

ENSIGN GROUP, INC  
Form 10-Q  
November 07, 2013  
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UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
Washington, D.C. 20549

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FORM 10-Q

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

For the quarterly period ended September 30, 2013.

☐ 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

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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)

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Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. ☒ Yes ☐ 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). ☒ Yes ☐ 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 ☐ Accelerated filer ☒ Non-accelerated filer ☐

Smaller reporting company ☐

(Do not check if a smaller reporting  
company)

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

As of November 4, 2013, 22,004,590 shares of the registrant's common stock were outstanding.



THE ENSIGN GROUP, INC.  
 QUARTERLY REPORT ON FORM 10-Q  
 FOR THE THREE AND NINE MONTHS ENDED SEPTEMBER 30, 2013  
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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)

	September 30, 2013	December 31, 2012
Assets		
Current assets:		
Cash and cash equivalents	\$45,997	\$40,685
Accounts receivable—less allowance for doubtful accounts of \$15,568 and \$13,811 at September 30, 2013 and December 31, 2012, respectively	102,428	94,187
Investments—current	3,783	5,195
Prepaid income taxes	11,435	3,787
Prepaid expenses and other current assets	7,700	8,606
Deferred tax asset—current	13,966	14,871
Assets held for sale—current (Note 4)	—	268
Total current assets	185,309	167,599
Property and equipment, net	479,837	447,855
Insurance subsidiary deposits and investments	18,712	17,315
Escrow deposits	250	4,635
Deferred tax asset	3,576	2,234
Restricted and other assets	12,086	8,640
Intangible assets, net	5,976	6,115
Long-term assets held for sale (Note 4)	—	11,324
Goodwill	24,754	21,557
Other indefinite-lived intangibles	7,740	3,588
Total assets	\$738,240	\$690,862
Liabilities and equity		
Current liabilities:		
Accounts payable	\$22,212	\$26,069
Accrued charge related to U.S. Government inquiry (Note 17)	48,000	15,000
Accrued wages and related liabilities	35,628	35,847
Accrued self-insurance liabilities—current	16,154	16,034
Liabilities held for sale—current (Note 4)	—	339
Other accrued liabilities	21,525	20,871
Current maturities of long-term debt	7,354	7,187
Total current liabilities	150,873	121,347
Long-term debt—less current maturities	205,046	200,505
Accrued self-insurance liabilities—less current portion	35,393	34,849
Fair value of interest rate swap	2,003	2,866
Long-term liabilities held for sale (Note 4)	—	130
Deferred rent and other long-term liabilities	3,155	3,281
Total liabilities	396,470	362,978

Commitments and contingencies (Note 17)

Equity:

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Ensign Group, Inc. stockholders' equity:

Common stock; \$0.001 par value; 75,000 shares authorized; 22,499 and 21,978 shares issued and outstanding at September 30, 2013, respectively, and 22,244 and 21,719 shares issued and outstanding at December 31, 2012, respectively		22	
Additional paid-in capital	98,077	90,949	
Retained earnings	245,710	239,344	
Common stock in treasury, at cost, 295 and 301 shares at September 30, 2013 and December 31, 2012, respectively	(2,059)	(2,099)	)
Accumulated other comprehensive loss	(1,214)	(1,745)	)
Total Ensign Group, Inc. stockholders' equity	340,536	326,471	
Non-controlling interest	1,234	1,413	
Total equity	341,770	327,884	
Total liabilities and equity	\$738,240	\$690,862	

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 September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Revenue	\$229,261	\$206,691	\$667,548	\$612,650
Expense:				
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	186,172	164,579	538,146	487,291
U.S. Government inquiry settlement (Note 17)	—	—	33,000	—
Facility rent—cost of services	3,404	3,359	10,056	10,034
General and administrative expense	10,601	8,099	28,321	23,933
Depreciation and amortization	8,795	7,147	25,198	21,071
Total expenses	208,972	183,184	634,721	542,329
Income from operations	20,289	23,507	32,827	70,321
Other income (expense):				
Interest expense	(3,181 )	(3,092 )	(9,441 )	(9,131 )
Interest income	141	69	363	172
Other expense, net	(3,040 )	(3,023 )	(9,078 )	(8,959 )
Income before provision for income taxes	17,249	20,484	23,749	61,362
Provision for income taxes	6,607	7,528	11,440	23,114
Income from continuing operations	10,642	12,956	12,309	38,248
(Loss) income from discontinued operations, net of income tax (benefit) provision of (\$38) and (\$1,157) for the three and nine months ended September 30, 2013 and \$34 and (\$44) for the three and nine months ended September 30, 2012, respectively (Note 4)	(30 )	80	(1,804 )	(105 )
Net income	10,612	13,036	10,505	38,143
Less: net income (loss) attributable to noncontrolling interests	148	(258 )	(179 )	(511 )
Net income attributable to The Ensign Group, Inc.	\$10,464	\$13,294	\$10,684	\$38,654
Amounts attributable to The Ensign Group, Inc.:				
Income from continuing operations attributable to The Ensign Group, Inc.	\$10,494	\$13,214	\$12,488	\$38,759
(Loss) income from discontinued operations, net of income tax	(30 )	80	(1,804 )	(105 )
Net income attributable to The Ensign Group, Inc.	\$10,464	\$13,294	\$10,684	\$38,654
Net income (loss) per share:				
Basic:				
Income from continuing operations attributable to The Ensign Group, Inc.	\$0.48	\$0.61	\$0.57	\$1.81
Income (loss) from discontinued operations	\$—	\$0.01	\$(0.08 )	\$—
Net income attributable to The Ensign Group, Inc.	\$0.48	\$0.62	\$0.49	\$1.81
Diluted:				
Income from continuing operations attributable to The Ensign Group, Inc.	\$0.47	\$0.60	\$0.56	\$1.77
Loss from discontinued operations	\$—	\$—	\$(0.08 )	\$—
Net income attributable to The Ensign Group, Inc.	\$0.47	\$0.60	\$0.48	\$1.77
Weighted average common shares outstanding:				
Basic	21,941	21,488	21,857	21,369

Diluted	22,409	22,010	22,316	21,899
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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 September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Net income	\$10,612	\$13,036	\$10,505	\$38,143
Other comprehensive income (loss), net of tax:				
Unrealized gain (loss) on interest rate swap, net of income tax expense (benefit) of \$27 and (\$332) for the three and nine months ended September 30, 2013, respectively, and \$154 and \$380 for the three and nine months ended September 30, 2012, respectively.	(28	) (239	) 531	(593
Comprehensive income	10,584	12,797	11,036	37,550
Less: net income (loss) attributable to noncontrolling interests	148	(258	) (179	) (511
Comprehensive income attributable to The Ensign Group, Inc.	\$10,436	\$13,055	\$11,215	\$38,061

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)

	Nine Months Ended September 30,	
	2013	2012
Cash flows from operating activities:		
Net (loss) income	\$ 10,505	\$ 38,143
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Loss from sale of discontinued operations (Note 4)	2,837	—
U.S. Government inquiry accrual (Note 17)	33,000	—
Depreciation and amortization	25,229	21,145
Amortization of deferred financing fees and debt discount	616	620
Deferred income taxes	(768)	) 124
Provision for doubtful accounts	8,505	6,195
Share-based compensation	2,932	2,484
Excess tax benefit from share-based compensation	(1,501)	) (1,145)
Gain on sale of equity method investment	(380)	) —
Loss on disposition of property and equipment	1,164	258
Change in operating assets and liabilities		
Accounts receivable	(16,746)	) (17,938)
Prepaid income taxes	(7,648)	) 2,650
Prepaid expenses and other current assets	987	(306)
Insurance subsidiary deposits and investments	14	(5,651)
Accounts payable	(2,950)	) 1,143
Accrued wages and related liabilities	(219)	) (7,090)
Other accrued liabilities	1,241	4,853
Accrued self-insurance	552	5,796
Deferred rent liability	(260)	) 312
Net cash provided by operating activities	57,110	51,593
Cash flows from investing activities:		
Purchase of property and equipment	(21,884)	) (26,755)
Cash payment for business acquisitions	(45,364)	) (22,557)
Cash payment for asset acquisitions	—	(11,261)
Escrow deposits	(250)	) —
Escrow deposits used to fund business acquisitions	4,635	175
Cash Proceeds on sale of urgent care franchising business, net of note receivable	3,610	—
Cash proceeds on sale of equity method investment	1,600	—
Cash proceeds from the sale of property and equipment	787	39
Restricted and other assets	(180)	) (1,482)
Net cash used in investing activities	(57,046)	) (61,841)
Cash flows from financing activities:		
Proceeds from issuance of debt	10,000	21,525
Payments on long-term debt	(5,383)	) (10,055)
Repurchase of shares of common stock	—	(174)
Issuance of treasury stock upon exercise of options	40	386
Issuance of common stock upon exercise of options	2,694	3,996
Dividends paid	(2,874)	) (3,873)

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Excess tax benefit from share-based compensation	1,501	1,145
Payments of deferred financing costs	(730	) (258
Net cash provided by financing activities	5,248	12,692
Net increase in cash and cash equivalents	5,312	2,444
Cash and cash equivalents beginning of period	40,685	29,584
Cash and cash equivalents end of period	\$45,997	\$32,028
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	\$9,464	\$9,220
Income taxes	\$17,238	\$19,116
Non-cash financing and investing activity:		
Acquisition of redeemable noncontrolling interest	\$—	\$11,600
Accrued capital expenditures	\$826	\$899
Note receivable on sale of urgent care franchising business	\$4,000	\$—
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., through its subsidiaries (collectively, Ensign or the Company), provides skilled nursing and rehabilitative care services through the operation of 119 facilities, nine home health and seven hospice operations, six urgent care centers and a mobile x-ray and diagnostic company as of September 30, 2013, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. The Company's operations, 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 and hospice, mobile x-ray and diagnostic, and urgent care services, including physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. The Company's facilities have a collective capacity of approximately 13,000 operational skilled nursing, assisted living and independent living beds. As of September 30, 2013, the Company owned 96 of its 119 facilities and operated an additional 23 facilities through long-term lease arrangements, and had options to purchase two of those 23 facilities.

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

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

**Spin-Off** — On November 7, 2013, the Company announced a proposed plan to separate its healthcare business and its real estate business into two separate, publicly traded companies:

Ensign, which will continue to provide healthcare services through its existing operations; and

CareTrust REIT, Inc. (CareTrust), which will own, acquire and lease real estate serving the healthcare industry.

The Company intends accomplish the proposed separation by distributing all of the outstanding shares of CareTrust common stock to the Company's stockholders on a pro rata basis (the Spin-Off). At the time of the Spin-Off, CareTrust, which is currently a wholly owned subsidiary of the Company, will hold substantially all of the real property owned by the Company, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for three independent living facilities that CareTrust will operate) will be leased to the Company on a triple-net basis, under which the Company will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs. See further discussion at Note 2, Proposed Spin-Off of Real Estate Assets Through a Real Estate Investment Trust (REIT).

