ENSIGN GROUP, INC
Form 10-Q
August 04, 2015
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended June 30, 2015

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

For the transition period from to .

Commission file number: 001-33757

THE ENSIGN GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

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

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

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

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

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

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

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

As of July 31, 2015, 25,558,912 shares of the registrant's common stock were outstanding.

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE AND SIX MONTHS ENDED JUNE 30, 2015
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Part I. Financial Information

Item 1. Financial Statements

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

	June 30, 2015	December 31, 2014
Assets		
Current assets:		
Cash and cash equivalents	$50,635	$50,408
Restricted cash—current	1,481	5,082
Accounts receivable—less allowance for doubtful accounts of $23,913 and $20,438 at June 30, 2015 and December 31, 2014, respectively	171,362	130,051
Investments—current	4,751	6,060
Prepaid income taxes	4,719	2,992
Prepaid expenses and other current assets	12,395	8,434
Deferred tax asset—current	10,602	10,615
Total current assets	255,945	213,642
Property and equipment, net	243,881	149,708
Insurance subsidiary deposits and investments	19,857	17,873
Escrow deposits	3,344	16,153
Deferred tax asset	11,500	11,509
Restricted and other assets	6,825	6,833
Intangible assets, net	38,580	35,568
Goodwill	32,781	30,269
Other indefinite-lived intangibles	16,226	12,361
Total assets	$628,939	$493,916
Liabilities and equity		
Current liabilities:		
Accounts payable	$33,843	$33,186
Accrued wages and related liabilities	58,482	56,712
Accrued self-insurance liabilities—current	16,537	15,794
Other accrued liabilities	34,431	24,630
Current maturities of long-term debt	501	111
Total current liabilities	143,794	130,433
Long-term debt—less current maturities	49,019	68,279
Accrued self-insurance liabilities—less current portion	35,856	34,166
Deferred rent and other long-term liabilities	3,357	3,235
Total liabilities	232,026	236,113
Commitments and contingencies (Notes 17, 19, and 20)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 25,868 and 25,536 shares issued and outstanding at June 30, 2015, respectively, and 22,924 and 22,591 shares issued and outstanding at December 31, 2014, respectively (Note 3)	26	22
Additional paid-in capital (Note 3)	228,912	114,293

Retained earnings	170,355	145,846
Common stock in treasury, at cost, 146 and 150 shares at June 30, 2015 and December 31, 2014, respectively	(1,294)	(1,310)
Total Ensign Group, Inc. stockholders' equity	397,999	258,851
Non-controlling interest	(1,086)	(1,048)
Total equity	396,913	257,803
Total liabilities and equity	$628,939	$493,916

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Revenue	$311,056	$250,043	$617,585	$489,696
Expense:				
Cost of services (exclusive of rent, general and administrative and depreciation and amortization expenses shown separately below)	248,292	202,057	489,748	391,795
Rent—cost of services (Note 2 and 19)	19,066	8,283	38,031	11,832
General and administrative expense	15,335	18,257	29,751	31,414
Depreciation and amortization	6,379	7,804	12,896	16,666
Total expenses	289,072	236,401	570,426	451,707
Income from operations	21,984	13,642	47,159	37,989
Other income (expense):				
Interest expense	(567)	(8,720)	(1,233)	(12,083)
Interest income	195	134	361	293
Other expense, net	(372)	(8,586)	(872)	(11,790)
Income before provision for income taxes	21,612	5,056	46,287	26,199
Provision for income taxes	8,379	3,523	17,964	11,625
Net income	13,233	1,533	28,323	14,574
Less: net income (loss) attributable to noncontrolling interests	45	(474)	(37)	(959)
Net income attributable to The Ensign Group, Inc.	$13,188	$2,007	$28,360	$15,533
Net income per share attributable to The Ensign Group, Inc.:				
Basic	$0.52	$0.09	$1.15	$0.70
Diluted	$0.50	$0.09	$1.11	$0.68
Weighted average common shares outstanding:				
Basic	25,474	22,259	24,695	22,214
Diluted	26,433	22,960	25,636	22,915
Dividends per share	$0.075	$0.070	$0.150	$0.140

See accompanying notes to condensed consolidated financial statements.

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THE ENSIGN GROUP, INC.

CONDENSED CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME
(In thousands)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Net income	$13,233	$1,533	$28,323	$14,574
Other comprehensive income, net of tax:				
Unrealized (loss) gain on interest rate swap, net of income tax of $0 and $78 for the three and six months ended June 30, 2014.	—	(30)	—	89
Reclassification of derivative loss to income, net of income tax benefit of $638 for the three and six months ended June 30, 2014.	—	1,023	—	1,023
Comprehensive income	13,233	2,526	28,323	15,686
Less: net income (loss) attributable to noncontrolling interests	45	(474)	(37)	(959)
Comprehensive income attributable to The Ensign Group, Inc.	$13,188	$3,000	$28,360	$16,645

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
	2015	2014
Cash flows from operating activities:		
Net income	$28,323	$14,574
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	12,896	16,666
Amortization of deferred financing fees and debt discount	296	391
Deferred income taxes	16	(543)
Provision for doubtful accounts	8,468	6,634
Share-based compensation	3,226	2,383
Excess tax benefit from share-based compensation	(1,900)	(1,932)
Loss on extinguishment of debt	—	4,067
Loss on termination of interest rate swap	—	1,661
Loss on disposition of property and equipment	—	5
Change in operating assets and liabilities		
Accounts receivable	(49,735)	(19,712)
Prepaid income taxes	(1,728)	(329)
Prepaid expenses and other assets	(3,909)	1,605
Insurance subsidiary deposits and investments	(676)	267
Accounts payable	(654)	3,733
Accrued wages and related liabilities	1,770	4,521
Other accrued liabilities	7,991	3,233
Accrued self-insurance liabilities	2,301	(72)
Deferred rent liability	123	(75)
Net cash provided by operating activities	6,808	37,077
Cash flows from investing activities:		
Purchase of property and equipment	(28,774)	(32,577)
Cash payment for business acquisitions	(61,007)	(38,442)
Cash payment for asset acquisitions	(15,853)	(7,513)
Escrow deposits	(3,344)	(1,880)
Escrow deposits used to fund business acquisitions	16,153	1,000
Increase in restricted cash	—	(8,219)
Use of restricted cash	3,601	—
Restricted and other assets	(203)	226
Net cash used in investing activities	(89,427)	(87,405)
Cash flows from financing activities:		
Proceeds from revolving credit facility (Note 17)	129,000	340,677
Payments on revolving credit facility and other debt	(154,118)	(241,171)
Proceeds from common stock offering (Note 3)	112,078	—
Issuance costs in connection with common stock offering (Note 3)	(5,751)	—
Issuance of treasury stock upon exercise of options	16	171
Cash retained by CareTrust at separation	—	(78,731)
Issuance of common stock upon exercise of options	3,344	2,197
Dividends paid	(3,629)	(3,166)

Excess tax benefit from share-based compensation	1,906	1,941
Prepayment penalty on early retirement of debt	—	(2,069)
Payments of deferred financing costs	—	(12,883)
Net cash provided by financing activities	82,846	6,966
Net increase (decrease) in cash and cash equivalents	227	(43,362)
Cash and cash equivalents beginning of period	50,408	65,755
Cash and cash equivalents end of period	$50,635	$22,393

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
	2015	2014
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$1,280	$6,976
Income taxes	$17,766	$13,683
Non-cash financing and investing activity:		
Accrued capital expenditures	$4,244	$676
Refundable deposits assumed as part of business acquisition	$3,488	$—
Debt assumed as part of asset acquisition	$6,248	$—

See accompanying notes to condensed consolidated financial statements.

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

1. DESCRIPTION OF BUSINESS

The Company - The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. The Company, through its operating subsidiaries, is a provider of skilled nursing, rehabilitative care services, home health, home care, hospice care, assisted living and urgent care services. As of June 30, 2015, the Company operated 150 facilities, fourteen home health and twelve hospice agencies, three home care operations, one transitional care management company, seventeen urgent care centers and a mobile x-ray and diagnostic company, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah, Washington and Wisconsin. The Company's operating subsidiaries, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted living, home health, home care, hospice, mobile x-ray and diagnostic and urgent care services. The Company's operating subsidiaries have a collective capacity of approximately 16,000 operational skilled nursing, assisted living and independent living beds. As of June 30, 2015, the Company owned 26 of its 150 affiliated facilities and leased an additional 124 facilities through long-term lease arrangements, and had options to purchase three of those 124 facilities. As of December 31, 2014, the Company owned 11 of its 136 affiliated facilities and leased an additional 125 facilities through long-term lease arrangements, and had options to purchase three of those 125 facilities.

Certain of the Company’s wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide certain accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. The Company also has a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to the Company’s operating subsidiaries for general and professional liability, as well as coverage for certain workers’ compensation insurance liabilities.

Each of the Company's affiliated operations are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar terms in this quarterly report is not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries, are operated by The Ensign Group.

Other Information — The accompanying condensed consolidated financial statements as of June 30, 2015 and for the three and six months ended June 30, 2015 and 2014 (collectively, the Interim Financial Statements) are unaudited. Certain information and note disclosures normally included in annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company’s audited consolidated financial statements and notes thereto for the year ended December 31, 2014 which are included in the Company’s annual report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company’s financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

2. SPIN-OFF OF REAL ESTATE ASSETS THROUGH A REAL ESTATE INVESTMENT TRUST

On June 1, 2014, the Company completed its plan to separate into two separate publicly traded companies by creating a newly formed, publicly traded real estate investment trust (REIT), known as CareTrust REIT, Inc. (CareTrust), through a tax free spin-off (the Spin-Off). The Company effected the Spin-Off by distributing to its stockholders one share of CareTrust common stock for each share of Ensign common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. The Company received a private letter ruling from the Internal Revenue Service (IRS) substantially to the effect that the Spin-Off will qualify as a tax-free transaction for U.S. federal income

tax purposes. The private letter ruling relies on certain facts, representations, assumptions and undertakings.

In connection with the Spin-Off, the Company contributed to CareTrust the assets and liabilities associated with 94 real property and three independent living facilities that CareTrust now operates and that were previously owned by the Company. The Company also retired all outstanding borrowings as of the date of the Spin-Off with a portion of the proceeds received from the Spin-Off.

As a result of the Spin-Off, CareTrust owns all of the 94 real property and leases back those assets to the Company under eight “triple-net” master lease agreements (collectively, the Master Leases), which have terms ranging from 12 to 19 years that,

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

at the Company's option, may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The Company continues to operate the affiliated skilled nursing, assisted living and independent living facilities that are leased from CareTrust pursuant to the Master Leases.

Commencing in the third year of the term of the Master Leases, the rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. Annual rent expense under the Master Leases will be approximately $56,000 during each of the first two years of the Master Leases. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. See further discussion at Note 19, Leases.

The Company incurred transaction costs of $7,281 and $8,871 for the three and six months ended June 30, 2014 associated with the Spin-Off, which are included in general and administrative expenses within the condensed consolidated statements of income, which did not recur in 2015.

3. COMMON STOCK OFFERING

On July 15, 2014, the Company filed a Registration Statement on Form S-3 with the SEC for future public offerings of any combination of common stock, preferred stock and warrants.

