FIVE STAR QUALITY CARE INC
Form 10-K
September 17, 2014

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

FORM 10-K

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

For the fiscal year ended December 31, 2013

or

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

Commission File Number 001-16817

FIVE STAR QUALITY CARE, INC.

(Exact Name of Registrant as Specified in Its Charter)

Maryland	**04-3516029**
(State or Other Jurisdiction of Incorporation or Organization)	(IRS Employer Identification No.)

400 Centre Street, Newton, Massachusetts 02458
(Address of Principal Executive Offices) (Zip Code)

(Registrant's Telephone Number, Including Area Code): **617-796-8387**

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

Title Of Each Class	**Name Of Each Exchange On Which Registered**
Common Stock	New York Stock Exchange

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

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

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

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and

(2) has been subject to such filing requirements for the past 90 days. Yes o No ý

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 during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes o No ý

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See 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 ý	Non-accelerated filer o	Smaller reporting company o
		(Do not check if a smaller reporting company)	

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

The aggregate market value of the voting shares of common stock, $.01 par value, or common shares, of the registrant held by non-affiliates was $240.4 million based on the $5.61 closing price per common share on the New York Stock Exchange on June 28, 2013. For purposes of this calculation, an aggregate of 1,185,361.1 common shares held directly by, or by affiliates of, the directors and the officers of the registrant, plus 4,235,000 common shares held by Senior Housing Properties Trust, have been included in the number of common shares held by affiliates.

Number of the registrant's common shares outstanding as of September 8, 2014: 48,613,442.

References in this Annual Report on Form 10-K to "we," "us" or "our" mean Five Star Quality Care, Inc. and its consolidated subsidiaries unless the context otherwise requires.

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WARNING CONCERNING FORWARD LOOKING STATEMENTS

THIS ANNUAL REPORT ON FORM 10-K CONTAINS STATEMENTS THAT CONSTITUTE FORWARD LOOKING STATEMENTS WITHIN THE MEANING OF THE PRIVATE SECURITIES LITIGATION REFORM ACT OF 1995 AND OTHER SECURITIES LAWS. ALSO, WHENEVER WE USE WORDS SUCH AS "BELIEVE", "EXPECT", "ANTICIPATE", "INTEND", "PLAN", "ESTIMATE" OR SIMILAR EXPRESSIONS, WE ARE MAKING FORWARD LOOKING STATEMENTS. THESE FORWARD LOOKING STATEMENTS ARE BASED UPON OUR PRESENT INTENT, BELIEFS OR EXPECTATIONS, BUT FORWARD LOOKING STATEMENTS ARE NOT GUARANTEED TO OCCUR AND MAY NOT OCCUR. FORWARD LOOKING STATEMENTS IN THIS REPORT RELATE TO VARIOUS ASPECTS OF OUR BUSINESS, INCLUDING:

- OUR ABILITY TO OPERATE OUR SENIOR LIVING COMMUNITIES PROFITABLY,
- OUR ABILITY TO COMPLY AND TO REMAIN IN COMPLIANCE WITH APPLICABLE MEDICARE, MEDICAID AND OTHER FEDERAL AND STATE REGULATORY, RULE MAKING AND RATE SETTING REQUIREMENTS,
- OUR ABILITY TO MEET OUR RENT AND DEBT OBLIGATIONS,
- OUR ABILITY TO RAISE EQUITY OR DEBT CAPITAL,
- OUR ABILITY TO COMPETE FOR ACQUISITIONS EFFECTIVELY, TO MANAGE ADDITIONAL SENIOR LIVING COMMUNITIES AND TO SELL PROPERTIES WE OFFER FOR SALE,
- THE FUTURE AVAILABILITY OF BORROWINGS UNDER OUR CREDIT FACILITIES,
- OUR EXPECTATION THAT WE WILL BENEFIT FINANCIALLY BY PARTICIPATING IN AFFILIATES INSURANCE COMPANY, OR AIC, WITH REIT MANAGEMENT & RESEARCH LLC, OR RMR, AND COMPANIES TO WHICH RMR PROVIDES MANAGEMENT SERVICES,
- THE IMPACT OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AS AMENDED BY THE HEALTHCARE AND EDUCATION RECONCILIATION ACT, OR COLLECTIVELY, THE ACA, AND OTHER RECENTLY ENACTED, ADOPTED OR PROPOSED LEGISLATION OR REGULATIONS ON US, AND
- OTHER MATTERS.

OUR ACTUAL RESULTS MAY DIFFER MATERIALLY FROM THOSE CONTAINED IN OR IMPLIED BY OUR FORWARD LOOKING STATEMENTS AS A RESULT OF VARIOUS FACTORS. FACTORS THAT COULD HAVE A MATERIAL ADVERSE EFFECT ON OUR FORWARD LOOKING STATEMENTS AND UPON OUR BUSINESS, RESULTS OF OPERATIONS, FINANCIAL CONDITION, CASH FLOWS, LIQUIDITY AND PROSPECTS INCLUDE, BUT ARE NOT LIMITED TO:

- CHANGES IN MEDICARE AND MEDICAID POLICIES, INCLUDING THOSE THAT MAY RESULT FROM THE IMPACT OF THE ACA AND OTHER RECENTLY ENACTED, ADOPTED OR PROPOSED LEGISLATION OR REGULATIONS, WHICH COULD RESULT IN REDUCED RATES OF PAYMENT TO US,
- THE IMPACT OF CHANGES IN THE ECONOMY AND THE CAPITAL MARKETS ON US AND OUR RESIDENTS AND OTHER CUSTOMERS,

COMPETITION WITHIN THE SENIOR LIVING SERVICES BUSINESS,

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INCREASES IN INSURANCE AND TORT LIABILITY COSTS,

INCREASES IN OUR LABOR COSTS OR IN COSTS WE PAY FOR GOODS AND SERVICES,

ACTUAL AND POTENTIAL CONFLICTS OF INTEREST WITH OUR MANAGING DIRECTORS, SENIOR HOUSING PROPERTIES TRUST OR ITS SUBSIDIARIES, OR SNH, RMR, AIC AND THEIR RELATED PERSONS AND ENTITIES,

DELAYS OR NONPAYMENTS OF GOVERNMENT PAYMENTS TO US THAT COULD RESULT FROM GOVERNMENT SHUTDOWNS, PAYMENT DEFAULTS OR PAYMENT DELAYS,

COMPLIANCE WITH, AND CHANGES TO FEDERAL, STATE AND LOCAL LAWS AND REGULATIONS THAT COULD AFFECT OUR SERVICES OR IMPOSE REQUIREMENTS, COSTS AND ADMINISTRATIVE BURDENS THAT MAY REDUCE OUR ABILITY TO PROFITABLY OPERATE OUR BUSINESS, AND

ACTS OF TERRORISM, OUTBREAKS OF SO CALLED PANDEMICS OR OTHER MANMADE OR NATURAL DISASTERS BEYOND OUR CONTROL.

FOR EXAMPLE:

THE VARIOUS GOVERNMENTS WHICH PAY US FOR THE SERVICES WE PROVIDE TO OUR RESIDENTS ARE CURRENTLY EXPERIENCING BUDGETARY CONSTRAINTS AND MAY LOWER THE MEDICARE, MEDICAID AND OTHER RATES THEY PAY US. BECAUSE WE OFTEN CANNOT ETHICALLY LOWER THE QUALITY OF THE SERVICES WE PROVIDE TO MATCH THE AVAILABLE MEDICARE, MEDICAID AND OTHER RATES WE ARE PAID, WE MAY EXPERIENCE LOSSES AND SUCH LOSSES MAY BE MATERIAL,

THIS ANNUAL REPORT ON FORM 10-K STATES OR IMPLIES THAT WE EXPECT THAT WE MAY ENTER INTO ADDITIONAL MANAGEMENT ARRANGEMENTS OR POOLING AGREEMENTS WITH SNH SIMILAR TO THOSE CURRENTLY IN EFFECT FOR US TO MANAGE ADDITIONAL SENIOR LIVING COMMUNITIES SNH MAY OWN OR ACQUIRE. HOWEVER, THERE CAN BE NO ASSURANCE THAT SNH WILL ACQUIRE OTHER COMMUNITIES OR THAT WE AND SNH WILL ENTER INTO ANY ADDITIONAL MANAGEMENT ARRANGEMENTS OR POOLING AGREEMENTS,

OUR ABILITY TO OPERATE AND MANAGE NEW SENIOR LIVING COMMUNITIES PROFITABLY DEPENDS UPON MANY FACTORS, INCLUDING OUR ABILITY TO INTEGRATE NEW COMMUNITIES INTO OUR EXISTING OPERATIONS AND SOME FACTORS WHICH ARE BEYOND OUR CONTROL SUCH AS THE DEMAND FOR OUR SERVICES ARISING FROM ECONOMIC CONDITIONS GENERALLY AND COMPETITION FROM OTHER PROVIDERS OF SENIOR LIVING SERVICES. WE MAY NOT BE ABLE TO SUCCESSFULLY INTEGRATE NEW COMMUNITIES OR OPERATE AND MANAGE NEW COMMUNITIES PROFITABLY,

OUR BELIEF THAT THE AGING OF THE U.S. POPULATION WILL INCREASE DEMAND FOR SENIOR LIVING COMMUNITIES MAY NOT BE REALIZED OR MAY NOT RESULT IN INCREASED DEMAND FOR OUR SERVICES,

THIS ANNUAL REPORT ON FORM 10-K STATES THAT AT DECEMBER 31, 2013, WE HAD $23.6 MILLION OF CASH AND CASH EQUIVALENTS AND $35.0 MILLION OF BORROWINGS OUTSTANDING UNDER OUR

CREDIT FACILITIES, LEAVING $139.4 MILLION OF AVAILABILITY, AND THAT WE HAVE IN THE PAST SOLD

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IMPROVEMENTS TO SNH AND EXPECT TO REQUEST TO SELL ADDITIONAL IMPROVEMENTS TO SNH FOR INCREASED RENT PURSUANT TO OUR LEASES WITH SNH; ALL OF WHICH MAY IMPLY THAT WE HAVE ABUNDANT CASH LIQUIDITY. HOWEVER, OUR OPERATIONS AND BUSINESS REQUIRE SIGNIFICANT AMOUNTS OF WORKING CASH AND REQUIRE US TO MAKE SIGNIFICANT CAPITAL EXPENDITURES TO MAINTAIN OUR COMPETITIVENESS. ACCORDINGLY, WE MAY NOT HAVE SUFFICIENT CASH LIQUIDITY,

THIS ANNUAL REPORT ON FORM 10-K STATES THAT SPECIAL COMMITTEES OF EACH OF OUR BOARD OF DIRECTORS AND SNH'S BOARD OF TRUSTEES COMPOSED SOLELY OF OUR INDEPENDENT DIRECTORS AND SNH'S INDEPENDENT TRUSTEES WHO ARE NOT ALSO DIRECTORS OR TRUSTEES OF THE OTHER PARTY AND WHO WERE REPRESENTED BY SEPARATE COUNSEL REVIEWED AND APPROVED THE TERMS OF THE MANAGEMENT AGREEMENTS AND POOLING AGREEMENTS BETWEEN US AND SNH AND THAT A SPECIAL COMMITTEE OF OUR BOARD OF DIRECTORS COMPOSED SOLELY OF OUR INDEPENDENT DIRECTORS NEGOTIATED AND APPROVED THE TERMS OF OUR HEADQUARTERS LEASE WITH RMR. AN IMPLICATION OF THESE STATEMENTS MAY BE THAT THE TERMS OF THE AGREEMENTS ARE AS FAVORABLE TO US AS TERMS WE COULD OBTAIN FROM UNRELATED THIRD PARTIES. HOWEVER, DESPITE THESE PROCEDURAL SAFEGUARDS, WE COULD STILL BE SUBJECTED TO CLAIMS CHALLENGING THESE TRANSACTIONS OR OUR ENTRY INTO THESE AGREEMENTS BECAUSE OF THE MULTIPLE RELATIONSHIPS AMONG US, SNH AND RMR AND THEIR RELATED PERSONS AND ENTITIES, AND DEFENDING EVEN MERITLESS CLAIMS COULD BE EXPENSIVE AND DISTRACTING TO MANAGEMENT,

THIS ANNUAL REPORT ON FORM 10-K STATES THAT DURING THE PAST SEVERAL YEARS, WEAK ECONOMIC CONDITIONS THROUGHOUT THE COUNTRY HAVE NEGATIVELY AFFECTED MANY ENTITIES BOTH IN AND OUTSIDE OF OUR INDUSTRY, THAT THESE CONDITIONS HAVE RESULTED IN, AMONG OTHER THINGS, A DECREASE IN OUR COMMUNITIES' OCCUPANCY, AND THAT ALTHOUGH THE ECONOMY MODESTLY IMPROVED IN 2013, IT IS UNCLEAR WHETHER THAT IMPROVEMENT WILL CONTINUE OR BE SUSTAINED, IN LIGHT OF THE MODEST, VARIABLE AND UNSTEADY ECONOMIC IMPROVEMENTS EXPERIENCED SINCE THE END OF THE RECENT U.S. ECONOMIC RECESSION. THESE STATEMENTS MAY IMPLY THAT OUR BUSINESS AND RESULTS OF OPERATIONS WILL IMPROVE AS GENERAL ECONOMIC CONDITIONS IMPROVE BUT THERE CAN BE NO ASSURANCE THAT OUR BUSINESS AND RESULTS OF OPERATIONS WILL IMPROVE IF AND AS GENERAL ECONOMIC CONDITIONS IMPROVE,

RESIDENTS WHO PAY FOR OUR SERVICES WITH THEIR PRIVATE RESOURCES MAY BECOME UNABLE TO AFFORD OUR SERVICES WHICH COULD RESULT IN DECREASED OCCUPANCY AND DECREASED REVENUES AT OUR SENIOR LIVING COMMUNITIES AND INCREASED RELIANCE ON LOWER RATES FROM GOVERNMENT AND OTHER PAYERS,

WE MAY BE UNABLE TO REPAY OUR DEBT OBLIGATIONS WHEN THEY BECOME DUE,

THE AMOUNT OF AVAILABLE BORROWINGS UNDER OUR CREDIT FACILITIES IS SUBJECT TO OUR HAVING QUALIFIED COLLATERAL, WHICH IS PRIMARILY

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BASED ON THE VALUE OF OUR ACCOUNTS RECEIVABLE SECURING OUR $25.0 MILLION CREDIT AGREEMENT AND THE VALUE OF THE PROPERTIES SECURING OUR $150.0 MILLION CREDIT FACILITY. ACCORDINGLY, THE AVAILABILITY OF BORROWINGS UNDER OUR CREDIT FACILITIES AT ANY TIME MAY BE LESS THAN $25.0 MILLION AND $150.0 MILLION, RESPECTIVELY. ADDITIONALLY, THE AVAILABILITY OF BORROWINGS UNDER OUR CREDIT FACILITIES IS SUBJECT TO OUR SATISFYING CERTAIN FINANCIAL COVENANTS AND MEETING OTHER CUSTOMARY CONDITIONS,

ACTUAL COSTS UNDER OUR CREDIT FACILITIES WILL BE HIGHER THAN LIBOR PLUS A PREMIUM BECAUSE OF OTHER FEES AND EXPENSES ASSOCIATED WITH OUR CREDIT FACILITIES,

THIS ANNUAL REPORT ON FORM 10-K STATES THAT OUR LENDERS HAVE WAIVED, UNTIL OCTOBER 15, 2014, NOVEMBER 15, 2014 AND DECEMBER 15, 2014, RESPECTIVELY, ANY DEFAULT UNDER OUR CREDIT FACILITIES RESULTING FROM OUR NOT TIMELY DELIVERING OUR FINANCIAL STATEMENTS FOR THE QUARTER ENDED MARCH 31, 2014, THE QUARTER ENDED JUNE 30, 2014 AND THE QUARTER ENDED SEPTEMBER 30, 2014, AS REQUIRED UNDER THESE CREDIT FACILITIES. THIS MAY IMPLY THAT WE WILL BE ABLE TO DELIVER THOSE FINANCIAL STATEMENTS BY THOSE DATES. HOWEVER, THERE CAN BE NO ASSURANCE THAT WE WILL BE ABLE TO DELIVER THOSE FINANCIAL STATEMENTS BY THOSE DATES OR THAT THE LENDERS WOULD GRANT US ANY FURTHER WAIVER OF ANY DEFAULT BEYOND OCTOBER 15, 2014, NOVEMBER 15, 2014 AND DECEMBER 15, 2014, AS APPLICABLE, IF WE ARE UNABLE TO DELIVER THOSE FINANCIAL STATEMENTS BY THOSE DATES,

THIS ANNUAL REPORT ON FORM 10-K STATES THAT WE AND SNH HAVE DECIDED TO OFFER FOR SALE CERTAIN SENIOR LIVING COMMUNITIES THAT WE LEASE FROM SNH, WHICH HAVE NOT YET BEEN SOLD, AND THAT WE HAVE DECIDED TO OFFER FOR SALE ONE COMMUNITY WHICH WE OWN. SNH MAY BE UNABLE TO SELL ANY OF THOSE COMMUNITIES WE LEASE FROM SNH, AND WE MAY BE UNABLE TO SELL THE ONE COMMUNITY WE OWN, ON ACCEPTABLE TERMS. ACCORDINGLY, WE CAN PROVIDE NO ASSURANCE THAT THESE COMMUNITIES WILL BE SOLD OR WHAT THE TERMS OR TIMING OF ANY SALE WOULD BE, AND

THIS ANNUAL REPORT ON FORM 10-K STATES THAT WE BELIEVE THAT OUR CONTINUING RELATIONSHIPS WITH SNH, RMR AND AIC AND THEIR AFFILIATED AND RELATED PERSONS AND ENTITIES MAY BENEFIT US AND PROVIDE US WITH COMPETITIVE ADVANTAGES IN OPERATING AND GROWING OUR BUSINESS. IN FACT, THE ADVANTAGES WE BELIEVE WE MAY REALIZE FROM THESE RELATIONSHIPS MAY NOT MATERIALIZE.