In accordance with Accounting Standards Codification (ASC) 505-60, Equity-Spinoffs and Reverse Spinoffs, the accounting for the separation of the Company follows its legal form, with Ensign as the legal and accounting spinor and CareTrust as the legal and accounting spinnee, due to the relative significance of Ensign's healthcare business, the

relative fair values of the respective companies, the retention of all senior management except Mr. Stapley by Ensign, and other relevant indicators.

Other Information — The accompanying condensed consolidated financial statements as of September 30, 2013 and for the three and nine months ended September 30, 2013 and 2012 (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, 2012 which are included in the Company's annual report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (the SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company's financial position and results of operations in all material respects.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

**2. PROPOSED SPIN-OFF OF REAL ESTATE ASSETS THROUGH A REAL ESTATE INVESTMENT TRUST (REIT)**

On November 7, 2013, the Company announced a proposed plan to separate its healthcare business and its real estate business into two separate, publicly traded companies:

Ensign, which will continue to provide healthcare services through its existing operations; and  
CareTrust, which will own, acquire and lease real estate serving the healthcare industry.

The Company intends to accomplish the proposed separation through a Spin-Off in which it will distribute all of the outstanding shares of CareTrust common stock to the Company's stockholders on a pro rata basis. At the time of the Spin-Off, CareTrust, which is currently a wholly owned subsidiary of the Company, will hold substantially all of the real property owned by the Company, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for the three independent living facilities that CareTrust will operate) will be leased to the Company on a triple-net basis, under which the Company will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

As part of the proposed Spin-Off, CareTrust intends to elect to be taxed and intends to qualify as a real estate investment trust (REIT) for U.S. federal income tax purposes commencing with its taxable year ending December 31, 2014. As a REIT, CareTrust will have to satisfy certain requirements relating to diversity of ownership, including a requirement that not more than 50% of its stock may be owned by five or fewer individuals. In order to help CareTrust satisfy the REIT requirements, its charter will include "excess share" provisions typical for REITs that will prohibit ownership of more than 9.8% of its outstanding shares. On November 7, 2013, the board of directors of the Company adopted a stockholder rights plan to discourage anyone from exceeding this ownership level at the Company prior to the Spin-Off, and thereby facilitate CareTrust's REIT qualification after the Spin-Off. In connection with the adoption of the stockholder rights plan, the board of directors declared a dividend of one right (a Right) for each share of Company common stock held by stockholders of record at the close of business on November 18, 2013. The Company will also issue one Right with each new share of the Company's common stock that is subsequently issued while the stockholder rights plan is in place. The Rights are issued pursuant to a Rights Agreement, dated as of November 7, 2013 (the Rights Agreement), between the Company and Registrar and Transfer Company, as Rights Agent. Initially, the Rights will not be exercisable and will trade with the shares of Company common stock. The Rights will generally be exercisable only if a person or group becomes an "acquiring person" by (i) acquiring beneficial ownership of 9.8% or more of the Company's common stock or, in the case of any person (including such person's affiliates and associates) that beneficially owns 9.8% or more of the Company's common stock, upon the acquisition of additional shares by such person, or (ii) commencing a tender offer or exchange offer which, if consummated, could result in a person owning 9.8% or more of the Company's common stock.

If a person or group becomes an acquiring person, the Rights will generally entitle each holder, other than the acquiring person, to acquire, for the exercise price of \$200 per Right (subject to adjustment), shares of the Company's common stock (or, in certain circumstances, other consideration) having a market value equal to twice the exercise price. The Rights will expire at 5:00 P.M., New York City time, on the earlier of (i) the first business day after consummation of the proposed Spin-Off, or (ii) November 6, 2014, unless redeemed or exchanged earlier or unless the board of directors extends the expiration date. The Rights will not prevent a takeover of the Company, but may

cause substantial dilution to a person that acquires 9.8% or more of the Company's common stock.

The proposed Spin-Off is conditioned on, among other things, final approval by the Board of Directors of the Company, the receipt of a ruling from the IRS that, among other things the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes, the receipt of an opinion of counsel as to the satisfaction of certain requirements for such tax-free treatment and, the receipt of an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014, CareTrust has been organized in conformity with the requirements for qualification as a REIT under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

3. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

**Basis of Presentation** — The accompanying Interim Financial Statements have been prepared in accordance with accounting principles generally accepted in the United States of America. The Company is the sole member or shareholder of various consolidated limited liability companies and corporations; each established to operate various acquired skilled nursing and assisted living facilities, home health and hospice 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 (loss) 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 September 30, 2013.

On March 25, 2013, the Company agreed to terms to sell Doctors Express (DRX), a national urgent care franchise system. The asset sale was effective on April 15, 2013. The results of operations for DRX have been classified as discontinued operations for all periods presented (see Note 4, Discontinued Operations) in the accompanying Interim Financial Statements. Certain assets and liabilities included in the sale of DRX have been presented as held for sale in the accompanying condensed consolidated balance sheet as of December 31, 2012. In addition, the results of operations of DRX and the loss or impairment related to this divestiture have been classified as discontinued operations in the accompanying condensed consolidated statements of income for all periods presented.

**Estimates and Assumptions** — The preparation of Interim Financial Statements in conformity with U.S. generally accepted accounting principles (GAAP) requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company's 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, other contingent liabilities, interest rate swaps, and income taxes. Actual results could differ from those estimates.

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

**Fair Value of Financial Instruments** — The Company's financial instruments consist principally of cash and cash equivalents, debt security investments, interest rate swap agreements, 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. The interest rate swap is carried at fair



value on the balance sheet. The Company's fixed-rate debt instruments do not actively trade in an established market. The fair values of this debt are estimated by discounting the principal and interest payments at rates available to the Company for debt with similar terms and maturities. See further discussion of debt security investments in Note 6, Fair Value Measurements.

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

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

Revenue from the Medicare and Medicaid programs accounted for 71.2% and 72.2% of the Company's revenue for the three and nine months ended September 30, 2013, respectively, and 73.8% for both the three and nine months ended September 30, 2012. 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 retroactive adjustments to revenue which were not material to the Company's consolidated revenue for the three and nine months ended September 30, 2013 and 2012.

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

**Skilled Nursing 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 on a per patient, daily basis. The Company records revenue from private pay patients, at the agreed-upon rate, as services are performed.

**Home Health Revenue**

**Medicare Revenue**

Net service revenue is recorded under the Medicare prospective payment system (PPS) 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 (LUPA) 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.

We make 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, we believe that our reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, we also recognize 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.

**Non-Medicare Revenue**

**Episodic Based Revenue** — The Company recognizes revenue in a similar manner as we recognize 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 our 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 we deliver. 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.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

**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.

**Equity Investment** — As of December 31, 2012, one of the Company's subsidiaries had a non-marketable equity investment which was accounted for under the equity method. The investment was initially recorded at cost and the Company adjusted the carrying amount for its share of the earnings or losses of the investee after the date of investment. On April 23, 2013, the Company entered into a common unit redemption agreement with the investee where the non-marketable equity investment was repurchased. See further discussion at Note 12, Restricted and Other Assets.

**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 (generally ranging from three to 30 years). Leasehold improvements are amortized on a straight-line basis over the shorter of their estimated useful lives or the remaining lease term.

**Impairment of Long-Lived Assets** — The Company reviews the carrying value of long-lived assets that are held and used in the Company's operations for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operations to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and has not identified any asset impairment during the three and nine months ended September 30, 2013 or 2012.

**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 ten to 20 years. Patient base is amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date. Trade names at facilities are amortized over 30 years and customer relationships are amortized over 20 years.

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 below its carrying amount. The Company defines reporting units as the individual operations. The Company performs its annual test for

impairment during the fourth quarter of each year. See further discussion at Note 11, 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 occurrence, per location and on an aggregate basis for the Company. For claims made after April 1, 2013, the combined self-insured retention was \$500 per claim with an aggregate \$1,750 deductible limit. For all facilities, except those located in Colorado, the third-party coverage above these limits was \$1,000 per occurrence, \$3,000 per facility, with a \$10,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was \$1,000 per occurrence and \$3,000 per facility, which is independent of the \$10,000 blanket aggregate applicable to our other 113 facilities.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The self-insured retention and deductible limits for general and professional liability and 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 \$31,350 and \$33,215 as of September 30, 2013 and December 31, 2012, respectively.

The Company's operating subsidiaries are self-insured for workers' compensation liability in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed \$500 for each claim. In Texas, the operating subsidiaries have elected non-subscriber status for workers' compensation claims and, effective February 1, 2011, the Company has purchased individual stop-loss coverage that insures individual claims that exceed \$750 for each claim. The Company's operating subsidiaries in other states have third party guaranteed cost coverage. In California and Texas, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers' compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were \$14,174 and \$11,983 as of September 30, 2013 and December 31, 2012, respectively.

In addition, the Company has recorded an asset and equal liability of \$3,330 and \$3,219 at September 30, 2013 and December 31, 2012, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis.

The Company provides self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed \$300 for each covered person with an 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 \$2,693 and \$2,467 at September 30, 2013 and December 31, 2012, respectively.

The Company believes that adequate provision has been made in the Financial Statements for liabilities that may arise out of patient care, workers' compensation, healthcare benefits and related services provided to date. The amount of the Company's reserves was determined based on an estimation process that uses information obtained from both company-specific and industry data. This estimation process requires the Company to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and the Company's assumptions about emerging trends, the Company, with the assistance of an independent actuary, develops information about the size of ultimate claims based on the Company's historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damage awards with respect to unpaid claims. 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.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

In determining the need for a valuation allowance, the annual income tax rate for interim periods, 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.

**Derivatives and Hedging Activities** — The Company evaluates variable and fixed interest rate risk exposure on a routine basis and to the extent the Company believes that it is appropriate, it will offset most of its variable risk exposure by entering into interest rate swap agreements. It is the Company's policy to only utilize derivative instruments for hedging purposes (i.e. not for speculation). The Company formally designates its interest rate swap agreements as hedges and documents all relationships between hedging instruments and hedged items. The Company formally assesses effectiveness of its hedging relationships, both at the hedge inception and on an ongoing basis, then measures and records ineffectiveness. The Company would discontinue hedge accounting prospectively (i) if it is determined that the derivative is no longer effective in offsetting change in the cash flows of a hedged item, (ii) when the derivative expires or is sold, terminated or exercised, (iii) if it is no longer probable that the forecasted transaction will occur, or (iv) if management determines that designation of the derivative as a hedge instrument is no longer appropriate. The Company's derivative is recorded on the balance sheet at its fair value.

