, the American Recovery and Reinvestment Act passed in February 2009 contained several temporary measures expected to increase Medicaid expenditures. In order to qualify for increases in Medicaid matching funds from the federal government, states must refrain from implementing eligibility standards, methodologies or procedures that are more restrictive than those in effect as of July 1, 2008. Implementation of these and other 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.

Recently, the President and members of Congress proposed significant reforms to the U.S. healthcare system. Both the U.S. Senate and House of Representatives have conducted hearings about U.S. healthcare reform. In the administration s fiscal year 2010 federal budget proposal, the administration emphasized maintaining patient choice, reducing inefficiencies and costs, increasing prevention programs, increasing coverage portability and universality, improving quality of care and maintaining fiscal sustainability. The administration s fiscal year 2010 budget included proposals to limit Medicare payments, reduce drug spending and increase taxes. In addition, members of Congress have proposed a single-payer healthcare system, a government health insurance option to compete with private plans and other expanded public healthcare measures.

We cannot predict what healthcare initiatives, if any, will be implemented, or the effect any future legislation or regulation will have on us. However, an expansion in government s role in the U.S. healthcare industry may lower reimbursements and adversely affect our business.

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 implements

spending cuts in several areas, including Medi-Cal spending. Some of the spending cuts are triggered only if an inadequate amount of federal funding is received from the American Recovery and Reinvestment Act of 2009 described above. In July 2009, the State amended the budget for the fiscal year beginning July 1, 2009 to include another $24 billion in solutions to address the further deterioration of the state s fiscal situation identified in the May Budget Revision. This amendment included reductions to Medi-Cal spending of $1.4 billion. However, we anticipate overall reimbursement from Medi-Cal will remain stable. Any decrease in California s Medi-Cal spending for skilled nursing facilities could adversely affect our financial condition and results of operation. 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. We expect continuing cost containment pressures on Medicaid outlays for skilled nursing facilities.

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.

Table of Contents

If Medicare reimbursement rates decline, our revenue, financial condition and results of operations could be adversely affected.

Over the past several years, the federal government has periodically changed various aspects of Medicare reimbursements for skilled nursing facilities. Medicare Part A covers inpatient hospital services, skilled nursing care and some home healthcare. Medicare Part B covers physician and other health practitioner services, some supplies and a variety of medical services not covered under Medicare Part A.

Medicare coverage of skilled nursing services is available only if the patient is hospitalized for at least three consecutive days, the need for such services is related to the reason for the hospitalization, and the patient is admitted to the facility within 30 days following discharge from a Medicare participating hospital. Medicare coverage of skilled nursing services is limited to 100 days per benefit period after discharge from a Medicare participating hospital or critical access hospital. The patient must pay coinsurance amounts for the twenty-first day and each of the remaining days of covered care per benefit period.

Medicare payments for skilled nursing services are paid on a case-mix adjusted per diem prospective payment system (PPS) for all routine, ancillary and capital-related costs. The prospective payment for skilled nursing services is based solely on the adjusted federal per diem rate. On July 31, 2009, CMS released its final rule on the fiscal year 2010 PPS reimbursement rates for skilled nursing facilities, which resulted in a 2.2% market basket increase. The fiscal year 2010 recalibration of the case mix index (CMI) is expected to correct a forecast error resulting in a 3.3% rate reduction.

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

Skilled nursing facility prospective payment rates, as they may change from time to time, may be insufficient to cover our actual costs of providing skilled nursing services to Medicare patients. In addition, we may not be fully reimbursed for all services for which each facility bills through consolidated billing. If Medicare reimbursement rates decline, it could adversely affect our revenue, financial condition and results of operations.

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Private pay sources also reserve the right to conduct audits. An adverse review, audit or investigation could result in:

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

an increase in private litigation against us; and

damage to our reputation in various markets.

Table of Contents

We believe that billing and reimbursement errors and disagreements are common in our industry. We are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the processes related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce.

In 2004, our Medicare fiscal intermediary began to conduct selected reviews of claims previously submitted by and paid to some of our facilities. While we have always been subject to post-payment audits and reviews, more intensive probe reviews appear to be a permanent procedure with our fiscal intermediary.

In some cases, probe reviews can also result in a facility being temporarily placed on prepayment review of reimbursement claims, requiring additional documentation and adding steps and time to the reimbursement process for the affected facility. Payment delays resulting from the prepayment review process could have an adverse effect on our cash flow, and such adverse effect could be material if multiple facilities were placed on prepayment review simultaneously.

Failure to meet claim filing and documentation requirements during the prepayment review could subject a facility to an even more intensive targeted review, where a corrective action plan addressing perceived deficiencies must be prepared by the facility and approved by the fiscal intermediary. During a targeted review, additional claims are reviewed pre-payment to ensure that the prescribed corrective actions are being followed. Failure to make corrections or to otherwise meet the claim documentation and submission requirements could eventually result in Medicare decertification.

Separately, in 2006, the federal government introduced a program that utilizes independent contractors (other than the fiscal intermediaries) known as recovery audit contractors to identify and recoup Medicare overpayments. These recovery audit contractors are paid a contingent fee based on recoupments. In October 2008, this program was permanently implemented and requires the expansion of the program to all 50 states by no later than 2010. We anticipate that the number of overpayment reviews could increase in the future, and that the reviewers could be more aggressive in making claims for recoupment. In 2006, one of our facilities was subjected to review under this program, resulting in a recoupment to the federal government of approximately $12,000. If future Medicare reviews result in significant refund payments to the federal government, it would have an adverse effect on our financial results.

The reduction in overall Medicaid and Medicare spending pursuant to the Deficit Reduction Act of 2005 and the increased costs to comply with the Deficit Reduction Act of 2005 could adversely affect our revenue, financial condition or results of operations.

The DRA provides for a reduction in overall Medicaid and Medicare spending by approximately $11.0 billion over five years. Under the DRA, individuals who transferred assets for less than fair market value during a five year look-back period will be ineligible for Medicaid for so long as they would have been able to fund their cost of care absent the transfer or until the transfer would no longer have been made during the look-back period. This period is referred to as the penalty period. The DRA also changes the calculation for determining when the penalty period begins, and prohibits states from ignoring small asset transfers and other asset transfer mechanisms. In addition, the legislation reduces Medicare skilled nursing facility bad debt payments by 30% for those individuals who are not dually eligible for Medicaid and Medicare. If any of our existing Medicaid patients become ineligible under the DRA during their stay, it would be difficult for us to collect from them or transfer them, and our revenue could decrease without a corresponding decrease in expenses related to the care of those patients. The loss of revenue associated with potential reductions in skilled nursing facility payments could adversely affect our revenue, financial condition or results of operations. The DRA also requires entities which receive at least $5.0 million in annual Medicaid dollars each year to provide education to their employees concerning false claims laws and protections for whistleblowers. The DRA also requires those entities to provide contractors and vendors with similar information. As a result, we have and will continue to expend resources to meet these requirements. Further, the requirement that we provide education to employees and contractors regarding false claims laws and other fraud and abuse laws may result in increased investigations into these matters.

