ENSIGN GROUP, INC
Form 10-Q
August 09, 2010

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

FORM 10-Q

þ **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934.**
For the quarterly period ended June 30, 2010.

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

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

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

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

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. þ Yes o No
Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). o Yes o No
Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, or a smaller reporting company. See the definitions of large accelerated filer , accelerated filer and smaller reporting company in Rule 12b-2 of the Exchange Act. (Check one):

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

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). o Yes þ No
As of July 31, 2010, 20,751,734 shares of the registrant s common stock were outstanding.

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE SIX MONTHS ENDED JUNE 30, 2010
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Part I. Financial Information

Item 1. ***Financial Statements***

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

	June 30, 2010	December 31, 2009
Assets		
Current assets:		
Cash and cash equivalents	$ 26,353	$ 38,855
Accounts receivable less allowance for doubtful accounts of $8,095 and $7,575 at June 30, 2010 and December 31, 2009, respectively	72,678	62,606
Prepaid income taxes	1,245	1,242
Prepaid expenses and other current assets	6,695	6,498
Deferred tax asset current	8,868	8,126
Total current assets	115,839	117,327
Property and equipment, net	251,320	230,774
Insurance subsidiary deposits and investments	15,397	13,810
Escrow deposits		7,595
Deferred tax asset	6,659	4,262
Restricted and other assets	6,036	5,650
Intangible assets, net	4,288	4,498
Goodwill	10,524	7,432
Other indefinite-lived intangibles	672	
Total assets	$ 410,735	$ 391,348
Liabilities and stockholders equity		
Current liabilities:		
Accounts payable	$ 16,267	$ 15,498
Accrued wages and related liabilities	27,538	28,756
Accrued self-insurance liabilities current	10,500	10,074
Other accrued liabilities	13,442	15,375
Current maturities of long-term debt	2,125	2,065
Total current liabilities	69,872	71,768
Long-term debt less current maturities	106,363	107,401
Accrued self-insurance liabilities less current portion	25,059	22,096
Deferred rent and other long-term liabilities	2,897	2,524
Commitments and contingencies (Note 14)		
Stockholders equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 21,360 and 20,748 shares issued and outstanding at June 30, 2010, respectively, and 21,280 and 20,642 shares issued and outstanding at December 31, 2009, respectively	21	21

	June 30, 2010	December 31, 2009
Additional paid-in capital	68,699	66,765
Retained earnings	141,802	124,910
Common stock in treasury, at cost, 612 and 638 shares at June 30, 2010 and December 31, 2009, respectively	(3,978)	(4,137)
Total stockholders equity	206,544	187,559
Total liabilities and stockholders equity	$ 410,735	$ 391,348

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	**2009**	**2010**	**2009**
Revenue	$ 157,948	$ 132,178	$ 312,122	$ 262,463
Expense:				
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	125,808	105,290	248,991	209,489
Facility rent cost of services	3,616	3,724	7,191	7,425
General and administrative expense	6,407	5,417	12,181	10,378
Depreciation and amortization	4,023	3,209	7,978	6,174
Total expenses	139,854	117,640	276,341	233,466
Income from operations	18,094	14,538	35,781	28,997
Other income (expense):				
Interest expense	(2,308)	(1,141)	(4,588)	(2,469)
Interest income	63	69	130	139
Other expense, net	(2,245)	(1,072)	(4,458)	(2,330)
Income before provision for income taxes	15,849	13,466	31,323	26,667
Provision for income taxes	6,230	5,282	12,356	10,560
Net income	$ 9,619	$ 8,184	$ 18,967	$ 16,107
Net income per share:				
Basic	$ 0.46	$ 0.40	$ 0.92	$ 0.78
Diluted	$ 0.46	$ 0.39	$ 0.90	$ 0.77
Weighted average common shares outstanding:				
Basic	20,741	20,586	20,713	20,579
Diluted	21,126	20,874	21,103	20,883

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
	2010	**2009**
Cash flows from operating activities:		
Net income	$ 18,967	16,107
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	7,978	6,174
Amortization of deferred financing fees and debt discount	327	58
Deferred income taxes	(3,140)	(1,242)
Provision for doubtful accounts	2,948	2,030
Stock-based compensation	1,266	992
Excess tax benefit from share based compensation	(357)	(65)
Impairment of software development costs	297	
Loss on disposition of property and equipment	22	64
Change in operating assets and liabilities		
Accounts receivable	(13,020)	(6,386)
Prepaid expenses and other current assets	(200)	(1,097)
Insurance subsidiary deposits and investments	(1,587)	(1,052)
Accounts payable	769	1,657
Accrued wages and related liabilities	(1,218)	(1,758)
Other accrued liabilities	(1,641)	597
Accrued self-insurance	3,389	2,788
Deferred rent liability	103	(167)
Net cash provided by operating activities	14,903	18,700
Cash flows from investing activities:		
Purchase of property and equipment	(13,753)	(11,671)
Cash payment for business acquisitions	(18,809)	(22,133)
Escrow deposits used to fund business acquisitions	7,595	10,090
Cash proceeds from the sale of fixed assets	58	
Restricted and other assets	(244)	(358)
Net cash used in investing activities	(25,153)	(24,072)
Cash flows from financing activities:		
Payments on long term debt	(1,039)	(534)
Issuance of treasury stock upon exercise of options	159	40
Issuance of common stock upon exercise of options	348	104
Dividends paid	(2,069)	(1,852)
Principal payments on capital lease obligations		(13)