**Accumulated Other Comprehensive Loss and Total Comprehensive Income (Loss)** — Accumulated other comprehensive loss refers to revenue, expenses, gains, and losses that are recorded as an element of stockholders' equity but are excluded from net income. The Company's other comprehensive loss consists of net deferred gains and losses on certain derivative instruments accounted for as cash flow hedges. As of September 30, 2013, accumulated other comprehensive losses were \$2,003, recorded net of tax of \$789 or \$1,214, in stockholders' equity. As of December 31, 2012, accumulated other comprehensive losses were \$2,866, net of tax of \$1,121 or \$1,745.

**Recent Accounting Pronouncements** — Except for rules and interpretive releases of the SEC under authority of federal securities laws and a limited number of grandfathered standards, the FASB Accounting Standards Codification™ (ASC) is the sole source of authoritative GAAP literature recognized by the FASB and applicable to the Company. The Company has reviewed the FASB issued Accounting Standards Update (ASU) accounting pronouncements and interpretations thereof that have effectiveness dates during the periods reported and in future periods. The Company has carefully considered the new pronouncements that alter previous generally accepted accounting principles and does not believe that 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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## 4. DISCONTINUED OPERATIONS

On March 25, 2013, the Company agreed to terms to sell DRX, a national urgent care franchise system for approximately \$8,000, adjusted for certain assets and liabilities. The asset sale was effective on April 15, 2013. The sale resulted in a pre-tax loss of \$2,837 for the nine months ended September 30, 2013. The assets acquired at the initial purchase of DRX, including noncontrolling interest, were recorded at fair value. The initial fair value was greater than total cash paid to acquire all interests in DRX and the subsequent sale price. The sale of DRX has been accounted for as discontinued operations. Accordingly, the results of operations of this business for all periods presented and the loss related to this divestiture have been classified as discontinued operations in the accompanying condensed consolidated statements of income. As the sale was effective April 15, 2013, all assets and liabilities included in the sale were recorded as held for sale on the Company's condensed consolidated balance sheets as of December 31, 2012.

A summary of discontinued operations follows (in thousands):

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Revenue	\$—	\$459	\$728	\$968
Cost of services (exclusive of facility rent, general and administrative and depreciation and amortization expenses shown separately below)	(68	) (298	) (807	) (1,014
Charges to discontinued operations for the excess carrying amount of goodwill and other indefinite-lived intangible assets	—	—	(2,837	) —
Facility rent—cost of services	—	(15	) (12	) (29
Depreciation and amortization	—	(32	) (33	) (74
(Loss) income from discontinued operations	(68	) 114	(2,961	) (149
(Benefit from) provision for income taxes	(38	) 34	(1,157	) (44
(Loss) income from discontinued operations, net of income tax	\$(30	) \$80	\$(1,804	) \$(105

A summary of the net assets held for sale are as follows (in thousands):

	September 30, 2013	December 31, 2012
Current assets	\$ —	\$268
Long-term assets:		
Goodwill, net	—	1,099
Other identifiable intangible assets, net	—	10,200
Other long-term assets, net	—	25
Total assets held for sale	—	11,592
Current liabilities	—	(339
Long-term liabilities	—	(130
Total liabilities held for sale	—	(469
Net assets held for sale	\$ —	\$11,123

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

## 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 September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Numerator:				
Income from continuing operations	\$10,642	\$12,956	\$12,309	\$38,248
Less: net income (loss) attributable to noncontrolling interests	148	(258)	(179)	(511)
Income from continuing operations attributable to The Ensign Group, Inc.	10,494	13,214	12,488	38,759
(Loss) income from discontinued operations, net of income tax	(30)	80	(1,804)	(105)
Net income attributable to The Ensign Group, Inc.	\$10,464	\$13,294	\$10,684	\$38,654
Denominator:				
Weighted average shares outstanding for basic net income per share	21,941	21,488	21,857	21,369
Basic net income (loss) per common share:				
Income from continuing operations attributable to The Ensign Group, Inc.	\$0.48	\$0.61	\$0.57	\$1.81
Income (loss) from discontinued operations	\$—	\$0.01	\$(0.08)	\$—
Net income attributable to The Ensign Group, Inc.	\$0.48	\$0.62	\$0.49	\$1.81

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Numerator:				
Income from continuing operations	\$10,642	\$12,956	\$12,309	\$38,248
Less: net income (loss) attributable to the noncontrolling interests	148	(258)	(179)	(511)
Income from continuing operations attributable to The Ensign Group, Inc.	10,494	13,214	12,488	38,759
(Loss) income from discontinued operations, net of income tax	(30)	80	(1,804)	(105)
Net income attributable to The Ensign Group, Inc.	\$10,464	\$13,294	\$10,684	\$38,654
Denominator:				
Weighted average common shares outstanding	21,941	21,488	21,857	21,369
Plus: incremental shares from assumed conversion (1)	468	522	459	530

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Adjusted weighted average common shares outstanding	22,409	22,010	22,316	21,899
Diluted net income (loss) per common share:				
Income from continuing operations attributable to The Ensign Group, Inc.	\$0.47	\$0.60	\$0.56	\$1.77
Loss from discontinued operations	\$—	\$—	\$(0.08)	) \$—
Net income attributable to The Ensign Group, Inc.	\$0.47	\$0.60	\$0.48	\$1.77
(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 249 and 402 for the three and nine months ended September 30, 2013 and 269 and 271 for the three and nine months ended September 30, 2012, respectively.				

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

## 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 observable 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 September 30, 2013 and December 31, 2012:

	September 30, 2013			December 31, 2012		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	\$45,997	\$—	\$—	\$40,685	\$—	\$—
Fair value of interest rate swap	\$—	\$2,003	\$—	\$—	\$2,866	\$—

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 3 for further discussion of our significant accounting policies.

## Debt Security Investments - Held to Maturity

At September 30, 2013 and December 31, 2012, the Company had approximately \$22,495 and \$22,510, 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, at September 30, 2013, \$6,115 is held in AA-rated debt securities backed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program, and \$16,380 is held in A-rated debt securities.

## Interest Rate Swap Agreement

In connection with the Senior Credit Facility with a six-bank lending consortium arranged by SunTrust and Wells Fargo (the Senior Credit Facility), in July 2011, the Company entered into an interest rate swap agreement in accordance with Company policy to reduce risk from volatility in the income statement due to changes in the LIBOR interest rate. The swap agreement, with a notional amount of \$75,000, amortizing concurrently with the related term loan portion of the Senior Credit Facility, was five years in length and set to mature on July 15, 2016. The interest rate swap has been designated as a cash flow hedge and, as such, changes in fair value are reported in other comprehensive income in accordance with hedge accounting. Under the terms of this swap agreement, the net effect of the hedge was to record swap interest expense at a fixed rate of approximately 4.3%, exclusive of fees. Net interest paid under the swap was \$269 and \$783 for the three and nine months ended September 30, 2013 and \$240 and \$710 for the three and nine months ended September 30, 2012, respectively. In addition, based on the September 30, 2013 interest rate swap valuation, the Company expects to record swap interest expense of approximately \$1,000 during the year ended December 31, 2013.

The Company assesses hedge effectiveness at inception and on an ongoing basis by performing a regression analysis. The regression analysis compares the historical monthly changes in fair value of the interest rate swap to the historical monthly changes in the fair value of a hypothetically perfect interest rate swap over the trailing 30 months. The change in fair value of the hypothetical derivative is regarded as a proxy for the present value of the cumulative change in the expected future cash flows on the hedged transaction. The regression analysis serves as the Company's prospective and retrospective assessment of hedge effectiveness. Assuming the hedging relationship qualifies as highly effective, the actual swap will be recorded at fair value on the balance sheet and accumulated other comprehensive income (loss) will be adjusted to reflect the lesser of either the cumulative change in the fair value of the actual swap or the cumulative change in the fair value of the hypothetical derivative.

The interest rate swap agreement is recorded at fair value based upon valuation models which utilize relevant factors such as the contractual terms of the interest rate swap agreements, credit spreads for the contracting parties and interest rate curves. Based on this valuation method, the Company categorized the interest rate swap as Level 2 and recorded accumulated other comprehensive losses as of September 30, 2013 of \$2,003, net of tax of \$789, or \$1,214, in stockholders' equity, compared to \$2,866 net of tax of \$1,121, or \$1,745 as of December 31, 2012. There are no amounts attributable to hedge ineffectiveness that were required to be recognized in earnings.

## 7. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and nine months ended September 30, 2013 and 2012 is summarized in the following tables:

	Three Months Ended September 30, 2013		2012		
	Revenue	% of Revenue	Revenue	% of Revenue	
Medicaid	\$81,802	35.7	% \$76,709	37.1	%
Medicare	72,138	31.5	69,526	33.6	
Medicaid — skilled	9,204	4.0	6,316	3.1	
Total Medicaid and Medicare	163,144	71.2	152,551	73.8	
Managed care	30,886	13.5	26,316	12.7	
Private and other payors <sup>(1)</sup>	35,231	15.3	27,824	13.5	
Revenue	\$229,261	100.0	% \$206,691	100.0	%

  

	Nine Months Ended September 30, 2013		2012		
	Revenue	% of Revenue	Revenue	% of Revenue	
Medicaid	\$237,301	35.5	% \$223,934	36.6	%
Medicare	218,214	32.7	209,715	34.2	
Medicaid — skilled	26,616	4.0	18,590	3.0	
Total Medicaid and Medicare	482,131	72.2	452,239	73.8	
Managed care	87,446	13.1	77,738	12.7	
Private and other payors <sup>(1)</sup>	97,971	14.7	82,673	13.5	
Revenue	\$667,548	100.0	% \$612,650	100.0	%

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

Accounts receivable as of September 30, 2013 and December 31, 2012 is summarized in the following table:

	September 30, 2013	December 31, 2012
Medicaid	\$32,840	\$28,534

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Managed care	29,542	26,707
Medicare	34,267	32,168
Private and other payors	21,347	20,589
	117,996	107,998
Less: allowance for doubtful accounts	(15,568	) (13,811
Accounts receivable	\$ 102,428	\$ 94,187

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

8. ACQUISITIONS

The Company's acquisition policy is generally to purchase or lease operations to complement the Company's existing portfolio. The results of all the Company's operations are included in the accompanying Interim Financial Statements subsequent to the date of acquisition. Acquisitions are typically paid for in cash and are accounted for using the acquisition method of accounting. Where the Company enters into facility lease agreements, the Company typically does not pay any material amount to the prior facility operator nor does the Company acquire any assets or assume any liabilities, other than rights and obligations under the lease and operations transfer agreement, as part of the transaction. Some leases include options to purchase the facilities. As a result, from time to time, the Company will acquire facilities that the Company has been operating under third-party leases.