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

Some of our rehabilitation therapy revenue is paid by the Medicare Part B program under a fee schedule. Congress has established annual caps that limit the amounts that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to any Medicare beneficiary under Medicare Part B. The BBA requires a combined cap for physical therapy and speech-language pathology and a separate cap for occupational therapy. Due to a series of moratoria enacted subsequent to the BBA, the caps were only in effect in 1999 and for a few months in 2003. With the expiration of the most recent moratorium, the caps were reinstated on January 1, 2006 at $1,740 for physical therapy and speech therapy, and $1,740 for occupational therapy. Each of these caps increased to $1,780 on January 1, 2007, $1,810 on January 1, 2008 and $1,840 on January 1, 2009.

Table of Contents

The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006 for patients with certain conditions or multiple complexities whose therapy services are reimbursed under Medicare Part B. A significant portion of the residents in our skilled nursing facilities and patients served by our rehabilitation therapy programs whose therapy is reimbursed under Medicare Part B have qualified for the exceptions to these reimbursement caps. On July 15, 2008, the Medicare Improvements for Patients and Providers Act of 2008 extended the exceptions to these therapy caps until December 31, 2009.

The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond December 31, 2009, which could also have an adverse effect on our revenue after that date.

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

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

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

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

We are subject to federal and state laws, such as the Federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, and the federal Stark laws, that govern financial and other arrangements among healthcare providers, their owners, vendors and referral sources, and that are intended to prevent healthcare fraud and abuse. Among other things, these laws prohibit kickbacks, bribes and rebates, as well as other direct and indirect payments or fee-splitting arrangements that are designed to induce the referral of patients to a particular provider for medical products or services payable by any federal healthcare program, and prohibit presenting a false or misleading claim for payment under a federal or state

program. They also prohibit some physician self-referrals. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. Changes in these laws could increase our cost of doing business. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations, refund payments to the government, enter into corporate integrity, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

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 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.

Table of Contents

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

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

Any changes in the interpretation and enforcement of the laws or regulations governing our business could cause us to modify our operations, increase our cost of doing business and subject us to potential regulatory action.

The interpretation and enforcement of federal and state laws and regulations governing our operations, including, but not limited to, laws and regulations relating to Medicaid and Medicare, the Federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, the federal Stark laws, and HIPAA, are subject to frequent change. Governmental authorities may interpret these laws in a manner inconsistent with our interpretation and application. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations and reduce, forego or refund reimbursements to the government, or incur other significant penalties. We could also be compelled to divert personnel and other resources to responding to an investigation or other enforcement action under these laws or regulations, or to ongoing compliance with a corporate integrity agreement, deferred prosecution agreement, court order or similar agreement. The diversion of these resources, including our management team, clinical and compliance staff, and others, would take away from the time and energy these individuals devote to routine operations. Furthermore, federal, state and local officials are increasingly focusing their efforts on enforcement of these laws, particularly with respect to providers who share common ownership or control with other providers. The increased enforcement of these requirements could affect our ability to expand into new markets, to expand our services and facilities in existing markets and, if any of our presently licensed facilities were to operate outside of its licensing authority, may subject us to penalties, including closure of the facility.

We are unable to predict the intensity of federal and state enforcement actions or the areas in which regulators may choose to focus their investigations at any given time. Changes in government agency interpretation of applicable regulatory requirements, or changes in enforcement methodologies, including increases in the scope and severity of deficiencies determined by survey or inspection officials, could increase our cost of doing business. Furthermore, should we lose licenses or certifications for any of our facilities as a result of changing regulatory interpretations, enforcement actions or otherwise, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness and lease obligations.

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

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

- cost reporting and billing practices;

quality of care;

financial relationships with referral sources; and

medical necessity of services provided.

Table of Contents

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

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

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

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

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

Public and governmental calls for increased survey and enforcement efforts against long-term care facilities could result in increased scrutiny by state and federal survey agencies.

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. CMS is taking steps to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to

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

Table of Contents

In addition, CMS has adopted, and is considering additional regulations expanding federal and state authority to impose civil monetary penalties in instances of noncompliance. When a facility is found to be deficient under state licensing and Medicaid and Medicare standards, sanctions may be threatened or imposed such as denial of payment for new Medicaid and Medicare admissions, civil monetary penalties, focused state and federal oversight and even loss of eligibility for Medicaid and Medicare participation or state licensure. Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance. Facilities with otherwise acceptable regulatory histories generally are given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within six months, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility s existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously-certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators. In addition, CMS has increased its focus on facilities with a history of serious quality of care problems through the special focus facility initiative. A facility s administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility s compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility graduates from the program once it demonstrates significant improvements in quality of care that are continued over time. We have had several facilities placed on special focus facility status, due largely or entirely to their respective regulatory histories prior to our acquisition of the operations, and have successfully graduated three of them from the program to date. We currently have one facility operating under special focus status, and the state survey agency has indicated that some or all of the historical non-compliance considered in placing this facility on special focus status predated our late 2006 acquisitions of the facility.

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

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

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

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

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

Table of Contents

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

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

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

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

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

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

Our revenue is affected by the percentage of our patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. Governmental payment programs are subject to statutory and regulatory changes, retroactive rate adjustments, administrative or executive orders and government funding restrictions, all of which may materially increase or decrease the rate of program payments to us for our services. For both periods during the three and six months ended June 30, 2009, approximately 75% of our revenue was provided by government payors that reimburse us at predetermined rates. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of our patients for whom we receive

Medicaid reimbursement, our results of operations may be adversely affected.

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

Table of Contents

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

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

We operate one or more skilled nursing facilities in the states of California, Arizona, Texas, Washington, Utah, Colorado and Idaho. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities operating in that state. In California, the Department of Health Services (DHS) enforces legislation that requires each skilled nursing facility to provide a minimum of 3.2 nursing hours per patient day. DHS enforces this requirement primarily through on-site reviews conducted during periodic licensing and certification surveys and in response to complaints. If a facility is determined to be out of compliance with this minimum staffing requirement, DHS may issue a notice of deficiency, or a citation, depending on the impact on patient care. A citation carries with it the imposition of monetary fines that can range from $100 to $100,000 per citation. The issuance of either a notice of deficiency or a citation requires the facility to prepare and implement an acceptable plan of correction. If we are unable to satisfy the minimum staffing requirements required by DHS, we could be subject to significant monetary fines. In addition, if DHS 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.