THESE RESULTS COULD OCCUR DUE TO MANY DIFFERENT CIRCUMSTANCES, SOME OF WHICH ARE BEYOND OUR CONTROL, SUCH AS NATURAL DISASTERS, CHANGED MEDICARE AND MEDICAID RATES, NEW LEGISLATION, REGULATIONS OR RULE MAKING AFFECTING OUR BUSINESS, OR CHANGES IN CAPITAL MARKETS OR THE ECONOMY GENERALLY.

THE INFORMATION CONTAINED ELSEWHERE IN THIS ANNUAL REPORT ON FORM 10-K OR IN OUR FILINGS WITH THE SECURITIES AND EXCHANGE COMMISSION, OR SEC, INCLUDING UNDER THE CAPTION "RISK FACTORS", OR INCORPORATED HEREIN OR THEREIN, IDENTIFIES OTHER IMPORTANT FACTORS THAT COULD CAUSE

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DIFFERENCES FROM OUR FORWARD LOOKING STATEMENTS. OUR FILINGS WITH THE SEC ARE AVAILABLE ON THE SEC'S WEBSITE AT WWW.SEC.GOV.

YOU SHOULD NOT PLACE UNDUE RELIANCE UPON OUR FORWARD LOOKING STATEMENTS.

EXCEPT AS REQUIRED BY LAW, WE DO NOT INTEND TO UPDATE OR CHANGE ANY FORWARD LOOKING STATEMENTS AS A RESULT OF NEW INFORMATION, FUTURE EVENTS OR OTHERWISE.

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FIVE STAR QUALITY CARE, INC.

2013 ANNUAL REPORT ON FORM 10-K

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PART I

Item 1. Business

GENERAL

We operate senior living communities, including independent living communities, assisted living communities and skilled nursing facilities, or SNFs. As of December 31, 2013, we operated 255 senior living communities located in 31 states containing 30,023 living units, including 224 primarily independent and assisted living communities with 27,201 living units and 31 SNFs with 2,822 living units. As of December 31, 2013, we owned and operated 30 communities (2,946 living units), we leased and operated 181 communities (20,026 living units) and we managed 44 communities (7,051 living units). Our 255 senior living communities included 10,368 independent living apartments, 14,399 assisted living suites and 5,256 skilled nursing units. The foregoing numbers exclude, as of December 31, 2013: (i) 48 living units of an assisted living community that has been temporarily closed for a major renovation; (ii) one assisted living community with 32 living units that we own which is being offered for sale and is classified as a discontinued operation; and (iii) six SNFs and four assisted living communities with a total of 712 living units that are leased by us from SNH that are being offered for sale and are classified as discontinued operations.

As of December 31, 2013, we and SNH completed the sale of the real estate and transfer of operations at two rehabilitation hospitals with 321 beds and 13 out-patient clinics affiliated with those rehabilitation hospitals to unrelated third parties. We previously leased the rehabilitation hospitals from SNH and the out-patient clinics from others. In accordance with generally accepted accounting principles, or GAAP, we have classified our historical rehabilitation hospital business as discontinued operations.

We were created by SNH in April 2000 to operate 54 SNFs and two assisted living communities repossessed from former SNH tenants. As of December 31, 2013, we leased from SNH 187 senior living communities (including six SNFs and four assisted living communities we have classified as discontinued operations) pursuant to four long term leases. For more information about our leases with SNH see "Our SNH Leases and Management Agreements" in Item 2 of this Annual Report on Form 10-K. We were incorporated in Delaware in April 2000 and reincorporated in Maryland in September 2001. On December 31, 2001, SNH distributed substantially all of our then outstanding shares of common stock, $.01 par value, or our common shares, to its shareholders and we became a separate, publicly owned company listed on the American Stock Exchange (now the NYSE MKT). In February 2011, we transferred the listing of our common shares to the New York Stock Exchange, or the NYSE.

Our principal executive offices are located at 400 Centre Street, Newton, Massachusetts 02458, and our telephone number is (617) 796-8387.

TYPES OF PROPERTIES

Our present business plan contemplates the ownership, leasing and management of independent living communities, assisted living communities and SNFs. Some of our properties combine more than one type of service in a single building or campus.

Independent Living Communities. Independent living communities provide high levels of privacy to residents and require residents to be capable of relatively high degrees of independence. An independent living apartment usually bundles several services as part of a regular monthly charge. For example, the base charge may include one or two meals per day in a central dining room, weekly maid service or services of a social director. Additional services are generally available from staff employees on a fee for service basis. In some independent living communities, separate parts of the community

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are dedicated to assisted living or nursing services. As of December 31, 2013, our continuing operations included 10,368 independent living apartments in 86 communities.

Assisted Living Communities. Assisted living communities are typically comprised of one bedroom units which include private bathrooms and efficiency kitchens. Services bundled within one charge usually include three meals per day in a central dining room, daily housekeeping, laundry, medical reminders and 24 hour availability of assistance with the activities of daily living such as dressing and bathing. Professional nursing and healthcare services are usually available at the community as requested or at regularly scheduled times. As of December 31, 2013, our continuing operations included 14,399 assisted living suites in 199 communities.

Skilled Nursing Facilities. SNFs generally provide extensive nursing and healthcare services similar to those available in hospitals, without the high costs associated with operating theaters, emergency rooms or intensive care units. A typical purpose built SNF generally includes one or two beds per room with a separate bathroom in each room and shared dining facilities. SNFs are staffed by licensed nursing professionals 24 hours per day. As of December 31, 2013, our continuing operations included 5,256 skilled nursing units in 72 communities.

OUR RECENT HISTORY

Senior Living

We have grown our business through acquisitions, through initiation of long term leases of independent and assisted living communities where residents' private resources account for a large majority of revenues and, beginning in 2011, through entering into long term contracts to manage independent and assisted living communities. In 2013 we began managing five additional communities containing 373 living units pursuant to long term contracts with SNH, bringing the total number of managed communities to 44 as of December 31, 2013.

Sale of Institutional Pharmacy Business

We previously operated five institutional pharmacies providing large quantities of drugs at locations where patients with recurring pharmacy requirements are concentrated. In September 2012, we sold our pharmacy business to Omnicare, Inc., or Omnicare. We received $34.3 million in sale proceeds from Omnicare, including $3.8 million in working capital and excluding transaction costs and taxes. We recorded a pre-tax capital gain on the sale of the pharmacy business of $23.3 million. In connection with the sale of our pharmacy business, Omnicare did not acquire the real estate we own associated with one pharmacy located in South Carolina. In July 2014, we sold this real estate for a sales price of $205,000. We recorded an asset impairment charge of $57,000 during the fourth quarter of 2013 to reduce the carrying value of this real estate to its estimated fair value, less costs to sell.

Sale and Transfer of Operations at Rehabilitation Hospitals and Clinics

As of December 31, 2013, we and SNH completed the sale of the real estate and the transfer of operations at two rehabilitation hospitals and 13 out-patient clinics affiliated with those rehabilitation hospitals to unrelated third parties. We previously leased the rehabilitation hospitals from SNH and the out-patient clinics from others. As a result of this transaction, SNH received proceeds of approximately $90.0 million for the sale of the real estate associated with the rehabilitation hospitals, we retained certain net assets of approximately $9.6 million and our annual rent payable to SNH and others decreased by approximately $11.5 million. In 2013, we recorded losses of $2.2 million relating to closing costs and legal fees associated with this transaction and we incurred $2.6 million of non-cash asset impairment charges to reduce the fixed assets we owned which are related to the rehabilitation hospitals to their estimated fair market values.

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Debt Repayments

In October 2006, we issued $126.5 million principal amount of Convertible Senior Notes due 2026, or the Notes. Our net proceeds from this issuance were approximately $122.6 million. The Notes bore interest at a rate of 3.75% per annum and were convertible into our common shares at any time. The conversion rate, which was subject to adjustment, was 76.9231 common shares per $1,000 principal amount of the Notes, which represented a conversion price of $13.00 per share. The Notes were guaranteed by certain of our wholly owned subsidiaries. The Notes were scheduled to mature on October 15, 2026. We were permitted to prepay the Notes at any time and the holders were permitted to require us to purchase all or a portion of these Notes on each of October 15, 2013, 2016 and 2021 at a repurchase price equal to 100% of the principal amount of the Notes to be repurchased, plus any accrued and unpaid interest. We have periodically repurchased Notes in open market transactions or in privately negotiated transactions, and, on July 8, 2013, we redeemed all of the $24.9 million principal amount of the Notes then outstanding at a redemption price equal to the principal amount, plus accrued and unpaid interest. We recorded a loss on early extinguishment of debt, net of unamortized issuance costs, of $599,000 in the third quarter of 2013. As of December 31, 2013 and 2012, we had $0 and $24.9 million, respectively, principal amount of the Notes outstanding, which were classified as current liabilities in our December 31, 2012 consolidated balance sheet.

Discontinued Operations

Under our leases with SNH, we may request SNH to sell certain noneconomic properties that we lease pursuant to those leases, which if sold, would reduce our rent payable to SNH, as determined pursuant to the applicable leases. For more information about our leases with SNH, see "Our SNH Leases and Management Agreements" in Item 2 of this Annual Report on Form 10-K. During 2011, we agreed with SNH that SNH should sell one assisted living community located in Pennsylvania with 103 living units, which we lease from SNH. We and SNH are in the process of offering this assisted living community for sale and, if sold, our annual minimum rent payable to SNH will decrease by 9.0% of the net proceeds of the sale to SNH, in accordance with the terms of our applicable lease.

In 2011, we decided to offer for sale two SNFs we owned located in Michigan with a total of 271 living units. In April 2013, we sold these two SNFs for an aggregate sales price of $8.0 million, which included as part of the sales price the prepayment by the buyer of the then outstanding $7.5 million of United States Department of Housing and Urban Development, or HUD, guaranteed mortgage debt that encumbered these SNFs.

In June 2013, we agreed with SNH that SNH would offer for sale 10 senior living communities we lease from SNH with 721 living units. Seven of these 10 communities with 578 living units are SNFs and three of these 10 communities with 143 living units are assisted living communities. In August 2013, SNH sold one of these communities, a SNF with 112 living units, for a sales price of $2.6 million, and as a result of this sale, our annual minimum rent payable to SNH decreased by $255,000, or 10% of the net proceeds of the sale to SNH, in accordance with the terms of the applicable lease. In January 2014, SNH sold another one of these communities, an assisted living community with 48 living units, for a sales price of $2.4 million, and as a result of this sale, our annual minimum rent payable to SNH decreased by $210,000, or 8.75% of the net proceeds of the sale to SNH, in accordance with the terms of the applicable lease. In June 2014, SNH sold two of these communities, both of which are SNFs, with a combined total of 155 living units, for a sales price of $4.5 million, and as a result of this sale, our annual minimum rent payable to SNH decreased by $450,000, or 10% of the net proceeds of the sale to SNH, in accordance with the terms of the applicable lease. We and SNH are in the process of offering the other six communities for sale, and if sold, our annual minimum rent payable to SNH will decrease in accordance with the terms of our applicable leases.

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Also in June 2013, we decided to offer for sale one assisted living community we own with 32 living units. We are in the process of offering this assisted living community for sale.

We can provide no assurance that we or SNH will be able to sell any of these discontinued operations which are being offered for sale or what the terms or timing of any sales may be.

OUR GROWTH STRATEGY

We believe that the aging of the U.S. population will increase demand for senior living communities. Our principal growth strategy is to profit from this anticipated demand by operating communities that provide high quality services to residents who pay with private resources.

We seek to improve the profitability of our existing operations by increasing our revenues and improving our operating margins. We attempt to increase revenues by increasing rates and occupancies. We attempt to improve margins by limiting increases in expenses and otherwise improving operating efficiencies. For example, during the recent economic recession experienced in the United States, the senior living industry generally experienced declining occupancies as a result of this slowdown in the U.S. economy. During this same period, we improved our operating margins and profitability by increasing rates and limiting increases in our expenses. As the U.S. economy and the housing market gradually improve, we expect that our occupancies may increase and our profitability may grow; however, the condition of the U.S. economy and the housing market are beyond our control and may not improve. Further, the reductions in government payments for our services, such as the reductions we experienced during 2013 as a result of the sequestration rate cuts, negatively impacted our results of operations and may continue to do so. For more information about government payments for our services, see "Government Regulation and Reimbursement."

In addition to managing our existing operations, we currently intend to continue to grow our business by adding to our operations primarily independent and assisted living communities where residents' private resources account for a large majority of revenues. We expect some of these increases may be achieved by our entering leases or management agreements and some may be achieved by our purchasing communities. Since we became a public company in late 2001, we have acquired or have begun to lease 180 primarily independent and assisted living communities that are included in our continuing operations as of December 31, 2013, which realized approximately 87% of their revenues from residents' private resources, rather than from Medicare and Medicaid in the year ended December 31, 2013. Historically, we have principally expanded our operations by entering operating leases. Recently, we have started to expand our operations by acquiring senior living communities for our own account and entering agreements to manage senior living communities which are owned by SNH. In the future, we expect to continue to grow our business by adding communities that we either own, lease or manage.

OPERATING STRUCTURE

We have four operating divisions. Three of our divisions are each responsible for multiple geographic regions with respect to our senior living communities that consist of independent, assisted living and skilled nursing units. One of our divisions is responsible for our rehabilitation and wellness inpatient and outpatient clinics which are associated with our senior living communities. Each division is headed by a divisional vice president with extensive experience in the senior living industry. We have several regional offices within our divisions. Each regional office is responsible for multiple communities and is headed by a regional director of operations with extensive experience in the senior living industry. Each regional office is typically supported by a clinical or wellness director, a rehabilitation services director, a regional accounts manager, a human resources specialist and a sales

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and marketing specialist. Regional staff are responsible for all of our senior living community operations within a geographic region, including:

- resident services;
- Medicare and Medicaid billing;
- marketing and sales;
- hiring of community personnel;
- compliance with applicable legal and regulatory requirements; and
- supporting our development and acquisition plans within their region.

Our corporate office staff, located in Massachusetts, provides services such as:

- the establishment of company wide policies and procedures relating to resident care;
- human resources policies and procedures;
- information technology;
- private pay billing for our independent living apartments and assisted living communities;
- maintenance of licensing and certification;
- legal services;
- central purchasing;
- budgeting and supervision of maintenance and capital expenditures;
- implementation of our growth strategy; and
- accounting and finance functions, including operations, budgeting, certain accounts receivable and collections functions, accounts payable, payroll and financial reporting.

As described in this Annual Report on Form 10-K, we have a business management and shared services agreement, or the business management agreement, with RMR, pursuant to which RMR provides to us certain business management, administrative and information system services, including internal audit, capital markets, legal, investor relations and tax services, among other matters.

STAFFING

Independent and Assisted Living Community Staffing. Each of the independent and assisted living communities we operate has an executive director responsible for the day to day operations of the community, including quality of care, resident services, sales and marketing, financial performance and staff supervision. The executive director is supported by department heads who oversee the care and service of the residents, a wellness director who is responsible for coordinating the services necessary to meet the healthcare needs of our residents and a marketing director who is responsible for selling our services. Other important staff includes the dining services coordinator, the activities coordinator and the property maintenance coordinator.