During the nine months ended September 30, 2013, the Company acquired seven stand-alone skilled nursing facilities, three stand-alone assisted living facilities, three home health operations, three hospice operations and one urgent care center. The aggregate purchase price of the 17 business acquisitions was approximately \$45,364, which was paid in cash. The Company also entered into a separate operations transfer agreement with the prior tenant as part of each transaction. The operations acquired during the nine months ended September 30, 2013 are as follows:

On January 1, 2013, the Company acquired a home health operation in Washington for approximately \$2,801, which was paid in cash. The acquisition did not have an impact on the Company's operational bed count. The Company recognized \$1,966 and \$815 in goodwill and other indefinite-lived intangible assets, respectively, as part of this transaction.

- On January 1, 2013, the Company acquired two hospice operations in Arizona and California, respectively, for approximately \$1,825, which was paid in cash. The acquisition did not have an impact on the Company's operational bed count. The Company recognized \$1,825 in other indefinite-lived intangible assets as part of these transactions.

On February 16, 2013, the Company acquired a home health operation in Texas for approximately \$375, which was paid in cash. This acquisition did not have an impact on the Company's operational bed count. The Company recognized \$375 in other indefinite-lived intangible assets as part of this transaction.

On March 1, 2013, the Company acquired a home health and hospice operation in Washington for approximately \$1,137, which was paid in cash. This acquisition did not have an impact on the Company's operational bed count. The Company recognized \$1,137 in other indefinite-lived intangible assets as part of this transaction.

In addition, on March 1, 2013, the Company purchased a skilled nursing facility in Texas for approximately \$4,508, which was paid in cash. This acquisition added 150 operational skilled nursing beds to the Company's operations.

On April 1, 2013, the Company acquired three skilled nursing facilities in Texas for an aggregate purchase price of approximately \$7,114, which was paid in cash. These acquisitions added 280 operational skilled nursing beds to the Company's operations.

On May 1, 2013, the Company acquired a skilled nursing facility and an assisted living facility in Washington for an aggregate purchase price of \$11,585, which was paid in cash. These acquisitions added 102 operational assisted living units and 110 operational skilled nursing beds to the Company's operations.

In addition, on May 1, 2013, the Company acquired a skilled nursing facility in Nebraska for approximately \$2,846, which was paid in cash. This acquisition added 70 operational skilled nursing beds to the Company's operations.

On June 1, 2013, the Company acquired an assisted living facility in California for approximately \$4,263, which was paid in cash. This acquisition added 110 operational assisted living units to the Company's operations.

In addition, on June 1, 2013, the Company acquired an assisted living facility in Utah for approximately \$2,856, which was paid in cash. This acquisition added 69 operational assisted living units to the Company's operations.

On July 1, 2013 the Company acquired a skilled nursing facility in Washington for approximately \$4,499, which was paid in cash. This acquisition added 82 operational skilled nursing beds to the Company's operations.





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In addition, on September 16, 2013, the Company acquired an existing leased urgent care center for approximately \$1,555, which was paid in cash. The Company assumed the existing lease that was in place at the time of acquisition. The urgent care center acquisition did not have an impact on the Company's bed count. As part of this acquisition, the Company recognized \$1,231 in goodwill.

The table below presents the allocation of the purchase price for the operations acquired in business combinations during the nine months ended September 30, 2013 and 2012:

	September 30,	
	2013	2012
Land	\$9,312	\$893
Building and improvements	26,593	15,303
Equipment, furniture, and fixtures	1,386	1,003
Assembled occupancy	724	239
Goodwill	3,197	2,279
Other indefinite-lived intangible assets	4,152	1,217
	\$45,364	\$20,934

The Company's acquisition strategy has been focused on identifying both opportunistic and strategic acquisitions within its target markets that offer strong opportunities for return on invested capital. The operations acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not meaningful, representative of the Company's current operating results or indicative of the integration potential of its newly acquired operations. The businesses acquired during the nine months ended September 30, 2013 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the September 30, 2013 condensed consolidated balance sheet of the Company, and the operating results have been included in the condensed consolidated statement of income of the Company since the dates the Company gained effective control.

**9. PROPERTY AND EQUIPMENT**

Property and equipment consist of the following:

	September 30,	December 31,
	2013	2012
Land	\$79,795	\$70,487
Buildings and improvements	375,457	341,096
Equipment	95,124	80,860
Furniture and fixtures	8,854	8,790
Leasehold improvements	43,329	32,570
Construction in progress	1,490	14,185
	604,049	547,988
Less: accumulated depreciation	(124,212)	(100,133)
Property and equipment, net	\$479,837	\$447,855

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

## 10. INTANGIBLE ASSETS — Net

Intangible Assets	Weighted Average Life (Years)	September 30, 2013			December 31, 2012		
		Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	15.5	\$684	\$(578)	) \$106	\$684	\$(545)	) \$139
Favorable lease	15.0	1,596	(506)	) 1,090	1,596	(426)	) 1,170
Assembled occupancy	0.5	2,979	(2,785)	) 194	2,255	(2,211)	) 44
Facility trade name	30.0	733	(189)	) 544	733	(171)	) 562
Customer relationships	20.0	4,200	(158)	) 4,042	4,200	—	4,200
Total		\$10,192	\$(4,216)	) \$5,976	\$9,468	\$(3,353)	) \$6,115

Amortization expense was \$356 and \$863 for the three and nine months ended September 30, 2013 and \$130 and \$569 for the three and nine months ended September 30, 2012, respectively. Of the \$863 in amortization expense incurred during the nine months ended September 30, 2013, approximately \$574 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
2013 (remainder)	\$274
2014	416
2015	365
2016	345
2017	345
2018	345
Thereafter	3,886
	\$5,976

## 11. 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.

On March 25, 2013, the Company agreed to terms to sell DRX, a national urgent care franchise system for approximately \$8,000, adjusted for certain assets and liabilities. The asset sale was effective on April 15, 2013. The sale resulted in a pre-tax loss of \$2,837 for the nine months ended September 30, 2013. The Company recognized charges to discontinued operations for the excess carrying amount of goodwill and other indefinite-lived intangible assets of \$1,099 and \$1,738, respectively, during the nine months ended September 30, 2013 as part of this transaction. See Note 4, Discontinued Operations for additional information.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The following table represents activity in goodwill as of and for the nine months ended September 30, 2013:

	Goodwill
December 31, 2012	\$22,656
Less: charges to discontinued operations for the excess carrying amount of goodwill	(1,099 )
	21,557
Additions	3,197
September 30, 2013	\$24,754

As of September 30, 2013, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes.

During the nine months ended September 30, 2013, the Company recorded \$4,109 and \$43 in home health and hospice Medicare license and trade name indefinite-lived intangible assets, respectively, as part of its acquisition of three home health and three hospice operations.

Other indefinite-lived intangible assets consists of the following:

	September 30, 2013	December 31, 2012
Trade name	\$1,033	\$990
Home health and hospice Medicare license	6,707	2,598
	\$7,740	\$3,588

**12. RESTRICTED AND OTHER ASSETS**

Restricted and other assets consist of the following:

	September 30, 2013	December 31, 2012
Note receivable	\$4,000	\$—
Debt issuance costs, net	2,975	2,769
Long-term insurance losses recoverable asset	3,330	3,219
Deposits with landlords	871	749
Capital improvement reserves with landlords and lenders	740	683
Equity method investment	—	1,220
Other long-term assets	170	—
Restricted and other assets	\$12,086	\$8,640

Included in other assets as of September 30, 2013, 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, capitalized debt issuance costs and a note receivable from the sale of DRX effective April 15, 2013. Included in other assets, as of December 31, 2012, was a non-marketable equity investment accounted for under the equity method. On April 23, 2013, the Company entered into a common unit redemption agreement with the investee where the non-marketable equity investment was repurchased for \$1,600. The Company recognized a gain on the sale of its non-marketable equity investment of \$380 in the second quarter of 2013.

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## 13. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	September 30, 2013	December 31, 2012
Quality assurance fee	\$2,977	\$2,010
Resident refunds payable	4,369	4,564
Deferred revenue	2,238	5,661
Cash held in trust for residents	1,515	1,520
Resident deposits	1,670	1,666
Dividends payable	1,443	—
Property taxes	3,546	2,264
Other	3,767	3,186
Other accrued liabilities	\$21,525	\$20,871

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

## 14. INCOME TAXES

During the first quarter of 2012, the State of California initiated an examination of the Company's income tax returns for the 2008 and 2009 income tax years. The examination is primarily focused on the Captive and the treatment of related insurance matters. California has not proposed any adjustments. The Company is not currently under examination by any other major income tax jurisdiction. During 2013, the statute of limitations has lapsed on the Company's 2009 Federal tax year and will lapse on certain 2008 and 2009 state tax years during the fourth quarter. The lapse of the Federal statute had no significant impact on the balance of unrecognized tax benefits. The Company does not believe the state statute lapses, the California examination, 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 nine months ended September 30, 2013 or 2012.

The Company recorded total pre-tax charges related to the pending settlement with the U.S. Department of Justice (DOJ) and related expenses of \$33,000 and \$15,000 during the three months ended March 31, 2013 and December 31, 2012, respectively, for a total charge of \$48,000. The Company recorded estimated tax benefits of \$10,435 and \$5,865 during the nine months ended September 30, 2013 and three months ended December 31, 2012, respectively. See Note 17, Commitments and Contingencies.

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## 15. DEBT

Long-term debt consists of the following:

	September 30, 2013	December 31, 2012
Promissory note with RBS, principal and interest payable monthly and continuing through March 2019, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	\$20,522	\$21,032
Senior Credit Facility with SunTrust and Wells Fargo, principal and interest payable quarterly, balance due at February 1, 2018, secured by substantially all of the Company's personal property.	96,562	89,375
Ten Project Note with GECC, principal and interest payable monthly; interest is fixed, balance due June 2016, collateralized by deeds of trust on real property, assignment of rents, security agreements and fixture financing statements.	49,177	50,072
Promissory note with RBS, principal and interest payable monthly and continuing through January 2018, interest at a fixed rate, collateralized by real property, assignment of rents and Company guaranty.	32,389	33,167
Promissory notes, principal, and interest payable monthly and continuing through October 2019, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	8,991	9,203
Mortgage note, principal, and interest payable monthly and continuing through February 2027, interest at fixed rate, collateralized by deed of trust on real property, assignment of rents and security agreement.	5,490	5,665
	213,131	208,514
Less current maturities	(7,354)	(7,187)
Less debt discount	(731)	(822)
	\$205,046	\$200,505

Senior Credit Facility with Six-Bank Lending Consortium Arranged by SunTrust and Wells Fargo (the Senior Credit Facility)

On April 22, 2013, the Company entered into the fourth amendment to the Senior Credit Facility (the Fourth Amendment), which amended the Company's existing Senior Credit Facility Agreement, dated as of July 15, 2011, to amend certain covenants, representations and other key provisions in the credit agreement to, among other things, (i) allow for the settlement relating to the previously disclosed federal civil investigation that has been conducted by the U.S. Department of Justice (DOJ) and related federal agencies in an amount up to \$50,000 and (ii) permit the Company to enter into a corporate integrity agreement with the Office of Inspector General-HHS. Except as set forth in the Fourth Amendment, all other terms and conditions of the Senior Credit Facility, as amended, remained in full force.