Washington requires that at least one registered nurse directly supervise resident care for a minimum of 16 hours per day, seven days per week, and that one registered nurse or licensed practical nurse directly supervise resident care during the remaining eight hours per day, seven days per week. State regulators may inspect skilled nursing facilities at any time to verify compliance with these requirements. If deficiencies are found, regulators may issue a citation and require the facility to prepare and execute a plan of correction. Failure to satisfactorily complete a plan of correction can result in civil fines of between $50 and $3,000 per day or between $1,000 and $3,000 per instance. Failure to correct deficiencies can also result in the suspension, revocation or nonrenewal of the skilled nursing facility s license. In addition, deficiencies can result in the suspension of resident admissions and/or the termination of Medicaid participation. If we are unable to satisfy the minimum staffing requirements in Washington, we could be subject to monetary fines and potential loss of license.

In Idaho, skilled nursing facilities with 59 or fewer residents must provide an average of 2.4 nursing hours per resident per day, including the supervising nurse s hours. Skilled nursing facilities with 60 or more residents must provide an average of 2.4 nursing hours per resident per day, excluding the supervising nurse s hours. A facility complies with these requirements if the total nursing hours for the previous seven days equal or exceed the minimum staffing ratio for the period, averaged on a daily basis, if the facility has received prior approval to calculate nursing hours in this manner. State regulators may inspect a facility at any time to verify compliance with these requirements. If any deficiencies are found and not timely or adequately corrected, regulators can revoke the facility s skilled nursing facility license. If we are unable to satisfy the minimum staffing requirements in Idaho, we could be subject to potential loss of our license.

Texas requires that a facility maintain a ratio of one licensed nursing staff person for each 20 residents for every 24 hour period, or a minimum of 0.4 licensed-care hours per resident day. State regulators may inspect a facility at any time to verify compliance with these requirements. Uncorrected deficiencies can result in the civil fines of between $100 and $10,000 per day per deficiency. Failure to correct deficiencies can further result in the revocation of the facility s skilled nursing facility license. In addition, deficiencies can result in the suspension of patient admissions and/or the termination of Medicaid participation. If we are unable to satisfy the minimum staffing requirements in

Texas, we could be subject to monetary fines and potential loss of our license.

Arizona requires that at least one nurse must be present and responsible for providing direct care to not more than 64 residents. State regulators may impose civil fines for a facility s failure to comply with the laws and regulations governing skilled nursing facilities. Violations can result in civil fines in an amount not to exceed $500 per violation. Each day that a violation occurs constitutes a separate violation. In addition, such noncompliance can result in the suspension or revocation of the facility s license. If we are unable to satisfy the minimum staffing requirements in Arizona, we could be subject to fines and/or revocation of license.

Table of Contents

In Colorado, skilled nursing facilities with 59 or fewer residents must provide an average of 2.0 nursing hours per resident per day, including the supervising nurse s hours. Skilled nursing facilities with 60 residents or more must provide an average of 2.0 nursing hours per resident per day, excluding the supervising nurse s hours. Violations can result in civil money penalties in an amount not less than $100 per day or more than $10,000 per day for each day the facility is found to have been in violation. Failure to correct deficiencies can result in further civil penalties and/or denial of payment under the state plan.

Utah has no state-specific minimum staffing requirement beyond those required by federal regulations. Federal law requires that a facility have sufficient nursing staff to provide nursing and related services. Sufficient staff means, unless waived under certain circumstances, a licensed nurse to function as the charge nurse, and the services of a registered nurse for at least eight consecutive hours per day, seven days per week.

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.

Increased competition for or a shortage of nurses or other trained personnel, or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge to our patients. Turnover rates and the magnitude of the shortage of nurses or other trained personnel vary substantially from facility to facility. An increase in costs associated with, or a shortage of, skilled nurses, could negatively impact our business. In addition, if we fail to attract and retain qualified and skilled personnel, our ability to conduct our business operations effectively would be harmed.

Compliance with State and Federal Employment, Immigration, Licensing and Other Laws Could Increase our Cost of Doing Business.

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

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

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

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

In addition, plaintiffs attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers and other long-term care companies, and have employed a wide variety of advertising and publicity strategies. Among other things, these strategies include establishing their own Internet websites, paying for premium advertising space on other websites, paying Internet search engines to optimize their plaintiff solicitation advertising so that it appears in advantageous positions on Internet search results, including results from searches for our company and facilities, using newspaper, magazine and television ads targeted at customers of the healthcare industry generally, as well as at customers of specific providers, including us. From time to time, law firms claiming to specialize in long-term care litigation have named us, our facilities and other specific healthcare providers and facilities in their advertising and solicitation materials. These advertising and solicitation

activities could result in more claims and litigation, which could increase our liability exposure and legal expenses, divert the time and attention of our personnel from day-to-day business operations, and materially and adversely affect our financial condition and results of operations. Furthermore, to the extent the frequency and/or severity of losses from such claims and suits increases, our liability insurance premiums could increase and/or available insurance coverage levels could decline, and materially and adversely affect our financial condition and results of operations. Certain lawsuits filed on behalf of patients of long-term care facilities for alleged negligence and/or alleged abuses have resulted in large damage awards against other companies, both in and related to our industry. In addition, there has been an increase in the number of class action suits filed against long-term and rehabilitative care companies. A class action suit was previously filed against us alleging, among other things, violations of certain California Health and Safety Code provisions and a violation of the California Consumer Legal Remedies Act at certain of our facilities. We settled this class action suit and this settlement was approved by the affected class and the Court in April 2007. However, we could be subject to similar actions in the future.

Table of Contents

In addition to the class action, professional liability and other types of lawsuits and claims described above, we are also subject to potential lawsuits under the Federal False Claims Act and comparable state laws governing submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. These lawsuits, which may be initiated by the government or by a private party asserting direct knowledge of the claimed fraud or misconduct, can result in the imposition on a company of significant monetary damages, fines and attorney fees (a portion of which may be awarded to the private parties who successfully identify the subject practices), as well as significant legal expenses and other costs to the company in connection with defending against such claims. Insurance is not available to cover such losses. Penalties for Federal False Claims Act violations include fines ranging from $5,500 to $11,000 for each false claim, plus up to three times the amount of damages sustained by the federal government. A violation may also provide the basis for exclusion from federally-funded healthcare programs. If one of our facilities or key employees were excluded from such participation, such exclusion could have a correlative negative impact on our financial performance. In addition, some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations.