Excess tax benefit from share based compensation		357	65
Payments of deferred financing costs		(8)	(77)
Net cash used in financing activities		(2,252)	(2,267)
Net decrease in cash and cash equivalents		(12,502)	(7,639)
Cash and cash equivalents beginning of period		38,855	41,326
Cash and cash equivalents end of period	$	26,353	33,687
Supplemental disclosures of cash flow information:			
Cash paid during the period for:			
Interest	$	4,526	2,557
Income taxes	$	14,050	12,200

See accompanying notes to condensed consolidated financial statements.

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 81 facilities and two home health and hospice operations as of June 30, 2010, located in California, Arizona, Texas, Washington, Utah, Colorado and Idaho. All of these facilities are skilled nursing facilities, other than three stand-alone assisted living facilities in Arizona, Texas and Colorado and five campuses that offer both skilled nursing and assisted living services located in California, Arizona and Utah. The Company s facilities, each of which strives to be the facility of choice in the community it serves, provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. The Company s facilities have a collective capacity of approximately 9,300 operational skilled nursing, assisted living and independent living beds. As of June 30, 2010, the Company owned 51 of its 81 facilities and operated an additional 30 facilities through long-term lease arrangements, and had options to purchase 8 of those 30 facilities.

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

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

Other Information The accompanying condensed consolidated financial statements as of June 30, 2010 and for the three and six month periods ended June 30, 2010 and 2009 (collectively, the Interim Financial Statements), are unaudited. Certain information and footnote disclosures normally included in annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company s audited consolidated statements and notes thereto for the year ended December 31, 2009 which are included in the Company s annual report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (the SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company s financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation The accompanying 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. All intercompany transactions and balances have been eliminated in consolidation.

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 Interim Financial Statements relate to revenue, allowance for doubtful accounts, intangible assets and goodwill, impairment of long-lived assets, patient liability, general and professional liability, worker s compensation, and healthcare claims included in accrued self-insurance liabilities, stock-based compensation and income taxes. Actual results could differ from those estimates.

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

Business Segments The Company has a single reportable segment long-term care services, which includes the operation of skilled nursing and assisted living facilities, and related ancillary services. 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 reporting segment.

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

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

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 Recognition

Medicare Revenue Net service revenue is recorded under the Medicare payment program (PPS) based on a 60-day episode payment rate. The Company makes adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The Company records an estimate for the impact of such payment adjustments based on its historical experience. In addition to revenue recognized on completed episodes, the Company also recognizes a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. The Company estimates this revenue on a monthly basis based upon historical trends. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and our estimate of the average percentage complete based on visits performed.

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

Non-Medicare Revenue Non-episodic Based Revenue. Gross 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. Contractual adjustments are recorded for the difference between the Company s standard rates and the contracted rates to be realized from patients, third parties and others for services provided and are deducted from gross revenue to determine net service revenue and are also recorded as a reduction to our outstanding patient accounts receivable. In addition, the Company receives a minimal amount of its net service revenue from patients who are either self-insured or are obligated for an insurance co-payment.

Hospice Revenue Recognition

Hospice Medicare Revenue Gross 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 or hourly rates for each of the levels of care we deliver. The Company makes adjustments to Medicare revenue for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The Company estimates the impact of these adjustments based on its historical experience, which primarily includes historical collection rates on Medicare claims, and records it during the period services are rendered as an estimated revenue adjustment and as a reduction to our outstanding patient accounts receivable. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, the Company monitors its provider numbers and estimate 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.

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

Hospice Non-Medicare Revenue The Company records gross revenue on an accrual basis based upon the date of service at amounts equal to its established rates or estimated per visit rates, as applicable. Contractual adjustments are recorded for the difference between the Company s established rates and the amounts estimated to be realizable from patients, third parties and others for services provided and are deducted from gross revenue to determine our net service revenue and patient accounts receivable.