Skilled Nursing Facility Staffing. Each of our SNFs is managed by a state licensed administrator who is supported by other professional personnel, including a director of nursing, an activities director, a marketing director, a social services director, a business office manager, and physical, occupational and speech therapists. Our directors of nursing are state licensed nurses who supervise our registered nurses, licensed practical nurses and nursing assistants. Staff size and composition vary depending on the size and occupancy of each SNF and on the type of care provided by the SNF. Our SNFs also contract with physicians who provide certain medical services.

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EMPLOYEES

As of September 8, 2014, we had approximately 25,100 employees, including approximately 15,500 full time equivalents. We believe our relations with our employees are good.

GOVERNMENT REGULATION AND REIMBURSEMENT

The healthcare industry is subject to extensive and frequently changing federal, state and local laws and regulations. These laws and regulations vary by jurisdiction but may address, among other things, licensure, personnel training, staffing ratios, quality of medical care, physical facility requirements, government healthcare program participation, fraud and abuse, payments for patient services and patient records.

We are subject to, and our operations must comply with, these laws and regulations. From time to time, our facilities receive notices from federal, state and local agencies regarding noncompliance with such requirements. Upon receipt of these notices, we review them for correctness and, based on our review, we either take corrective action or contest the allegation of noncompliance. When corrective action is required, we work with the relevant agency to address and remediate any violations. Challenging and appealing any notices or allegations of noncompliance require the expenditure of significant legal fees and management attention. Any adverse determination concerning any of our licenses or eligibility for Medicare or Medicaid reimbursement, any penalties, repayments or sanctions, and the increasing costs of required compliance with applicable laws may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

The healthcare industry depends significantly upon federal and state programs for revenues and, as a result, is affected by the budgetary policies of both the federal and state governments. Reimbursements under the Medicare and Medicaid programs for skilled nursing, physical therapy and rehabilitation services provided operating revenues at our rehabilitation hospitals and affiliated clinics (the operations of which we transferred to third parties during the fourth quarter of 2013 in connection with SNH's sale of those rehabilitation hospitals), and provided operating revenues at our outpatient clinics and some of our senior living communities (principally our SNFs). We derived approximately 23%, 24% and 26% of our consolidated revenues from continuing operations from Medicare and Medicaid programs for each of the years ended December 31, 2013, 2012 and 2011, respectively. We derived approximately 68%, 70% and 68% of our rehabilitation hospital revenues from Medicare and Medicaid programs for each of the years ended December 31, 2013, 2012 and 2011, respectively.

In addition to existing government regulation, we are aware of numerous healthcare regulatory initiatives on the federal, state and local levels, which may affect our business operations if implemented.

Independent Living Communities. Government benefits are not generally available for services at independent living communities, and residents in those communities use private resources to pay for their living units and the services they receive. The rates in these communities are determined by local market conditions and operating costs. However, a number of federal Supplemental Security Income program benefits pay housing costs for elderly or disabled recipients to live in these types of residential communities. The Social Security Act requires states to certify that they will establish and enforce standards for any category of group living arrangement in which a significant number of Supplemental Security Income recipients reside or are likely to reside. Categories of living arrangements that may be subject to these state standards include independent living communities and assisted living communities. Because independent living communities usually offer common dining facilities, in many jurisdictions they are required to obtain licenses applicable to food service establishments in addition to complying with land use and life safety requirements. In addition, in many states, state or county health departments, social service agencies or offices on aging have jurisdiction over group residential communities for seniors and license independent living communities. To the extent that independent

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living communities include units to which assisted living or nursing services are provided, these units are subject to applicable state licensing regulations. If the communities receive Medicaid or Medicare funds, they are subject to certification standards and conditions of participation. In some states, insurance or consumer protection agencies regulate independent living communities in which residents pay entrance fees or prepay for services.

Assisted Living Communities. A majority of states provide or are approved to provide Medicaid payments for personal care and medical services to some residents in licensed assisted living communities under waivers granted by or under Medicaid state plans approved by the Centers for Medicare and Medicaid Services, or CMS, of the United States Department of Health and Human Services, or HHS. State Medicaid programs control costs for assisted living and other home and community based services by various means such as restrictive financial and functional eligibility standards, enrollment limits and waiting lists. Because rates paid to assisted living community operators are generally lower than rates paid to nursing home operators, some states use Medicaid funding of assisted living as a means of lowering the cost of services for residents who may not need the higher level of health services provided in SNFs. States that administer Medicaid programs for services in assisted living communities are responsible for monitoring the services at, and physical conditions of, the participating communities.

As a result of the large number of states using Medicaid funds to purchase services at assisted living communities and the growth of assisted living in recent years, states have adopted licensing standards applicable to assisted living communities. According to the National Center for Assisted Living, all states regulate assisted living and residential care communities, although states do not use a uniform approach. Most state licensing standards apply to assisted living communities regardless of whether they accept Medicaid funding. Also, a few states require certificates of need from state health planning authorities before new assisted living communities may be developed. Based on our analysis of recent economic and regulatory trends, we believe that assisted living communities that become dependent upon Medicaid or other public payments for a majority of their revenues may decline in value because Medicaid and other public rates may fail to keep up with increasing costs. We also believe that assisted living communities located in states that adopt certificate of need requirements or other limitations on the development of new assisted living communities may increase in value because those limitations may help ensure higher non-governmental rates.

HHS, the Senate Special Committee on Aging, and the Government Accountability Office, or the GAO, have studied and reported on the development of assisted living and its role in the continuum of long term care and as an alternative to SNFs. Since 2003, CMS has commenced a series of actions to increase its oversight of state quality assurance programs for assisted living facilities and has provided guidance and technical assistance to states to improve their ability to monitor and improve the quality of services paid for through Medicaid waiver programs. CMS is encouraging state Medicaid programs to expand their use of home and community based services as alternatives to institutional services, pursuant to provisions of the Deficit Reduction Act of 2005, or the DRA, the ACA (as defined and described below) and other authorities, through the use of several programs. One such program, the Community First Choice, or the CFC Option, grants states that choose to participate in the program a 6% increase in federal matching payments for related medical assistance expenditures. California implemented the CFC Option in fiscal year 2012 followed by Oregon in 2013 and Maryland in 2014. At least five other states have reported that they are considering implementing it in 2014. We are unable to predict the effect of the implementation of the CFC Option and other similar programs, but their impact may be adverse and material to our operations and our future financial results of operations.

Skilled Nursing Facilities Reimbursement. A majority of all nursing home revenues in the United States comes from publicly funded programs. According to CMS, Medicaid is the largest source of public funding for nursing homes, followed by Medicare. In 2012, approximately 31% of nursing care facility and continuing care retirement community revenues came from Medicaid and 23% from

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Medicare. SNFs are highly regulated businesses. The federal and state governments regularly monitor the quality of care provided at SNFs. State health departments conduct surveys of resident care and inspect the physical condition of nursing home properties. These periodic inspections and occasional changes in life safety and physical plant requirements sometimes require nursing home operators to make significant capital improvements. These mandated capital improvements have usually resulted in Medicare and Medicaid rate adjustments, albeit on the basis of amortization of expenditures over expected useful lives of the improvements. Under the Medicare prospective payment system, or the PPS, for SNFs, capital costs are part of the prospective rate and are not community specific. The PPS and other recent legislative and regulatory actions with respect to state Medicaid rates limit the reimbursement levels for some nursing home services. At the same time, federal and state enforcement has increased oversight of SNFs, making licensing and certification of these communities more rigorous.

CMS implemented the PPS for SNFs pursuant to the Balanced Budget Act of 1997, or the BBA. Under the PPS, SNFs receive a fixed payment for each day of care provided to residents who are Medicare beneficiaries. The PPS requires SNFs to assign each resident to a care group depending on that resident's medical characteristics and service needs. These care groups are known as Resource Utilization Groups, or RUGs, and CMS establishes a per diem payment rate for each RUG. CMS currently uses the RUG-IV case mix classification system and a resident assessment instrument called the Minimum Data Set 3.0, which SNFs must use to collect clinical data to assign residents to RUG-IV reimbursement categories. Medicare PPS payments cover substantially all services provided to Medicare residents in SNFs, including ancillary services such as rehabilitation therapies.

CMS updates PPS payment rates each year by a market basket update to account for inflation and periodically implements changes to the RUG categories and payment rates.

In 2011, CMS adopted a final rule designed to recalibrate Medicare PPS rates for SNFs, which resulted in a reduction in aggregate Medicare payment rates for SNFs of approximately 11.1%, or $3.87 billion, in federal fiscal year 2012.

For federal fiscal year 2013, CMS adopted a final rule updating Medicare PPS rates for SNFs which resulted in an increase in aggregate Medicare payment rates of approximately 1.8%. CMS estimated this update resulted in an overall increase of $670 million in Medicare payments to SNFs in federal fiscal year 2013 as compared to federal fiscal year 2012. On October 1, 2013, CMS adopted a final rule updating Medicare payments to SNFs for federal fiscal year 2014, which CMS estimates will increase payments to SNFs by an aggregate of 1.3%, or approximately $470 million, compared to federal fiscal year 2013. On July 31, 2014, CMS released its final rule for the Medicare prospective payment system for SNFs for federal fiscal year 2015 to be effective on October 1, 2014. As part of this rule, CMS will apply a net increase of 2.0% to Medicare payment rates for SNFs, which takes into account a 2.5% increase for inflation reduced by a 0.5% productivity adjustment and will result in an aggregate increase of approximately $750 million in payments to SNFs from federal fiscal year 2014. Due to the previous reduction of Medicare payment rates of approximately 11.1% for federal fiscal year 2011 discussed above, however, Medicare payment rates will be lower for federal fiscal year 2015 than they were in federal fiscal year 2011.

The Middle Class Tax Relief and Job Creation Act of 2012, enacted in February 2012, incrementally reduces the SNF reimbursement rate for Medicare bad debt from 100% to 65% by federal fiscal year 2015 for beneficiaries dually eligible for Medicare and Medicaid. Because nearly 90% of SNF bad debt is related to dual-eligible beneficiaries, this rule has a substantial negative effect on SNFs. The Middle Class Tax Relief and Job Creation Act of 2012 also reduced the SNF Medicare bad debt reimbursement rate for Medicare beneficiaries not eligible for Medicaid from 70% to 65% in federal fiscal year 2013 and going forward.

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In addition, the Budget Control Act of 2011 and the Bipartisan Budget Act of 2013 allow for automatic reductions in federal spending by means of a process called sequestration, which reduces Medicare payment rates by up to 2% through 2023. In February 2014, Congress approved an additional one year extension of Medicare sequestration, through 2024. Medicaid is exempt from the automatic reductions, as are certain Medicare benefits. The automatic 2% payment cuts took effect on April 1, 2013, and had an adverse effect on our operations and financial results during 2013. We are unable to predict the future financial impact on us of those automatic payment cuts; however, they may continue to have similar or worse impacts in the future.

The federal government is seeking to slow the growth of Medicare and Medicaid payments for nursing home services by several methods. In 2006, the government implemented limits on Medicare payments for outpatient therapies and then, pursuant to the DRA, created an exception process under which beneficiaries could request an exception from the cap and be granted the amount of services deemed medically necessary by Medicare. On April 1, 2014, the Protecting Access to Medicare Act of 2014, or PAMA, extended the Medicare outpatient therapy cap exception process through March 31, 2015, further postponing the implementation of firm limits on Medicare payments for outpatient therapies. PAMA also extended the 0.5% increase to the Medicare Physician Fee Schedule, or MPFS, rates through December 31, 2014 and provided no increase in the MPFS rates, to which our Medicare outpatient therapy rates are tied, in the period between January 1, 2015 and March 31, 2015. Unless further delayed, the MPFS rates are scheduled to be reduced by up to 24% effective April 1, 2015. Additionally, PAMA established a SNF value-based purchasing program. Under this program, HHS will assess SNFs based on hospital readmissions measures and make these assessments available to the public no later than October 1, 2017. Beginning in federal fiscal year 2019, SNFs will face a 2% withholding of SNF payments and will receive incentive payments based on the higher of their performance or improvement on certain hospital readmission measures. The collective amount of incentive payments to all SNFs are anticipated to be between 50% and 70% of the total payment amounts withheld. We are unable to predict the impact on us of these or other recent legislative and regulatory actions or proposed actions with respect to federal Medicare rates, state Medicaid rates, and the federal payments to states for Medicaid programs. In addition, the DRA increased the "look-back" period for prohibited asset transfers that disqualify individuals from Medicaid nursing home benefits from three to five years. The period of Medicaid ineligibility begins on the date of the prohibited transfer or the date an individual has entered the nursing home and would otherwise be eligible for Medicaid coverage, whichever occurs later, rather than on the date of the prohibited transfer, effectively extending the Medicaid penalty period and placing added burdens on SNFs to collect charges directly from residents and their transferees.

The DRA also established the five year Money Follows the Person demonstration project in 2007 to award competitive grants to 30 states to provide home and community based long term care services to qualified individuals relocated from SNFs, and to increase federal medical assistance for each qualifying beneficiary for a limited time period. The ACA expanded eligibility for this program and extended this program for an additional five years through 2016. According to an April 25, 2014 Henry J. Kaiser Family Foundation report, as of August 2013, 41 states and the District of Columbia had active Money Follows the Person programs, two states were in the planning stages, and one state had an inactive program. The DRA also established the Post Acute Care Payment Reform demonstration project under which CMS compared and assessed patient care needs, costs and outcomes of services at different post acute care sites over three years. In January 2012 CMS issued a report to Congress regarding the project stating that CMS successfully used a new uniform patient assessment tool to measure patient acuity in acute care hospitals and post acute settings, providing the basis for the potential development of new standardized information reporting requirements and more uniform post acute case mix payment systems. States are also permitted to include home and community based services as optional services under their Medicaid state plans or through Medicaid waiver programs, and states opting to do so may establish more stringent needs based criteria for

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nursing home services than for home and community based services. The ACA expands the services that states may provide and limits their ability to set caps on enrollment, waiting lists or geographic limitations on home and community based services.

Skilled Nursing Facilities Survey and Enforcement. Over 25 years ago, Congress enacted major reforms to federal and state regulatory systems for SNFs that participate in the Medicare and Medicaid programs, under the Omnibus Reconciliation Act of 1987. Since then, the GAO has reported that, although much progress has been made, substantial problems remain in the effectiveness of federal and state regulatory activities. The HHS Office of Inspector General, or OIG, has issued several reports concerning quality of care in SNFs, and the GAO has issued several reports recommending that CMS and states strengthen their compliance and enforcement practices, including federal oversight of state actions and to ensure that SNFs provide adequate care and states act more consistently.

The Senate Special Committee on Aging and other congressional committees have also held hearings on these issues. As a result, CMS has undertaken several initiatives to increase the effectiveness of Medicare and Medicaid nursing home survey and enforcement activities. CMS has been taking steps to identify communities with, and focus enforcement efforts on, SNFs and chains of SNF operators with findings of substandard care or repeat violations of Medicare and Medicaid standards. CMS has increased its oversight of state survey agencies and has improved the process by which data is captured from these surveys. As an added measure of improving patient care, the ACA provides for the funding of a state background check system for job applicants to long term care providers who will have direct access to clients and patients. CMS has begun the administration of this program, to which approximately half of the states have already applied.

In addition, CMS adopted regulations expanding federal and state authority to impose civil monetary penalties in instances of noncompliance. When CMS or state agencies identify deficiencies under state licensing and Medicare and Medicaid standards, they may impose sanctions and remedies such as denials of payment for new Medicare and Medicaid admissions, civil monetary penalties, state oversight, temporary management or receivership and loss of Medicare and Medicaid participation or licensure on nursing home operators. Our communities incur sanctions and penalties from time to time. If we are unable to cure deficiencies that have been identified or that are identified in the future, or if appeals of proposed sanctions or penalties are not successful, decertification or additional sanctions or penalties may be imposed. These consequences may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

Inpatient Rehabilitation Facility Regulation and Rate Setting. We transferred our operations at our inpatient rehabilitation facilities, or IRFs, and affiliated clinics in the fourth quarter of 2013 to third parties in connection with SNH's sale of those IRFs. Our IRFs were subject to federal, state and local regulation that affected their business activities and determined the rates they received for services. CMS certified these facilities to participate in the Medicare program, and these facilities received a significant portion of their revenues from that program.

CMS establishes standards that facilities must meet in order to be classified as IRFs under the Medicare program. One such standard is known as the "60% Rule." As amended by the Medicare, Medicaid and the SCHIP Extension Act of 2007, the 60% Rule provides that, to be considered an IRF and receive reimbursement under the IRF PPS, at least 60% of a facility's total inpatient population must receive the facility's services for treatment of at least one of 13 designated medical conditions. To comply with the 60% Rule and maintain revenue levels, many IRFs have reduced the number of non-qualifying patients treated and replaced them with qualifying patients, established other sources of revenues or both. We believe that our IRFs were operated in compliance with the 60% Rule during the period in which we operated them; however, we can provide no assurance that CMS will not make a determination that we were non-compliant during this period.