In addition, the DRA created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. The DRA sets forth standards for state false claims acts to meet, including: (a) liability to the state for false or fraudulent claims with respect to any expenditure described in the Medicaid program; (b) provisions at least as effective as federal provisions in rewarding and facilitating whistleblower actions; (c) requirements for filing actions under seal for sixty days with review by the state s attorney general; and (d) civil penalties no less than authorized under the federal statutes. As such, we could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in existing and future markets in which we do business. Any of this potential litigation could result in significant legal costs and large settlement amounts or damage awards.

In addition, we contract with a variety of landlords, lenders, vendors, suppliers, consultants and other individuals and businesses. These contracts typically contain covenants and default provisions. If the other party to one or more of our contracts were to allege that we have violated the contract terms, we could be subject to civil liabilities which could have a material adverse effect on our financial condition and results of operations.

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

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

As Medicare and Medicaid certified providers, our operating subsidiaries undergo periodic audits and probe reviews by government agents, which can result in recoupments of prior revenue of the government, cause further reimbursements to be delayed or held and could result in civil or criminal sanctions.

Our facilities undergo regular claims submission audits by government reimbursement programs in the normal course of their business, and such audits can result in adjustments to their past billings and reimbursements from such programs. In addition to such audits, several of our facilities have recently participated in more intensive probe reviews as described above, conducted by our Medicare fiscal intermediary. Some of these probe reviews identified patient miscoding, documentation deficiencies and other errors in recordkeeping and Medicare billing. If the government or court were to conclude that such errors and deficiencies constituted criminal violations, or were to conclude that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or

if it were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable levels, we and certain of our officers might face potential criminal charges and/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. Such amounts could include claims for treble damages and penalties of up to $11,000 per false claim submitted to a federal healthcare program.

In addition, we and/or some of our key personnel could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare. In any event, it is likely that a governmental investigation alone, regardless of its outcome, would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings.

Table of Contents

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

In March 2007, we and certain of our officers received a series of notices from our bank indicating that the United States Attorney for the Central District of California had issued an authorized investigative demand, a request for records similar to a subpoena, to our bank. The U.S. Attorney subsequently rescinded that demand. The rescinded demand requested documents from our bank related to financial transactions involving us, ten of our operating subsidiaries, an outside investor group, and certain of our current and former officers. Subsequently, in June of 2007, the U.S. Attorney sent a letter to one of our current employees requesting a meeting. The letter indicated that the U.S. Attorney and the U.S. Department of Health and Human Services Office of Inspector General were conducting an investigation of claims submitted to the Medicare program for rehabilitation services provided at unspecified facilities. Although both we and the employee offered to cooperate, the U.S. Attorney later withdrew its meeting request.

On December 17, 2007, we were informed by Deloitte & Touche LLP, our independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of our operating subsidiaries. The subpoena confirmed our previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of our operating subsidiaries. All together, the March 2007 authorized investigative demand and the December 2007 subpoena specifically covered information from a total of 18 of our 70 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. Both we and the employees contacted have offered to cooperate and meet with the U.S. Attorney, however, to date, the U.S. Attorney has declined these offers. Based on these events, we believe that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group and one or more of our skilled nursing facilities.

Pursuant to these investigations, on December 17, 2008, representatives from the U.S. Department of Justice (DOJ) served search warrants on our Service Center and six of our Southern California skilled nursing facilities. Following the execution of the warrants on the six facilities, a subpoena was issued covering eight additional facilities. Among other things, the warrants covered specific patient records at the six facilities. On May 4, 2009, the U.S. Attorney served a second subpoena requesting additional patient records on the same patients who were covered by the original warrants. We have worked with the U.S. Attorney s office to produce information responsive to both subpoenas. We and our regulatory counsel continue to actively work with the U.S. Attorney s office to determine what additional information, if any, will be assistive.

We are cooperating with the U.S. Attorney s office, and intend to continue working with them to the extent they will allow us to help move their inquiry forward. To our knowledge, however, neither The Ensign Group, Inc. nor any of its operating subsidiaries or employees has been formally charged with any wrongdoing. We cannot predict or provide any assurance as to the possible outcome of the investigation or any possible related proceedings, or as to the possible outcome of any *qui tam* litigation that may follow, nor can we estimate the possible loss or range of loss that may result from any such proceedings and, therefore, we have not recorded any related accruals. To the extent the U.S. Attorney s office elects to pursue this matter, or if the investigation has been instigated by a *qui tam* relator who elects to pursue the matter, and we are subjected to or alleged to be liable for claims or obligations under federal Medicare statutes, the federal False Claims Act, or similar state and federal statutes and related regulations, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

We conducted an internal investigation into the billing and reimbursement processes of some of our operating subsidiaries. Future reviews could result in additional billing and reimbursement noncompliance, which would also decrease our revenue.

We initiated an internal investigation in November 2006 when we became aware of an allegation of possible reimbursement irregularities at one or more of our facilities. This investigation focused on 12 facilities, and included all six of the facilities which were covered by the warrants served in December 2008. We retained outside counsel to assist us in looking into these matters. We and our outside counsel concluded this investigation in February 2008 without identifying any systemic or patterns and practices of fraudulent or intentional misconduct. We made observations at certain facilities regarding areas of potential improvement in some of our recordkeeping and billing

practices and have implemented measures, some of which were already underway before the investigation began, that we believe will strengthen our recordkeeping and billing processes. None of these additional findings or observations appears to be rooted in fraudulent or intentional misconduct. We continue to evaluate the measures we have implemented for effectiveness, and we are continuing to seek ways to improve these processes.

As a byproduct of our investigation we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. We, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, we treated the claims as overpayments. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the year ended December 31, 2007, we accrued a liability of approximately $224,000, plus interest, for selected Medicare claims for which documentation has not been located or for other billing deficiencies identified to date. These claims have been submitted for settlement with the Medicare Fiscal Intermediary. If additional reviews result in identification and quantification of additional amounts to be refunded, we would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

Table of Contents

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

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

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

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

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

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

So far, in 2009, we have acquired five skilled nursing facilities, one skilled nursing facility which also offers assisted living and independent living services and one assisted living facility with a total of 670 operational beds. In 2008, we acquired two skilled nursing facilities with a total of 199 operational beds. In 2007, we acquired three skilled nursing facilities and one campus that offers both skilled nursing and assisted living services, with a total of 438 operational beds. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such facilities quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our facility acquisitions, and our business may suffer.