On February 9, 2015, the Company entered into an underwriting agreement with Wells Fargo Securities, LLC as representative of the underwriters named therein (collectively, the Underwriters), pursuant to which the Company agreed to issue and sell to the Underwriters 2,500 shares of its common stock and also agreed to issue and sell to the Underwriters, at the option of the Underwriters, an aggregate of up to 375 additional shares of common stock (the Common Stock Offering).

Subsequently, the Company issued 2,734 shares for approximately $41.00 per share. After deducting $5,604 in underwriting discounts and commissions, the Company received net proceeds of $106,474, before other issuance costs of $321. The Company used $94,000 of the net proceeds to pay off the outstanding amounts under its revolving credit facility with a lending consortium arranged by SunTrust (the Credit Facility).

4. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation — The accompanying Interim Financial Statements have been prepared in accordance with accounting principles generally accepted (GAAP) in the United States. The Company is the sole member or shareholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing and assisted living operations, home health, hospice and home care operations, urgent care centers and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interest within the equity section of its consolidated balance sheets. The Company presents the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interest in its consolidated statements of income.

The consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest and the accounts of any variable interest entities (VIEs) where the Company is subject to a majority of the risk of loss from the VIE's activities, or entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impact" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. The Company's relationship with variable interest entities was not material at June 30, 2015.

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

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Fair Value of Financial Instruments —The Company's financial instruments consist principally of cash and cash equivalents, debt security investments, accounts receivable, insurance subsidiary deposits, accounts payable and borrowings. The Company believes all of the financial instruments' recorded values approximate fair values because of their nature or respective short durations.

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

Revenue from the Medicare and Medicaid programs accounted for 68.5% and 68.8% of the Company's revenue for the three and six months ended June 30, 2015, respectively, and 70.2% and 70.7% for the three and six months ended June 30, 2014, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. The Company recorded adjustments to revenue which were not material to the Company's consolidated revenue for the three and six months ended June 30, 2015 and 2014, except for additional payments from the State of California for quality improvements under the Quality and Accountability Supplemental Payment Program.

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

Skilled Nursing, Assisted and Independent Living Revenue

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

The Company is participating in the recently established Upper Payment Limit (UPL) supplemental payment program in the state of Texas that provides supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as county hospital districts. The Company's operating subsidiaries, previously operating ten company-owned Texas skilled nursing facilities, entered into transactions with several such hospital districts providing for the transfer of the licenses for those skilled nursing facilities to the hospital districts through management agreements with the respective hospital districts, and providing further for the Company's operating subsidiaries to retain the management of those facilities on behalf of the hospital districts, which are all participating in the UPL program. Each affected operating subsidiary therefore retains operations of its skilled nursing facility and each agreement between the hospital district and the Company's subsidiary is terminable by either party to fully restore the prior license status.

Home Health Revenue

Medicare Revenue

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

overpayments.

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

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In addition to revenue recognized on completed episodes, the Company also recognizes a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and its estimate of the average percentage complete based on visits performed.

Non-Medicare Revenue

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

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

Hospice Revenue

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

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

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

Property and Equipment — Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 59 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

Impairment of Long-Lived Assets — The Company reviews the carrying value of long-lived assets that are held and used in the Company’s operating subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiaries to which the assets relate, utilizing management’s best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has not identified any asset impairment during the three and six months ended June 30, 2015 or

2014.

Intangible Assets and Goodwill — Definite-lived intangible assets consist primarily of favorable leases, lease acquisition costs, patient base, facility trade names and customer relationships. Favorable leases and lease acquisition costs are amortized over the life of the lease of the facility, typically ranging from five to 52 years. Patient base is amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date. Trade names at affiliated facilities are amortized over 30 years and customer relationships are amortized over a period up to 20 years.

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

The Company's indefinite-lived intangible assets consist of trade names and home health and hospice Medicare licenses. The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable. Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit (operating segment or one level below an operating segment) below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. See further discussion at Note 13, Goodwill and Other Indefinite-Lived Intangible Assets.

Self-Insurance — The Company is partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. For claims made after January 1, 2013, the combined self-insured retention was $500 per claim, subject to an additional one-time deductible of $1,000 for California affiliated facilities and a separate, one-time, deductible of $750 for non-California facilities. For all California affiliated facilities, the third-party coverage above these limits was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate limit. For all facilities outside of California, except those located in Colorado, the third-party coverage above these limits was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1,000 per claim and $3,000 per facility for skilled nursing facilities, which is independent of the aforementioned blanket aggregate limits that apply outside of Colorado. The self-insured retention and deductible limits for general and professional liability and workers' compensation for all states (except Texas and Washington for workers' compensation) are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying condensed consolidated balance sheets. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. The Company’s policy is to accrue amounts equal to the actuarially estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. Accrued general liability and professional malpractice liabilities on an undiscounted basis, net of anticipated insurance recoveries, were $28,700 and $29,313 as of June 30, 2015 and December 31, 2014, respectively.

The Company’s operating subsidiaries are self-insured for workers’ compensation in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed $500 per occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers’ compensation claims and, effective February 1, 2011, the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 per occurrence. As of July 1, 2014, the Company’s operating subsidiaries in all other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $350 per occurrence. In Washington, the operating subsidiaries' coverage is financed through premiums paid by the employers and employees. The claims and pay benefits are managed through a state insurance pool. Outside of California, Texas, and Washington, the Company has purchased insurance coverage that insures individual claims that exceed $350 per accident. In all states except Washington, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers’ compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $17,180 and $14,590 as of June 30, 2015 and December 31, 2014, respectively.

In addition, the Company has recorded an asset and equal liability of $2,388 and $2,256 at June 30, 2015 and December 31, 2014, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis. See Note 14, Restricted and Other Assets.

The Company self-funds medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 for each covered person with an additional one-time aggregate individual stop loss deductible of $75. The Company’s accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $4,125 and $3,801 as of June 30, 2015 and December 31, 2014, respectively.

The Company believes that adequate provision has been made in the Interim Financial Statements for liabilities that may arise out of patient care, workers’ compensation, healthcare benefits and related services provided to date. The amount of the

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

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

For interim reporting purposes, the provision for income taxes is determined based on the estimated annual effective income tax rate applied to pre-tax income, adjusted for certain discrete items occurring during the period. In determining the effective income tax rate for interim financial statements, the Company must consider expected annual income, permanent differences between financial reporting and tax recognition of income or expense and other factors. When the Company takes uncertain income tax positions that do not meet the recognition criteria, it records a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, the Company must consider the potential outcomes from a review of the positions by the taxing authorities.
In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

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

Stock-Based Compensation — The Company measures and recognizes compensation expense for all share-based payment awards made to employees and directors including employee stock options based on estimated fair values, ratably over the requisite service period of the award. Net income has been reduced as a result of the recognition of the fair value of all stock options and restricted stock awards issued, the amount of which is contingent upon the number of future grants and other variables.

Leases and Leasehold Improvements - At the inception of each lease, the Company performs an evaluation to determine whether the lease should be classified as an operating or capital lease. The Company records rent expense for operating leases that contain scheduled rent increases on a straight-line basis over the term of the lease. The lease term used for straight-line rent expense is calculated from the date the Company is given control of the leased premises through the end of the lease term. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements, as well as the period over which the Company records straight-line rent expense.

Recent Accounting Pronouncements — Except for rules and interpretive releases of the Securities and Exchange Commission (SEC) under authority of federal securities laws and a limited number of grandfathered standards, the Financial Accounting Standards Board (FASB) ASC is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. For any new pronouncements announced, the Company considers whether the new pronouncements could alter previous generally accepted accounting principles and determines whether any new or modified principles will have a material impact on the Company's reported financial position or operations in the near term. The applicability of any standard is subject to the formal review of the Company's financial management and certain standards are under consideration.

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In February 2015, the FASB issued amendments to the consolidation analysis, which amends the consolidation requirements and significantly changes the consolidation analysis required under U.S. GAAP. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2015, which will be the Company's fiscal year 2016, with early adoption permitted. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

In April 2015, the FASB issued its final standard on presentation of debt issuance costs, which changes the presentation of debt issuance costs in the financial statement to represent such costs in the balance sheet as a direct deduction from the related debt liability rather than as an asset. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2015, which will be the Company's fiscal year 2016, with early adoption permitted. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

In May 2014, the FASB and International Accounting Standards Board issued their final standard on revenue from contracts with customers that outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. The new standard supersedes most current revenue recognition guidance, including industry-specific guidance. In July 2015, the FASB formally deferred for one year the effective date of the new revenue standard and decided to permit entities to early adopt the standard. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be the Company's fiscal year 2018. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

5. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing income from continuing operations attributable to The Ensign Group, Inc. stockholders by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share except that the denominator is increased to include the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Numerator:				
Net Income	$13,233	$1,533	$28,323	$14,574
Less: net income (loss) attributable to noncontrolling interests	45	(474)	(37)	(959)
Net income attributable to The Ensign Group, Inc.	$13,188	$2,007	$28,360	$15,533
Denominator:				
Weighted average shares outstanding for basic net income per share	25,474	22,259	24,695	22,214
Basic net income per common share attributable to The Ensign Group, Inc.	$0.52	$0.09	$1.15	$0.70

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Numerator:				
Net Income	$13,233	$1,533	$28,323	$14,574
Less: net income (loss) attributable to noncontrolling interests	45	(474)	(37)	(959)
Net income attributable to The Ensign Group, Inc.	$13,188	$2,007	$28,360	$15,533
Denominator:				
Weighted average common shares outstanding	25,474	22,259	24,695	22,214
Plus: incremental shares from assumed conversion [1]	959	701	941	701
Adjusted weighted average common shares outstanding	26,433	22,960	25,636	22,915
Diluted net income per common share attributable to The Ensign Group, Inc.	$0.50	$0.09	$1.11	$0.68

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 107 and 143 for the three and six months ended June 30, 2015, respectively, and 608 and 447 for the three and six months ended June 30, 2014, respectively.

6. FAIR VALUE MEASUREMENTS

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

The following table summarizes the financial assets and liabilities measured at fair value on a recurring basis as of June 30, 2015 and December 31, 2014:

	June 30, 2015			December 31, 2014		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$50,635	$—	$—	$50,408	$—	$—
Restricted cash	$1,481	$—	$—	$5,082	$—	$—

Our non-financial assets, which include long-lived assets, including goodwill, intangible assets and property and equipment, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, we assess our long-lived assets for impairment. When impairment has occurred, such long-lived assets are written down to fair value. See Note 4, Summary of Significant Accounting Policies for further discussion of the Company's significant accounting policies.

Debt Security Investments - Held to Maturity

At June 30, 2015 and December 31, 2014, the Company had approximately $24,608 and $23,933, respectively, in debt security investments which were classified as held to maturity and carried at amortized cost. The carrying value of the debt securities approximates fair value. The Company has the intent and ability to hold these debt securities to

maturity. Further, as of June 30, 2015, the debt security investments are held in AA, A and BBB+ rated debt securities.