Medicare reimburses IRFs under a PPS implemented in 2002 pursuant to the BBA. Under the IRF PPS, reimbursement is paid at a predetermined per-discharge rate. To determine the per-discharge

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rate, CMS classifies patients into case mix groups based on their clinical characteristics and expected resource needs. IRFs must assign each patient to one of these groups, and separate payment rates are calculated for each group. The IRF PPS case mix group payment rates are calculated to cover all operating and capital costs that an IRF is expected to incur while furnishing that group's covered inpatient rehabilitation services. Capital costs are not facility-specific.

CMS updates IRF Medicare payment rates each year. For federal fiscal year 2012, CMS adopted a final rule updating IRF Medicare payments, which CMS estimated would result in an aggregate net increase of 2.2% in IRF Medicare payments compared to the prior federal fiscal year. For federal fiscal year 2013, CMS adopted a final rule that updated IRF Medicare payments effective October 1, 2012, which resulted in a 2.1% increase in aggregate IRF PPS payments. Effective October 1, 2013, CMS updated IRF Medicare payment rates for federal fiscal year 2014, which CMS estimates will increase aggregate IRF PPS payments by 2.3% compared to the prior federal fiscal year. Medicare revenues realized at our IRFs in the years ended December 31, 2012 and 2013 were approximately $71.1 million and $71.3 million, respectively. As previously noted, in the fourth quarter of 2013, we transferred our operations at our IRFs and affiliated clinics to third parties in connection with SNH's sale of those IRFs.

Certificates of Need. As a mechanism to prevent overbuilding and subsequent healthcare price inflation, most states limit the number of SNFs and hospitals by requiring developers to obtain certificates of need before new facilities may be built or additional beds may be added to existing facilities. A few states also limit the number of assisted living facilities by requiring certificates of need. In addition, some states (such as California and Texas) that have eliminated certificate of need laws have retained other means of limiting new development, including moratoria, licensing laws or limitations upon participation in the state Medicaid program. These governmental requirements limit expansion, which we believe may make existing SNFs more valuable by limiting competition.

Healthcare Reform. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, or collectively the ACA, signed into law in March 2010, has resulted in changes to insurance, payment systems and healthcare delivery systems. The ACA is intended to expand access to health insurance coverage and reduce the growth of healthcare expenditures while simultaneously maintaining or improving the quality of healthcare. Some of the provisions of the ACA took effect immediately, whereas others will take effect at later dates. Due to the complexity of the ACA, its ramifications may only become apparent through later regulatory and judicial interpretations.

The ACA automatically reduced the Medicare IRF PPS annual market basket adjustments by 0.25% for federal fiscal years 2010 (for discharges on and after April 1, 2010) and 2011, 0.1% for federal fiscal years 2012 and 2013, and 0.3% for federal fiscal year 2014. As previously noted, in the fourth quarter of 2013, we transferred our operations at our IRFs and affiliated clinics to third parties in connection with SNH's sale of those IRFs. Beginning in federal fiscal year 2012, the ACA also reduced both the SNF PPS and IRF PPS annual adjustments for inflation by a productivity adjustment based on national economic productivity statistics. We are unable to predict the impact of these reductions on Medicare rates for SNFs, but their impact may be adverse and material to our operations and our future financial results of operations.

The ACA establishes an Independent Payment Advisory Board to submit legislative proposals to Congress and take other actions with a goal of reducing Medicare spending growth. When and if such spending reductions take effect they may be adverse and material to our financial results. The ACA also provides for the National Pilot Program on Payment Bundling to develop and evaluate making bundled payments for services provided during an episode of care, to include hospital and physician services and post-acute care such as SNF and IRF services. The pilot program can be expanded in January 2016 if it meets its goals. The ACA also includes the development of Medicare value-based

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purchasing plans to include quality measures as a basis for bonuses and several initiatives to encourage states to develop and expand home and community based services under Medicaid.

The ACA includes various other provisions affecting Medicare and Medicaid providers, including expanded public disclosure requirements for SNFs and other providers, enforcement reforms and increased funding for Medicare and Medicaid program integrity control initiatives. The ACA has resulted in several changes to existing healthcare fraud and abuse laws, established additional enforcement tools and funding to the government, and provided for increased cooperation between agencies by establishing mechanisms for sharing information relating to noncompliance. Furthermore, the ACA has resulted in enhanced criminal and administrative penalties for noncompliance. For example, the ACA amended the Anti-Kickback Statute to provide that a claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim for purposes of the False Claims Act.

In June 2012, the U.S. Supreme Court upheld two major provisions of the ACA the individual mandate, which requires most Americans to maintain health insurance or to pay a penalty, and the Medicaid expansion, which requires states to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes not exceeding 133% of the federal poverty level. In upholding the Medicaid expansion, the Supreme Court held that it violated the U.S. Constitution as drafted but remedied the violation by modifying the expansion to preclude the Secretary of HHS from withholding existing federal Medicaid funds from states that fail to comply with Medicaid expansion, instead allowing the Secretary only to deny new expansion funding. Under the ACA, the federal government will pay for 100% of a state's Medicaid expansion costs for the first three years (2014-2016) and gradually reduce its subsidy to 90% for 2020 and future years. As of August 28, 2014, 21 states have elected not to broaden Medicaid eligibility under the ACA at this time, and two remain undecided; those states choosing not to participate in Medicaid expansion are forgoing the federal funds that would otherwise be available for that purpose. We are unable to predict the impact of these or other recent legislative and regulatory actions or proposed actions with respect to state Medicaid rates and payments to states for Medicaid programs on us.

We cannot estimate the type and magnitude of the potential Medicare and Medicare policy changes, rate reductions or other changes and the impact on us of the possible failure of these programs to increase rates to match our increasing expenses, but they may be material to and adversely affect our future results of operations. Similarly, we are unable to predict the impact on us of the insurance reforms, payment reforms, and healthcare delivery systems reforms contained in and to be developed pursuant to the ACA. Expanded insurance availability may provide more paying customers for the services we provide. If the changes to be implemented under the ACA result in reduced payments for our services or the failure of Medicare, Medicaid or insurance payment rates to cover our costs, however, our future financial results could be adversely and materially affected.

In addition, other aspects of the ACA that affect employers generally, including the employer shared responsibility provisions that the IRS will begin enforcing on January 1, 2015, may have an impact on the design and cost of the health coverage that we offer to our employees. Due to the scope and complexity of the provisions of the ACA that apply to employers and employer group health plans, it is difficult to predict the overall impact of the ACA on our employee benefit plans and our cost of doing business over the coming years. We will continue to analyze how to provide our employees with cost-effective coverage, taking into account the various requirements of the ACA and the impact of any changes on our ability to attract and retain employees. For information on some recent changes that we have made to the health insurance coverage we offer employees in response to the rising cost of health insurance generally, please see the information contained below under the caption "Insurance" in this Business section of this Annual Report on Form 10-K.

Other Matters. Federal and state efforts to target false claims, fraud and abuse and violations of anti-kickback laws, physician referral laws (including the Ethics in Patient Referrals Act of 1989) and

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privacy laws by Medicare and Medicaid providers and providers under other public and private programs have increased in recent years, as have civil monetary penalties, treble damages, repayment requirements and criminal sanctions for noncompliance. The federal False Claims Act, as amended and expanded by the Fraud Enforcement and Recovery Act of 2009, and the ACA, provides significant civil money penalties and treble damages for false claims and authorizes individuals to bring claims on behalf of the federal government for false claims. The federal Civil Monetary Penalties Law authorizes the Secretary of HHS to impose substantial civil penalties, treble damages, and program exclusions administratively for false claims or violations of the federal Anti-Kickback Statute. In addition, the ACA increased penalties under federal sentencing guidelines by between 20% and 50% for healthcare fraud offenses involving more than $1.0 million.

Governmental authorities are devoting increasing attention and resources to the prevention, detection, and prosecution of healthcare fraud and abuse. The HHS OIG has guidelines for SNFs and IRFs intended to assist them in developing voluntary compliance programs to prevent fraud and abuse; these guidelines recommend that CMS identify SNFs that are billing for higher paying RUGs and more closely monitor compliance with patient therapy assessments as methods of fraud prevention. CMS contractors are expanding the retroactive audits of Medicare claims submitted by IRFs, SNFs and other providers, and recouping alleged overpayments for services determined by auditors not to have been medically necessary or not to meet Medicare coverage criteria as billed. State Medicaid programs and other third party payers are conducting similar medical necessity and compliance audits. The ACA facilitates the Department of Justice's, or the DOJ's, ability to investigate allegations of wrongdoing or fraud at SNFs, in part because of increased cooperation and data sharing among CMS, OIG, DOJ and the states. In addition, the ACA requires all states to terminate the Medicaid participation of any provider that has been terminated under Medicare or any Medicaid state plan.

Our facilities must comply with laws designed to protect the confidentiality and security of individually identifiable patient information. Under the federal Health Insurance Portability and Accountability Act of 1996, or HIPAA, and the Health Information Technology for Economic and Clinical Health Act, or the HITECH Act, our facilities that are "covered entities" within the meaning of HIPAA must comply with rules adopted by HHS governing the privacy, security, use and disclosure of individually identifiable information, including financial information and protected health information, or PHI, and security rules for electronic PHI. HIPAA and the HITECH Act are intended to ensure patient privacy and the efficiency of healthcare claims and payment transactions. There may be both civil monetary penalties and criminal sanctions for noncompliance with such federal laws. Under the HITECH Act, penalties for violation of certain provisions may be as high as $50,000 per violation for a maximum civil penalty of $1.5 million per calendar year. On January 17, 2013, HHS released the HIPAA Omnibus Rule, or the Omnibus Rule, which went into effect on March 26, 2013 and required compliance with most provisions by September 23, 2013. Pursuant to the Omnibus Rule, "covered entities" were required to make certain modifications to any business associate agreements that they have in place with their "business associates" within the meaning of HIPAA, depending on the circumstances. In addition, the Omnibus Rule required "covered entities" to modify and redistribute their notices of privacy practices to include certain provisions relating to the use of PHI. Further, the Omnibus Rule modified the standard for providing breach notices, which was previously based on an analysis of the harm resulting from any disclosure, to a more objective analysis on whether any PHI was actually acquired or viewed as a result of the breach. In addition to HIPAA, many states have enacted their own security and privacy laws relating to individually identifiable information, including financial information and PHI. In some states, these laws are more burdensome than HIPAA. In instances in which the state provisions are more stringent than HIPAA, our facilities must comply with applicable federal and state standards.

Our facilities must comply with the Americans with Disabilities Act, or the ADA, and similar state and local laws to the extent that such facilities are "public accommodations" as defined in those

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statutes. The obligation to comply with the ADA and other similar laws is an ongoing obligation, and we continue to assess our facilities and make appropriate modifications.

Other legislative proposals introduced in Congress, proposed by federal or state agencies or under consideration by some state governments include the option of block grants for states rather than federal matching money for certain state Medicaid services, laws authorizing or directing Medicare to negotiate rate reductions for prescription drugs, additional Medicare and Medicaid enforcement procedures and federal and state cost containment measures, such as freezing Medicare or Medicaid SNF payment rates at their current levels and reducing or eliminating annual Medicare or Medicaid inflation allowances or gradually reducing rates for SNFs.

Some of the states in which we operate either have not raised Medicaid rates by amounts sufficient to offset increased costs or have frozen or reduced, or are likely to freeze or reduce, Medicaid rates. Despite these freezes, Medicaid expenditures are projected to increase by 12.2% in 2014 and by an average annual rate of 7.9% in 2015 and 2016, due in part to the expansion in Medicaid eligibility under the ACA beginning in 2014. From 2017 through 2022, Medicaid spending is expected to grow by an average annual rate of 6.6% per year, mainly driven by spending for aged and disabled beneficiaries. Effective June 30, 2011, Congress ended certain temporary increases in federal payments to states for Medicaid programs that had been in effect since 2008. We expect the ending of these temporary federal payments, combined with other state budgetary pressures, to result in continued challenging state fiscal conditions, particularly in those states that are not participating in Medicaid expansion. As a result, some state budget deficits may increase, and certain states may continue to reduce Medicaid payments to healthcare services providers like us as part of an effort to balance their budgets. These state-level cuts have the potential to negatively impact our revenue from Medicaid sources.

INSURANCE

Litigation against senior living and healthcare companies has increased during the past few years. As a result, liability insurance costs have risen. Also, our insurance costs for workers' compensation and employee healthcare have increased. To partially offset these insurance cost increases, we have taken a number of actions including the following:

- we have become fully self-insured for all health related claims of covered employees;
- we have increased the deductible or retention amounts for which we are liable under our liability insurance;
- we have established an offshore captive insurance company which participates in our liability, workers' compensation and automobile insurance programs. These programs may allow us to reduce our net insurance costs by allowing us to retain the earnings on our reserves, provided that our claims experience matches that projected by various statutory and actuarial formulas;
- we have increased the amounts that some of our employees are required to pay for health insurance coverage and as co-payments for health services and pharmaceutical prescriptions and decreased the amount of certain healthcare benefits as well as adding a high deductible health insurance plan as an option for our employees;
- we have hired professional advisors to help us establish programs to reduce our insured workers' compensation and professional and general liabilities, including a program to monitor and proactively settle liability claims and to reduce workplace injuries;
- we have hired insurance and other professionals to help us establish appropriate reserves for our retained liabilities and captive insurance programs; and
- in order to obtain more control over our insurance costs, we, RMR and other companies, including SNH, to which RMR provides management services, organized AIC. We and the six other current shareholders of AIC have purchased property insurance providing $500.0 million of coverage pursuant to an insurance program arranged by AIC and with respect to which AIC

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is a reinsurer of certain coverage amounts. In June 2014, we renewed our participation in this program and paid AIC a premium, including taxes and fees, of approximately $3.9 million in connection with that policy, which amount may be adjusted from time to time as we acquire or dispose of properties that are covered in the policy. We periodically consider the possibilities for expanding our insurance relationships with AIC to include other types of insurance and may in the future participate in additional insurance offerings AIC may provide or arrange.

We partially self-insure up to certain limits for workers' compensation, professional liability and property coverage. Claims in excess of these limits are insured up to contractual limits, over which we are self-insured. Our current insurance arrangements are generally renewable annually in June. We do not know if our insurance charges and self-insurance reserve requirements will increase, and we cannot now predict the amount of any such increase, or to what extent, if at all, we may be able to offset any increase through use of higher deductibles, retention amounts, self-insurance or other means in the future. For more information about our insurance initiatives see "Management's Discussion and Analysis of Financial Condition and Results of Operations Related Person Transactions" of this Annual Report on Form 10-K.

COMPETITION

The senior living services business is highly competitive. We compete with numerous other companies that provide senior living services, including home healthcare companies and other real estate based service providers. We have large lease obligations and limited financeable assets. Many of our existing competitors are larger than us and have greater financial resources than us. We may expand our business with SNH and our relationships with SNH and RMR may provide us with competitive advantages; however, SNH is not obligated to provide us with opportunities to lease or manage additional properties. Some of our competitors are not for profit entities which have endowment income and may not have the same financial pressures that we face. We cannot provide any assurance that we will be able to compete successfully for business. For additional information on competition and the risks associated with our business, please see "Risk Factors" of this Annual Report on Form 10-K.

ENVIRONMENTAL AND CLIMATE CHANGE MATTERS

Under various laws, owners as well as tenants and operators of real estate may be required to investigate and clean up or remove hazardous substances present at or migrating from properties they own, lease or operate and may be held liable for property damage or personal injuries that result from hazardous substances. These laws also expose us to the possibility that we may become liable to reimburse governments for damages and costs they incur in connection with hazardous substances. Under our leases with SNH, we have also agreed to indemnify SNH for any such liabilities related to the properties we lease from SNH. In addition, some environmental laws create a lien on a contaminated site in favor of the government for damages and costs it incurs in connection with the contamination, which lien may be senior in priority to our debt obligations or our leases. Based upon our review of environmental surveys of certain of our leased and owned communities, we do not believe that there are environmental conditions at any of our properties that have had or will have a material adverse effect on us. However, no assurances can be given that conditions are not present at our properties or that costs we may be required to incur in the future to remediate contamination will not have a material adverse effect on our business or financial condition.

The current political debate about climate change has resulted in various treaties, laws and regulations which are intended to limit carbon emissions. We believe these laws being enacted or proposed may cause energy costs at our communities to increase in the future. In the longer term, we believe any such increased costs will be passed through and paid by our residents and other customers in higher charges for our services. However, in the short term, these increased costs, if material in amount, could materially and adversely affect our financial condition and results of operations. For more information regarding climate change matters and their possible adverse impact on us, please see "Management's Discussion and Analysis of Financial Condition and Results of Operations Impact of Climate Change."