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

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those facilities, against whom we may have little or no recourse. Many facilities we have

historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved operations and patient care at facilities that we have acquired, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant facilities into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often

Table of Contents

represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable. For example, in July of 2006 we acquired a facility that had a history of intermittent noncompliance. Although the facility had been already surveyed once by the local state survey agency after being acquired by us, and that survey would have met the heightened requirements of the special focus facility program, based upon the facility s compliance history prior to our acquisition, in January 2008, state officials nevertheless recommended to CMS that the facility be placed on special focus facility status. In addition, in October of 2006, we acquired a facility which had a history of intermittent non-compliance. This facility was surveyed by the local state survey agency during the third quarter of 2008 and passed the heightened survey requirements of the special focus facility program. Both facilities have successfully graduated from the Centers for Medicare and Medicaid Services Special Focus program. We currently have one facility remaining on special focus facility status.

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

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

We are subject to reviews relating to Medicare overpayments, which could result in recoupment to the federal government of Medicare revenue.

We are subject to reviews relating to Medicare services, billings and potential overpayments. Recent probe reviews, as described above, resulted in Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments of approximately $4,000 and $35,000 during the years ended December 31, 2008 and 2007, respectively. We anticipate that these probe reviews will increase in frequency in the future. In addition, two of our facilities are currently on prepayment review, and others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies. We have no facilities that are currently undergoing targeted review.

Potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our facilities. CMS has included one of our facilities on its recently released list of special focus facilities, which are described above and other facilities may be identified for

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

Table of Contents

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other enforcement actions. The diversion of these resources, including our management team, clinical and compliance staff, and others take away from the time and energy that these individuals could otherwise spend on routine operations. As noted, from time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. The focus of these deficiency reports tends to vary from year to year. Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility, which could result in the imposition of fines, imposition of a provisional or conditional license, suspension or revocation of a license, suspension or denial of payment for new admissions, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including criminal penalties. In the past, we have experienced inspection deficiencies that have resulted in the imposition of a provisional license and could experience these results in the future. We currently have one facility whereby the provisional license status is the result of inspection deficiencies. Furthermore, in some states citations in one facility impact other facilities in the state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew existing licenses at other facilities, which may also trigger defaults or cross-defaults under our leases and our credit arrangements, or adversely affect our ability to operate or obtain financing in the future. If state or federal regulators were to determine, formally or otherwise, that one facility s regulatory history ought to impact another of our existing or prospective facilities, this could also increase costs, result in increased scrutiny by state and federal survey agencies, and even impact our expansion plans. Therefore, our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations as a whole.

We may not be successful in generating internal growth at our facilities by expanding occupancy at these facilities. We also may be unable to improve patient mix at our facilities.

Overall operational occupancy across all of our facilities was approximately 79.6% and 81.5% for the six months ended June 30, 2009 and 2008, respectively, leaving opportunities for internal growth without the acquisition or construction of new facilities. Because a large portion of our costs are fixed, a decline in our occupancy could adversely impact our financial performance. In addition, our profitability is impacted heavily by our patient mix. We generally generate greater profitability from non-Medicaid patients. If we are unable to maintain or increase the proportion of non-Medicaid patients in our facilities, our financial performance could be adversely affected.

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

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

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

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

nursing and assisted living facilities, and with inpatient rehabilitation facilities, long-term acute care hospitals, home healthcare and other similar services and care alternatives. Increased competition could limit our ability to attract and retain patients, attract and retain skilled personnel, maintain or increase private pay and managed care rates or expand our business. Our ability to compete successfully varies from location to location depending upon a number of factors, including:

- our ability to attract and retain qualified facility leaders, nursing staff and other employees;
- the number of competitors in the local market;
- the types of services available;
- our local reputation for quality care of patients;
- the commitment and expertise of our staff;
- our local service offerings; and
- the cost of care in each locality and the physical appearance, location, age and condition of our facilities.

Table of Contents

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

Competition for the acquisition of strategic assets from buyers with lower costs of capital than us or that have lower return expectations than we do could limit our ability to compete for strategic acquisitions and therefore to grow our business effectively.

Several real estate investment trusts (REITs), other real estate investment companies, institutional lenders who have not traditionally taken ownership interests in operating businesses or real estate, as well as several skilled nursing and assisted living facility providers, have similar asset acquisition objectives as we do, along with greater financial resources and lower costs of capital than we are able to obtain. This may increase competition for acquisitions that would be suitable to us, making it more difficult for us to compete and successfully implement our growth strategy. Significant competition exists among potential acquirers in the skilled nursing and assisted living industries, including with REITs, and we may not be able to successfully implement our growth strategy or complete acquisitions, which could limit our ability to grow our business effectively.

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

CMS, as well as certain private organizations engaged in similar monitoring activities, provides comparative data available to the public on its web site, rating every skilled nursing facility operating in each state based upon quality-of-care indicators. These quality-of-care indicators include such measures as percentages of patients with infections, bedsores and unplanned weight loss. In addition, CMS has undertaken an initiative to increase Medicaid and Medicare survey and enforcement activities, to focus more survey and enforcement efforts on facilities with findings of substandard care or repeat violations of Medicaid and Medicare standards, and to require state agencies to use enforcement sanctions and remedies more promptly when substandard care or repeat violations are identified. For example, one of our facilities is now surveyed every six months instead of every 12 to 15 months as a result of historical survey results that may date back to prior operators. We have found a correlation between negative Medicaid and Medicare surveys and the incidence of professional liability litigation. From time to time, we experience a higher than normal number of negative survey findings in some of our facilities.

In December 2008, CMS introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each nursing home a rating of between one and five stars in various categories. Nursing homes with five stars are intended to be considered to have above average quality and nursing homes with one star are intended to be considered to have quality much below average. The overall five-star rating for each nursing home is determined using the following three sources of information:

Health Inspections the health inspection rating contains information from the last three years of onsite inspections, including both standard surveys and any complaint surveys.

Staffing the staffing rating is based on the number of hours of care on average provided to each resident each day by nursing staff.

Quality Measures the quality measure rating has information on ten different physical and clinical measures for nursing home residents, such as presence of pressure sores or changes to resident s mobility.

In cases of acquisitions, the previous operator s clinical ratings are included in our overall Five-Star Quality Rating. The prior operator s results will impact our rating until we have sufficient clinical measurements subsequent to the acquisition date.

If we are unable to achieve quality of care ratings that are comparable or superior to those of our competitors, our ability to attract and retain patients could be adversely affected.

Table of Contents

Significant legal actions and liability claims against us in excess of insurance limits or outside of our insurance coverage could subject us to increased insurance costs, litigation reserves, operating costs and substantial uninsured liabilities.

We maintain liability insurance policies in amounts and with coverage limits and deductibles we believe are appropriate based on the nature and risks of our business, historical experience, industry standards and the price and availability of coverage in the insurance market. At any given time, we may have multiple current professional liability cases and/or other types of claims pending, which is common in our industry. Since the inception of our current insurance policy, we have settled one claim in excess of the policy limits of our insurance coverages. We may face claims which exceed our insurance limits or are not covered by our policies.