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7. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and six months ended June 30, 2015 and 2014 is summarized in the following tables:

	Three Months Ended June 30,					
	2015			2014		
	Revenue	% of Revenue		Revenue	% of Revenue	
Medicaid	$100,873	32.4	%	$85,937	34.4	%
Medicare	95,396	30.7		77,333	30.9	
Medicaid — skilled	16,745	5.4		12,353	4.9	
Total Medicaid and Medicare	213,014	68.5		175,623	70.2	
Managed care	47,633	15.3		35,776	14.3	
Private and other payors[1]	50,409	16.2		38,644	15.5	
Revenue	$311,056	100.0	%	$250,043	100.0	%

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

	Six Months Ended June 30,					
	2015			2014		
	Revenue	% of Revenue		Revenue	% of Revenue	
Medicaid	$202,502	32.8	%	$169,279	34.6	%
Medicare	189,752	30.7		153,803	31.4	
Medicaid — skilled	32,282	5.3		22,961	4.7	
Total Medicaid and Medicare	424,536	68.8		346,043	70.7	
Managed care	93,963	15.2		68,754	14.0	
Private and other payors[1]	99,086	16.0		74,899	15.3	
Revenue	$617,585	100.0	%	$489,696	100.0	%

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

Accounts receivable as of June 30, 2015 and December 31, 2014 is summarized in the following table:

	June 30, 2015	December 31, 2014
Medicaid	$69,954	$45,943
Managed care	48,410	39,782
Medicare	40,509	32,861
Private and other payors	36,402	31,903
	195,275	150,489
Less: allowance for doubtful accounts	(23,913)	(20,438)
Accounts receivable	$171,362	$130,051

8. BUSINESS SEGMENTS

The Company has two reportable operating segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of the Company's business and (2) home health and hospice services, which includes the Company's home health, home care and hospice businesses. The Company's Chief Executive Officer, who is the chief

operating decision maker, or CODM, reviews financial information at the operating segment level.

The Company also reports an “all other” category that includes revenue from its urgent care centers and a mobile x-ray and diagnostic company. The urgent care centers and mobile x-ray and diagnostic business are neither significant individually nor in

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aggregate and therefore do not constitute a reportable segment. The reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. The "all other" category also includes operating expenses that the Company does not allocate to operating segments as these expenses are not included in the segment operating performance measures evaluated by the CODM. Previously, the Company had a single reportable segment, healthcare services, which included providing skilled nursing, assisted living, home health and hospice, urgent care and related ancillary services. The Company has presented 2014 financial information on a comparative basis to conform with the current period segment presentation.

As of June 30, 2015, TSA services included 150 wholly-owned skilled nursing affiliated facilities that offer post-acute, rehabilitative custodial and specialty skilled nursing care, as well as wholly-owned assisted and independent living affiliated facilities that provide room and board and social services. Home health and hospice services were provided to patients through the Company's 26 agencies. The Company's urgent care services, which is included in "all other" category, were provided to patients by the Company's wholly owned urgent care operating subsidiaries. As of June 30, 2015, the Company held 80% of the membership interest of a mobile x-ray and diagnostic company, which revenue is included in the "all other" category.

The Company evaluates performance and allocates capital resources to each segment based on an operating model that is designed to maximize the quality of care provided and profitability. General and administrative expenses are not allocated to any segment for purposes of determining segment profit or loss, and are included in the "all other" category in the selected segment financial data that follows. The accounting policies of the reporting segments are the same as those described in Note 4, Summary of Significant Accounting Policies. The Company's CODM does not review assets by segment in his resource allocation and therefore assets by segment are not disclosed below.

Segment revenues by major payor source were as follows:

	Three Months Ended June 30, 2015					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$98,461	$2,412	$—	$100,873	32.4	%
Medicare	81,831	13,565	—	95,396	30.7	
Medicaid-skilled	16,745	—	—	16,745	5.4	
Subtotal	197,037	15,977	—	213,014	68.5	
Managed care	45,241	2,392	—	47,633	15.3	
Private and other	39,358	1,575	9,476	50,409	16.2	
Total revenue	$281,636	$19,944	$9,476	$311,056	100.0	%
	Three Months Ended June 30, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$84,838	$1,099	$—	$85,937	34.4	%
Medicare	68,447	8,886	—	77,333	30.9	
Medicaid-skilled	12,353	—	—	12,353	4.9	
Subtotal	165,638	9,985	—	175,623	70.2	

Managed care	33,883	1,893	—	35,776	14.3	
Private and other	32,494	826	5,324	38,644	15.5	
Total revenue	$232,015	$12,704	$5,324	$250,043	100.0	%

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	Six Months Ended June 30, 2015					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$198,168	$4,334	$—	$202,502	32.8	%
Medicare	163,521	26,231	—	189,752	30.7	%
Medicaid-skilled	$32,282	$—	$—	32,282	5.3	%
Subtotal	393,971	30,565	—	424,536	68.8	
Managed care	$89,348	$4,615	$—	93,963	15.2	%
Private and other	77,090	3,080	18,916	99,086	16.0	%
Total revenue	$560,409	$38,260	$18,916	$617,585	100.0	%

	Six Months Ended June 30, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$167,225	$2,054	$—	$169,279	34.6	%
Medicare	136,954	16,849	—	153,803	31.4	%
Medicaid-skilled	$22,961	$—	$—	$22,961	4.7	%
Subtotal	327,140	18,903	—	346,043	70.7	%
Managed care	$65,179	$3,575	$—	$68,754	14.0	%
Private and other	63,818	1,372	9,709	74,899	15.3	%
Total revenue	$456,137	$23,850	$9,709	$489,696	100.0	%

The following table sets forth selected financial data consolidated by business segment:

	Three Months Ended June 30, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$281,636	$19,944	$9,476		$311,056
Intersegment revenue (1)	573	—	188	(761)	—
Total revenue	$282,209	$19,944	$9,664	$(761)	$311,056
Income from operations	$35,067	$2,996	$(16,079)	$—	$21,984
Interest expense, net of interest income					$372
Income before provision for income taxes					$21,612
Depreciation and amortization	$4,877	$224	$1,278	$—	$6,379

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, mobile x-ray and diagnostic company and urgent care centers to the Company's other operating subsidiaries.

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	Three Months Ended June 30, 2014				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$232,015	$12,704	$5,324		$250,043
Intersegment revenue (1)	470	—	150	(620)	—
Total revenue	$232,485	$12,704	$5,474	$(620)	$250,043
Income from operations	$31,372	$2,213	$(19,943)	$—	$13,642
Interest expense, net of interest income					$8,586
Income before provision for income taxes					$5,056
Depreciation and amortization	$6,600	$126	$1,078	$—	$7,804

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, mobile x-ray and diagnostic company and urgent care centers to the Company's other operating subsidiaries.

	Six Months Ended June 30, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$560,409	$38,260	$18,916		$617,585
Intersegment revenue (1)	1,047	—	391	(1,438)	—
Total revenue	$561,456	$38,260	$19,307	$(1,438)	$617,585
Income from operations	$72,366	$5,671	$(30,878)	$—	$47,159
Interest expense, net of interest income					$872
Income before provision for income taxes					$46,287
Depreciation and amortization	$9,826	$445	$2,625	$—	$12,896

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, mobile x-ray and diagnostic company and urgent care centers to the Company's other operating subsidiaries.

	Six Months Ended June 30, 2014				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$456,137	$23,850	$9,709		$489,696
Intersegment revenue (1)	916	—	332	(1,248)	—
Total revenue	$457,053	$23,850	$10,041	$(1,248)	$489,696
Income from operations	$68,304	$4,085	$(34,400)	$—	$37,989
Interest expense, net of interest income					$11,790
Income before provision for income taxes					$26,199
Depreciation and amortization	$14,461	$247	$1,958	$—	$16,666

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, mobile x-ray and diagnostic company and urgent care centers to the Company's other operating subsidiaries.

9. ACQUISITIONS

The Company’s acquisition strategy is to purchase or lease operating subsidiaries that are complementary to the Company’s current affiliated facilities, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company’s operating subsidiaries are included in the accompanying Interim Financial Statements subsequent to the date of

acquisition. Acquisitions are accounted for using the acquisition method of accounting. The Company also enters into long-term leases that include options to purchase the affiliated facilities. As a result, from time to time, the Company will acquire affiliated facilities that the Company has been operating under third-party leases.

During the six months ended June 30, 2015, the Company continued to expand its operations with the addition of nine stand-alone skilled nursing operations, five assisted and independent living operations, two home health agencies, one home care operation and three urgent care centers to its operations. The aggregate purchase price of the 18 business acquisitions was approximately $64,495, which was paid with cash of $61,007 and assumed liabilities of $3,488. In addition, the Company also entered into a long-term lease agreement for one skilled nursing operation. The details of the operating subsidiaries acquired during the three and six months ended June 30, 2015 are as follows:

- On January 1, 2015, the Company acquired three skilled nursing operations, one assisted and independent living operation, one home health agency and two urgent care centers for an aggregate purchase price of approximately $19,045, which included the real estate of the skilled nursing and assisted and independent living operations. The acquisitions for the skilled nursing and assisted living operations added 244 and 17 operational skilled nursing beds and operational assisted and independent living units, respectively, operated by the Company's operating subsidiaries. The acquisition of the home health agency and urgent care centers did not impact the Company's operational bed count.
- On February 1, 2015, the Company acquired two skilled nursing operations and one assisted and independent living operation for an aggregate purchase price of approximately $23,152, which included assumed liabilities of $3,488. The Company acquired the real estate of the skilled nursing and assisted and independent living operations as part of the acquisitions. The acquisitions added 163 and 328 operational skilled nursing beds and operational assisted and independent living units, respectively, operated by the Company's operating subsidiaries.
- On April 1, 2015, the Company entered into a long-term lease agreement for one skilled nursing operation, which includes an option to purchase the real estate. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The long-term lease added 60 operational skilled nursing beds operated by the Company's operating subsidiaries.
- On April 15, 2015, the Company acquired three assisted living operations for an aggregate purchase price of approximately $11,305, including the real estate of the assisted living operations. The acquisitions added 263 operational assisted living units operated by the Company's operating subsidiaries.
- On May 1, 2015, the Company acquired three skilled nursing operations and one home care operation for an aggregate purchase price of approximately $10,043, including the real estate of the skilled nursing operations. The acquisitions of the skilled nursing operations added 262 operational skilled nursing beds operated by the Company's operating subsidiaries. The acquisition of the home care operation did not impact the Company's operational bed count.
- On June 1, 2015, the Company acquired one home health agency for a purchase price of approximately $950. This acquisition did not impact the Company's operational bed count.

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The table below presents the allocation of the purchase price for the operations acquired in business combinations during the six months ended June 30, 2015 and 2014:

	June 30, 2015	2014
Land	$8,321	$8,094
Building and improvements	44,877	27,228
Equipment, furniture, and fixtures	2,204	1,344
Assembled occupancy	287	425
Definite-lived intangible assets	360	360
Goodwill	2,512	391
Favorable leases	2,069	—
Other indefinite-lived intangible assets	3,865	600
	$64,495	$38,442

In addition to the business combinations above, the Company acquired the following assets during the six months ended June 30, 2015:

•On April 1, 2015, the Company acquired the underlying assets of one skilled nursing operation, which the Company previously operated under a long-term lease agreement. The purchase price of the asset acquisition was $7,378, which included a promissory note of $6,248. This acquisition did not impact the Company's operational bed count.