Revenue from the Medicare and Medicaid programs accounted for approximately 76% of the Company s revenue for both periods during the three and six months ended June 30, 2010 and 75% for both periods during the three and six months ended June 30, 2009. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company s revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlements. The Company recorded retroactive adjustments that increased (decreased) revenue by $(561) and $(241) for the three and six months ended June 30, 2010, respectively, and $57 and $465 for the three and six months ended June 30, 2009, respectively. The decrease in revenue from retroactive revenue adjustments in 2010 is attributable to the item disclosed in FN 14.

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

In evaluating the 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. The percentages applied to the aged receivable balances are based on the Company s historical experience and time limits, if any, for managed care, Medicare and Medicaid. The Company periodically refines its procedures for estimating the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances.

Property and Equipment Property and equipment are initially recorded at their historical cost. Repairs and maintenance are expensed as incurred. Depreciation is computed using the straight-line method over the estimated useful lives of the depreciable assets (ranging from three to 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 impairment during the six months ended June 30, 2010 or 2009.

Intangible Assets and Goodwill Intangible assets consist primarily of favorable lease, lease acquisition costs, patient base, trade names and other indefinite-lived intangibles. 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 three 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.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit below its carrying amount. The Company defines reporting units as the individual facilities. The Company performs its annual test for

impairment during the fourth quarter of each year. The Company did not record any impairment charges during the six months ended June 30, 2010 or the year ended December 31, 2009.

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

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, 2010, the combined self-insured retention was $500 per claim with an aggregate $1,736 deductible limit. As of April 1, 2009, for all facilities except those located in Colorado, the third-party coverage above these limits was $1,000 per occurrence, $3,000 per facility, with a $10,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1,000 per occurrence and $3,000 per facility, which is independent of the $10,000 blanket aggregate applicable to our other 77 facilities.

The self-insured retention and deductible limits for general and professional liability and worker s compensation are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying Interim Financial Statements. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. The Company s policy is to accrue amounts equal to the actuarially estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. Accrued general liability and professional malpractice liabilities recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets were $24,556 and $22,279 as of June 30, 2010 and December 31, 2009, respectively.

The Company s operating subsidiaries are self-insured for workers compensation liability in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $500 for each claim. In Texas, the operating subsidiaries have elected non-subscriber status for workers compensation claims. The Company s operating subsidiaries in other states have third party guaranteed cost coverage. In California and Texas, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $8,575 and $7,624 as of June 30, 2010 and December 31, 2009, respectively.

The Company provides self-insured medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $250 for each covered person and an aggregate individual stop loss deductible of $75, which resets every plan year or a lifetime maximum of $5,000 per each covered person s lifetime on the PPO and EPO plans. The aforementioned coverage only applies to claims paid during the plan year. The Company s accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $2,428 and $2,267 at June 30, 2010 and December 31, 2009, respectively.

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

The self-insured liabilities are based upon estimates, and while management believes that the estimates of loss are reasonable, the ultimate liability may be in excess of or less than the recorded amounts. Due to the inherent volatility of actuarially determined loss estimates, it is reasonably possible that the Company could experience changes in estimated losses that could be material to net income. If the Company s actual liability exceeds its estimates of loss, its future earnings and financial condition would be adversely affected.

Income Taxes Deferred tax assets and liabilities are established for temporary differences between the financial reporting basis and the tax basis of the Company s assets and liabilities at tax rates in effect when such temporary differences are expected to reverse. The 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.

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

The provision for income taxes is determined by applying the estimated annual effective tax rate to pretax income, adjusted for discrete transactions occurring during the period. In determining the annual income tax rate for financial statements for interim periods, 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, it records a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, the Company must consider the potential outcomes from a review of the positions by the taxing authorities.

In determining the need for a valuation allowance, 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.

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 on and subsequent to January 1, 2006, the amount of which is contingent upon the number of future grants and other variables.

Adoption of New Accounting Pronouncements In February 2010, the FASB issued amendments to address certain implementation issues related to an entity s requirement to perform and disclose subsequent events procedures. The amendment requires (1) SEC filers and (2) conduit debt obligors for conduit debt securities that are traded in a public market to evaluate subsequent events through the date the financial statements are issued. All other entities are required to evaluate subsequent events through the date the financial statements are available to be issued. It further exempts SEC filers from disclosing the date through which subsequent events have been evaluated. For all entities (except conduit debt obligors), these requirements are effective immediately for financial statements that are (1) issued or available to be issued or (2) revised. For conduit debt obligors, the requirements are effective for interim and annual periods ending after June 15, 2010. The adoption of these requirements during the quarter ended June 30, 2010, did not have an impact on the Company s Interim Financial Statements.