On February 1, 2013, the Company entered into the third amendment to the Senior Credit Facility (the Third Amendment), which amended the Company's existing Senior Credit Facility Agreement, dated as of July 15, 2011. The Third Amendment revised the Senior Credit Facility Agreement to, among other things, (i) increase the revolving credit portion of the Senior Credit Facility by \$75,000 to an aggregate principal amount of \$150,000, of which \$30,000 was drawn as of September 30, 2013, and (ii) extend the maturity date of the Senior Credit Facility from July 15, 2016 to February 1, 2018. Except as set forth in the Third Amendment, all other terms and conditions of the Senior

Credit Facility remained in full force and effect as described below.

On July 15, 2011, the Company entered into the Senior Credit Facility in an aggregate principal amount of up to \$150,000 comprised of a \$75,000 revolving credit facility and a \$75,000 term loan advanced in one drawing on July 15, 2011. Borrowings under the term loan portion of the Senior Credit Facility amortize in equal quarterly installments commencing on September 30, 2011, in an aggregate annual amount equal to 5% per annum of the original principal amount. Interest rates per annum applicable to the Senior Credit Facility are, at the option of the Company, (i) LIBOR plus an initial margin of 2.5% or (ii) the Base Rate (as defined by the agreement) plus an initial margin of 1.5%. Under the terms of the Senior Credit Facility, the applicable margin adjusts based on the Company's leverage ratio as set forth in further detail in the Senior Credit Facility agreement. Amounts borrowed pursuant to the Senior Credit Facility are guaranteed by certain of the Company's wholly-owned subsidiaries and secured by substantially all of their personal property. To reduce the risk related to interest rate fluctuations, the Company, on behalf of



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the subsidiaries, entered into an interest rate swap agreement to effectively fix the interest rate on the term loan portion of the Senior Credit Facility. See further details of the interest rate swap at Note 6, Fair Value Measurements.

Among other things, under the Senior Credit Facility, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a maximum net leverage ratio, minimum interest coverage ratio and minimum asset coverage ratio. The loan documents also include certain additional reporting, affirmative and negative covenants including limitations on the incurrence of additional indebtedness, liens, investments in other businesses, dividends declared in excess of 20% of consolidated net income and repurchases and capital expenditures. As of September 30, 2013, we were in compliance with all loan covenants.

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.

**16. 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 nine months ended September 30, 2013 and 2012 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan), all of which have been approved by the stockholders. The total number of shares available under all of the Company's stock incentive plans was 1,851 as of September 30, 2013.

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 184 options and 73 restricted stock awards from the 2007 Plan during the nine months ended September 30, 2013.

The Company used the following assumptions for stock options granted during the three months ended September 30, 2013 and 2012:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield	
2013	34	1.87	% 6.5 years	55	% 0.93	%
2012	83	0.84	% 6.5 years	55	% 0.93	%

The Company used the following assumptions for stock options granted during the nine months ended September 30, 2013 and 2012:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average	Weighted Average
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						Volatility	Dividend Yield	
2013	184	1.18	% - 1.87	% 6.5 years	55	%	0.93	%
2012	175	0.84	% - 1.18	% 6.5 years	55	%	0.93	%

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

For the nine months ended September 30, 2013 and 2012, 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
2013	184	\$33.16	\$16.37
2012	175	\$27.04	\$12.44

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 September 30, 2013 and 2012 and therefore, the intrinsic value was \$0 at date of grant.

The following table represents the employee stock option activity during the nine months ended September 30, 2013:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2013	1,387	\$16.06	739	\$11.88
Granted	184	33.16		
Forfeited	(54)	) 23.27		
Exercised	(199)	) 11.73		
September 30, 2013	1,318	\$18.81	730	\$13.13

The following summary information reflects stock options outstanding, vested and related details as of September 30, 2013:

						Stock Options Vested
Stock Options Outstanding						
Year of Grant	Exercise Price		Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2003	\$0.67	-0.81	4	*	0	4
2005	4.99	-5.75	40	*	2	40
2006	7.05	-7.50	148	1,431	3	148
2008	9.38	-14.87	276	1,546	5	249
2009	14.88	-16.70	293	2,321	6	199
2010	17.47	-18.16	79	706	7	39
2011	21.61	-29.30	84	1,031	8	23
2012	24.04	-29.16	219	2,951	9	28
2013	29.25	-38.83	175	2,880	10	—
Total			1,318	\$ 12,866		730

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

In addition to the above, during the three and nine months ended September 30, 2013, the Company granted 13 and 73 restricted stock awards, respectively. During the three and nine months ended September 30, 2012, the Company granted 13 and 114 restricted stock awards, respectively. All awards were granted at an exercise price of \$0 and vest over five years.

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A summary of the status of the Company's nonvested restricted stock awards as of September 30, 2013, and changes during the nine-month period ended September 30, 2013 is presented below:

	Nonvested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2013	224	\$23.04
Granted	73	33.36
Vested	(38)	) 23.81
Forfeited	(33)	) 23.75
Nonvested at September 30, 2013	226	\$27.25

Total share-based compensation expense recognized for the three and nine months ended September 30, 2013 and 2012 was as follows:

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
Share-based compensation expense related to stock options	\$538	\$476	\$1,617	\$1,396
Share-based compensation expense related to restricted stock awards	357	292	1,000	809
Share-based compensation expense related to stock awards	93	102	700	1,639
Total	\$988	\$870	\$3,317	\$3,844

In future periods, the Company expects to recognize approximately \$6,481 and \$5,536 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of September 30, 2013. Future share-based compensation expense will be recognized over 3.7 and 3.6 weighted average years for unvested options and restricted stock awards, respectively. There were 588 unvested and outstanding options at September 30, 2013, of which 551 are expected to vest. The weighted average contractual life for options vested at September 30, 2013 was 6.1 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of September 30, 2013 and December 31, 2012 is as follows:

	September 30, 2013	December 31, 2012
Options		
Outstanding	\$29,380	\$15,703
Vested	20,423	11,285
Expected to vest	7,942	4,088
Exercised	4,614	7,123

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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17. COMMITMENTS AND CONTINGENCIES

**Leases** — The Company leases certain facilities and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company also leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments, was \$3,518 and \$10,400 for the three and nine months ended September 30, 2013 and \$3,489 and \$10,407 for the three and nine months ended September 30, 2012, respectively.

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

In addition, a number of the Company's individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the landlords under separate but cross-defaulted leases. The Company is not aware of any defaults as of September 30, 2013.

**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.

A significant portion of the Company's revenue is derived from Medicaid and Medicare, for which reimbursement rates are subject to regulatory changes and government funding restrictions. Any significant future change to reimbursement rates or regulation on how services are provided could have a material effect on the Company's operations.

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

**Income Tax Examinations** — During the first quarter of 2012, the State of California initiated an examination of the Company's income tax returns for the 2008 and 2009 income tax years. The examination is primarily focused on the Captive and the treatment of related insurance matters. California has not proposed any adjustments. The Company is not currently under examination by any other major income tax jurisdiction. During 2013, the statute of limitations has lapsed on the Company's 2009 Federal tax year and will lapse on certain 2008 and 2009 state tax years during the fourth quarter. The lapse of the Federal statute had no significant impact on the balance of unrecognized tax benefits. The Company does not believe the state statute lapses, the California examination, or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. See Note 14, Income Taxes.

**Indemnities** — From time to time, the Company enters into certain types of contracts that contingently require the Company to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which the Company may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from the Company's use of the applicable premises, (ii) operations transfer agreements, in which the Company agrees to indemnify past operators of facilities

the Company acquires against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, (iv) agreements with certain lenders under which the Company may be required to indemnify such lenders against various claims and liabilities, and (v) certain agreements with the Company's officers, directors and employees, under which the Company may be required to indemnify such persons for liabilities arising out of their employment relationships. The terms of such obligations vary by contract and, in most instances, a specific or maximum dollar amount is not explicitly stated therein. Generally, amounts under these contracts cannot be reasonably estimated until a specific claim is asserted. Consequently, because no claims have been asserted, no liabilities have been recorded for these obligations on the Company's balance sheets for any of the periods presented.

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NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

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

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

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

In July 2010, Congress passed the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank Act). The Dodd-Frank Act establishes rigorous standards and supervision to protect the economy and American consumers, investors and businesses. Included under Section 922 of the Dodd-Frank Act, the Securities and Exchange Commission (SEC) will be required to pay a reward to individuals who provide original information to the SEC resulting in monetary sanctions exceeding \$1,000 in civil or criminal proceedings. The award will range from 10 to 30 percent of the amount recouped and the amount of the award shall be at the discretion of the SEC. The purpose of this reward program is to "motivate those with inside knowledge to come forward and assist the Government to identify and prosecute persons who have violated securities laws and recover money for victims of financial fraud."

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 become increasingly aggressive in their pursuit of these staffing and similar claims.

A class action staffing suit was previously filed against the Company 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 at certain of the Company's California facilities. In 2007, the Company settled this class action suit, and the settlement was approved by the affected class and the Court. The Company has been defending a second such staffing



class-action claim filed in Los Angeles Superior Court; however, a settlement was reached with class counsel and has received Court approval. The total costs associated with the settlement, including attorney's fees, estimated class payout, and related costs and expenses, are projected to be approximately \$6,500, of which, approximately \$1,500 of this amount was recorded during the nine months ended September 30, 2013, with the balance having been expensed in prior periods. The settlement will not have 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.

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

The Company has been, and continues to be, subject to claims and legal actions that arise in the ordinary course of business, including potential claims related to care and treatment provided at its facilities as well as employment related claims. The Company does not believe that the ultimate resolution of these actions will have a material adverse effect on the Company's 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 is 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, its 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 Company's assumption of specific procedural and financial obligations 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 operation subject to probe review during the nine months ended September 30, 2013. The Company anticipates that these probe reviews will increase in frequency in the future. Further, the Company currently has no 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. The Company has no facilities that are currently undergoing targeted review.

**U.S. Government Inquiry** — In late 2006, the Company learned that it might be the subject of an on-going criminal and civil investigation by the DOJ. This was confirmed in March 2007. The investigation was prompted by a whistleblower complaint, and related primarily to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. The Company, through its outside counsel and a special committee of independent directors established by its board, worked cooperatively with the U.S. Attorney's office to produce information requested by the government as part of an ongoing dialogue designed to resolve the issue.