•On June 29, 2015, the Company acquired the underlying assets of one skilled nursing operation, which the Company previously operated under a long-term lease agreement. The purchase price of the asset acquisition was $10,576. This acquisition did not impact the Company's operational bed count. As of the date of this filing, the preliminary allocation of the purchase price was not completed as necessary valuation information was not yet available

•In addition, the Company acquired land for an aggregate purchase price of $4,147 in June 2015. These acquisitions did not impact the Company's operational bed count.

Subsequent to June 30, 2015, the Company acquired one skilled nursing operation for approximately $5,500, which was acquired through the assumption of an existing HUD-insured mortgage loan. The Company acquired the real estate of the skilled nursing operation as part of the acquisition. In addition, the Company assumed a long-term lease agreement for fifteen assisted and independent living operations. The Company paid $12,000 to assume the long-term lease agreement. Further, the Company entered into a long-term lease agreement for seven skilled nursing operations and five assisted and independent living operations, which include an option to purchase the real estate. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term leases. The purchase of one skilled nursing facility and the operations acquired through long-term lease agreements added 855 and 1,733 operational skilled nursing beds and operational assisted and independent living units, respectively, operated by the Company's operating subsidiaries.

In addition, subsequent to June 30, 2015, the Company acquired one hospice agency for a purchase price of approximately $4,500, which was purchased with cash. In connection with this transaction, the Company began operating an affiliated home health agency under a management agreement. The acquisition of the hospice agency did not have an impact on the Company’s operational bed count.

As of the date of this filing, the preliminary allocation of the purchase price was not completed as necessary valuation information was not yet available for the acquisitions subsequent to June 30, 2015.

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10. ACQUISITIONS - PRO FORMA FINANCIAL INFORMATION

The Company has established an acquisition strategy that is focused on identifying acquisitions within its target markets that offer the greatest opportunity for investment return at attractive prices. The facilities acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming facilities, is often inadequate, inaccurate or unavailable. As a result, the Company has developed an acquisition assessment program that is based on existing and potential resident mix, the local available market, referral sources and operating expectations based on the Company's experience with its existing facilities. Following an acquisition, the Company implements a well-developed integration program to provide a plan for transition and generation of profits from facilities that have a history of significant operating losses. Consequently, the Company believes that prior operating results are not meaningful as the information is not generally representative of the Company's current operating results or indicative of the integration potential of its newly acquired facilities.

The following table represents pro forma results of consolidated operations as if the acquisitions through the issuance date of the financial statements had occurred at the beginning of 2014, after giving effect to certain adjustments.

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Revenue	$347,769	$305,466	$697,564	$600,542
Net income attributable to The Ensign Group, Inc.	16,803	4,111	35,424	19,741
Diluted net income per common share	$0.64	$0.18	$1.38	$0.86

Our pro forma assumptions are as follows:

- Revenues and operating costs were based on actual results from the prior operator or from regulatory filings where available. If actual results were not available, revenues and operating costs were estimated based on available partial operating results of the prior operator of the facility, or if no information was available, estimates were derived from the Company’s post-acquisition operating results for that particular facility. Prior year results for the 2015 acquisitions were obtained from available financial information provided by prior operators or available cost reports filed by the prior operators.

- Interest expense is based upon the purchase price and average cost of debt borrowed during each respective year when applicable and depreciation is calculated using the purchase price allocated to the related assets through acquisition accounting.

The foregoing pro forma information is not indicative of what the results of operations would have been if the acquisitions had actually occurred at the beginning of the periods presented, and is not intended as a projection of future results or trends. Included in the table above are pro forma revenue generated during the three and six months ended June 30, 2015 by individually immaterial business acquisitions completed through June 30, 2015 of $36,713 and $79,979, respectively, and $55,423 and $110,846 for the three and six months ended June 30, 2014, respectively. Included in the table above are pro forma income incurred during the three and six months ended June 30, 2015, by individually immaterial business acquisitions completed through June 30, 2015, of $3,614 and $7,065, respectively, and $2,104 and $4,208 for the three and six months ended June 30, 2014, respectively.

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11. PROPERTY AND EQUIPMENT

Property and equipment consist of the following:

	June 30, 2015	December 31, 2014
Land	$34,176	$18,994
Buildings and improvements	118,940	57,947
Equipment	97,821	80,112
Furniture and fixtures	6,807	5,732
Leasehold improvements	61,196	50,671
Construction in progress	88	423
	319,028	213,879
Less: accumulated depreciation	(75,147)	(64,171)
Property and equipment, net	$243,881	$149,708

See Note 9, Acquisitions for information on acquisitions during the six months ended June 30, 2015.

12. INTANGIBLE ASSETS — Net

	Weighted	June 30, 2015			December 31, 2014		
Intangible Assets	Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	19.9	$604	$(575)	$29	$684	$(634)	$50
Favorable lease	31.8	35,074	(1,697)	33,377	30,890	(783)	30,107
Assembled occupancy	0.6	4,171	(4,056)	115	3,884	(3,461)	423
Facility trade name	30.0	733	(232)	501	733	(220)	513
Customer relationships	11.1	5,300	(742)	4,558	4,940	(465)	4,475
Total		$45,882	$(7,302)	$38,580	$41,131	$(5,563)	$35,568

Amortization expense was $665 and $1,818 for the three and six months ended June 30, 2015, respectively, and $258 and $406 for the three and six months ended June 30, 2014, respectively. Of the $1,818 in amortization expense incurred during the six months ended June 30, 2015, approximately $593 related to the amortization of patient base intangible assets at recently acquired facilities, which is typically amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date.

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

Year	Amount
2015 (remainder)	$1,372
2016	2,914
2017	2,914
2018	2,914
2019	2,914
2020	2,914
Thereafter	22,638
	$38,580

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13. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

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

The following table represents activity in goodwill by segment as of and for the six months ended June 30, 2015:

	Goodwill			
	TSA Services	Home Health and Hospice Services	All Other	Total
January 1, 2015	$15,977	$10,929	$3,363	$30,269
Impairments	—	—	—	—
Additions	—	—	2,512	2,512
June 30, 2015	$15,977	$10,929	$5,875	$32,781

As of June 30, 2015, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes. See further discussion of goodwill acquired at Note 9, Acquisitions.

Other indefinite-lived intangible assets consists of the following:

	June 30, 2015	December 31, 2014
Trade name	$1,855	$1,055
Home health and hospice Medicare license	14,371	11,306
	$16,226	$12,361

14. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	June 30, 2015	December 31, 2014
Debt issuance costs, net	$2,316	$2,612
Long-term insurance losses recoverable asset	2,388	2,256
Deposits with landlords	1,650	1,143
Capital improvement reserves with landlords and lenders	471	774
Other long-term assets	—	48
Restricted and other assets	$6,825	$6,833

Included in restricted and other assets as of June 30, 2015 and December 31, 2014, are anticipated insurance recoveries related to the Company's general and professional liability claims that are recorded on a gross rather than net basis in accordance with an Accounting Standards Update issued by the FASB and capitalized debt issuance costs.

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15. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2015	December 31, 2014
Quality assurance fee	$3,572	$2,855
Refunds payable	10,528	7,014
Deferred revenue	3,473	3,471
Cash held in trust for patients	1,970	1,824
Resident deposits	5,796	1,593
Dividends payable	1,929	1,708
Property taxes	2,771	3,043
Other	4,392	3,122
Other accrued liabilities	$34,431	$24,630

Quality assurance fee represents amounts payable to Arizona, California, Colorado, Idaho, Iowa, Nebraska, Utah, Washington and Wisconsin as a result of a mandated fee based on patient days. Refunds payable includes payables related to overpayments and duplicate payments from various payor sources. Deferred revenue occurs when the Company receives payments in advance of services provided. Resident deposits include refundable deposits to patients assumed from acquisitions. See Note 8, Acquisitions. Cash held in trust for patients reflects monies received from, or on behalf of, patients. Maintaining a trust account for patients is a regulatory requirement and, while the trust assets offset the liabilities, the Company assumes a fiduciary responsibility for these funds. The cash balance related to this liability is included in other current assets in the accompanying condensed consolidated balance sheets.

16. INCOME TAXES

During the second quarter of 2015, the Company completed the Internal Revenue Service (IRS) examination of the Company's 2012 tax return without adjustment. The Company is not currently under examination by any major income tax jurisdiction. During 2015, the statutes of limitations will lapse on the Company's 2011 federal tax year and certain 2010 and 2011 state tax years. The Company does not believe the federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the six months ended June 30, 2015 or 2014.

17. DEBT

Long-term debt consists of the following:

	June 30, 2015	December 31, 2014
Credit Facility with SunTrust, interest payable monthly and quarterly, balance due at May 1, 2019, secured by substantially all of the Company’s personal property.	$40,000	$65,000
Mortgage note, principal and interest payable monthly and continuing through October 2037, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	3,335	3,390
Promissory note, principal and interest payable monthly and continuing through April 30, 2027, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	6,185	—
	49,520	68,390
Less current maturities	(501)	(111)

	$49,019	$68,279

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Promissory Note with Vannovi Properties, LLC

On April 1, 2015, the Company entered into a promissory note with Vannovi Properties, LLC for approximately $6,248 in connection with an acquisition. The unpaid balance of principal and accrued interest from the note is due on April 30, 2027. The note bears interest at a rate of 5.3% per annum. As of June 30, 2015, the Company's operating subsidiary had $6,185 outstanding under the note, of which $389 is classified as short-term and the remaining $5,796 is classified as long-term.

Mortgage Loan with Ziegler Financing Corporation

On July 1, 2015, the Company assumed an existing mortgage loan with Ziegler Financing Corporation of approximately $5,500 in connection with an acquisition. The mortgage loan is insured with the U.S. Department of Housing and Urban Development (HUD), which subjects the facility to HUD oversight and periodic inspections. The mortgage loan bears interest at a rate of 3.5% per annum. Amounts borrowed under the mortgage loan may be prepaid starting after the second anniversary of the note subject to prepayment fees of 8.0% of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% per year for years three through ten of the loan. There is no prepayment penalty after year eleven. The term of the mortgage loan is 33 years, with monthly principal and interest payments through March 1, 2045. The mortgage loan is secured by the real property comprising the facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

Based on Level 2, the carrying value of the Company's long-term debt is considered to approximate the fair value of such debt for all periods presented based upon the interest rates that the Company believes it can currently obtain for similar debt.

Off-Balance Sheet Arrangements

As of June 30, 2015, the Company had approximately $2,726 on the Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit. Subsequent to June 30, 2015, the Company increased the letters of credit by $500.

18. OPTIONS AND AWARDS

Stock-based compensation expense consists of share-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company’s condensed consolidated statements of income for the three and six months ended June 30, 2015 and 2014 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan), all of which have been approved by the Company's stockholders. The total number of shares available under all of the Company’s stock incentive plans was 1,514 as of June 30, 2015.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for all share-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and

market information, which can change significantly over time. The Company granted 147 options and 91 restricted stock awards from the 2007 Plan during the six months ended June 30, 2015.