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INTERNET WEBSITE

Our internet website address is www.fivestarseniorliving.com. Copies of our governance guidelines, or Governance Guidelines, code of business conduct and ethics, or Code of Conduct, our policy outlining procedures for handling concerns or complaints about internal accounting controls or auditing matters and the charters of our audit, quality of care, compensation and nominating and governance committees are posted on our website and may be obtained free of charge by writing to our Secretary, Five Star Quality Care, Inc., 400 Centre Street, Newton, Massachusetts, 02458 or at our website. We make available, free of charge, on our website, our Annual Reports on Form 10-K, our Quarterly Reports on Form 10-Q, our Current Reports on Form 8-K and amendments to these reports filed or furnished pursuant to Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended, or the Exchange Act, as soon as reasonably practicable after these forms are filed with, or furnished to, the SEC. Any stockholder or other interested party who desires to communicate with our non-management Directors, individually or as a group, may do so by filling out a report on our website. Our Board of Directors also provides a process for security holders to send communications to our entire Board of Directors. Information about the process for sending communications to our Board of Directors can be found on our website. Our website address and website addresses of one or more unrelated third parties are included several times in this Annual Report on Form 10-K as textual references only and the information in any such website is not incorporated by reference into this Annual Report on Form 10-K.

Item 1A. Risk Factors

Our business faces many risks. The risks described below may not be the only risks we face but are the risks we know of that we believe may be material at this time. Additional risks that we do not yet know of, or that we currently think are immaterial, may also impair our business operations or financial results. If any of the events or circumstances described in the following risks occurs, our business, financial condition or results of operations could suffer and the trading price of our securities could decline. Investors and prospective investors should consider the following risks and the information contained under the heading "Warning Concerning Forward Looking Statements" before deciding whether to invest in our securities.

RISKS RELATED TO OUR BUSINESS

A small percentage decline in our revenues or increase in our expenses could have a material negative impact upon our operating results.

For the year ended December 31, 2013, our revenues were $1.30 billion and our operating expenses were $1.29 billion. A small percentage decline in our revenues or increase in our expenses could have a material negative impact on our operating results because some of our fixed costs, such as our base rent, would not decrease during times of lower revenues and could not be reduced to offset other expenses which may be increasing.

The failure of Medicare and Medicaid rates to match our costs will reduce our income or create losses.

Some of our current operations, especially our SNFs, receive significant revenues from Medicare and Medicaid. During the years ended December 31, 2012 and 2013, we derived approximately 24% and 23%, respectively, of our senior living revenues from continuing operations from these programs. The Obama Administration and some members of Congress have proposed Medicare and Medicaid policy changes and rate reductions to take effect during the next several years. The ACA includes provisions that may result in future payment rates for a fiscal year being less than payment rates for a preceding fiscal year for SNFs. Effective as of October 1, 2011, CMS reduced aggregate Medicare payment rates for SNFs by approximately 11.1% for federal fiscal year 2012. We are unable to predict

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how the continued Medicare rate reductions under the ACA will affect our future financial results of operations.

In addition, our revenues received from Medicare and Medicaid may be subject to statutory and regulatory changes, retroactive rate adjustments, recovery of program overpayments or set-offs, administrative rulings and policy interpretations, and payment delays.

Pursuant to the Budget Control Act of 2011 and the Bipartisan Budget Act of 2013, the federal budget includes automatic spending reductions through 2023, including reductions of up to 2% to Medicare providers, but exempting reductions to Medicaid and certain Medicare benefits. In February 2014, Congress approved an additional one year extension of Medicare sequestration, through 2024. We are unable to predict the future financial impact on us of the automatic payments cuts; however, these payment cuts had an adverse impact on our operations and financial results during 2013 and may continue to have similar or worse impacts in the future.

Congress extended the process to allow medically necessary exceptions to annual caps on Medicare Part B payments for outpatient rehabilitation services to individual patients through March 31, 2015, but strict caps on reimbursement for these services will go into effect on April 1, 2015 if another extension is not granted. In addition, our Medicare Part B outpatient therapy revenue rates are tied to the Medicare Physician Fee Schedule, or MPFS. Although the MPFS had previously been scheduled to be reduced by more than 25% in 2013, MPFS rates remained fixed at the 2012 level throughout 2013, increased 0.5% for the period between January 1, 2014 and December 31, 2014, and are scheduled to be reduced by up to 24% effective April 1, 2015. Unless the reduction is once again delayed, it will likely result in a reduction of our Medicare Part B rates for outpatient therapy services and could be materially adverse to our future financial results of operations.

Some of the states in which we operate either have not raised Medicaid rates by amounts sufficient to offset increasing costs, have frozen or reduced Medicaid rates, or are likely to freeze or reduce Medicaid rates. Many states are experiencing difficult fiscal conditions or budgetary constraints, thus increasing the likelihood of Medicaid rate reductions, freezes or increases that are insufficient to offset increased operating costs. Also, certain temporary increases in federal payments to states for Medicaid programs ended on June 30, 2011. The ending of these temporary federal payments, combined with the anticipated slow recovery of state revenues, has resulted in and is expected to result in continued challenging state fiscal conditions. Some state budget deficits will likely increase, and it is possible that certain states will reduce Medicaid payments to healthcare service providers like us as part of an effort to balance their budgets. The ACA currently provides for an expansion of Medicaid eligibility beginning in 2014, which has the potential to increase Medicaid enrollment. The U.S. Supreme Court has held, however, that states may choose not to participate in the Medicaid expansion program without risking the loss of federal Medicaid funding. As of August 28, 2014, 21 states have elected not to broaden Medicaid eligibility under the ACA at this time and, instead, forgo the federal funds that would otherwise be available for Medicaid expansion, and two remain undecided.

We cannot currently estimate the magnitude of the potential Medicare and Medicaid rate reductions, the impact of the failure of these programs to increase rates to match increasing expenses, the impact of states that choose not to expand Medicaid eligibility and the impact on us of potential Medicare and Medicaid policy changes proposed by members of Congress and the Obama Administration, but they may be material to our operations and may affect our future results of operations. We cannot now predict whether future Medicare and Medicaid rates will be sufficient to cover our costs. Future Medicare and Medicaid rate declines or a failure of these rates to cover our costs could result in our experiencing materially lower earnings or losses.

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Circumstances that adversely affect the ability of seniors or their families to pay for our services could have a material adverse effect on us.

Our residents paid approximately 77% of our senior living revenues from continuing operations during the year ended December 31, 2013 from their private resources. We expect to continue to rely on the ability of our residents to pay for our services from their own financial resources. Inflation, continued high levels of unemployment, market declines affecting the value and liquidity of personal assets, or other circumstances that adversely affect the ability of the elderly or their families to pay for our services could have a material adverse effect on our business, financial condition and results of operations.

Seniors' inability to sell real estate may delay their moving into senior living facilities.

Recent housing price declines and reduced home mortgage financing availability have negatively affected the U.S. housing market. Although home prices and sales activity have recently been generally increasing, they continue to be below levels experienced prior to the recent economic recession in the United States. Further, although mortgage financing availability has improved since the recession, interest rates have generally increased; if interest rates rise sharply, the prices for homes or sales activity may decline. Difficulties in the U.S. housing market may have a negative effect on our revenues or lead to increased reliance on Medicare and Medicaid for our revenues. Specifically, if seniors have a difficult time selling their homes, fewer seniors may relocate to our senior living communities or finance their stays at our facilities with private resources.

Private third party payers continue to try to reduce healthcare costs.

Private third party payers such as insurance companies continue their efforts to control healthcare costs through direct contracts with healthcare providers, increased utilization review practices and greater enrollment in managed care programs and preferred provider organizations. These third party payers increasingly demand discounted fee structures and the assumption by healthcare providers of all or a portion of the financial risk. These efforts of third party payers to limit the amount of payments we receive for healthcare services could adversely affect us. Reimbursement payments under third party payer programs may not remain at levels comparable to present levels or be sufficient to cover the costs allocable to patients participating in such programs. Future changes in, or renegotiations of, the reimbursement rates or methods of third party payers, or the implementation of other measures to reduce payments for our services could result in a substantial reduction in our net operating revenues. At the same time, as a result of competitive pressures, our ability to maintain operating margins through price increases to private pay residents may be limited.

Provisions of the Patient Protection and Affordable Care Act could reduce our income and increase our costs.

The ACA contains insurance changes, payment changes and healthcare delivery systems changes that have affected, and will continue to affect, us. The ACA provides for multiple reductions to the annual market basket updates for inflation that may result in reductions in SNF and IRF Medicare payment rates. In addition, certain provisions of the ACA that affect employers generally, including the employer shared responsibility provisions that become effective on January 1, 2015, may have an impact on the design and cost of the health coverage that we offer to our employees. We are unable to predict the impact of the ACA on our future financial results of operations, but it may be adverse and material. In addition, maintaining compliance with the ACA will require us to expend management time and financial resources.

The ACA also establishes an Independent Payment Advisory Board to submit legislative proposals to Congress and take other actions with a goal of reducing Medicare spending growth. When and if

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such spending reductions take effect, they may be adverse and material to our financial results. The ACA includes other changes that may affect us, such as enforcement reforms and Medicare and Medicaid program integrity control initiatives, new compliance, ethics and public disclosure requirements, initiatives to encourage the development of home and community based long term care services rather than institutional services under Medicaid, value-based purchasing plans and a Medicare post-acute care pilot program to develop and evaluate making a bundled payment for services, including physician and SNF services, provided during an episode of care. We are unable to predict the impact on us of the insurance, payment, and healthcare delivery systems reforms contained in and to be developed pursuant to the ACA. If the changes to be implemented under the ACA result in reduced payments for our services or the failure of Medicare, Medicaid or insurance payment rates to cover our increasing costs, our future financial results could be adversely and materially affected.

We have determined that we have material weaknesses in our internal control over financial reporting because we did not maintain adequate and effective internal control over accounting for income taxes and accounts payable, and we lacked sufficient personnel with requisite accounting competencies and had an insufficient level of oversight in the financial statement close process. Failure to establish and maintain effective internal control over financial reporting could have a material adverse effect on our business, results of operations and the value of our common shares.

In connection with the preparation of this Annual Report on Form 10-K, we assessed the effectiveness of our internal control over financial reporting and determined that we had material weaknesses because: (1) we did not maintain adequate and effective internal control over accounting for income taxes due to our failure to timely reconcile and review our income tax accounts; (2) we did not maintain adequate and effective internal control over accounts payable due to our failure to timely identify certain incurred obligations; and (3) we lacked sufficient personnel with requisite accounting competencies and had an insufficient level of oversight in the financial statement close process. As a result, we concluded that our internal control over financial reporting was ineffective. A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of our financial statements will not be prevented or detected on a timely basis. We are continuing to develop our remediation plan for the material weaknesses described above, which currently includes enhancing internal control over accounting for income taxes to include additional layers of review by qualified persons, recruitment of additional experienced personnel for certain accounting positions, restructuring of our accounting department and providing enhanced training for employees regarding our accounting policies and procedures. We have begun to implement this remediation plan while we are continuing to develop it. Successful remediation of the material weaknesses described above requires review and evidence of the effectiveness of the related internal control processes as part of our periodic assessments of our internal controls over financial reporting. As we continue to evaluate and work to enhance our internal control over financial reporting, we may determine that additional measures should be taken to address the material weaknesses described above or other control deficiencies, or that we should modify the remediation plan. We expect that the remediation of the material weaknesses described above will be completed by December 31, 2015.

If we fail to remediate these material weaknesses or to design, implement and maintain new or improved controls and procedures designed to prevent additional material weaknesses, or if our management or our independent registered public accounting firm were to conclude in their future reports that our internal control over financial reporting was not effective, our ability to meet our periodic reporting obligations may be adversely affected, and may result in additional errors and material misstatements not detected by management in our financial statements. Any such failure could adversely affect the results of periodic management evaluations and annual auditor attestation reports regarding the effectiveness of our internal control over financial reporting. Any such failure could also

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cause investors to lose confidence in our reported financial information and could therefore adversely affect our business, results of operations and the value of our common shares.

Increases in our labor costs may have a material adverse effect on us.

Wages and employee benefits associated with our continuing operations were approximately 43% of our 2013 total operating costs. We compete with other operators of senior living communities to attract and retain qualified personnel responsible for the day to day operations of our communities. The market for qualified nurses, therapists and other healthcare professionals is highly competitive. Periodic and geographic area shortages of nurses or other trained personnel may require us to increase the wages and benefits offered to our employees in order to attract and retain these personnel or to hire more expensive temporary personnel. Also, we may have to compete with numerous other employers for lesser skilled workers. Further, when we acquire new facilities we may be required to pay increased compensation or offer other incentives to retain key personnel and other employees. Employee benefits costs, including employee health insurance and workers' compensation insurance costs, have materially increased in recent years and, as discussed above, we cannot predict the future impact of the ACA on the cost of employee health insurance. Although we have determined our self-insurance reserves with guidance from third party professionals, our reserves may be inadequate. Increasing employee health and workers' compensation insurance costs and increasing self-insurance reserves for labor related insurance may materially and negatively affect our earnings. We cannot assure that our labor costs will not increase or that any increase will be matched by corresponding increases in rates we charge to residents or other revenues. Any significant failure by us to control labor costs or to pass on any such increased labor costs to residents through rate increases could have a material adverse effect on our business, financial condition and results of operations.

Our business is subject to extensive regulation which increases our costs and may result in losses.

Licensing and Medicare and Medicaid laws require operators of senior living communities and rehabilitation and wellness clinics to comply with extensive standards governing operations and physical environments. Federal and state laws also prohibit fraud and abuse by senior living providers, rehabilitation and wellness clinic operators, including civil and criminal laws that prohibit false claims and that regulate patient referrals in Medicare, Medicaid and other programs. In recent years, federal and state governments have devoted increased resources to monitoring the quality of care at senior living communities and to anti-fraud investigations in healthcare generally. CMS contractors are expanding the retroactive audits of Medicare claims submitted by IRFs, SNFs and other providers, and recouping alleged overpayments for services determined by auditors not to have been medically necessary or not to meet Medicare coverage criteria as billed. State Medicaid programs and other third party payers are conducting similar medical necessity and compliance audits. When federal or state agencies identify violations of anti-fraud, false claims, anti-kickback and physician referral laws, they may impose or seek civil or criminal penalties, treble damages and other governmental sanctions, and may revoke the healthcare facility's license or make conditional or exclude the healthcare facility from Medicare or Medicaid participation. The ACA amended the federal Anti-Kickback Statute and the False Claims Act, making it easier for government agencies and private plaintiffs to prevail in lawsuits brought against healthcare providers, and for severe fines and penalties to be imposed on healthcare providers that violate applicable laws and regulations. In addition, when these agencies determine that there have been quality of care deficiencies or improper billing, they may impose or seek various remedies or sanctions, including denial of new admissions, exclusion from Medicare or Medicaid program participation, monetary penalties, restitution of overpayments, governmental oversight, temporary management, loss of licensure and criminal penalties. Certain states and the federal government may determine that citations relating to one facility affect other facilities operated by the same entity or related entities, which may negatively impact an operator's ability to maintain or renew other licenses or Medicare or Medicaid certifications or to secure new licenses or certifications.

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Our communities incur sanctions and penalties from time to time. As a result of the healthcare industry's extensive regulatory system and increasing enforcement initiatives, we have experienced increased costs for monitoring quality of care compliance, billing procedures, and compliance with referral laws and other laws that apply to us, and we expect these costs may continue to increase. In addition, we have been subjected to sanctions and penalties in the past, but none have been material to us. If we become subject to additional regulatory sanctions or repayment obligations at any of our existing communities (or any of our acquired communities with prior deficiencies that we are unable to correct or resolve following the acquisition), our business may be adversely affected, and we might experience financial losses. Any adverse determination concerning any of our licenses or eligibility for Medicare or Medicaid reimbursement or any penalties, repayments, or sanctions, and the increasing costs of required compliance with applicable federal and state laws, may adversely affect our ability to meet our financial obligations and negatively affect our financial condition and results of operations.

Successful union organization of our employees may adversely affect our business, financial condition and results of operations.

From time to time labor unions attempt to organize our employees. If federal legislation modifies the labor laws to make it easier for employee groups to unionize, then additional groups of employees may seek union representation. If more of our employees unionize it could result in business interruptions, work stoppages, the degradation of service levels at our senior living communities due to work rules, or increased operating expenses that may adversely affect our results of operations.

The nature of our business exposes us to litigation risks.