We also face potential exposure to other types of liability claims, including, without limitation, directors and officers liability, employment practices and/or employment benefits liability, premises liability, and vehicle or other accident claims. Given the litigious environment in which all businesses operate, it is impossible to fully catalogue all of the potential types of liability claim that might be asserted against us. As a result of the litigation and potential litigation described above, as well as factors completely external to our company and endemic to the skilled nursing industry, during the past several years the overall cost of both general and professional liability insurance to the industry has dramatically increased, while the availability of affordable and favorable insurance coverage has dramatically decreased. If federal and state medical liability insurance reforms to limit future liability awards are not adopted and enforced, we expect that our insurance and liability costs may continue to increase.

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

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

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

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

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

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

57

Table of Contents

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

Since 2001, we have maintained worker s compensation and general and professional liability insurance through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our SIR and deductibles as part of a continually evolving overall risk management strategy. In addition, from 2001 to 2002, we used Standardbearer to reinsure a fronted professional liability policy, and we may elect to do so again in the future. We establish the premiums to be paid to Standardbearer, and the loss reserves set by that subsidiary, based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted. Further, because our SIR under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.

Our self-insured liabilities are based upon estimates, and while our management believes that the estimates of loss are appropriate, the ultimate liability may be in excess of, or less than, recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that we could experience changes in estimated losses which could be material to net income. We believe that we have recorded reserves for general liability, professional liability, worker s compensation and healthcare benefits, at a level which has substantially mitigated the potential negative impact of adverse developments and/or volatility. In addition, if coverage becomes too difficult or costly to obtain from insurance carriers, we would have to self-insure a greater portion of our risks.

In May 2006, we began self-insuring our employee health benefits. With respect to our health benefits self-insurance, we do not yet have a meaningful multi-year loss history by which to set reserves or premiums, and have consequently relied heavily on general industry data that is not specific to our own company to set reserves and premiums. Even with a combination of limited company-specific loss data and general industry data, our loss reserves are based on actuarial estimates that may not correlate to actual loss experience in the future. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.

In August 2008, Section 111 of the Medicare, Medicaid and State Children s Health Insurance Program (SCHIP) Extension Act of 2007 added new mandatory reporting requirements for group health plan (GHP) arrangements and for liability insurance (including self-insurance), no-fault insurance, and workers compensation. Under the new reporting requirements, self-insured employers and insurers will be required as of April 1, 2010 to report eligible workers compensation, liability and no-fault claims payments made (settlements, judgments, awards, etc.) on or after July 1, 2009 to a Medicare beneficiary.

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

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

natural disaster may not be covered by insurance or may exceed our insurance limits and may also lead to an increase in the cost of insurance.

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

We continue to maintain our right to inform our employees about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staffs at our facilities that have been approached to unionize have uniformly rejected union organizing efforts. Because a majority of certain categories of service and maintenance employees at one of our facilities voted to accept union representation, we had recognized the union and been engaged in collective bargaining with that union since 2005; however, in March 2008, a substantial majority of the represented employees at that facility petitioned to remove the union as their bargaining representative, and we acceded to their wishes by withdrawing recognition of the union. The union filed, withdrew and then re-filed an unfair labor charge opposing the withdrawal of recognition. The National Labor Relations Board (NLRB) subsequently rejected the charge and affirmed the propriety of our withdrawal of recognition, effectively terminating the union s representation of the employee group. If employees of other facilities decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, and strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.

Table of Contents

The unwillingness on the part of both our management and staff to accede to union demands for neutrality and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union actively prosecuted a negative retaliatory publicity action, also known as a corporate campaign, against us and filed, promoted or participated in multiple legal actions against us. The union s campaign asserted, among other allegations, poor treatment of patients, inferior medical services provided by our employees, poor treatment of our employees, and health code violations by us. In addition, the union has publicly mischaracterized actions taken by the DHS against us and our facilities. In numerous cases, the union s allegations created the false impression that violations and other events that occurred at facilities prior to our acquisition of those facilities were caused by us. Since a large component of our business involves acquiring underperforming and distressed facilities, and improving the quality of operations at these facilities, we may have been associated with the past poor performance of these facilities. To the extent this union or another elects to directly or indirectly prosecute a corporate campaign against us or any of our facilities, our business could be negatively affected.

This union, along with individuals and organizations allied with or sympathetic to this union, has demanded focused regulatory oversight and public boycotts of some of our facilities. It has also attempted to pressure hospitals, doctors, insurers and other healthcare providers and professionals to cease doing business with or referring patients to us. If this union or another union is successful in convincing our patients, their families or our referral sources to reduce or cease doing business with us, our revenue may be reduced and our profitability could be adversely affected. Additionally, if we are unable to attract and retain qualified staff due to negative public relations efforts by this or other union organizations, our quality of service and our revenue and profits could decline. Our strategy for responding to union allegations involves clear public disclosure of the union s identity, activities and agenda, and rebuttals to its negative campaign. Our ability to respond to unions, however, may be limited by some state laws, which purport to make it illegal for any recipient of state funds to promote or deter union organizing. For example, such a state law passed by the California Legislature was successfully challenged on the grounds that it was preempted by the National Labor Relations Act, only to have the challenge overturned by the Ninth Circuit in 2006 before being ultimately upheld by the United States Supreme Court in 2008. In addition, proposed legislation making it more difficult for employees and their supervisors to educate co-workers and oppose unionization, such as proposed Employer Free Choice Act which would allow organizing on a single card check and without a secret ballot, could make it more difficult to maintain union-free workplaces in our facilities. If proponents of these and similar laws are successful in facilitating unionization procedures or hindering employer responses thereto, our ability to oppose unionization efforts could be hindered, and our business could be negatively affected.

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

We currently occupy approximately 9% of our facilities under agreements that are structured as master leases. Under a master lease, we may lease a large number of geographically dispersed properties through an indivisible lease. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord. Failure to comply with Medicare or Medicaid provider requirements is a default under several of our master lease and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in our outstanding debt arrangements and other leases, which would have a negative impact on our capital structure and our ability to generate future revenue, and could interfere with our ability to pursue our growth strategy.

In addition, we occupy approximately 16% of our facilities under individual facility leases that are held by the same or related landlords, the largest of which covers five of our facilities. These leases typically contain cross-default provisions that could cause a default at one facility to trigger a technical default with respect to one or more other locations, potentially subjecting us to the various remedies available to the landlords under each of the related leases.