The Company used the following assumptions for stock options granted during the three months ended June 30, 2015 and 2014:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2015	75	1.71%	6.5 years	40%	0.62%
2014	664	1.80%	6.5 years	55%	0.64%

The Company used the following assumptions for stock options granted during the six months ended June 30, 2015 and 2014:

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Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2015	147	1.45% - 1.71 %	6.5 years	40% - 44 %	0.63%
2014	931	1.80% - 1.84 %	6.5 years	55%	0.64%

For the six months ended June 30, 2015 and 2014, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2015	147	$45.13	$18.45
2014	931	$24.38	$12.51

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended June 30, 2015 and 2014 and therefore, the intrinsic value was $0 at date of grant.

The following table represents the employee stock option activity during the six months ended June 30, 2015:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2015	2,766	$17.02	1,109	$9.39
Granted	147	45.13		
Forfeited	(59)	23.15		
Exercised	(133)	11.01		
June 30, 2015	2,721	$18.70	1,256	$11.79

The following summary information reflects stock options outstanding, vested and related details as of June 30, 2015:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2005	2.72 - 3.14	24	*	0	24
2006	3.85 - 4.09	63	330	1	63
2008	5.12 - 8.11	253	759	3	253
2009	8.12 - 9.11	366	1,572	4	366
2010	9.53 - 9.91	90	430	5	83
2011	11.79 - 15.98	110	745	6	66
2012	13.12 - 15.91	328	2,419	7	135
2013	15.96 - 22.98	373	3,650	8	103

2014	21.09 - 37.88	967	10,921	9	163
2015	43.58 - 46.62	147	2,708	10	—
Total		2,721	$ 23,534		1,256

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

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The Company granted 26 and 91 restricted stock awards during the three and six months ended June 30, 2015, respectively. The Company granted 2 and 4 restricted stock awards during the three and six months ended June 30, 2014, respectively. All awards were granted at an exercise price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the six months ended June 30, 2015 ranged from $42.59 to $46.62 based on the market price on the grant date.

A summary of the status of the Company's non-vested restricted stock awards as of June 30, 2015 and changes during the six month period ended June 30, 2015 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2015	183	$30.30
Granted	91	44.36
Vested	(79)	37.25
Forfeited	(9)	29.83
Nonvested at June 30, 2015	186	$34.23

During the three and six months ended June 30, 2015, the Company granted 4 and 8 automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards ranged from $42.59 to $46.00 based on the market price on the grant date.

Total share-based compensation expense recognized for the three and six months ended June 30, 2015 and 2014 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Share-based compensation expense related to stock options	$1,165	$711	$2,121	$1,354
Share-based compensation expense related to restricted stock awards	434	387	850	817
Share-based compensation expense related to stock awards	134	106	255	212
Total	$1,733	$1,204	$3,226	$2,383

In future periods, the Company expects to recognize approximately $15,119 and $5,518 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of June 30, 2015. Future share-based compensation expense will be recognized over 3.7 and 3.3 weighted average years for unvested options and restricted stock awards, respectively. There were 1,465 unvested and outstanding options at June 30, 2015, of which 1,337 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at June 30, 2015 was 6.7 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of and for the six months ended June 30, 2015 and as of and the twelve months ended December 31, 2014 is as follows:

Options	June 30, 2015	December 31, 2014
Outstanding	$88,036	$75,689
Vested	49,342	38,811
Expected to vest	32,830	31,160
Exercised	4,676	10,496

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

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19. LEASES

As a result of the Spin-Off, the Company leases from CareTrust real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities used in the Company's operations under the Master Leases, which ranges from 12 to 19 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and being continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases is subject to termination prior to the expiration of the then current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases.

The Company does not have the ability to terminate the obligations under a Master Lease prior to its expiration without CareTrust's consent. If a Master Lease is terminated prior to its expiration other than with CareTrust's consent, the Company may be liable for damages and incur charges such as continued payment of rent through the end of the lease term and maintenance and repair costs for the leased property.

Commencing the third year, the rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Annual rent expense under the Master Leases will be approximately $56,000 during each of the first two years of the Master Leases.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. The Company is not aware of any defaults as of June 30, 2015.

The Company also leases certain affiliated operations and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company has entered into multiple lease agreements with Mainstreet Property Group LLC to operate newly constructed state-of-the-art, full-service healthcare resorts upon completion of construction (Healthcare Resorts Leases). The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, the Company leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $19,180 and $38,261 for the three and six months ended June 30, 2015, respectively, and $8,398 and $12,062 for the three and six months ended June 30, 2014, respectively.

Future minimum lease payments for all leases as of June 30, 2015 are as follows:

Year	Amount
Remainder	$41,211
2016	89,165
2017	90,001
2018	89,942
2019	88,798
2020	86,052
Thereafter	823,274
	$1,308,443

Six of the Company's affiliated facilities, excluding the facilities that are operated under the Master Leases with CareTrust, are operated under two separate three-facility master lease arrangements. Under these master leases, a breach at a single facility could subject one or more of the other facilities covered by the same master lease to the same default risk. Failure to comply with Medicare and Medicaid provider requirements is a default under several of the Company's leases, master lease agreements and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire

master lease portfolio and could trigger cross-default provisions in the Company’s outstanding debt arrangements and other leases. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord.

In addition, a number of the Company's individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the landlords under separate but cross-defaulted leases. The Company is not aware of any defaults as of June 30, 2015.

20. COMMITMENTS AND CONTINGENCIES

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

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

Income Tax Examinations — During the third quarter of 2014, the Company received a notification from the IRS that the Company's 2012 tax return will be examined. During the second quarter of 2015, the examination was closed with no adjustments. The Company is not currently under examination by any major income tax jurisdiction. See Note 16, Income Taxes. The Company's employment tax returns for the 2012 tax year are under examination by IRS.

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

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

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

anti-fraud legislation modeled on the Federal False Claims Act. As such, the Company could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which it does business.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) of 2009 which made significant changes to the Federal False Claims Act (FCA), expanding the types of activities subject to prosecution and whistleblower liability. Following changes by FERA, health care providers face significant penalties for the knowing retention of government overpayments, even if no false claim was involved. Health care providers can now be liable for knowingly and improperly avoiding or decreasing an obligation to pay money or property to the government. This includes the retention of any government overpayment. The government

can argue, therefore, that a FCA violation can occur without any affirmative fraudulent action or statement, as long as it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, there is generally no need for an employment relationship in order to qualify for protection against retaliation for whistleblowing.

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

A class action staffing suit was previously filed against the Company and certain of its California subsidiaries in the State of California, alleging, among other things, violations of certain Health and Safety Code provisions and a violation of the Consumer Legal Remedies Act. In 2007, the Company settled this class action suit, and the settlement was approved by the affected class and the Court. A second such class action staffing suit was filed in Los Angeles in 2010 and was resolved in a settlement and Court approval in 2012. Neither of the referenced lawsuits or settlement had a material ongoing adverse effect on the Company's business, financial condition or results of operations.

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

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

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company and its operating subsidiaries are subjected to, alleged to be liable for, or agrees to a settlement of, claims or obligations under Federal Medicare statutes, the Federal False Claims Act, or similar State and Federal statutes and related regulations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.

Medicare Revenue Recoupments — The Company is subject to reviews relating to Medicare services, billings and potential overpayments. The Company had one operating subsidiary subject to probe review during the six months ended June 30, 2015. The Company anticipates that these probe reviews will increase in frequency in the future. Further, the Company currently has no affiliated facilities on prepayment review; however, others may be placed on prepayment review in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies.

U.S. Government Inquiry — In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the DOJ and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. Pursuant to the Settlement Agreement, the Company made a single lump-sum remittance to the government in the amount of $48,000 in October 2013. The Company has denied engaging in any illegal conduct, and has agreed to the settlement amount without any admission of wrongdoing in order to resolve the allegations and to avoid the uncertainty and expense of protracted litigation.

In connection with the settlement and effective as of October 1, 2013, the Company entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. The CIA acknowledges the existence of the Company’s current

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

compliance program, which is in accord with the Office of the Inspector General (OIG)'s guidance related to an effective compliance program, and requires that the Company continue during the term of the CIA to maintain a compliance program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, and all other Federal health care programs. The Company is also required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that the Company has committed a crime or has engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by federal health care programs. The Company is also required to retain an Independent Review Organization (IRO) to review certain clinical documentation annually for the term of the CIA.

The Company has met the requirements of its first year under the Settlement Agreement and passed its IRO audits. Participation in federal healthcare programs by the Company is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, the Company could be excluded from participation in federal healthcare programs and/or subject to prosecution.

Concentrations

Credit Risk — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's receivables from Medicare and Medicaid payor programs accounted for approximately 56.6% and 52.4% of its total accounts receivable as of June 30, 2015 and December 31, 2014, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 68.5% and 68.8% of the Company's revenue for the three and six months ended June 30, 2015, respectively, and 70.2% and 70.7% for the three and six months ended June 30, 2014, respectively.

Cash in Excess of FDIC Limits — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of July 31, 2015, the Company had approximately $1,100 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

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

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

This Report contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to the Company’s expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, plans and objectives of management. Forward-looking statements can often be identified by words such as “anticipates,” “expects,” “intends,” “plans,” “predicts,” “believes,” “seeks,” “estimates,” “may,” “will,” “should,” “would,” “continue,” “ongoing,” similar expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Therefore, our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section “Risk Factors” contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management’s beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law. As used in this Management’s Discussion and Analysis of Financial Condition and Results of Operations, the words, “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our affiliated operations, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of “we,” “us,” “our” and similar verbiage in this quarterly report is not meant to imply that any of our affiliated operations, the Service Center or the Captive are operated by the same entity. This Management’s Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with our consolidated financial statements and related notes included in the Annual Report.

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 150 facilities, fourteen home health and twelve hospice agencies, three home care operations, one transitional care management company, seventeen urgent care centers and a mobile x-ray and diagnostic company as of June 30, 2015, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the service of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted living, home health and hospice, mobile ancillary and urgent care services. As of June 30, 2015, we owned 26 of our 150 affiliated facilities and operated an additional 124 facilities under long-term lease arrangements, and had options to purchase three of those 124 facilities.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of June 30, 2015:

	Owned	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total
Number of facilities	26	3	121	150

Percentage of total	17.3	%	2.0	%	80.7	%	100.0	%
Operational skilled nursing, assisted living and independent living beds	2,795		406		12,818		16,019	
Percentage of total	17.4	%	2.6	%	80.0	%	100.0	%

The Ensign Group, Inc. (collectively, Ensign or the Company) is a holding company with no direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly-owned subsidiaries, referred to collectively as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. We also have a wholly-owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to our operating subsidiaries for general and

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professional liability, as well as coverage for certain workers' compensation insurance liabilities. References herein to the consolidated "Company" and "its" assets and activities, as well as the use of the terms "we," "us," "our" and similar terms i this quarterly report, are not meant to imply, nor should they be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group.

Real Estate Investment Trust (REIT) Spin-Off. On June 1, 2014, we completed the separation of our healthcare business and our real estate business into two publicly traded companies through a tax-free distribution of all of the outstanding shares of common stock of CareTrust REIT, Inc. (CareTrust) to our stockholders on a pro rata basis (the Spin-Off). Our stockholders received one share of CareTrust common stock for each share of our common stock held at the close of business on May 22, 2014, the record date for the Spin-Off. As a result of the Spin-Off, we lease back real property associated with 94 affiliated skilled nursing, assisted living and independent living facilities from CareTrust on a triple-net basis (the Master Leases), under which we are responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs. See further discussion at Note 2, Spin-Off of Real Estate Assets Through a Real Estate Investment Trust in the Notes to Condensed Consolidated Financial Statements.