In December 2011, the DOJ notified the Company that it had closed its criminal investigation without action although, as is typical, it reserved the right to reopen the criminal case if new facts came to light. This left only the civil investigation to resolve, and the Company continued to supply requested information to the DOJ and the Office of the Inspector General of the United States Department of Health and Human Services (HHS), including specific patient records and documents from 2007 to 2011 from six Southern California skilled nursing facilities that had been the subject of previous requests.

In early 2013, discussions between government representatives and the Company's special committee, its outside counsel and their experts had advanced sufficiently that the Company recorded an initial estimated liability in the amount of \$15,000 in the fourth quarter of 2012 for the resolution of claims connected to the investigation. In April 2013, the Company and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, the Company recorded and announced an additional charge in the amount of \$33,000 in the first quarter of 2013, increasing the total reserve to resolve the matter to \$48,000 (the Reserve Amount).

In October 2013, the Company completed and executed a settlement agreement (the Settlement Agreement) with the Department of Justice and received the final approval of the Office of Inspector General-HHS and the United States District Court for the Central District of California. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. 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, Ensign entered into a five-year corporate integrity agreement with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of the Company's current 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 maintain several elements of its existing program during the term of the CIA, including maintaining a compliance officer, a compliance committee of the board of directors, and a code of conduct. The CIA requires that the Company conduct certain additional compliance-related activities during the term of the CIA, including various training and monitoring procedures, and maintaining a disciplinary process for compliance obligations. Pursuant to the

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THE ENSIGN GROUP, INC.

NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS — (Continued)

CIA, the Company is 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 subject to periodic reporting and certification requirements attesting that the provisions of the CIA are being implemented and followed, as well as certain document and record retention mandates.

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 56.9% and 56.2% of its total accounts receivable as of September 30, 2013 and December 31, 2012, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 71.2% and 72.2% of the Company's revenue for the three and nine months ended September 30, 2013, respectively, and 73.8% for both periods during the three and nine months ended September 30, 2012, 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 November 6, 2013, the Company had approximately \$1,001 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 and the proposed Spin-Off. Forward-looking statements can often be identified by words such as "anticipates," "expects," "intends," "plans," "predicts," "believes," "seeks," "estimates," "may," "should," "would," "could," "potential," "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 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 facilities, 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 119 facilities, nine home health and seven hospice operations as of September 30, 2013, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. Our operations, 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 services, including physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. During the first quarter of 2012, we entered into a business to develop and operate urgent care facilities and related businesses. These walk-in clinics offer 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 September 30, 2013 we operated six urgent care centers in the state of Washington. In the fourth quarter of 2012, we acquired an 80% membership interest in a mobile x-ray and diagnostic company. The mobile x-ray and 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. As of September 30, 2013, we owned 96 of our 119 facilities and operated an additional 23 facilities under long-term lease arrangements, and had options to purchase two of those 23 facilities.

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The following table summarizes our facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of September 30, 2013:

	Owned		Leased (with a Purchase Option)		Leased (without a Purchase Option)		Total	
Number of facilities	96		2		21		119	
Percent of total	80.7	%	1.7	%	17.6	%	100.0	%
Operational skilled nursing, assisted living and independent living beds	10,443		414		2,347		13,204	
Percent of total	79.1	%	3.1	%	17.8	%	100.0	%

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

## Facility Acquisition History

	December 31,								September 30,
	2005	2006	2007	2008	2009	2010	2011	2012	2013
Cumulative number of facilities	46	57	61	63	77	82	102	108	119
Cumulative number of operational skilled nursing, assisted living and independent living beds	5,585	6,667	7,105	7,324	8,948	9,539	11,702	12,198	13,204

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of September 30, 2013:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	Total
Number of facilities	36	13	27	12	6	6	6	3	5	5	119
Operational skilled nursing, assisted living and independent living beds	3,973	1,902	3,353	1,413	505	555	477	304	366	356	13,204

On January 1, 2013, we acquired a home health operation in Washington and two hospice operations in Arizona and California, respectively, in two separate transactions, for an aggregate purchase price of approximately \$4.6 million, which was paid in cash. These acquisitions did not have an impact on our operational bed count.

On February 16, 2013, we acquired a home health operation in Texas for approximately \$0.4 million, which was paid in cash. This acquisition did not have an impact on our operational bed count.

On March 1, 2013, we acquired a home health and hospice operation in Washington and a skilled nursing facility in Texas, in two separate transactions, for an aggregate purchase price of approximately \$5.6 million, which was paid in cash. The home health and hospice operations did not have an impact on our operational bed count. The skilled nursing facility acquisition added 150 operational skilled nursing beds to our operations.

On April 1, 2013, we acquired three skilled nursing facilities in Texas for an aggregate purchase price of approximately \$7.1 million, which was paid in cash. These acquisitions added 280 operational skilled nursing beds to our operations.

On May 1, 2013, we acquired a skilled nursing facility and an assisted living facility in Washington and a skilled nursing facility in Nebraska, in two separate transactions, for an aggregate purchase price of \$14.4 million, which was paid in cash. These acquisitions added 102 operational assisted living units and 180 operational skilled nursing beds to our operations.

On June 1, 2013, we acquired one assisted living facility in California and one assisted living facility in Utah, in two separate transactions, for an aggregate purchase price of approximately \$7.1 million, which was paid in cash. These acquisitions added 179 operational assisted living units to our operations.

On July 1, 2013 we acquired a skilled nursing facility in Washington for approximately \$4.5 million, which was paid in cash. This acquisition added 82 operational skilled nursing beds to our operations.

On September 16, 2013, we acquired an existing leased urgent care center for approximately \$1.6 million, which was paid in cash. We assumed the existing lease that was in place at the time of acquisition. The urgent care center acquisition did not have an impact on our bed count.



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We also entered into a separate operations transfer agreement with the prior tenant as part of each transaction noted above. See further discussion of facility acquisitions in Note 8, Acquisitions in Notes to Condensed Consolidated Financial Statements.

### Recent Developments

**Real Estate Investment Trust (REIT) Spin-Off** — On November 7, 2013, we announced a proposed plan to separate our healthcare business and real estate business into two separate, publicly traded companies:

Ensign, which will continue to provide healthcare services through its existing operations; and  
CareTrust, which will own, acquire and lease real estate serving the healthcare industry.

We intend to accomplish the proposed separation by distributing all of the outstanding shares of CareTrust common stock to our stockholders on a pro rata basis (the Spin-Off). At the time of the Spin-Off, CareTrust, which is currently a wholly owned subsidiary of ours, will hold substantially all of the real property owned by us, and will own and operate three independent living facilities. After the Spin-Off, all of these properties (except for three independent living facilities that CareTrust will operate) will be leased to us on a triple-net basis, under which we will be responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs.

The proposed Spin-Off is conditioned on, among other things, final approval by our board of directors, the receipt of a ruling from the IRS that, among other things, the Spin-Off will qualify as a tax-free transaction for U.S. federal income tax purposes, the receipt of an opinion of counsel as to the satisfaction of certain requirements for such tax-free treatment, and the receipt of an opinion of counsel that, commencing with CareTrust's taxable year ending on December 31, 2014, CareTrust has been organized in conformity with the requirements for qualification as a REIT under the Internal Revenue Code of 1986, as amended, and its proposed method of operation will enable it to meet the requirements for qualification and taxation as a REIT.

**U.S. Government Inquiry Settlement** — In April 2013, we and government representatives reached an agreement in principle to resolve the allegations and close the investigation. Based on these discussions, we recorded and announced an additional charge in the amount of \$33.0 million in the first quarter of 2013, increasing the total reserve to resolve the matter to \$48.0 million (the Reserve Amount).

In October 2013, we completed and executed a settlement agreement (the Settlement Agreement) with the Department of Justice (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. The settlement agreement fully and finally resolves the previously disclosed DOJ investigation and any ancillary claims which have been pending since 2006. Pursuant to the settlement agreement, we made a single lump-sum remittance to the government in the amount of \$48.0 million in October 2013. We have denied engaging in any illegal conduct, and have 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, we entered into a five-year corporate integrity agreement with the Office of Inspector General-HHS (the CIA). The CIA acknowledges the existence of our current compliance program, and requires that we 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. Our participation in Federal healthcare programs is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, we could be excluded from participation in Federal healthcare programs and/or subject to prosecution. See further details of the CIA at Note 17, Commitments and Contingencies of Notes to Condensed Consolidated Financial Statements.

Urgent Care Franchising — On March 25, 2013 we announced that our urgent care subsidiary, Immediate Clinic Healthcare, Inc., agreed to terms to sell Doctors Express, a national urgent care franchise system. The sale of specific assets and liabilities of Doctors Express was finalized on April 15, 2013. In accordance with the authoritative guidance for the disposal of long-lived asset, the sale of Doctors Express has been accounted for as discontinued operations. Accordingly, the results of operations of this business for all periods presented and the loss or impairment related to this divestiture have been classified as discontinued operations in the accompanying condensed consolidated statements of income. As the sale was effective April 15, 2013, all assets and liabilities included in the sale were recorded as held for sale on our accompanying condensed consolidated balance sheets as of December 31, 2012. See Note 4, Discontinued Operations in Notes to Condensed Consolidated Financial Statements.

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### Key Performance Indicators

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

**Routine revenue:** Routine revenue is generated by the contracted daily rate charged for all contractually inclusive 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 our skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs.

The other skilled residents that are included in this population represent very high acuity residents who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care.

Skilled revenue excludes any revenue generated from our assisted living services.

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

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

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

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

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

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

	Three Months Ended September 30, 2013		September 30, 2012		Nine Months Ended September 30, 2013		September 30, 2012	
Skilled Mix:								
Days	26.0	%	25.2	%	26.6	%	25.8	%
Revenue	49.7	%	49.3	%	50.4	%	50.1	%
Quality Mix:								
Days	39.9	%	38.4	%	40.1	%	39.0	%
Revenue	59.5	%	58.8	%	59.8	%	59.6	%

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

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

	Three Months Ended September 30, 2013		September 30, 2012		Nine Months Ended September 30, 2013		September 30, 2012	
Occupancy:								
Operational beds at end of period	13,204		12,090		13,204		12,090	
Available patient days	1,214,768		1,108,622		3,496,000		3,256,086	
Actual patient days	940,054		872,701		2,701,513		2,580,026	
Occupancy percentage (based on operational beds)	77.4	%	78.7	%	77.3	%	79.2	%

## Revenue Sources

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

The following table sets forth our total revenue by payor source and as a percentage of total revenue for the periods indicated:

	Three Months Ended September 30, 2013				September 30, 2012				Nine Months Ended September 30, 2013				September 30, 2012			
	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%	\$	%
	(Dollars in thousands)															
Revenue:																
Medicaid	\$81,802	35.7	%	\$76,709	37.1	%	\$237,301	35.5	%	\$223,934	36.6	%				
Medicare	72,138	31.5		69,526	33.6		218,214	32.7		209,715	34.2					
Medicaid-skilled	9,204	4.0		6,316	3.1		26,616	4.0		18,590	3.0					
Total	163,144	71.2		152,551	73.8		482,131	72.2		452,239	73.8					
Managed Care	30,886	13.5		26,316	12.7		87,446	13.1		77,738	12.7					
Private and Other(1)	35,231	15.3		27,824	13.5		97,971	14.7		82,673	13.5					
Total revenue	\$229,261	100.0	%	\$206,691	100.0	%	\$667,548	100.0	%	\$612,650	100.0	%				

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

## Critical Accounting Policies Update

There have been no significant changes during the three-month period ended September 30, 2013 to the items that we disclosed as our critical accounting policies and estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K filed with the SEC.