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

At June 30, 2009, we had $60.0 million of outstanding indebtedness under our Third Amended and Restated Loan Agreement (the Term Loan), our Second Amended and Restated Loan and Security Agreement (the Revolver) and mortgage notes, plus $118.8 million of capital and operating lease obligations. We intend to continue financing our facilities through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

Table of Contents

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

Because our Term Loan, mortgage and lease obligations are fixed expenses and secured by specific assets, and because our revolving loan obligations are secured by virtually all of our assets, if reimbursement rates, patient acuity mix or occupancy levels decline, or if for any reason we are unable to meet our loan or lease obligations, we may not be able to cover our costs and some or all of our assets may become at risk. Our ability to make payments of principal and interest on our indebtedness and to make lease payments on our operating leases depends upon our future performance, which will be subject to general economic conditions, industry cycles and financial, business and other factors affecting our operations, many of which are beyond our control. If we are unable to generate sufficient cash flow from operations in the future to service our debt or to make lease payments on our operating leases, we may be required, among other things, to seek additional financing in the debt or equity markets, refinance or restructure all or a portion of our indebtedness, sell selected assets, reduce or delay planned capital expenditures or delay or abandon desirable acquisitions. Such measures might not be sufficient to enable us to service our debt or to make lease payments on our operating leases. The failure to make required payments on our debt or operating leases or the delay or abandonment of our planned growth strategy could result in an adverse effect on our future ability to generate revenue and sustain profitability. In addition, any such financing, refinancing or sale of assets might not be available on terms that are economically favorable to us, or at all.

Our existing credit facilities and mortgage loans contain restrictive covenants and any default under such facilities or loans could result in a freeze on additional advances, the acceleration of indebtedness, the termination of leases, or cross-defaults, any of which would negatively impact our liquidity and inhibit our ability to grow our business and increase revenue.

Our outstanding credit facilities and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage and project yield. The debt service coverage ratios are generally calculated as revenue less operating costs, including an implied management fee and a reserve for capital expenditures, divided by the outstanding principal and accrued interest under the debt. These restrictions may interfere with our ability to obtain additional advances under existing credit facilities or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue. At times in the past we have failed to timely deliver audited financial statements to our lender as required under our loan covenants. In each such case, we obtained waivers from our lender. In addition, in December 2000, we were unable to make balloon payments due under two mortgages on one of our facilities, but we were able to negotiate extensions with both lenders, and paid off both loans in January 2001 as required by the terms of the extensions. If we fail to comply with any of our loan requirements, or if we experience any defaults, then the related indebtedness could become immediately due and payable prior to its stated maturity date. We may not be able

to pay this debt if it becomes immediately due and payable.

If we decide to expand our presence in the assisted living industry, we would become subject to risks in a market in which we have limited experience.

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

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

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

Table of Contents

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

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

The condition of the financial markets, including volatility and deterioration in the capital and credit markets, could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business.

Financial markets experienced significant disruptions in 2008, which is continuing in 2009. These disruptions have impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. As a result of these market conditions, the cost and availability of credit has been and may continue to be adversely affected by illiquid credit markets and wider credit spreads. Concern about the stability of the markets has led many lenders and institutional investors to reduce, and in some cases, cease to provide credit to borrowers. These factors have led to a decrease in spending by businesses and consumers alike. Continued turbulence in the U.S. and prolonged declines in business and consumer spending may adversely affect our liquidity and financial condition. Though we anticipate that the cash amounts generated internally, together with amounts available under the Revolver, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available, or available on terms favorable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews. For example, in 2009, California again faced a budget impasse. In 2008, California delayed any reimbursement subsequent to the end of July until such time the budget was enacted. Further, and independent to the budget impasse, the State of California delayed all August 2008 payments until September. We anticipate similar reimbursement delays will continue in future fiscal years on a permanent basis. Medi-Cal had also delayed reimbursement of rate increases which were announced in November 2008. These rate increases were put in place on a retrospective basis, effective August 1, 2008. In January 2009, the State of California announced expected cash shortages in February which impacted payments to Medi-Cal providers from late March through April. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. Our working capital management procedures may not successfully ameliorate the effects of any delays in our receipt of payments or reimbursements. Accordingly, such delays could have an adverse effect on our liquidity and financial condition.

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

Four of our facilities are currently subject to regulatory agreements with the Department of Housing and Urban Development (HUD) that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection, which we are currently awaiting. If our facility fails the re-inspection, the HUD Commissioner could exercise its authority to replace us as the facility operator. In such event, we could be forced to repay the HUD mortgage on this facility to avoid being replaced as the facility operator, which would negatively impact our cash and financial condition. The balance on this mortgage as of June 30, 2009 was approximately $6.4 million. In addition, we would be required to pay a prepayment penalty of approximately $0.1 million if this mortgage was repaid on June 30, 2009. This alternative is not available to us if any of our other three HUD-insured facilities were determined by HUD to be operationally deficient because they are leased facilities. Compliance with HUD s requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

Table of Contents

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

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

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

Some of the facilities we lease, own or may acquire may have asbestos-containing materials. Federal regulations require building owners and those exercising control over a building s management to identify and warn their employees and other employers operating in the building of potential hazards posed by workplace exposure to installed asbestos-containing materials and potential asbestos-containing materials in their buildings. Significant fines can be assessed for violation of these regulations. Building owners and those exercising control over a building s management may be subject to an increased risk of personal injury lawsuits. Federal, state and local laws and regulations also govern the removal, encapsulation, disturbance, handling and disposal of asbestos-containing materials and potential asbestos-containing materials when such materials are in poor condition or in the event of construction, remodeling, renovation or demolition of a building. Such laws may impose liability for improper handling or a release into the environment of asbestos containing materials and potential asbestos-containing materials and may provide for fines to, and for third parties to seek recovery from, owners or operators of real properties for personal injury or improper work exposure associated with asbestos-containing materials and potential asbestos-containing materials. The presence of asbestos-containing materials, or the failure to properly dispose of or remediate such materials, also may adversely affect our ability to attract and retain patients and staff, to borrow when using such property as collateral or to make improvements to such property.

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

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

We are unable to predict the future course of federal, state and local environmental regulation and legislation. Changes in the environmental regulatory framework could result in increased costs. In addition, because environmental laws vary from state to state, expansion of our operations to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our facilities.

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

Each of our facilities is required by federal law to maintain a patient trust fund to safeguard certain assets of their residents and patients. If any money held in a patient trust fund is misappropriated, we are required to reimburse the patient trust fund for the amount of money that was misappropriated. In 2005 we became aware of two separate and unrelated instances of employees misappropriating an aggregate of approximately $380,000 in patient trust funds, some of which was recovered from the employees and some of which we were required to reimburse from our funds. If any monies held in our patient trust funds are misappropriated in the future and are unrecoverable, we will be required to reimburse such monies, and we may be subject to citations, fines and penalties pursuant to federal and

state laws.