Acquisition History

The following table sets forth the location of our affiliated facilities and the number of operational beds located at our facilities as of June 30, 2015:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	WI	Total
Cumulative number of skilled nursing, assisted and independent living operations	46	16	28	15	10	9	9	3	7	5	2	150
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	4,801	2,429	3,444	1,613	745	808	719	304	662	356	138	16,019

As of June 30, 2015, we provided home health and hospice services through our 26 agencies in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington.

During the first quarter of 2015, we acquired five skilled nursing operations, two assisted and independent living operations, one home health agency and two urgent care centers for an aggregate purchase price of $42.2 million. We acquired the real estate of the skilled nursing and assisted and independent living operations as part of the acquisitions. The acquisitions of skilled nursing and assisted living facilities added 407 and 345 operational skilled nursing beds and operational assisted and independent living units, respectively, to our operating subsidiaries. The acquisitions of the home health agency and urgent care centers did not have an impact on the number of beds operated by our operating subsidiaries.

During the second quarter of 2015, we acquired three skilled nursing operations, three assisted living operations, one home health agency and one home care operation for an aggregate purchase price of $22.3 million. We acquired the real estate of the skilled nursing and assisted and independent living operations as part of the acquisitions. The acquisitions of skilled nursing and assisted living facilities added 262 and 263 operational skilled nursing beds and operational assisted living units, respectively, to our operating subsidiaries. The acquisitions of the home health agency and home care operation did not have an impact on the number of beds operated by our operating subsidiaries. We also entered into a long-term lease agreement and assumed the operation for one skilled nursing operation, which

includes an option to purchase the real estate. We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The long-term lease added 60 operational skilled nursing beds to our operating subsidiaries. In a separate transaction, we acquired the underlying assets of two skilled nursing operations, which we previously operated under a long-term lease agreements, and land for an aggregate purchase price of approximately $22.1 million, which included a promissory note.

Subsequent to June 30, 2015, we acquired one skilled nursing operation for approximately $5.5 million, which was acquired through the assumption of an existing HUD-insured mortgage loan. We acquired the real estate of the skilled nursing operation as part of the acquisition. In addition, we assumed a long term lease agreement for fifteen assisted and independent living operations. We paid $12.0 million to assume the long-term lease agreement. Further, we entered into a long-term lease agreement for seven skilled nursing operations and five assisted and independent living operations, which include an option to purchase the real estate.

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We did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term leases. The purchase of one skilled nursing facility and the operations acquired through long-term lease agreements added 855 and 1,733 operational skilled nursing beds and operational assisted and independent living units, respectively, to our operating subsidiaries.

In addition, subsequent to June 30, 2015, we acquired one hospice agency for a purchase price of approximately $4.5 million. In connection with this transaction, we began operating an affiliated home health agency under a management agreement. The acquisition of the hospice agency did not have an impact on our operational bed count.
See further discussion of facility acquisitions in Note 9, Acquisitions in Notes to Condensed Consolidated Financial Statements.
Key Performance Indicators
We manage our fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. These indicators and their definitions include the following:
Transitional, Skilled and Assisted Living Services

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

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Skilled Mix:				
Days	30.1 %	27.8 %	30.2 %	27.8 %
Revenue	53.4 %	51.4 %	53.2 %	51.2 %
Quality Mix:				
Days	42.7 %	40.7 %	42.7 %	40.8 %
Revenue	62.0 %	60.5 %	61.7 %	60.4 %

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Occupancy:				
Operational beds at end of period	16,019	13,834	16,019	13,834
Available patient days	1,437,100	1,242,933	2,804,929	2,437,009
Actual patient days	1,121,158	967,403	2,198,396	1,900,270
Occupancy percentage (based on operational beds)	78.0 %	77.8 %	78.4 %	78.0 %

Home Health and Hospice

- Medicare episodic admissions. The total number of episodic admissions derived from patients who are receiving care under Medicare reimbursement programs.
- Average Medicare revenue per completed episode. The average amount of revenue for each completed 60-day episode generated from patients who are receiving care under Medicare reimbursement programs.
- Average daily census. The average number of patients who are receiving hospice care as a percentage of total number of patient days.

Segments

Beginning in the fourth quarter of 2014, we realigned our operating segments to more closely correlate with our service offerings, which coincide with the way that we measure performance and allocate resources. Previously, we had a single reportable segment, healthcare services, which included providing skilled nursing, assisted living, home health and hospice, urgent care and related ancillary services. We have presented 2014 financial information on a comparative basis to conform with the current period segment presentation.

We have two reportable segments: (1) transitional, skilled and assisted living services, which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of our business; and (2) home

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health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

We also report an “all other” category that includes revenue from our urgent care centers and a mobile x-ray and diagnostic company. Our urgent care centers and mobile x-ray and diagnostic businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations.

Revenue Sources

The following table sets forth our total revenue by payor source generated by each of our reportable segments and our "All Other" category and as a percentage of total revenue for the periods indicated (dollars in thousands):

	Three Months Ended June 30, 2015					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$98,461	$2,412	$—	$100,873	32.4	%
Medicare	81,831	13,565	—	95,396	30.7	
Medicaid-skilled	16,745	—	—	16,745	5.4	
Subtotal	197,037	15,977	—	213,014	68.5	
Managed care	45,241	2,392	—	47,633	15.3	
Private and other	39,358	1,575	9,476	(1) 50,409	16.2	
Total revenue	$281,636	$19,944	$9,476	$311,056	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers, mobile x-ray and diagnostic company and other ancillary businesses.

	Three Months Ended June 30, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$84,838	$1,099	$—	$85,937	34.4	%
Medicare	68,447	8,886	—	77,333	30.9	
Medicaid-skilled	12,353	—	—	12,353	4.9	
Subtotal	165,638	9,985	—	175,623	70.2	
Managed care	33,883	1,893	—	35,776	14.3	
Private and other	32,494	826	5,324	(1) 38,644	15.5	
Total revenue	$232,015	$12,704	$5,324	$250,043	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers, mobile x-ray and diagnostic company and other ancillary businesses.

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	Six Months Ended June 30, 2015					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$198,168	$4,334	$—	$202,502	32.8	%
Medicare	163,521	26,231	—	189,752	30.7	
Medicaid-skilled	32,282	—	—	32,282	5.3	
Subtotal	393,971	30,565	—	424,536	68.8	
Managed care	89,348	4,615	—	93,963	15.2	
Private and other	77,090	3,080	18,916 (1)	99,086	16.0	
Total revenue	$560,409	$38,260	$18,916	$617,585	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers, mobile x-ray and diagnostic company and other ancillary businesses.

	Six Months Ended June 30, 2014					
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %	
Medicaid	$167,225	$2,054	$—	$169,279	34.6	%
Medicare	136,954	16,849	—	153,803	31.4	
Medicaid-skilled	22,961	—	—	22,961	4.7	
Subtotal	327,140	18,903	—	346,043	70.7	
Managed care	65,179	3,575	—	68,754	14.0	
Private and other	63,818	1,372	9,709 (1)	74,899	15.3	
Total revenue	$456,137	$23,850	$9,709	$489,696	100.0	%

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers, mobile x-ray and diagnostic company and other ancillary businesses.

Transitional, Skilled and Assisted Living Services

Skilled Nursing Operations. Within our skilled nursing operations, we generate our revenue from Medicaid, private pay, managed care and Medicare payors. We believe that our skilled mix, which we define as the number of days our Medicare, managed care and other skilled patients are receiving services at our skilled nursing operations divided by the total number of days patients are receiving services at our skilled nursing operations, from all payor sources (less days from assisted living and independent living services) for any given period, is an important indicator of our success in attracting high-acuity patients because it represents the percentage of our patients who are reimbursed by Medicare, managed care and other skilled payors, for whom we receive higher reimbursement rates.

We are participating in the recently established Upper Payment Limit (UPL) supplemental payment program in the state of Texas that provides supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as county hospital districts. Our operating subsidiaries, previously operating ten company-owned Texas skilled nursing facilities, entered into transactions with several such hospital districts providing for the transfer of the licenses for those skilled nursing facilities to the hospital districts through management agreements with the respective hospital districts, and providing further for our operating subsidiaries to retain the management of those facilities on behalf of the hospital districts, which are all participating in the UPL program. Each affected operating subsidiary therefore retains operations of its skilled nursing facility and each agreement between the hospital district and our subsidiary is terminable by either party to fully restore the prior

license status. During the three months ended June 30, 2015, we did not record revenue related to the UPL supplemental payment program as no supplemental payment will be available between March 1, 2015 and September 30, 2015.

Assisted and Independent Living Operations. Within our assisted and independent living operations, we generate revenue primarily from private pay sources, with a small portion earned from Medicaid or other state-specific programs.

Home Health and Hospice Services

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Home Health. We provided home health care in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington as of June 30, 2015. We derive the majority of our revenue from our home health business from Medicare and managed care. The payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The home health prospective payment system (PPS) provides home health agencies with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin. There are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits was fewer than five; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (c) a payment adjustment based upon the level of therapy services required; (d) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes in the base episode payments established by the Medicare program; (f) adjustments to the base episode payments for case mix and geographic wages; and (g) recoveries of overpayments.

Hospice. As of June 30, 2015, we provided hospice care in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. We derive substantially all of the revenue from our hospice business from Medicare reimbursement. The estimated payment rates are daily rates for each of the levels of care we deliver. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimate amounts due back to Medicare if a cap has been exceeded.

Other

In addition, as of June 30, 2015, we operated seventeen urgent care clinics in Colorado and Washington. Our urgent care centers provide daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. As of June 30, 2015, we held 80% of the membership interest of a mobile x-ray and diagnostic company. The diagnostic company is a leader in providing mobile diagnostic services, including digital x-ray, ultrasound, electrocardiograms, ankle-brachial index, and phlebotomy services to people in their homes or at long-term care facilities. Payment for these services varies and is based upon the service provided. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk.

Critical Accounting Policies Update

There have been no significant changes during the six months ended June 30, 2015 to the items that we disclosed as our critical accounting policies and estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2014, filed with the SEC.

Industry Trends

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

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

patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.

- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.

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- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.
- Accountable Care Organizations and Reimbursement Reform. A significant goal of federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization (ACO) models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing demonstration programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. On January 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018. Providers who respond successfully to these trends and are able to deliver quality care at lower cost are likely to benefit financially.