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### Industry Trends

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

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

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

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

**Increased Demand Driven by Aging Populations and Increased Life Expectancy.** As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

### Effects of Changing Prices

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

**Centers for Medicare and Medicaid Services (CMS) Rulings** — On July 27, 2012, the CMS announced a final rule updating Medicare skilled nursing facility PPS payments in fiscal year 2013. The update, a 1.8% or \$670 million increase, reflects a 2.5% market basket increase, reduced by a 0.7% MFP adjustment mandated by the Patient Protection and Affordable Care Act (PPACA). This increase was offset by the 2% sequestration reduction, discussed below, which became effective April 1, 2013.

On July 31, 2013, CMS issued its final rule outlining fiscal year 2014 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by \$470 million, or 1.3%

for fiscal year 2014, relative to payments in 2013. This estimated increase reflects a 2.3% market basket increase, reduced by the 0.5% forecast error correction and further reduced by the 0.5% multi-factor productivity adjustment (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. For fiscal year 2012 (most recent available fiscal year), the projected market basket percentage change exceeded the actual market basket percentage change by 0.51%.

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In November 2012, CMS issued final regulations regarding Medicare payment rates for home health agencies effective January 1, 2013. These final regulations implement a net market basket increase of 1.3% consisting of a 2.3% market basket inflation increase, less a 1.0% adjustment mandated by the PPACA. In addition, CMS implemented a 1.3% reduction in case mix. CMS has projected the impact of these changes will result in a less than 0.1% decrease in payments to home health agencies.

Additionally, on June 27, 2013, CMS announced proposed changes to the Medicare home health prospective payment system (HH PPS) payment rates and wage index for calendar year 2014. As required by the PPACA, this rule proposes 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. CMS projects that Medicare payments to home health agencies in calendar year 2014 will be reduced by 1.5%, or \$290 million, reflecting the combined effects of the 2.4% home health payment update percentage, the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the NRS conversion factor, and the effects of ICD-9 coding adjustments. The proposed rule would also establish home health quality reporting requirements for 2014 payment and subsequent years and proposes 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 (SNF) and intermediate care facilities for individuals with intellectual disabilities (ICF-IID).

In July 2012, CMS issued its final rule for hospice services for its 2013 fiscal year. These final regulations implement a net market basket increase of 1.6% consisting of a 2.6% market basket inflation increase, less offsets to the standard payment conversion factor mandated by the PPACA of 0.7% to account for the effect of a productivity adjustment, and 0.3% as required by statute. CMS has projected the impact of these changes will result in a 0.9% increase in payments to hospice providers.

On August 2, 2013, CMS issued its final rule that would update fiscal year 2014 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Hospices will see an estimated 1.0% (\$160 million) increase in their payments for fiscal year 2014. The hospice payment increase is 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), and a 0.7% decrease in payments to hospices due to updated wage data and the fifth year of the CMS's seven-year phase-out of its wage index budget neutrality adjustment factor (BNAF). As finalized in this rule, CMS will 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.

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

**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 the Centers for Medicare and Medicaid Services to develop a process that allows exceptions for Medicare beneficiaries to therapy caps when continued therapy is deemed medically necessary.

The therapy cap exception was reauthorized in a number of subsequent laws, most recently in the American Taxpayer Relief Act of 2012 which extends the exceptions process through December 31, 2013. The statutory Medicare Part B outpatient therapy cap for occupational therapy and the combined cap for physical therapy and speech-language pathology services are \$1,880, respectively, for 2012. These amounts represent annual per beneficiary therapy caps determined for each calendar year. These cap amounts increased to \$1,900 in 2013. Similar to the therapy cap,



Congress established a threshold of \$3,700 for physical therapy and speech-language pathology services combined and a separate threshold of \$3,700 for occupational therapy services. All therapy services rendered above this limit are subject to medical review and beginning October 1, 2012, CMS rolled out a pilot program requiring some therapy providers to submit pre-approval requests for exceptions. Prior to October 1, 2012 there was no requirement for an exception request to be pre-approved when the threshold was exceeded. The pilot program was rolled out to our facilities in groups beginning in October 2012 and ended in December 2012.

In addition, the Multiple Procedure Payment Reduction (MPPR) was increased from a 25% to 50% reduction applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies are provided on the same day. The implementation of MPPR includes 1) facilities that provide Medicare Part B speech-language pathology, occupational therapy, and physical therapy services and bill under the same provider number; and 2) providers in private practice, including speech-language pathologists, who perform and bill for multiple services in a single day. The change from 25% of the practice expense to a 50% reduction went into effect for Medicare Part B services provided on or after April 1, 2013.

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The application of annual caps, or the discontinuation of exceptions to the annual caps, could have an adverse effect on our rehabilitation therapy revenue. Additionally, the exceptions to these caps may not be extended beyond December 31, 2013, which could also have an adverse effect on our revenue after that date.

**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 reimbursement for our services.

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

**State Regulations** — On March 24, 2011, the governor of California signed Assembly Bill 97 (AB 97), the budget trailer bill on health, into law. AB 97 outlines significant cuts to state health and human services programs. Specifically, the law reduced provider payments by 10% for physicians, pharmacies, clinics, medical transportation, certain hospitals, home health, and nursing facilities. AB X1 19 Long Term Care was subsequently approved by the governor on June 28, 2011. Federal approval was obtained on October 27, 2011. AB X1 19 limited the 10% payment reduction to skilled-nursing providers to 14 months for the services provided on June 1, 2011 through July 31, 2012. The 10% reduction in provider payments was repaid by December 31, 2012.

**Federal Health Care Reform** — On 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 January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute delays significant cuts in Medicare rates for physician services until December 31, 2013. The statute also 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 March 23, 2010, President Obama signed PPACA 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.

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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 and Escrow Provisions** — 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 \$50,000 and, in some cases, treble damages, for actions relating to alleged false statements to the federal government.

**Nursing Home Transparency Requirements** — In addition to expanded CMP provisions, PPACA imposed substantial new transparency requirements for Medicare-participating nursing facilities. Existing law required Medicare providers to disclose to CMS: (1) any person or entity that owns directly or indirectly an ownership interest of five percent or more in a provider; (2) officers and directors (if a corporation) and partners (if a partnership); and (3) holders of a mortgage, deed of trust, note or other obligation secured by the entity or the property of the entity. PPACA expanded the information required to be disclosed to include: (4) the facility's organizational structure; (5) additional information on officers, directors, trustees, and "managing employees" of the facility (including their names, titles, and start dates of services); and (6) information on any "additional disclosable party" of the facility. 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. Effective for patients with home health starts of care on or after January 1, 2011 and for hospice patients with a third or later benefit period on or after January 1, 2011, 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 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. Any overpayment retained after the deadline is considered an "obligation" for purposes of the federal False Claims Act.

**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. HHS delivered a report to Congress outlining its plans for implementing this value-based purchasing program. The value-based purchasing program would provide payment incentives for

Medicare-participating skilled nursing facilities to improve the quality of care provided to Medicare beneficiaries. Among the most relevant factors in HHS' plans to implement value-based purchasing for skilled nursing facilities is the current Nursing Home Value-Based Purchasing Demonstration Project, which concluded in December 2012. HHS indicates it will complete an evaluation of the demonstration program in the autumn of 2013, and any permanent value-based purchasing program for skilled nursing facilities will be implemented after that evaluation.

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

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bundled payments and bids from entities for episodes of care that begins three days prior to hospitalization and spans 30 days following discharge. The bundled payment will cover the costs of acute care inpatient services; physicians' services delivered in and outside of an acute care hospital; outpatient hospital services including emergency department services; post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services; and inpatient hospital services. The payment methodology will include payment for services, such as care coordination, medication reconciliation, discharge planning and transitional care services, and other patient-centered activities. Payments for items and services cannot result in spending more than would otherwise be expended for such entities if the pilot program were not implemented. As with Medicare's shared savings program discussed above, payment arrangements among providers on the backside of the bundled payment must take into account significant hurdles under the Anti-kickback Law, the Stark Law and the Civil Monetary Penalties Law. 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 Accountable Care Organizations (ACOs). ACOs are entities of providers and suppliers organized to deliver services to Medicare beneficiaries and eligible to receive a share of any cost 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 facilities or operations in a way that could have a material adverse impact on the 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 September 30,		Nine Months Ended September 30,		
	2013	2012	2013	2012	%
Revenue	100.0	% 100.0	% 100.0	% 100.0	%
Expenses:					
Cost of services (exclusive of facility rent, general and administrative expense and depreciation and amortization shown separately below)	81.2	79.6	80.6	79.5	
U.S. Government inquiry settlement	—	—	5.0	—	
Facility rent—cost of services	1.5	1.6	1.5	1.6	
General and administrative expense	4.6	3.9	4.2	3.9	
Depreciation and amortization	3.9	3.5	3.8	3.5	
Total expenses	91.2	88.6	95.1	88.5	
Income from operations	8.8	11.4	4.9	11.5	
Other income (expense):					
Interest expense	(1.4	) (1.5	) (1.4	) (1.5	)
Interest income	0.1	—	0.1	—	
Other expense, net	(1.3	) (1.5	) (1.3	) (1.5	)
Income before provision for income taxes	7.5	9.9	3.6	10.0	
Provision for income taxes	2.9	3.6	1.7	3.8	
Income from continuing operations	4.6	6.3	1.9	6.2	
Loss from discontinued operations	—	—	(0.3	) —	
Net income	4.6	6.3	1.6	6.2	
Less: net loss attributable to the noncontrolling interests	—	(0.1	) —	(0.1	)
Net income attributable to The Ensign Group, Inc.	4.6	% 6.4	% 1.6	% 6.3	%
	Three Months Ended September 30,		Nine Months Ended September 30,		
	2013	2012	2013	2012	
	(In thousands)				
Other Non-GAAP Financial Data:					
EBITDA <sup>(1)</sup>	\$28,936	\$30,912	\$58,204	\$91,903	
Adjusted EBITDA <sup>(1)(2)</sup>	31,939	32,200	99,453	97,369	
EBITDAR <sup>(1)</sup>	32,340	34,271	68,260	101,937	
Adjusted EBITDAR <sup>(1)(2)</sup>	35,163	35,323	108,822	106,815	