The nature of our business exposes us to litigation, and we are subject to lawsuits in the ordinary course of our business. In several well publicized instances, private litigation by residents of senior living communities for alleged abuses has resulted in large damage awards against other senior living companies. Some lawyers and law firms specialize in bringing litigation against senior living companies. As a result of this litigation and potential litigation, the cost of our liability insurance has increased during the past few years. Medical liability insurance reform has become a topic of political debate and some states have enacted legislation to limit future liability awards. However, such reforms have not generally been adopted and we expect our insurance costs may continue to increase. Although our reserves for liability self-insurance have been determined with guidance from third party professionals, our reserves may prove inadequate. Increasing liability insurance costs and increasing self-insurance reserves could have a material adverse effect on our business, financial condition and results of operations.

Our growth strategy may not succeed.

We have grown our business through acquisitions, through initiation of long term leases of senior living communities where residents' private resources account for a large majority of revenues and through entering into long term contracts to manage senior living communities. Our business plan includes seeking to take advantage of an expected increase in demand for senior living communities and acquiring, leasing or managing additional senior living communities. Our growth strategy involves risks, including the following:

- we may be unable to identify and operate additional senior living communities that receive a large percentage of their revenues from private resources;
- we may be unable to identify and operate senior living communities available for purchase at acceptable prices or lease or manage such senior living communities on acceptable terms;
- we may be unable to access capital to make acquisitions or operate acquired businesses;
- acquired, leased or managed additional operations may not perform in accord with our expectations;

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- we may be required to make significant capital expenditures to improve acquired or additional leased or managed facilities, including capital expenditures that may not have been anticipated by us at the time of the acquisition;

- we may have difficulty retaining key employees and other personnel at acquired, leased or managed facilities;

- acquired, leased or managed additional operations may subject us to unanticipated contingent liabilities or regulatory problems;

- to the extent we incur acquisition debt or leases, our operating leverage and resulting risks of debt defaults may increase; and, to the extent we issue additional equity to fund our acquisitions, our stockholders' percentage of ownership of us will be diluted; and

- combining our present operations with newly acquired, leased or managed operations may disrupt operations or cost more than anticipated.

For these reasons and others:

- our business plan to grow may not succeed;

- the benefits which we hope to achieve by growing may not be achieved;

- we may suffer declines in profitability or suffer recurring losses; and

- our existing operations may suffer from a lack of management attention or financial resources if such attention and resources are devoted to a failed growth strategy.

When we acquire, lease or manage new communities, we sometimes see a decline in community occupancy and it may take a period of time for us to stabilize acquired, leased or managed community operations. Our efforts to restore occupancy or stabilize acquired, leased or managed community operations may not be successful.

Our rehabilitation hospitals may be subject to retroactive Medicare reclassifications or repayments.

During the period we operated our rehabilitation hospitals, which were sold in the fourth quarter of 2013, Medicare payments accounted for a significant amount of the rehabilitation hospitals' revenues. CMS has established a standard known as the "60% Rule," which provides that at least 60% of an IRF's total inpatient population must require intensive rehabilitation services associated with treatment of at least one of 13 designated medical conditions in order for the facility to be classified as an IRF by the Medicare program. Although we believe that our IRFs were operated in compliance with the 60% Rule during the period in which we operated them, CMS could determine that we were non-compliant in a prior year. Such an event would result in these rehabilitation hospitals being subject to Medicare reclassification to a different type of provider and our receiving lower Medicare payment rates retroactively. Reductions in our Medicare payments as a result of the reclassification of our rehabilitation hospitals would materially and adversely affect our financial conditions and results of operations. Also, retroactive audits of Medicare claims submitted by IRFs and other providers are expanding, and CMS is recouping amounts paid for services determined by auditors not to have been medically necessary or not to meet Medicare criteria for coverage as billed. If our facilities were required to make substantial retroactive repayments to Medicare, our financial condition and results of operations could be materially and adversely affected.

Our failure to timely file periodic reports with the SEC limits us from quickly accessing the public markets to raise debt or equity capital.

We did not file this Annual Report on Form 10-K or our Quarterly Reports on Form 10-Q for the quarters ended March 31, 2014 and June 30, 2014 by the filing dates required by the SEC; therefore,

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we are not eligible to use our current shelf registration statement on Form S-3 (or file a new Form S-3 registration statement) to conduct public offerings of our securities until our filings with the SEC have been timely made for a full year. Our ineligibility to use Form S-3 during this time period will have a negative impact on our ability to quickly access the public capital markets because we would be required to file a long-form registration statement, which would be subject to an extended filing and possible review period.

Our failure or inability to meet certain terms of our credit agreements would adversely affect our business.

Our $25.0 million Credit Agreement and our $150.0 million Credit Facility agreement, or together, our credit agreements, include various conditions to our borrowing and various financial and other covenants and events of default. We may not be able to satisfy all of these conditions or may default on some of these covenants for various reasons, including matters which are beyond our control. If we are unable to borrow under our credit agreements we may be unable to meet our business obligations or to grow by buying additional properties, or we may be required to sell some of our properties. If we default under our credit agreements at a time when borrowed amounts are outstanding under these instruments, our lenders may demand immediate payment. In addition, if we default under our credit agreements, our lenders may cease to make borrowings available to us. Any default under our credit agreements would likely have serious and adverse consequences to us and would likely cause the market price of our securities to materially decline.

In the future, we may obtain additional debt financing, and the covenants and conditions which apply to any such additional indebtedness may be more restrictive than the covenants and conditions contained in our credit agreements.

We continue to seek acquisitions and other strategic opportunities that may require a significant amount of management resources and costs.

We continue to seek acquisitions and other strategic opportunities. Accordingly, we are often engaged in evaluating potential transactions and other strategic alternatives. In addition, from time to time, we engage in preliminary discussions that may result in one or more transactions. Although there is uncertainty that any of these discussions will result in definitive agreements or the completion of any transaction, we may devote a significant amount of our management resources to such transactions, which could negatively impact our existing and continuing operations. In addition, we may incur significant costs in connection with seeking acquisitions regardless of whether these acquisitions are completed.

Failure to comply with laws governing the privacy and security of personal information, including relating to health, could materially and adversely affect our business, financial condition and results of operations.

We are required to comply with federal and state laws governing the privacy, security, use and disclosure of personally identifiable information, including information relating to health. Under HIPAA and the HITECH Act, as updated by the HIPAA Omnibus Rule, we are required to comply with the HIPAA privacy rule, security standards, and standards for electronic healthcare transactions. State laws also govern the privacy of individual health information, and rules regarding state privacy rights may be more stringent than HIPAA. Other federal and state laws govern the privacy of other personal information. If we fail to comply with applicable federal or state standards, we could be subject to civil sanctions and criminal penalties, which could materially and adversely affect our business, financial condition and results of operations.

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We rely on information technology in our operations, and any material failure, inadequacy, interruption or security failure of that technology could harm our business.

We rely on information technology networks and systems, including the Internet, to process, transmit and store electronic information and to manage or support a variety of our business processes, including medical records, financial transactions and maintenance of records, which may include personally identifiable information of residents and other customers, payroll data and workforce scheduling information. We purchase some of our information technology from vendors, on whom our systems depend. We rely on commercially available systems, software, tools and monitoring to provide security for processing, transmitting and storing this confidential information, such as personally identifiable information relating to health and financial accounts. Although we have taken steps to protect the security of the data maintained in our information systems, it is possible that our security measures will not be able to prevent the systems' improper functioning, or the improper disclosure of personally identifiable information such as in the event of cyber attacks. Security breaches, including physical or electronic break-ins, computer viruses, attacks by hackers and similar breaches, can create system disruptions, shutdowns or unauthorized disclosure of confidential information. Any failure to maintain proper function, security and availability of our information systems could interrupt our operations, damage our reputation, subject us to liability claims or regulatory penalties and could materially and adversely affect us.

Termination of assisted living resident agreements and resident attrition could adversely affect our revenues and earnings.

State regulations governing assisted living facilities typically require a written resident agreement with each resident. Most of these regulations also require that each resident have the right to terminate these assisted living resident agreements for any reason on reasonable notice. Consistent with these regulations, most resident agreements allow residents to terminate their agreements on 30 days' notice. Thus, we may be unable to contract with assisted living residents to stay for longer periods of time, unlike typical apartment leasing arrangements that involve lease agreements with terms of up to a year or longer. If a large number of residents elected to terminate their resident agreements at or around the same time, our revenues and earnings could be materially and adversely affected. In addition, the advanced ages of our senior living residents makes the resident turnover rate in our senior living communities difficult to predict.

Our business requires us to make significant capital expenditures to maintain and improve our communities.

Our communities sometimes require significant expenditures to address ongoing required maintenance and to make them attractive to residents. Physical characteristics of senior living communities are mandated by various governmental authorities; changes in these regulations may require us to make significant expenditures. In addition, we often are required to make significant capital expenditures when we acquire new communities. Our available financial resources may be insufficient to fund these expenditures. SNH has historically provided most of the capital we need to improve the communities we lease from them; however, whenever SNH provides such capital, our rent increases and we may be unable to pay the increased rent without experiencing losses. In addition, for properties we manage for SNH, SNH funds these capital expenditures, resulting in the invested capital on which its returns are based increasing, which may reduce or prevent our receipt of incentive fees.

We face significant competition and we may be unable to operate profitably.

We compete with numerous other companies that provide senior living services, including home healthcare companies and other real estate based service providers. Although some states require certificates of need to develop new SNFs and assisted living communities, there are fewer barriers to

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competition for home healthcare or for independent and assisted living services. Many of our existing competitors are larger and have greater financial resources than us. Some of our competitors are not for profit entities which have endowment income and may not have the same financial pressures that we face. We cannot assure that we will be able to attract a sufficient number of residents to our communities or that we will be able to attract employees and keep wages and other employee benefits, insurance costs and other operating expenses at levels which will allow us to compete successfully or to operate profitably.

Increased leverage may harm our financial condition and results of operations.

Our total consolidated long term debt as of December 31, 2013 was approximately $36.5 million and represented approximately 10% of our total book capitalization as of that date. In addition to our indebtedness, we have substantial lease and other obligations.

Our level of indebtedness and substantial lease and other obligations could have important consequences to our business, because:

- it could affect our ability to satisfy our debt obligations;
- the portion of our cash flows from operations required to make interest and principal payments will not be available for operations, working capital, capital expenditures, expansion, acquisitions or general corporate or other purposes;
- it may impair our ability to obtain additional financing in the future;
- it may limit our flexibility in planning for, or reacting to, changes in our business and industry; and
- it may make us more vulnerable to downturns in our business, our industry or the economy in general than a company with less debt leverage.

Climate change legislation and resulting increased energy costs at our communities could materially and adversely affect our business, financial condition and results of operations.

The current political debate about climate change has resulted in various treaties, laws and regulations which are intended to limit carbon emissions. We believe these laws being enacted or proposed may cause energy costs at our communities to increase in the future. In the longer term, we believe any such increased costs will be passed through and paid by our residents and other customers in higher charges for our services. However, in the short term, these increased costs, if material in amount, could materially and adversely affect our financial condition and results of operations. For more information regarding climate change matters and their possible adverse impact on us, please see "Management's Discussion and Analysis of Financial Condition and Results of Operations Impact of Climate Change."

RISKS ARISING FROM CERTAIN RELATIONSHIPS OF OURS AND OUR ORGANIZATION AND STRUCTURE

We are subject to possible conflicts of interest; we have engaged in, and expect to continue to engage in, transactions with parties that may be considered related parties.

Our business is subject to possible conflicts of interest as follows:

- as of December 31, 2013, we leased from SNH 187 of our 255 senior living communities (including 10 that we have classified as discontinued operations) for total annual rent of approximately $190.1 million plus percentage rent based on increases in gross revenues at certain properties;

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as of December 31, 2013, we managed 44 senior living communities which are owned by SNH, and during 2013, we realized $9.2 million in management fees from SNH;

we manage a portion of a senior living community for D&R Yonkers LLC, which is owned by SNH's President and Chief Operating Officer and its Treasurer and Chief Financial Officer and to which a subsidiary of SNH subleases that portion of the community;

RMR, the manager of SNH, provides business management and shared services to us;

our Chief Executive Officer, Bruce J. Mackey Jr., and our Chief Financial Officer, Paul V. Hoagland, are also officers of RMR; our Managing Directors, Barry M. Portnoy and Gerard M. Martin, are directors of RMR; and Mr. Barry Portnoy is a managing trustee of SNH and is also the majority beneficial owner and the chairman of RMR;

RMR's simultaneous contractual obligations to us and SNH create potential conflicts of interest, or the appearance of such conflicts of interest, and under the business management agreement with RMR, in the event of a conflict between SNH and us, RMR may act on behalf of SNH rather than on our behalf; and

we lease our headquarters from an affiliate of RMR.

On December 31, 2001, SNH distributed substantially all of its ownership of our common shares to its shareholders. Simultaneously with the spin off, we entered into agreements with SNH and RMR which, among other things, limit (subject to certain exceptions) ownership of more than 9.8% of our voting shares, restrict our ability to take any action that could jeopardize the tax status of SNH as a real estate investment trust, or REIT, and limit our ability to acquire real estate of types which are owned by SNH or other businesses managed by RMR. As a result of these agreements, our leases and management contracts with SNH, and our business management agreement with RMR, SNH, RMR and their respective affiliates have significant roles in our business and we do not anticipate any changes to those roles in the future. In addition, as of December 31, 2013, SNH owned 4.2 million of our common shares, or approximately 8.7% of our outstanding common shares, and SNH is our largest stockholder.

We believe that our historical and ongoing business dealings with SNH, RMR and D&R Yonkers LLC have benefited us and that, despite the foregoing possible conflicts of interest, the transactions we have entered with SNH, RMR and D&R Yonkers LLC have been commercially reasonable and not less favorable than otherwise available to us. Nonetheless, in the past, in particular following periods of volatility in the overall market or declines in the market price of a company's securities, stockholder litigation, dissident stockholder director nominations and dissident stockholder proposals have often been instituted against companies alleging conflicts of interest in business dealings with affiliated and related persons and entities. Our relationships with SNH, RMR, D&R Yonkers LLC, AIC, the other businesses and entities to which RMR provides management services, Messrs. Portnoy and Martin and with other related parties of RMR may precipitate such activities. These activities, if instituted against us, could result in substantial costs and a diversion of our management's attention.

Our leases of certain of our senior living communities are subordinated to mortgage debt of SNH, and a default by SNH could result in the termination of those leases.

As of December 31, 2013, our leases with SNH for 27 of our senior living communities, which had 2013 revenues totaling $187.6 million, were subordinated to mortgage financing secured by such communities. As a result, in the event SNH was to default on such mortgage financing, by reason of our default under our leases or for reasons unrelated to us or beyond our control, and its lender were to foreclose on those properties, our leases would terminate as a matter of law. While we may be able to enter into new leases with the lenders or the purchaser or purchasers of such properties, or they

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may elect to continue our occupancy under the terms of the lease as if there had been no foreclosure, they would not be obligated to pursue either of those options and, if we are able to retain possession, the terms of our continued occupancy may not be as favorable to us as those contained in our leases with SNH. If we do not enter into new leases of such communities following a foreclosure, we would lose the right to continue to operate these communities and we may incur material obligations to residents, employees and other parties as a result of such loss, each of which could have a material and adverse effect on our results of operations.

Ownership limitations and certain provisions in our charter, bylaws and certain material agreements, as well as certain provisions of Maryland law, may deter, delay or prevent a change in our control or unsolicited acquisition proposals.

Our charter and bylaws contain separate provisions which prohibit any stockholder from owning more than 9.8% and 5% of the number or value of any class or series of our outstanding shares of stock. The 9.8% ownership limitation in our charter is consistent with our contractual obligation with SNH to not take actions that may conflict with SNH's status as a REIT under the Internal Revenue Code. The 5% ownership limitation in our bylaws is intended to help us preserve the tax treatment of our net operating losses and other tax benefits. We also believe these provisions promote good orderly governance. These provisions inhibit acquisitions of a significant stake in us and may deter, delay or prevent a change in our control or unsolicited acquisition proposals that a stockholder may consider favorable. Additionally, provisions contained in our charter and bylaws or under Maryland law may have a similar impact, including, for example, provisions relating to:

- the division of our Directors into three classes, with the term of one class expiring each year, which could delay a change of control;
- stockholder voting rights and standards for the election of Directors and other provisions which require larger majorities for approval of actions which are not approved by our Directors than for actions which are approved by our Directors;
- the authority of our Board of Directors, and not our stockholders, to adopt, amend or repeal our bylaws and to fill vacancies on our Board of Directors;
- required qualifications for an individual to serve as a Director and a requirement that certain of our Directors be "Independent Directors" and other Directors be "Managing Directors", as defined in our bylaws;
- limitations on the ability of our stockholders to propose nominees for election as Directors and propose other business to be considered at a meeting of stockholders;
- limitations on the ability of our stockholders to remove our Directors; and
- the authority of our Board of Directors to create and issue new classes or series of stock (including stock with voting rights and other rights and privileges that may deter a change in control) and issue additional common stock.