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

Effects of Changing Prices

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

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

On July 9, 2015, the Centers for Medicare & Medicaid Services (CMS) proposed a new mandatory Comprehensive Care for Joint Replacement (CCJR) model focusing on coordinated, patient-centered care. Under this proposed model, the hospital in which the hip or knee replacement takes place would be accountable for the costs and quality of care from the time of the surgery through 90 days after or an "episode" of care. Depending on the hospital's quality and cost performance during the episode, the hospital would either earn a financial reward or be required to repay Medicare for a portion of the costs. This payment would give hospitals an incentive to work with physicians, home health agencies, and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing

avoidable hospitalizations and complications. This proposed model would be in 75 geographic areas throughout the country and most hospitals in those regions would be required to participate. Following publication of a final rule and implementation of the CCJR program, our Medicare revenues derived from our affiliated skilled nursing facilities and other post-acute services related to lower extremity joint replacement hospital discharges could be increased or reduced in those geographic areas identified by CMS for mandatory participation in the bundled payment program. On July 13, 2015, CMS released a proposed rule that would reform requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in Medicare and Medicaid. The rule would reorder, clarify, and update regulations that the agency has not reviewed comprehensively since 1991. Under the proposed rule, facilities are required to 1) create interim care plans within 48 hours of admission, notify a resident's physician after a change in

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status, engage in interdisciplinary care planning, have a practitioner assess the patient in-person prior to a transfer to the hospital, and improve clinical records to ensure providers have the necessary information to decide on hospitalization; 2) conduct comprehensive assessments of their staff and patient needs, apply current requirements for antipsychotic drugs to all psychotropic drugs, and require physicians to document their response to irregularities identified by consultant pharmacists; 3) conduct assessments of their resident population, implement and update periodically an infection prevention and control program, and establish an antibiotic stewardship program; 4) address requirements related to behavioral health services, ensuring facilities have adequate staffing to meet the needs of residents with mental illness and cognitive impairment; and 5) conduct assessments of their patient populations and related care needs to determine adequate staffing levels (i.e., number and skillsets) for nursing, behavioral health, and nutritional services. CMS estimates that these proposed regulations would cost facilities nearly $46.5 million in the first year and over $40.6 million in subsequent years. However, these amounts would vary considerably among organizations. In addition to the monetary costs, these regulations may create compliance issues, as state regulators and surveyors interpret requirements that are less explicit.

Skilled Nursing

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

On July 31, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2.0% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% MFP adjustment required by the PPACA.

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimated that aggregate payments to skilled nursing facilities would increase by $470 million, or 1.3% for fiscal year 2014, relative to payments in 2013. This estimated increase reflected a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% MFP as required by PPACA. The forecast error correction is applied when the difference between the actual and projected market basket percentage change for the most recent available fiscal year exceeds the 0.5% threshold. In its 2014 report to congress, the Medicare Payment Advisory Commission recommended eliminating the market basket update and reducing payments through the SNF prospective payments system.

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

Home Health

On July 6, 2015, CMS published proposed changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2016. Under this rule, CMS proposes to decrease the national, standardized 60-day episode payment amount by 1.72% in each of calendar year 2016 and 2017 to account for nominal case-mix coding intensity growth unrelated to changes in patient acuity between calendar year 2012 and 2014. The decrease reflects the effects of the 2.3% home health payment update percentage and the rebasing adjustments to the national, standardized 60-day

episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor.

Further, CMS announced a proposal to launch Home Health Value-Based Purchasing model to test whether incentives for better care can improve outcomes in the delivery of home health services. The model would apply a payment reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 5.0% in each of the first two payment adjustment years, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years. CMS estimates that implementing a home health value-based model will result in a 1.8% decrease in Medicare payments to home health agencies across the industry.

Lastly, CMS proposed one standardized cross-setting measure for calendar year 2016. The Home Health Conditions of Participation (CoPs) require home health agencies to submit OASIS assessments as a condition of payment and also for quality

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measurement purposes. Home health agencies that do not submit quality measure data to CMS will see a 2.0% reduction in their annual home health payment update percentage. Under the proposed rule, all home health agencies are required to submit both admission and discharge OASIS assessments for a minimum of 70.0% of all patients with episodes of care occurring during the reporting period starting July 1, 2015. The proposed rule will incrementally increase this compliance threshold by 10.0% in each of the subsequent periods (July 1, 2016 and July 1, 2017) to reach 90.0%.

On October 30, 2014, CMS announced payment changes to the Medicare HH PPS for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the effects of the 2.1% home health payment update percentage and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor. CMS is also finalizing three changes to the face-to-face encounter requirements under the Affordable Care Act. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if each home health agency (HHA) claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services and c) clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care. This rule also established a minimum submission threshold for the number of OASIS assessments that each HHA must submit under the Home Health Quality Reporting Program and the Home Health Conditions of Participant for speech language pathologist personnel.

On November 22, 2013, CMS issued its final ruling regarding Medicare payment rates for home health agencies effective January 1, 2014. As required by the PPACA, this rule included rebasing adjustments, with a four-year phase-in, to the national, standardized 60-day episode payment rates; the national per-visit rates; and the NRS conversion factor. Under the ruling, CMS projected that Medicare payments to home health agencies in calendar year 2014 would be reduced by 1.05%, or $200 million, reflecting the combined effects of the 2.3% increase in the home health national payment update percentage; offset by a 2.7% decrease due to rebasing adjustments to the national, standardized 60-day episode payment rate, mandated by the Affordable Care Act; and a 0.6% decrease due to the effects of Home Health Prospective Payment Systems Grouper refinements. This final rule also updated the home health wage index for calendar year 2014. The ruling also established home health quality reporting requirements for 2014 payment and subsequent years to specify that Medicaid responsibilities for home health surveys be explicitly recognized in the State Medicaid Plan, which is similar to the current regulations for surveys of skilled nursing facilities and intermediate care facilities for individuals with intellectual disabilities.

Hospice

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

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a "hospital market basket" increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS' seven-year phase-out of its wage index BNAF. The final rule also states that CMS will begin national implementation of the CAHPS Hospice Survey starting January 1, 2015. In the final rule, CMS requires providers to complete their hospice cap determination within 150 days after the cap period and remit any overpayments. If a hospice does not complete its cap determination in a timely fashion, its Medicare payments would be suspended until the cap determination is complete and received by the contractor. This is similar to the current practice for all other provider types that file cost reports with Medicare.

On August 2, 2013, CMS issued its final rule that updated fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices were projected to see an estimated 1.0% increase in their payments for fiscal year 2014. The hospice payment increase was the net result of a hospice payment update percentage of 1.7% (a 2.5% hospital market basket increase minus a 0.8% reduction mandated by law), offset by a 0.7% decrease in payments to hospices due to updated

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wage data and the fifth year of the CMS's seven-year phase-out of its wage index BNAF. As finalized in this rule, CMS planned to update the hospice per diem rates for fiscal year 2014 and subsequent years through the annual hospice rule or notice, rather than solely through a Change Request, as has been done in prior years. The fiscal year 2014 hospice payment rates and wage index became effective on October 1, 2013.

Additional Federal rulings

On April 16, 2015, the President signed into law the H.R. 2 Medicare Access and State Children's Health Insurance Program (CHIP) Reauthorization Act of 2015. This bill includes a number of provisions, including replacement of the Sustainable Growth Rate (SGR) formula used by Medicare to pay physicians with new systems for establishing annual payment rate updates for physicians' services. In addition, it increases premiums for Part B and Part D of Medicare for beneficiaries with income above certain levels and makes numerous other changes to Medicare and Medicaid.

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

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

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

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

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

Annual limitations on beneficiary incurred expenses for outpatient therapy services under Medicare Part B are commonly referred to as “therapy caps.” All beneficiaries began a new cap year on January 1, 2015 since the therapy caps are determined on a calendar year basis. For physical therapy (PT) and speech-language pathology services (SLP) combined, the limit on incurred expenses is $1,940 in 2015. For occupational therapy (OT) services, the limit is $1,940 in 2015. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

An “exceptions process” to the therapy caps was in effect through March 31, 2015 under the Protecting Access to Medicare Act of 2014. For claims furnished through March 31, 2015 that exceed the therapy caps, therapy service providers and suppliers may request an exception when one is appropriate. When the beneficiary exceeds the therapy caps and qualifies for a therapy cap exception, the provider or supplier shall add a KX modifier to the therapy Healthcare Common Procedure Coding System (HCPCS) code subject to the cap limit. By using the KX modifier, the provider is attesting that the services are reasonable and necessary and that there is documentation of medical necessity in the beneficiary’s medical record. Manual policies relevant to the exceptions process apply only when exceptions to the therapy caps are in effect. The therapy exception process was again extended and the expected SGR of 21% to the Physician Fee Screen for outpatient therapy services was repealed through the H.R. 2 Medicare Access

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and CHIP Reauthorization Act of 2015. Under act, the therapy cap exception went into effect on April 1, 2015 and extends through December 31, 2017.

A manual medical review process, as part of the therapy exceptions process, applies to therapy claims when a beneficiary's incurred expenses exceed a threshold amount of $3,700 annually. Specifically, combined PT and SLP services that exceed $3,700 are subject to manual medical review, as well as OT services that exceed $3,700. A beneficiary's incurred expenses apply towards the manual medical review thresholds in the same manner as it applies to the therapy caps. Manual medical review was in effect through a post-payment review system until March 31, 2015. As part of the Medicare Access and CHIP Reauthorization Act of 2015, the manual medical review process will be replaced with a new process to be developed by the Secretary of Health and Human Services.
Medicare Coverage Settlement Agreement. A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved on January 24, 2013, which tasked CMS with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve. At the conclusion of the CMS education campaign, the members of the class will have the opportunity for re-review of their claims, and a two- or three-year monitoring period will commence. Implementation of the provisions of this settlement agreement could favorably impact Medicare coverage reimbursement for our services.

Federal Health Care Reform. On February 20, 2015, CMS modified the Five Star Quality Rating System for nursing homes to include the use of antipsychotics in calculating the star ratings, modified calculations for staffing levels and reflect higher standards for nursing homes to achieve a high rating on the quality measure dimension. Since the standards for performance on quality measures are increasing, the number of our 4 and 5 star facilities could be reduced. In addition, CMS announced proposals to adopt new standards that home health agencies must comply with in order to participate in the Medicare program, including the strengthening of patient rights and communication requirements that focus on patient well-being.

On October 6, 2014, the President signed into law the Improving Medicare Post-Acute Care Transformation Act of 2014. This legislation requires post-acute care providers, such as skilled nursing facilities, hospices, and home health providers, to report standardized patient assessment data, data on quality measures, and data on resource use and other measures, and directs HHS to provide feedback reports to providers and arrange for public reporting of provider performance on the reported data. Post-acute care providers that do not report such data will have their Medicare payments reduced.

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

On March 23, 2010, President Obama signed the PPACA or the Affordable Care Act into law, which contained several sweeping changes to America's health insurance system. Among other reforms contained in PPACA, many Medicare providers received reductions in their market basket updates. Unlike for some other Medicare providers,

PPACA made no reduction to the market basket update for skilled nursing facilities in fiscal years 2010 or 2011. However, under PPACA, the skilled nursing facility market basket update became subject to a full productivity adjustment beginning in fiscal year 2012. In addition, PPACA enacted several reforms with respect to skilled nursing facilities and hospice organizations, including payment measures to realize significant savings of federal and state funds by deterring and prosecuting fraud and abuse in both the Medicare and Medicaid programs.

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

- Enhanced CMPs. PPACA included expanded civil monetary penalty (CMP) provisions applicable to all Medicare and Medicaid providers. PPACA provided for the imposition of CMPs of up to $5,500 to $11,000 per claim and, in some cases, treble damages, for actions relating to alleged false statements to the federal government.