Table of Contents

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

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

Risks Related to Ownership of our Common Stock

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

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

While we do not have a formal dividend policy, we currently intend to continue to pay regular quarterly dividends to the holders of our common stock, but future dividends will continue to be at the discretion of our board of directors and will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, restrictions imposed by financing arrangements including pursuant to the loan and security agreement governing our revolving line of credit, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. From 2002 through 2008, we paid aggregate annual dividends equal to approximately 5% to 15% of our net income. We may not be able to pay or maintain dividends, and we may at any time elect not to pay dividends but to retain cash for other purposes. We also cannot assure you that the level of dividends will be maintained or increase over time or that increases in demand for our beds and monthly patient fees will increase our actual cash available for dividends to stockholders. It is possible that we may pay dividends in a future period that may exceed our net income for such period. The failure to pay or maintain dividends could adversely affect our stock price.

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

Our current executive officers, directors and their affiliates, if they act together, will have substantial control over the outcome of corporate actions requiring stockholder approval, including the election of directors, any merger, consolidation or sale of all or substantially all of our assets or any other significant corporate transactions. These stockholders may also delay or prevent a change of control of us, even if such a change of control would benefit our other stockholders. The significant concentration of stock ownership may adversely affect the trading price of our common stock due to investors perception that conflicts of interest may exist or arise.

If securities or industry analysts do not publish research or reports about our business, if they change their recommendations regarding our stock adversely or if our operating results do not meet their expectations, our stock price and trading volume could decline.

The trading market for our common stock is influenced by the research and reports that industry or securities analysts publish about us or our business. If one or more of these analysts cease coverage of our company or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our

operating results do not meet their expectations, our stock price could decline.

Table of Contents

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

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

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

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

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

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

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

The requirements of being a public company, including compliance with the reporting requirements of the Securities Exchange Act of 1934, as amended, and the requirements of the Sarbanes-Oxley Act of 2002, may strain our resources, increase our costs and distract management, and we may be unable to comply with these requirements in a timely or cost-effective manner.

As a public company, we need to comply with laws, regulations and requirements, certain corporate governance provisions of the Sarbanes-Oxley Act of 2002, related regulations of the Securities and Exchange Commission, and requirements of NASDAQ. As a result, we will incur significant legal, accounting and other expenses. Complying with these statutes, regulations and requirements occupies a significant amount of the time of our board of directors and management, requires us to have additional finance and accounting staff, makes it difficult to attract and retain

qualified officers and members of our board of directors, particularly to serve on our audit committee, and makes some activities difficult, time consuming and costly.

If we are unable to fulfill the requirements related to being a public company in a timely and effective fashion, our ability to comply with our financial reporting requirements and other rules that apply to reporting companies could be impaired. If our finance and accounting personnel insufficiently support us in fulfilling these public-company compliance obligations, or if we are unable to hire adequate finance and accounting personnel, we could face significant legal liability, which could have a material adverse effect on our financial condition and results of operations. Furthermore, if we identify any issues in complying with those requirements (for example, if we or our independent registered public accountants identified a material weakness in our internal control over financial reporting), we could incur additional costs rectifying those issues, and the existence of those issues could adversely affect us, our reputation or investor perceptions of us.

Table of Contents

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

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

- our board of directors are authorized, without prior stockholder approval, to create and issue preferred stock, commonly referred to as blank check preferred stock, with rights senior to those of common stock;
- advance notice requirements for stockholders to nominate individuals to serve on our board of directors or to submit proposals that can be acted upon at stockholder meetings;
- our board of directors are classified so not all members of our board are elected at one time, which may make it more difficult for a person who acquires control of a majority of our outstanding voting stock to replace our directors;
- stockholder action by written consent is limited;
- special meetings of the stockholders are permitted to be called only by the chairman of our board of directors, our chief executive officer or by a majority of our board of directors;
- stockholders are not permitted to cumulate their votes for the election of directors;
- newly created directorships resulting from an increase in the authorized number of directors or vacancies on our board of directors are filled only by majority vote of the remaining directors;
- our board of directors is expressly authorized to make, alter or repeal our bylaws; and
- stockholders are permitted to amend our bylaws only upon receiving the affirmative vote of at least a majority of our outstanding common stock.

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

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

None.

Item 3. ***Defaults Upon Senior Securities***

None.

Item 4. ***Submission of Matters to a Vote of Security Holders***

Our Annual Meeting of Stockholders was held on May 20, 2009. At the Annual Meeting of Stockholders Christopher R. Christensen was elected to serve as a Class II member of our board of directors until our annual meeting in 2012 or until his successor has been appointed and qualified. Mr. Christensen was elected by a plurality of votes in accordance with the Delaware General Corporation Law. There was no solicitation in opposition to management s director nominee. The figures reported reflect votes cast by holders of our common stock. Each share of common stock entitles its holder to one vote. A total of 13,850,780 shares were voted for Mr. Christensen (1,099,103 withheld).

The stockholders also ratified the appointment of Deloitte & Touche LLP as our independent registered public accounting firm for the year ending December 31, 2009, with 14,582,887 votes being cast for the ratification, 50,209 votes against, 46,787 abstaining and no broker non-votes.

The stockholders further ratified the Company s 2007 Omnibus Incentive Plan, with 12,884,360 votes being cast for the ratification, 161,723 votes against, 8,887 abstaining and 1,894,913 broker non-votes.

Item 5. ***Other Information***

On July 15, 2009, we entered into the fourth amendment to the lease for our Service Center. The amendment extended the lease term for ten years from the end of the existing lease term. In addition, the lease amendment expands the amount of rentable space by 9,110 square feet.

Subsequent to June 30, 2009, we entered into an agreement to purchase real property and assets, including approximately 260 operational skilled nursing facility beds, 39 independent living units and a hospice care operation for approximately $17.0 million. As of the date of this filing, this transaction is still in the preliminary stages and we cannot guarantee the purchase will occur.

Table of Contents

Item 6. ***Exhibits***

EXHIBIT INDEX

Exhibit	Description
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002

Table of Contents

SIGNATURES

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

THE ENSIGN GROUP, INC.

August 6, 2009

BY: /s/ ALAN J. NORMAN
Alan J. Norman
Chief Financial Officer and Duly Authorized Officer

Table of Contents

EXHIBIT INDEX

Exhibit	Description
31.1	Certification of Chief Executive Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
31.2	Certification of Chief Financial Officer pursuant to Section 302 of the Sarbanes-Oxley Act of 2002
32.1	Certification of Chief Executive Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002
32.2	Certification of Chief Financial Officer pursuant to Section 906 of the Sarbanes-Oxley Act of 2002