In addition, our shareholders agreement with respect to AIC provides that AIC and the other shareholders of AIC may have rights to acquire our interests in AIC in the event that anyone acquires more than 9.8% of our shares or we experience some other change in control. The terms of our leases and management contracts with SNH and our business management agreement with RMR provide that our rights under these agreements may be cancelled by SNH and RMR, respectively, upon the acquisition by any person or group of more than 9.8% of our voting stock, and upon other change in control events, as defined in those documents including, in certain of the SNH leases and management agreements, the adoption of any proposal (other than a precatory proposal) or the election to our Board of Directors of any individual if such proposal or individual was not approved, nominated or

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appointed, as the case may be, by vote of a majority of our Directors in office immediately prior to the making of such proposal or the nomination or appointment of such individual. If the breach of these ownership limitations causes a default, stockholders causing the default may become liable to us or to other stockholders for damages. In addition, a termination of our business management agreement is a default under our Credit Agreement, and a change in control event of us, including upon the acquisition by any person or group of more than 9.8% (or 35% for the purposes of our Credit Facility) of our voting stock, is a default under our Credit Agreement and our Credit Facility, unless approved by our lenders.

Our ownership interest in AIC may prevent stockholders from accumulating large share ownership, from nominating or serving as Directors, or from taking actions to otherwise control our business.

As an owner of AIC, we are licensed and approved as an insurance holding company; and any stockholder who owns or controls 10% or more of our securities or anyone who wishes to solicit proxies for election of, or to serve as, one of our Directors or for another proposal of business not approved by our Board of Directors may be required to receive pre-clearance from the concerned insurance regulators. These pre-approval procedures may discourage or prevent investors from purchasing our securities, from nominating persons to serve as our Directors or from taking other actions.

Our rights and the rights of our stockholders to take action against our Directors and officers are limited.

Our charter limits the liability of our Directors and officers to us and our stockholders for money damages to the maximum extent permitted under Maryland law. Under current Maryland law, our Directors and officers will not have any liability to us and our stockholders for money damages other than liability resulting from:

actual receipt of an improper benefit or profit in money, property or services; or

active and deliberate dishonesty by such director or officer that was established by a final judgment as being material to the cause of action adjudicated.

Our charter and contractual obligations authorize and may require us to indemnify our present and former Directors and officers for actions taken by them in those capacities to the maximum extent permitted by Maryland law. However, except with respect to proceedings to enforce rights to indemnification, we will indemnify any person referenced in the previous sentence in connection with a proceeding initiated by such person against us only if such proceeding is authorized by our charter or bylaws or by our Board of Directors or stockholders. In addition, we may be obligated to pay or reimburse the expenses incurred by our present and former Directors and officers without requiring a preliminary determination of their ultimate entitlement to indemnification. As a result, we and our stockholders may have more limited rights against our present and former Directors and officers than might otherwise exist absent the provisions in our charter and contracts or that might exist with other companies, which could limit your recourse in the event of actions not in your best interest.

Disputes with SNH and RMR and stockholder litigation against us or our Directors and officers may be referred to binding arbitration proceedings.

Our contracts with SNH and RMR provide that any dispute arising under those contracts may be referred to binding arbitration proceedings. Similarly, our bylaws provide that actions by our stockholders against us or against our Directors and officers, including derivative and class actions, may be referred to binding arbitration proceedings. As a result, we and our stockholders would not be able to pursue litigation for these disputes in courts against SNH, RMR or our Directors and officers if the disputes were referred to arbitration. In addition, the ability to collect attorneys' fees or other damages

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may be limited in the arbitration proceedings, which may discourage attorneys from agreeing to represent parties wishing to commence such a proceeding.

We may experience losses from our business dealings with AIC.

We have invested approximately $6.0 million in AIC, we have purchased substantially all our property insurance in a program designed and reinsured in part by AIC, and we periodically consider the possibilities for expanding our relationship with AIC to other types of insurance. We, RMR and five other companies to which RMR provides management services each own approximately 14.3% of AIC, and we and those other AIC shareholders participate in a combined insurance program designed and reinsured in part by AIC. Our principal reason for investing in AIC and for purchasing insurance in these programs is to seek to improve our financial results by obtaining improved insurance coverages at lower costs than may be otherwise available to us or by participating in any profits which we may realize as an owner of AIC. While we believe we have in the past benefitted from these arrangements, these beneficial financial results may not occur in the future, and we may need to invest additional capital in order to continue to pursue these results. AIC's business involves the risks typical of an insurance business, including the risk that it may not operate profitably. Accordingly, financial benefits from our business dealings with AIC may not be achieved in the future, and we may experience losses from these dealings.

RISKS RELATED TO OUR SECURITIES

We do not intend to pay cash dividends on our common shares in the foreseeable future.

We have never declared or paid any cash dividends on our common shares, and we currently do not anticipate paying any cash dividends in the foreseeable future.

The market price of our common shares has fluctuated and a number of factors may cause the market price of our common shares to decline.

The market price of our common shares has fluctuated and could fluctuate significantly in the future if any of the risks described herein occur or in response to various factors and events, including, but not limited to:

the liquidity of the market for our common shares;

changes in our operating results;

changes in analysts' expectations; and

general economic and industry trends and conditions.

In addition, the stock market in recent years has experienced broad price and volume fluctuations that often have been unrelated to the operating performance of particular companies. These market fluctuations may also cause the market price of our common shares to decline. Stockholders may be unable to resell our common shares at or above the price at which they purchased our common shares.

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Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

OUR SENIOR LIVING COMMUNITIES

As of December 31, 2013, we owned or leased and operated as continuing operations 211 senior living communities which we have categorized into two groups as follows:

Type of community	No. of communities	Type of units: Indep. living apts.	Type of units: Assist. living suites	Type of units: Skilled nursing beds	Type of units: Total living units	Average occupancy for the year ended Dec. 31, 2013	Revenues for the year ended Dec. 31, 2013 (in thousands)	Percent of revenues from private resources
Independent and assisted living communities	180	6,956	11,163	2,031	20,150	86.5%	$ 883,183	87.0%
SNFs	31	69		2,753	2,822	81.0%	180,664	25.6%
Totals:	211	7,025	11,163	4,784	22,972	85.8%	$ 1,063,847	76.6%

Excluded from the preceding and following data are 44 independent and assisted living communities containing 3,343 independent living apartments, 3,236 assisted living suites and 472 skilled nursing beds that we manage for the account of SNH. Also excluded are 48 living units of an assisted living community that has been temporarily closed for a major renovation, one assisted living community containing 32 living units that we own and six SNFs and four assisted living communities containing 712 living units that we lease from SNH that we have classified as discontinued operations, each as of December 31, 2013. Unless specifically provided below or unless the context provides otherwise, the discussion and analysis provided below does not include the senior living communities we have classified as discontinued operations.

Independent and Assisted Living Communities

As of December 31, 2013, we owned or leased and operated 180 independent and assisted living communities. We leased 146 of these communities from SNH and four of these communities from HCP, Inc., or HCP. We own the remaining 30 communities. These communities have 20,150 living units

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and are located in 26 states. The following table provides additional information about these communities and their operations as of December 31, 2013:

Location	No. of communities	Type of units: Indep. living apts.	Type of units: Assist. living suites	Type of units: Skilled nursing beds	Type of units: Total living units	Average occupancy for the year ended Dec. 31, 2013	Revenues for the year ended Dec. 31, 2013 (in thousands)	Percent of revenues from private resources
1. Alabama	7		287		287	88.4%	$ 11,269	100.0%
2. Arizona	4	471	350	204	1,025	76.0%	41,517	81.2%
3. California	8	496	423	59	978	83.4%	45,320	90.2%
4. Delaware	6	336	322	341	999	78.8%	63,777	66.6%
5. Florida	9	1,175	716	155	2,046	94.6%	80,989	78.5%
6. Georgia	11	111	524	40	675	89.4%	26,687	93.3%
7. Illinois	2	112	73		185	97.3%	5,412	100.0%
8. Indiana	16	950	577	140	1,667	85.6%	63,149	87.0%
9. Kansas	3	334	67	198	599	89.7%	30,206	68.6%
10. Kentucky	10	491	281	183	955	90.9%	45,196	84.2%
11. Maryland	10	270	661		931	91.5%	52,950	99.9%
12. Massachusetts	1		123		123	88.8%	8,232	100.0%
13. Minnesota	1		230		230	81.3%	12,228	97.5%
14. Mississippi	2		113		113	92.2%	3,684	100.0%
15. Missouri	1	110			110	90.7%	2,704	100.0%
16. Nebraska	2	27	111	62	200	84.5%	8,756	57.4%
17. New Jersey	5	215	555	60	830	90.4%	39,312	83.3%
18. New Mexico	1	114	35	60	209	84.5%	12,990	83.7%
19. North Carolina	15	211	1,225		1,436	85.4%	61,636	99.1%
20. Ohio	1	143	115	57	315	88.7%	18,767	87.0%
21. Pennsylvania	10		1,011		1,011	83.1%	37,816	100.0%
22. South Carolina	18	101	864	100	1,065	84.3%	41,541	93.3%
23. Tennessee	11	7	672		679	95.6%	25,486	100.0%
24. Texas	9	898	590	298	1,786	80.0%	80,486	85.6%
25. Virginia	11	284	718		1,002	90.6%	38,854	100.0%
26. Wisconsin	6	100	520	74	694	80.4%	24,219	71.4%
Totals:	180	6,956	11,163	2,031	20,150	86.5%	$ 883,183	87.0%

Skilled Nursing Facilities

As of December 31, 2013, we operated 31 SNFs that we lease from SNH. These facilities have 2,822 living units and are located in seven states. The following table provides additional information about these facilities and their operations as of December 31, 2013:

Location	No. of communities	Type of units: Indep. living apts.	Type of units: Assist. living suites	Type of units: Skilled nursing beds	Type of units: Total living units	Average occupancy for the year ended Dec. 31, 2013	Revenues for the year ended Dec. 31, 2013 (in thousands)	Percent of revenues from private resources

1. California	4		373	373	90.1%		34,886	13.2%
2. Colorado	7	46	755	801	80.1%		53,865	30.4%
3. Iowa	4	19	283	302	80.2%		15,846	30.3%
4. Kansas	1	4	56	60	84.3%		3,319	25.6%
5. Nebraska	10		611	611	84.2%		34,122	28.1%
6. Wisconsin	3		484	484	73.3%		27,529	25.9%
7. Wyoming	2		191	191	76.2%		11,096	25.5%
Totals:	31	69	2,753	2,822	81.0%	$	180,664	25.6%

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OUR SNH LEASES AND MANAGEMENT AGREEMENTS

SNH Leases

The following table provides a summary of our leases as of December 31, 2013 (including with respect to 10 senior living communities that we have classified as discontinued operations) and is followed by a summary of the material terms of our leases as of December 31, 2013 with SNH. Because it is a summary, it does not contain all of the information that may be important to you. If you would like more information, you should read the leases which are among the exhibits listed in Part IV, Item 15 of this Annual Report on Form 10-K and incorporated herein by reference.

	Number of properties	Annual minimum rent as of December 31, 2013	Initial expiration date	Renewal terms
1. Lease No. 1 for SNFs and independent and assisted living communities[1]	90	$ 58.7 million	December 31, 2024	Two 15-year renewal options.
2. Lease No. 2 for SNFs, independent and assisted living communities	51	62.5 million	June 30, 2026	Two 10-year renewal options.
3. Lease No. 3 for independent and assisted living communities[2]	17	34.2 million	December 31, 2028	Two 15-year renewal options.
4. Lease No. 4 for SNFs and independent and assisted living communities[3]	29	34.7 million	April 30, 2017	Two 15-year renewal options.
Totals	187	$ 190.1 million		

(1) Lease No. 1 is comprised of three separate leases. Two of these three leases exist to accommodate mortgage financings in effect at the time SNH acquired the properties; we have agreed with SNH to combine all three of these leases into one lease as and when these mortgage financings are paid.

(2) Lease No. 3 exists to accommodate certain mortgage financing by SNH.

(3) Lease No. 4 is comprised of two separate leases. One of these two leases exists to accommodate mortgage obligations in effect at the time SNH acquired the property; we have agreed with SNH to combine both of these leases into one lease when the mortgage financing is paid. We and SNH have entered into an amendment to Lease No. 4 pursuant to which we and SNH added a third option for us to extend the term of Lease No. 4 from May 1, 2047 to April 30, 2062. In addition, we exercised the first of our existing options to extend the term of Lease No. 4, extending the term from April 30, 2017 to April 30, 2032.

Percentage Rent. Our leases with SNH require us to pay percentage rent at 180 of the 187 senior living communities we lease from SNH (including 10 senior living communities that we have classified as discontinued operations) equal to 4% of the amount by which gross revenues, as defined in our leases, of each property exceeds gross revenues in a specific base year. These amounts are in addition

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to the minimum annual rent amounts payable by us to SNH. We paid total percentage rent of $5.1 million in 2013. Different base years apply to those communities that pay percentage rent. The base year is usually the first full calendar year after each community is leased.

Operating Costs. Each lease is a so-called "triple-net" lease which requires us to pay all costs incurred in the operation of the properties, including the costs of maintenance, personnel, services to residents, insurance and real estate and personal property taxes.

Rent During Renewal Term. For all but seven of the properties we lease from SNH, rent during each applicable renewal term is the same as the minimum rent and percentage rent payable during the initial term. For the remaining seven properties, rent during the second renewal term is based on the fair market rental value of such properties.

Licenses. Our leases require us to obtain, maintain and comply with all applicable permits and licenses necessary to operate the leased properties.

Maintenance and Alterations. We are required to operate continuously and maintain, at our expense, the leased properties in good order and repair, including structural and nonstructural components. We may request SNH to fund amounts needed for repairs and renovations in return for rent increases according to formulas in the leases; however, SNH is not obligated to fund such requests and we are not required to sell them to SNH. At the end of each lease term, we are required to surrender the leased properties in substantially the same condition as existed on the commencement date of the lease, subject to any permitted alterations and ordinary wear and tear.

Assignment and Subletting. SNH's consent is generally required for any direct or indirect assignment or sublease of any of the properties. Also, in the event of any assignment or subletting, we remain liable under the terms of the applicable lease.

Indemnification and Insurance. With limited exceptions, we are required to indemnify SNH from all liabilities which may arise from the ownership or operation of the leased properties. We generally are required to maintain insurance against such risks and in such amounts as SNH shall reasonably require and may be commercially reasonable. Each lease requires that SNH be named as an additional insured under these insurance policies.

Damage, Destruction, Condemnation and Environmental Matters. If any of the leased properties is damaged by fire or other casualty or taken for a public use, we are generally obligated to rebuild it unless the property cannot be restored. If the property cannot be restored, SNH will generally receive all insurance or taking proceeds and we are liable to SNH for the amount of any deductible or deficiency between the replacement cost and the insurance proceeds, and our rent will be adjusted pro rata. We are also required to remove and dispose of any hazardous substance at the leased properties in compliance with all applicable environmental laws and regulations.

Events of Default. Events of default under each lease generally include the following:

- our failure to pay rent or any money due under the lease when it is due, which failure continues for five business days;
- our failure to maintain the insurance required under such lease;
- any person or group acquiring ownership of 9.8% or more of our outstanding voting stock or any change in our control, the adoption of any stockholder proposal (other than a precatory proposal) or the election to our Board of Directors of any individual if such proposal or individual was not approved, nominated or appointed, as the case may be, by vote of a majority of our Directors in office immediately prior to the making of such proposal or the nomination or appointment of such individual;

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the occurrence of certain events with respect to our insolvency or dissolution;

our default under indebtedness which gives the holder the right to accelerate;

our being declared ineligible to receive reimbursement under Medicare or Medicaid programs for any of the leased properties which participate in such programs or the revocation of any material license required for our operations; and

our failure to perform any terms, covenants or agreements of such lease and the continuance thereof for a specified period of time after written notice.

Remedies. Upon the occurrence of any event of default, each lease provides that, among other things, SNH may, to the extent legally permitted:

accelerate the rents;

terminate the leases in whole or in part;

enter the property and take possession of any and all our personal property and retain or sell the same at a public or private sale;

make any payment or perform any act required to be performed by us under the leases; and

rent the property and recover from us the difference between the amount of rent which would have been due under the lease and the rent received from the re-letting.

We are obligated to reimburse SNH for all costs and expenses incurred in connection with any exercise of the foregoing remedies.

Management. We may not enter into any new management agreement affecting any leased property without the prior written consent of SNH.