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- Nursing Home Transparency Requirements. In addition to expanded CMP provisions, PPACA imposed substantial and onerous new transparency requirements for Medicare-participating nursing facilities. CMS has not yet promulgated final regulations to implement these provisions.

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

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

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

- Skilled Nursing Facility Value-Based Purchasing Program. PPACA required the U.S. Department of Health and Human Services (HHS) to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities. The value-based purchasing program would provide payment incentives for Medicare-participating skilled nursing facilities to improve the quality of care provided to Medicare beneficiaries. Among the most relevant factors in HHS' plans to implement value-based purchasing for skilled nursing facilities is the current Nursing Home Value-Based Purchasing Demonstration Project, which concluded in December 2012. HHS provided Congress with an outline of plans to implement a value-based purchasing program.

- Home Health Value-Based Purchasing Program. Authorized by the ACA and implemented by the Centers for Medicare & Medicaid Innovation (CMMI), the value-based purchasing program supports the HHS' efforts to build a health care system that delivers better care, spends health care dollars more wisely, and results in healthier people and communities.
The program would apply a payment reduction or increase to current Medicare-certified home health agency payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 5.0% in each of the first two payment adjustment years, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years.

- Voluntary Pilot Program — Bundled Payments. To support the policies of making all providers responsible during an episode of care and rewarding value over volume, HHS will establish, test and evaluate alternative payment

methodologies for Medicare services through a five-year, national, voluntary pilot program starting in 2013. This program will provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization. HHS will develop qualifying provider payment methods that may include bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 to 90 days following discharge. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. Payment arrangements among providers participating in the bundled payment must navigate regulatory compliance under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law and the related waivers. This pilot program may expand in 2016 if expansion would reduce Medicare spending without also reducing quality of care.

- Accountable Care Organizations. PPACA authorized CMS to enter into contracts with ACOs, which are entities of providers and suppliers organized to deliver services to Medicare beneficiaries and eligible to receive a share of any cost

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savings the entity can achieve by delivering services to those beneficiaries at a cost below a set baseline and with sufficient quality of care. CMS recently finalized regulations to implement the ACO initiative. The widespread adoption of ACO payment methodologies in the Medicare program, and in other programs and payors, could impact our operations and reimbursement for our services.

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

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

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Results of Operations

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
Revenue	100.0 %	100.0 %	100.0 %	100.0 %
Expenses:				
Cost of services (exclusive of rent, general and administrative expense and depreciation and amortization shown separately below)	79.8	80.8	79.3	80.0
Rent—cost of services	6.1	3.3	6.2	2.4
General and administrative expense	4.9	7.3	4.8	6.4
Depreciation and amortization	2.1	3.1	2.1	3.4
Total expenses	92.9	94.5	92.4	92.2
Income from operations	7.1	5.5 %	7.6	7.8
Other income (expense):				
Interest expense	(0.2)	(3.5)	(0.2)	(2.5)
Interest income	0.1	—	0.1	0.1
Other expense, net	(0.1)	(3.5)	(0.1)	(2.4)
Income before provision for income taxes	7.0	2.0	7.5	5.4
Provision for income taxes	2.7	1.4	2.9	2.4
Net income	4.3	0.6	4.6	3.0
Less: net income (loss) attributable to the noncontrolling interests	—	(0.2)	—	(0.2)
Net income attributable to The Ensign Group, Inc.	4.3 %	0.8 %	4.6 %	3.2 %

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)		(In thousands)	
Other Non-GAAP Financial Data:				
EBITDA[1]	$28,318	$21,920	$60,092	$55,614
Adjusted EBITDA[1][2]	31,738	29,812	64,146	65,656
EBITDAR[1]	47,384	30,203	98,123	67,446
Adjusted EBITDAR[1][2]	50,277	37,570	101,161	76,359

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

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

they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall operating performance of companies in our industry without regard to items such as interest expense, net and depreciation and

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amortization, which can vary substantially from company to company depending on the book value of assets, capital structure and the method by which assets were acquired; and

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

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

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

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

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

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

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

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

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

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

- expenses incurred in connection with our spin-off of real estate assets to CareTrust;

- stock-based compensation expense;
- costs incurred related to new systems implementation;

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- results at our urgent care centers (including the portion related to non-controlling interest);
- costs incurred for facilities currently being constructed;
- results at three independent living facilities transferred to CareTrust as part of the Spin-Off transaction;
- acquisition-related costs;
- breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder;
- costs incurred to recognize income tax credits; and
- rent related to our urgent care centers and three independent living facilities which were transferred to CareTrust.

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

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2015	2014	2015	2014
	(In thousands)		(In thousands)	
Consolidated statements of income data:				
Net income	$13,233	$1,533	$28,323	$14,574
Less: net income (loss) attributable to noncontrolling interests	45	(474)	(37)	(959)
Interest expense, net	372	8,586	872	11,790
Provision for income taxes	8,379	3,523	17,964	11,625
Depreciation and amortization	6,379	7,804	12,896	16,666
EBITDA	$28,318	$21,920	$60,092	$55,614
Rent—cost of services	19,066	8,283	38,031	11,832
EBITDAR	$47,384	$30,203	$98,123	$67,446
EBITDA	$28,318	$21,920	$60,092	$55,614
Expenses related to the Spin-Off(a)	—	7,281	—	8,871
Stock-based compensation expense(b)	1,733	—	3,226	—
Costs incurred related to new systems implementation(c)	858	—	1,145	—
Urgent care center earnings(d)	(625)	(3)	(1,565)	(32)
Costs incurred for facilities currently being constructed(e)	462	—	608	—
Earnings at three operations transferred to CareTrust (f)	—	(30)	—	(122)
Acquisition related costs(g)	438	90	590	134
Breakup fee, net of costs, received in connection with a public auction(h)	—	—	(1,019)	—
Costs incurred to recognize income tax credits(i)	27	29	53	62
Rent related to item(d) and (f) above(j)	527	525	1,016	1,129
Adjusted EBITDA	$31,738	$29,812	$64,146	$65,656
Rent—cost of services	19,066	8,283	38,031	11,832
Less: rent related to item(d) and (f) above(j)	(527)	(525)	(1,016)	(1,129)
Adjusted EBITDAR	$50,277	$37,570	$101,161	$76,359

(a) Expenses incurred in connection with the Spin-Off.

(b) Stock-based compensation expense incurred during the three and six months ended June 30, 2015. Adjusted EBITDA and EBITDAR for the three and six months ended June 30, 2014 did not include non-GAAP adjustment related to stock-based compensation expense of $1.2 million and $2.4 million, respectively. If adjusted for stock-based compensation expense, Adjusted EBITDA for the three and six months ended June 30, 2014 would

have been $31.0 million and $68.0 million, respectively, and Adjusted EBITDAR for the three and six months ended June 30, 2014 would have been $38.8 million and $78.7 million, respectively. EBITDA for the three and six months ended June 30, 2014 reflects one month increase in rent expense as a result of the Spin-Off compared to three and six months increase in rent expense for the three and six months ended June 30, 2015.

(c) Costs incurred related to new systems implementation.

(d) Operating results at urgent care centers. This amount for the three and six months ended June 30, 2015 excluded rent of $0.5 million and $1.0 million, respectively, and depreciation expense of $0.3 million and 0.6 million, respectively. This amount for the three and six months ended June 30, 2014 excluded rent of $0.4 million and $0.7 million, respectively, and depreciation expense of $0.2 million and $0.3 million, respectively. The results also excluded the net loss attributable to the variable interest entity associated with our urgent care business of approximately $0.2 million for the six months ended June 30, 2015 and $1.0 million and $2.1 million for the three and six months ended June 30, 2014, respectively.

(e) Costs incurred for facilities currently being constructed during the three and six months ended June 30, 2015.

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(f) Results at three independent living facilities which were transferred to CareTrust REIT as part of the Spin-Off transaction, excluding rent, depreciation, interest and income taxes.
(g) Costs incurred to acquire operations which are not capitalizable.
(h) Breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder.
(i) Costs incurred to recognize income tax credits which contributed to a decrease in effective tax rate.
(j) Rent related to urgent care centers and three independent living facilities which were transferred to CareTrust not included in item (d) and (f) above.

Three Months Ended June 30, 2015 Compared to Three Months Ended June 30, 2014

Revenue

Total consolidated revenue increased $61.1 million, or 24.4%, to $311.1 million for the three months ended June 30, 2015 from $250.0 million for the three months ended June 30, 2014.

	Three Months Ended June 30,					
	2015			2014		
	Revenue Dollars	Revenue Percentage		Revenue Dollars	Revenue Percentage	
Transitional, skilled and assisted living services:						
Skilled nursing facilities	$265,709	85.4	%	$219,863	87.9	%
Assisted and independent living facilities	15,927	5.1		12,152	4.9	
Total transitional, skilled and assisted living services	281,636	90.5		232,015	92.8	
Home health and hospice services:						
Home health	11,294	3.6		7,132	2.9	
Hospice	8,650	2.8		5,572	2.2	
Total home health and hospice services	19,944	6.4		12,704	5.1	
All other (1)	9,476	3.1		5,324	2.1	
Total revenue	$311,056	100.0	%	$250,043	100.0	%

(1) Includes revenue from services provided at our urgent care clinics and a mobile x-ray and diagnostic company.

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Transitional, Skilled and Assisted Living Services

	Three Months Ended June 30,			
	2015	2014	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Skilled nursing revenue	$265,709	$219,863	$45,846	20.9 %
Assisted and independent living revenue	15,927	12,152	3,775	31.1 %
Total transitional, skilled and assisted living revenue	$281,636	$232,015	$49,621	21.4 %
Number of facilities at period end	150	125	25	20.0 %
Actual patient days	1,121,158	967,403	153,755	15.9 %
Occupancy percentage — Operational beds	78.0 %	77.8 %		0.2 %
Skilled mix by nursing days	30.1 %	27.8 %		2.3 %
Skilled mix by nursing revenue	53.4 %	51.4 %		2.0 %

	Three Months Ended June 30,			
	2015	2014	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Skilled nursing revenue	$208,613	$198,954	$9,659	4.9 %
Assisted and independent living revenue	8,001	7,950	51	0.6 %
Total transitional, skilled and assisted living revenue	$216,614	$206,904	$9,710	4.7 %
Number of facilities at period end	101	101	—	— %
Actual patient days	822,751	828,881	(6,130)	(0.7)%
Occupancy percentage — Operational beds	80.8 %	80.7 %		0.1 %
Skilled mix by nursing days	30.3 %	28.5 %		1.8 %
Skilled mix by nursing revenue	53.9 %	52.3 %		1.6 %

	Three Months Ended June 30,			
	2015	2014	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Skilled nursing revenue	$16,082	$15,244	$838	5.5 %
Assisted and independent living revenue	3,224	2,876	348	12.1 %
Total transitional, skilled and assisted living revenue	$19,306	$18,120	$1,186	6.5 %
Number of facilities at period end	17	17	—	— %
Actual patient days	100,478	98,290	2,188	2.2 %
Occupancy percentage — Operational beds	68.2 %	65.9 %		2.3 %
Skilled mix by nursing days	20.4 %			