(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 Securities Exchange Act of 1934, as amended, define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income 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 facility rent—cost of services. These non-GAAP financial measures are used in addition to and in conjunction with results presented in accordance with GAAP. These non-GAAP financial measures should not be relied upon to the exclusion of GAAP financial measures. These non-GAAP financial measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding

GAAP financial measures, provide a more complete understanding of factors and trends affecting our business. 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:



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

We use EBITDA, 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, facility rent — cost of services, which may vary from period-to-period depending upon various factors, including the method used to finance facilities, the amount of debt that we have incurred, whether a facility is owned or leased, the date of acquisition of a facility or business, 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:

• Charge related to the U.S. Government inquiry;

• Expenses incurred in connection with the Company's proposed spin-off of real estate assets in a newly formed publicly traded real estate investment trust (REIT);

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- Legal costs incurred in connection with the U.S. Government inquiry;
- Settlement of a class action lawsuit;
- Losses incurred by our newly opened urgent care centers;
- Losses incurred by one newly constructed skilled nursing facility;
- Acquisition-related costs; and
- Costs incurred to recognize income tax credits.

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

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

	Three Months Ended September 30,		Nine Months Ended September 30,	
	2013	2012	2013	2012
	(In thousands)			
Consolidated statements of income Data:				
Net income	\$10,612	\$13,036	\$10,505	\$38,143
Net (income) loss attributable to noncontrolling interests	(148)	) 258	179	511
Loss (income) from discontinued operations	30	(80)	) 1,804	105
Interest expense, net	3,040	3,023	9,078	8,959
Provision for income taxes	6,607	7,528	11,440	23,114
Depreciation and amortization	8,795	7,147	25,198	21,071
EBITDA	\$28,936	\$30,912	\$58,204	\$91,903
Facility rent—cost of services	3,404	3,359	10,056	10,034
EBITDAR	\$32,340	\$34,271	\$68,260	\$101,937
		\$—		
EBITDA	\$28,936	\$30,912	\$58,204	\$91,903
Charge related to the U.S. Government inquiry(a)	—	—	33,000	—
Expenses related to the Spin-Off(b)	1,648	—	1,857	—
Legal costs(c)	98	593	1,111	1,441
Settlement of class action lawsuit(d)	915	—	1,524	2,596
Urgent care center losses(e)	105	152	1,447	172
Losses at skilled nursing facility not at full operation(f)	—	—	1,256	—
Acquisition related costs(g)	38	110	264	230
Costs incurred to recognize income tax credits(h)	19	197	103	439
Rent related to items (e) and (f) above(i)	180	236	687	588
Adjusted EBITDA	\$31,939	\$32,200	\$99,453	\$97,369
Facility rent—cost of services	3,404	3,359	10,056	10,034
Less: rent related to items (e) and (f) above(i)	(180)	) (236)	) (687)	) (588)
Adjusted EBITDAR	\$35,163	\$35,323	\$108,822	\$106,815

(a) Liability related to our efforts to achieve a global, company-wide, resolution of any claims connected to the U.S. Department of Justice (DOJ) investigation.

(b) Expenses incurred in connection with the Company's proposed spin-off of its real estate assets to a newly formed publicly traded real estate investment trust (REIT).

(c) Legal costs incurred in connection with the ongoing investigation into the billing and reimbursement processes of some of our subsidiaries being conducted by the DOJ.

(d) Settlement of a class action lawsuit regarding minimum staffing requirements in the state of California.

- (e) Losses incurred at newly opened urgent care centers, excluding rent, depreciation, interest and income taxes.  
Losses incurred through the second quarter at one newly constructed skilled nursing facility which began operations during the first quarter of 2013, excluding rent, depreciation, interest and income taxes.
- (f) The facility began running at full capacity during the third quarter of 2013, and therefore, results for the third quarter were not included in the three or nine month results above.
- (g) Costs incurred to acquire an operation which are not capitalizable.
- (h) Costs incurred to recognize income tax credits which contributed to a decrease in effective tax rate.
- (i) Rent related to newly opened urgent care centers and one newly constructed skilled nursing facility which began operations during the first quarter of 2013, not included in items (e) and (f) above.

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## Three Months Ended September 30, 2013 Compared to Three Months Ended September 30, 2012

	Three Months Ended September 30, 2013		2012		
	(Dollars in thousands)			Change	% Change
Total Facility Results:					
Revenue	\$229,261		\$206,691	\$22,570	10.9 %
Number of facilities at period end	119		107	12	11.2 %
Actual patient days	940,054		872,701	67,353	7.7 %
Occupancy percentage — Operational beds	77.4	%	78.7	%	(1.3 )%
Skilled mix by nursing days	26.0	%	25.2	%	0.8 %
Skilled mix by nursing revenue	49.7	%	49.3	%	0.4 %
	Three Months Ended September 30, 2013		2012		
	(Dollars in thousands)			Change	% Change
Same Facility Results(1):					
Revenue	\$168,484		\$167,165	\$1,319	0.8 %
Number of facilities at period end	77		77	—	— %
Actual patient days	659,373		661,001	(1,628 )	(0.2 )%
Occupancy percentage — Operational beds	80.7	%	81.0	%	(0.3 )%
Skilled mix by nursing days	27.9	%	26.9	%	1.0 %
Skilled mix by nursing revenue	52.0	%	51.4	%	0.6 %
	Three Months Ended September 30, 2013		2012		
	(Dollars in thousands)			Change	% Change
Transitioning Facility Results(2):					
Revenue	\$35,696		\$33,729	\$1,967	5.8 %
Number of facilities at period end	25		25	—	— %
Actual patient days	183,381		185,325	(1,944 )	(1.0 )%
Occupancy percentage — Operational beds	74.2	%	74.9	%	(0.7 )%
Skilled mix by nursing days	19.8	%	17.8	%	2.0 %
Skilled mix by nursing revenue	41.3	%	38.6	%	2.7 %
	Three Months Ended September 30, 2013		2012		
	(Dollars in thousands)			Change	% Change
Recently Acquired Facility Results(3):					
Revenue	\$25,081		\$5,797	\$19,284	NM
Number of facilities at period end	17		5	12	NM
Actual patient days	97,300		26,375	70,925	NM
Occupancy percentage — Operational beds	64.5	%	58.1	%	NM
Skilled mix by nursing days	18.6	%	10.6	%	NM
Skilled mix by nursing revenue	38.5	%	22.1	%	NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2010.

(2)

Transitioning Facility results represents all facilities purchased from January 1, 2010 to December 31, 2011.

(3) Recently Acquired Facility (or “Acquisitions”) results represent all facilities purchased on or subsequent to January 1, 2012.

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Revenue. Revenue increased \$22.6 million, or 10.9%, to \$229.3 million for the three months ended September 30, 2013 compared to \$206.7 million for the three months ended September 30, 2012. Of the \$22.6 million increase, Medicare and managed care revenue increased \$9.1 million, or 9.6%, Medicaid custodial revenue increased \$5.1 million, or 6.6%, private and other revenue increased \$7.4 million, or 26.6% and Medicaid skilled revenue increased \$1.0 million, or 12.4%. Revenue generated by Recently Acquired Facilities increased by approximately \$19.3 million. Since January 1, 2012, the Company has acquired seventeen facilities, five home health and four hospice operations in seven states.

Revenue generated by Same Facilities increased \$1.3 million, or 0.8%, for the three months ended September 30, 2013 compared to the three months ended September 30, 2012. This increase was primarily due to an increase in managed care days of 14.7% during the three months ended September 30, 2013 as compared to the three months ended September 30, 2012. This increase was partially offset by a decrease in Medicare days of 5.8% during the three months ended September 30, 2013 as compared to the three months ended September 30, 2012.

Revenue at Transitioning Facilities increased by \$2.0 million, or 5.8% for the three months ended September 30, 2013 as compared to the three months ended September 30, 2012. This increase was due to increases in Medicare days of 7.2% and Medicare revenue per patient day of 1.7% for the three months ended September 30, 2013 as compared to the three months ended September 30, 2012.

Further, these increases were achieved despite a net Medicare per patient day payment reduction of 0.2%, comprised of a 1.8% market basket increase announced by the Centers of Medicare and Medicaid Services (CMS) in July 2012, which went into effect in October 2012, offset by a 2% sequestration reduction, which went into effect on April 1, 2013. The increases in Medicare revenue per patient day at Same and Transitioning Facilities of 0.1% and 1.7%, respectively, were primarily due to the continuous shift towards higher acuity residents and variations in the impact of the market basket increase on revenue per patient day.

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

	Three Months Ended September 30,									
	Same Facility 2013	2012	Transitioning 2013	2012	Acquisitions 2013	2012	Total 2013	2012	% Change	
Skilled Nursing Average Daily Revenue Rates:										
Medicare	\$554.78	\$554.00	\$473.35	\$465.28	\$450.37	\$415.79	\$535.03	\$539.13	(0.8)	)%
Managed care	404.51	396.32	366.67	394.36	463.79	363.10	406.35	396.17	2.6	%
Other skilled	467.02	458.30	690.75	567.72	—	—	471.27	459.89	2.5	%
Total skilled revenue	489.36	491.74	458.25	454.50	455.23	413.86	484.01	487.11	(0.6)	)%
Medicaid	172.77	168.83	158.44	150.99	169.73	175.01	170.81	166.74	2.4	%
Private and other payors	188.48	187.80	165.59	167.87	156.71	165.17	178.62	180.75	(1.2)	)%
Total skilled nursing revenue	\$262.87	\$257.77	\$219.83	\$209.98	\$220.74	\$198.88	\$253.35	\$249.38	1.6	%

Medicare daily rates decreased by 0.8%, primarily due to a net Medicare per patient day payment reduction of 0.2%, comprised of a 1.8% market basket increase announced by the Centers of Medicare and Medicaid Services (CMS) in July 2012, which went into effect in October 2012, offset by a 2% sequestration reduction, which went into effect on April 1, 2013. In addition, historically, we have generally experienced lower occupancy rates, lower skilled mix and

quality mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth. Accordingly, the overall average Medicare daily rate decreased by 0.8% for the three months ended September 30, 2013 as compared to the three months ended September 30, 2012 as a result of the impact of lower acuity levels at Transitioning and Recently Acqui