Lease Subordination. Our leases may be subordinated to any mortgages on properties leased from SNH. As of December 31, 2013, SNH had mortgages on 27 of our communities to which our leases were subordinated. These 27 communities had 4,001 living units and 2013 revenues totaling $187.6 million. SNH's outstanding borrowing secured by mortgages on these 27 communities totaled $346.2 million as of December 31, 2013.

Financing Limitations; Security. Our leases subject to mortgage financings of SNH require SNH's consent before we incur debt secured by our investments in our tenant subsidiaries that lease or operate the properties subject to these leases. Further, our leases subject to mortgage financings prohibit our tenant subsidiaries from incurring liabilities, other than operating liabilities incurred in the ordinary course of business, secured by our accounts receivable or purchase money debt. We may pledge interests in our leases only if the pledge is approved by SNH. In addition, in connection with our leases subject to mortgage financings with SNH, certain of our subsidiaries pledged to the lenders under such mortgage financings certain tangible and intangible personal property, such as accounts receivable and contract rights, located at, or arising from the operations of, the properties subject to such leases to secure their obligations under such leases and certain of their obligations relating to such mortgage financings.

Non-Economic Circumstances. If we determine that continued operations of one or more properties is not economical, we may negotiate with SNH to close or sell that community, including SNH's ownership in the property. In the event of such a sale, SNH receives the net proceeds and our rent for the remaining properties in the applicable lease is reduced according to formulas contained in the applicable lease.

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Our Relationship with SNH. SNH is our largest landlord. We were a 100% owned subsidiary of SNH before December 31, 2001. On December 31, 2001, SNH distributed substantially all of our then outstanding common shares to its shareholders. Both we and SNH receive management services from RMR. SNH owns 4,235,000, or 8.7%, of our outstanding common shares as of December 31, 2013. For more information about our dealings with SNH, and about the risks which may arise as a result of these related person transactions, see "Management's Discussion and Analysis of Financial Condition and Results of Operations Related Person Transactions" of this Annual Report on Form 10-K.

Management Contracts

We began managing communities for SNH's account in June 2011 in connection with SNH's acquisition of certain senior living communities at that time. We have since begun managing additional communities that SNH has acquired. With the exception of the management agreement for the senior living community in New York, described in Note 14 to the Notes to our Consolidated Financial Statements included in Part IV, Item 15 of this Annual Report on Form 10-K, or Note 14, which is incorporated herein by reference, the management agreements for the communities we manage for SNH's account provide us with a management fee equal to 3% of the gross revenues realized at the communities, plus reimbursement for our direct costs and expenses related to the communities and an incentive fee equal to 35% of the annual net operating income of the communities after SNH realizes an annual return equal to 8% of its invested capital. The management agreements provide that we and SNH each have the option to terminate the contracts upon the acquisition by a person or group of more than 9.8% of the other's voting stock and upon other change in control events affecting the other party, as defined in those documents, including the adoption of any shareholder proposal (other than a precatory proposal) or the election to the board of directors or board of trustees of any individual if such proposal or individual was not approved, nominated or appointed, as the case may be, by vote of a majority of the board of directors or board of trustees in office immediately prior to the making of such proposal or the nomination or appointment of such individual.

In connection with the management agreements, we and SNH have entered into four combination agreements, or pooling agreements: three pooling agreements combine our management agreements with SNH for communities that include assisted living units, or the AL Pooling Agreements, and a fourth pooling agreement combines our management agreements with SNH for communities that include only independent living units, or the IL Pooling Agreement. We entered into the initial AL Pooling Agreement in May 2011 and the second AL Pooling Agreement in October 2012. The first AL Pooling Agreement includes 20 identified communities and the second AL Pooling Agreement currently includes 19 identified communities. We and SNH entered into our third AL Pooling Agreement in November 2013 and that pooling agreement currently includes the management agreement for the community we began managing in November 2013, as further discussed in Note 14. We entered into the IL Pooling Agreement in August 2012 and that agreement currently includes management agreements for two communities that have only independent living units. The senior living community in New York and the senior living community known as Villa Valencia that we manage for the account of SNH are not included in any of our pooling agreements. Each of the AL Pooling Agreements and the IL Pooling Agreement aggregates the determinations of fees and expenses of the various communities that are subject to such pooling agreement, including determinations of our incentive fees and SNH's return of its invested capital. Under each of the pooling agreements, SNH has the right, after the period of time specified in the agreement has elapsed and subject to our cure rights, to terminate all, but not less than all, of the management agreements that are subject to the pooling agreement if SNH does not receive its minimum return in each of three consecutive years. In addition, under each of the pooling agreements, we have a limited right to require the sale of underperforming communities. Also, under each of the pooling agreements, any nonrenewal notice given by us with respect to a community is deemed a nonrenewal with respect to all the communities that are the subject of the agreement. Special committees of each of our Board of Directors and SNH's board of

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trustees composed solely of our Independent Directors and SNH's independent trustees who are not also directors or trustees of the other party and who were represented by separate counsel reviewed and approved the terms of these management agreements and pooling agreements. Please see Note 14 to our Consolidated Financial Statements included in Part IV, Item 15 of this Annual Report for further information relating to our management arrangements with SNH.

Item 3. Legal Proceedings

We are routinely involved in various legal and administrative proceedings incidental to the ordinary course of business, none of which we expect, individually or in the aggregate, to have a material adverse effect on our business, financial condition, results of operations or cash flows.

Item 4. Mine Safety Disclosures

Not applicable.

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PART II

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

Our common shares are traded on the NYSE (symbol: FVE). The following table sets forth for the periods indicated the high and low sale prices for our common shares as reported by the NYSE:

	High	Low
2012		
First Quarter	$ 3.95	$ 2.92
Second Quarter	3.80	2.98
Third Quarter	5.29	3.09
Fourth Quarter	5.98	4.45
2013		
First Quarter	$ 6.72	$ 4.97
Second Quarter	6.87	4.44
Third Quarter	6.20	5.04
Fourth Quarter	5.66	4.41

The closing price of our common shares on the NYSE on September 8, 2014 was $4.49 per share.

As of September 8, 2014, there were approximately 2,200 stockholders of record of our common shares.

We have never paid or declared any cash dividends on our common shares. At present, we intend to retain our future earnings, if any, to fund our operations and the growth of our business. Furthermore, our credit agreements restrict our payment of cash dividends on our common shares, unless certain requirements are met. Our future decisions concerning the payment of dividends on our common shares will depend upon our results of operations, financial condition, and capital expenditure and investment plans, as well as other factors as our Board of Directors, in its discretion, may consider relevant, and the extent to which the declaration or payment of dividends may be limited by agreements we have entered or cause us to lose the benefits of certain of our agreements.

On December 11, 2013, pursuant to our equity compensation plan, as amended, or the Share Award Plan, we granted an aggregate of 347,900 of our common shares, valued at $4.53 per share, the closing price of our common shares on the NYSE on that day, to our officers and certain employees of RMR. We made these grants pursuant to an exemption from registration contained in Section 4(a)(2) of the Securities Act of 1933, as amended.

Item 6. Selected Financial Data

The following table sets forth selected financial data for the periods and dates indicated. Our comparative results are impacted by community acquisitions and dispositions during the periods shown. This data should be read in conjunction with, and is qualified in its entirety by reference to "Management's Discussion and Analysis of Financial Condition and Results of Operations" of this Annual Report on Form 10-K and our Consolidated Financial Statements and accompanying notes included in Part IV, Item 15 of this Annual Report on Form 10-K. As described in Notes 2 and 17 to the Notes to our Consolidated Financial Statements included in Part IV, Item 15 of this Annual Report on Form 10-K, we identified errors related to our accounts payable and certain other errors for the years ended December 31, 2012 and 2011 and prior periods. The revisions for the prior period corrections, which we have concluded are immaterial to all prior period financial statements, are

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reflected in the table below, in the tables included in Part II, Item 7 and in the consolidated financial statements included in Part IV, Item 15 of this Annual Report on Form 10-K.

	Year ended December 31,				
	2013	2012	2011	2010	2009
	(in thousands, except per share data)				
Operating data:					
Total revenues	$ 1,296,787	$ 1,207,806	$ 1,060,602	$ 991,195	$ 927,321
Net income from continuing operations	3,449	10,590	75,555	23,566	40,553
Net income (loss) from discontinued operations	(5,789)	11,717	(3,381)	(1,213)	(2,320)
Net income (loss)	(2,340)	22,307	72,174	22,353	38,233
Basic net income (loss) per share:					
Income from continuing operations	0.07	0.23	1.79	0.65	1.21
Income (loss) from discontinued operations	(0.12)	0.24	(0.08)	(0.03)	(0.07)
Net income (loss)	(0.05)	0.47	1.71	0.62	1.14
Diluted net income (loss) per share:					
Income from continuing operations	0.07	0.23	1.70	0.63	1.10
Income (loss) from discontinued operations	(0.12)	0.23	(0.08)	(0.03)	(0.05)
Net income (loss)	(0.05)	0.46	1.62	0.60	1.05
Balance sheet data (as of December 31):					
Total assets	590,183	594,991	600,301	379,897	413,100
Total long term indebtedness	36,461	37,621	75,996	37,905	54,167
Other long term obligations	44,816	43,067	38,039	39,211	33,590

As noted above, the consolidated statements of operations were revised to correct certain immaterial errors which increased (decreased) net income by $(1,234), $1,387, $(1,139) and $(97) for the years ended December 31, 2012, 2011, 2010 and 2009, respectively.

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

GENERAL INDUSTRY TRENDS

The senior living industry generally is experiencing growth as a result of demographic factors. According to census data, the population in the United States over age 75 is growing much faster than the general population. A large number of independent and assisted living communities were built in the 1990s. This development activity caused an excess supply of new, high priced communities. Longer than projected fill up periods resulted in low occupancy, price discounting and financial distress for many independent and assisted living operators. Development activity was significantly reduced beginning in the early part of the last decade. We believe that the nationwide supply and demand for these types of facilities is about balanced today. We believe that the aging of the United States population and the significant reliance of independent and assisted living services upon revenues from residents' private resources may enable these types of facilities to be profitably operated.

The increasing availability of assisted living facilities in the 1990s caused occupancy at many SNFs to decline. This fact, together with restrictions on development of new SNFs by most states and assisted living facilities in some states, has generally caused nursing care to be delivered in older facilities. We believe that many SNFs currently in operation are becoming physically obsolete and that political

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pressures from an aging population will eventually cause governmental authorities to permit increased new construction.

Beginning in 2007, problems in certain domestic credit markets presaged a global credit crisis that led to a recession in the United States. The recession resulted in aggressive government spending in the United States, significant employee layoffs, reduced availability of credit on reasonable terms in most markets, and lower real estate prices. The weakened economic conditions created by the recession negatively affected our occupancy. While the economy continued to grow and the housing market continued to improve in 2013, it is unclear whether that growth and improvement will continue or be sustained, in light of the modest, variable and unsteady economic improvements experienced since the end of the recent United States economic recession. Although many of the services we provide are needs driven, some of those needs may be deferred during recessions; for example, relocating to a senior living community may be delayed when sales of houses are delayed. Also, we believe we experience greater pricing pressures from competition during periods when the industry as a whole has lower occupancy as a result of macro-economic conditions, such as those which occurred during the recent recession.

OPERATIONS

We earn our senior living revenue primarily by providing housing and services to our senior living residents. During 2013, approximately 23% of our senior living revenues from continuing operations came from the Medicare and Medicaid programs and approximately 77% of our senior living revenues from continuing operations came from residents' private resources. We bill all private pay residents in advance for the housing and services to be provided in the following month.

Our material expenses are:

Wages and benefits includes wages and wage related expenses, such as health insurance, workers' compensation insurance and other benefits for our employees working at our senior living communities.

Other senior living operating expenses includes utilities, housekeeping, dietary, maintenance, marketing, insurance and community level administrative costs at our senior living communities.

Rent expense we lease 187 senior living communities (including 10 senior living communities that we have classified as discontinued operations) from SNH and four senior living communities from HCP.

General and administrative expenses principally wage related costs for headquarters and regional staff supporting our communities.

Costs incurred on behalf of managed communities includes wages and benefits for staff and other operating expenses related to the communities that we manage for the account of SNH, which are reimbursed to us by SNH, including from revenues we receive from the applicable managed communities, pursuant to our management agreements with SNH.

Depreciation and amortization expense we incur depreciation expense on buildings and furniture and equipment that we own and we incur amortization expense on certain identifiable intangible assets.

Interest and other expenses primarily includes interest on outstanding debt and amortization of deferred financing costs.

In 2013, we added four managed communities to our senior living portfolio, we sold two SNFs that we owned, SNH sold one SNF that we leased from SNH and we and SNH completed the sale of the real estate and the transfer of operations at two rehabilitation hospitals which we leased from SNH and

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13 outpatient clinics which we leased from others to unrelated third parties. We have two operating segments: senior living communities and rehabilitation and wellness. In the senior living community segment, we operate for our own account or manage for the account of SNH independent living communities, assisted living communities and SNFs that are subject to centralized oversight and provide housing and services to elderly residents. Our rehabilitation and wellness operating segment does not meet any of the quantitative thresholds of a reportable segment as prescribed under Financial Accounting Standards Board, or FASB, *Accounting Standards Codification* , or ASC, Topic 280. After the reclassification of our rehabilitation hospital business as discontinued operations, our business is comprised of one reportable segment, senior living. All of our operations and assets are located in the United States, except for the operations of our captive insurance company subsidiary, which participates in our workers' compensation, professional liability and automobile insurance programs and which is organized in the Cayman Islands.

INVESTMENT ACTIVITIES

In 2011, we acquired from unrelated parties seven senior living communities containing 854 living units with one community located in Arizona and six communities located in Indiana, or the Indiana Communities, for an aggregate purchase price of $148.4 million, excluding closing costs and including $38.0 million of assumed mortgage notes and $2.6 million of assumed net working capital liabilities.

In 2012, we sold our pharmacy business to Omnicare. We received $34.3 million in sale proceeds from Omnicare, which included $3.8 million in working capital. We recorded a pre-tax capital gain on sale of our pharmacy business of $23.3 million.

During 2013 and 2012, we made capital expenditures for property, plant and equipment related to our continuing operations, on a net basis after considering the proceeds from sales of property and equipment to SNH, of $29.1 million and $27.0 million, respectively.

During 2013 and 2012, we received gross proceeds of $6.3 million and $4.2 million, respectively, in connection with the sale of available for sale securities and recorded a net realized loss of $5,000 and $19,000, respectively.

During 2013 and 2012, we redeemed or purchased and retired $24.9 million and $12.4 million par value of the outstanding Notes, respectively, and recorded a loss of $599,000 and a gain of $45,000, respectively, net of related unamortized costs, on early extinguishment of debt.

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Key Statistical Data For the Years Ended December 31, 2013 and 2012

The following tables present a summary of our operations for the years ended December 31, 2013 and 2012:

(dollars in thousands, except average monthly rate)	For the years ended December 31, 2013	2012	Change	%/bps Change
Senior living revenue	$ 1,077,062	$ 1,074,333	$ 2,729	0.3%
Management fee revenue	9,234	5,817	3,417	58.7%
Reimbursed costs incurred on behalf of managed communities	210,491	127,656	82,835	64.9%
Total revenue	1,296,787	1,207,806	88,981	7.4%
Senior living wages and benefits	(525,733)	(522,444)	(3,289)	(0.6)%
Other senior living operating expenses	(265,764)	(261,749)	(4,015)	(1.5)%
Costs incurred on behalf of managed communities	(210,491)	(127,656)	(82,835)	(64.9)%
Rent expense	(193,820)	(190,184)	(3,636)	(1.9)%
General and administrative expenses	(63,509)	(61,817)	(1,692)	(2.7)%
Depreciation and amortization expense	(27,022)	(24,480)	(2,542)	(10.4)%
Impairment of long-lived assets	(186)		(186)	(100.0)%
Gain on settlement		3,365	(3,365)	(100.0)%
Interest, dividend and other income	781	881	(100)	(11.4)%
Interest and other expense	(5,227)	(6,268)	1,041	16.6%
Acquisition related costs	(181)	(108)	(73)	(67.6)%
(Loss) gain on early extinguishment of debt	(599)	45	(644)	(1,431.1)%
Loss on sale of available for sale securities	(5)	(19)	14	73.7%
Provision for income taxes	(1,916)	(7,098)	5,182	73.0%
Equity in earnings of Affiliates Insurance Company	334	316	18	5.7%
Income from continuing operations	$ 3,449	$ 10,590	$ (7,141)	(67.4)%
Total number of communities (end of period):				
Owned and leased communities	211	211		
Managed communities	44	39	5	12.8%
Number of total communities[1]	255	250	5	2.0%
Total number of living units (end of period):				
Owned and leased living units	22,972	22,972		
Managed living units	7,051	6,678	373	5.6%
Number of total living units[2]	30,023	29,650	373	1.3%