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

3. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing net income attributable to common shares by the weighted average number of outstanding common shares for the period. The computation of diluted net income per share is similar to the computation of basic net income per share except that the denominator is increased to include contingently returnable shares and the number of additional common shares that would have been outstanding if the dilutive potential common shares had been issued.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Numerator:				
Net income	$ 9,619	$ 8,184	$ 18,967	$ 16,107
Denominator:				
Weighted average shares outstanding for basic net income per share	20,741	20,586	20,713	20,579
Basic net income per common share	$ 0.46	$ 0.40	$ 0.92	$ 0.78

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Numerator:				
Net income	$ 9,619	$ 8,184	$ 18,967	$ 16,107
Denominator:				
Weighted average common shares outstanding	20,741	20,586	20,713	20,579
Plus: incremental shares from assumed conversion (1)	385	288	390	304
Adjusted weighted average common shares outstanding	21,126	20,874	21,103	20,883
Diluted net income per common share	$ 0.46	$ 0.39	$ 0.90	$ 0.77

(1) In addition, as of June 30, 2010 and 2009, the Company had 785 and 627, respectively,

options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above.

4. INSURANCE SUBSIDIARY DEPOSITS AND INVESTMENTS

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

At June 30, 2010, the Company had approximately $12,050 in debt security investments, which are held to maturity and carried at amortized cost. The fair value of the investments is determined based on Level 1 inputs, which consist of unadjusted quoted prices in active markets that are accessible at the measurement date for identical, unrestricted assets. The carrying value of the debt securities approximates fair value.

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

5. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three and six months ended June 30, 2010 and 2009 is summarized in the following tables:

	Three Months Ended June 30,			
	2010		2009	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$ 64,002	40.5%	$ 53,603	40.6%
Medicare	50,589	32.1	43,156	32.7
Medicaid skilled	4,624	2.9	2,705	2.0
Total Medicaid and Medicare	119,215	75.5	99,464	75.3
Managed care	20,222	12.8	17,182	13.0
Private and other payors	18,511	11.7	15,532	11.7
Revenue	$ 157,948	100.0%	$ 132,178	100.0%

	Six Months Ended June 30,			
	2010		2009	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$ 125,656	40.3%	$ 105,839	40.3%
Medicare	101,711	32.6	86,362	32.9
Medicaid skilled	9,041	2.9	4,988	1.9
Total Medicaid and Medicare	236,408	75.8	197,189	75.1
Managed care	40,791	13.0	34,679	13.2
Private and other payors	34,923	11.2	30,595	11.7
Revenue	$ 312,122	100.0%	$ 262,463	100.0%

Accounts receivable as of June 30, 2010 and December 31, 2009 is summarized in the following table:

	June 30, 2010	December 31, 2009
Medicaid	$ 29,413	$ 23,902
Managed care	20,661	17,919
Medicare	19,237	17,481
Private and other payors	11,462	10,879
	80,773	70,181
Less allowance for doubtful accounts	(8,095)	(7,575)
Accounts receivable	$ 72,678	$ 62,606

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

6. ACQUISITIONS

The Company s acquisition policy is generally to purchase or lease facilities to complement the Company s existing portfolio of long-term care facilities. The 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 six months ended June 30, 2010, the Company acquired four skilled nursing facilities and one home health and hospice operation. The aggregate purchase price of the five acquisitions was approximately $18,809, which was paid in cash. The facilities acquired during the six months ended June 30, 2010 are as follows:

On January 1, 2010, the Company purchased two skilled nursing facilities in Idaho for $7,617, which was paid in cash. These acquisitions added 158 operational skilled nursing beds to the Company s operations. The Company also entered into a separate operations transfer agreement with the prior owner as a part of this transaction.

On May 1, 2010, the Company purchased two skilled nursing facilities in Texas for approximately $8,491, which was paid in cash. This acquisition added approximately 277 operational skilled nursing beds to the Company s operations. The Company also entered into a separate operations transfer agreement with the prior owner as part of this transaction. Approximately $1,542 was recognized in goodwill as a part of this transaction.

On May 1, 2010, the Company purchased a home health and hospice operation in Idaho for approximately $2,701, which was paid in cash. The acquisition did not have an impact on the Company s operational bed count. The Company also entered into a separate operations transfer agreement with the prior owner as part of this transaction. Approximately $1,550 and $672 was recognized as goodwill and other indefinite lived intangibles, respectively, as a part of this transaction.

The Company expensed $93 in acquisition related costs during the six months ended June 30, 2010.

The table below presents the allocation of the purchase price for the facilities acquired in business combinations during the six months ended June 30, 2010 and 2009:

	June 30, 2010	June 30, 2009
Land	$ 2,709	$ 3,485
Building and improvements	11,029	13,101
Equipment, furniture, and fixtures	1,003	675
Goodwill	3,092	2,887
Other indefinite-lived intangible assets	672	
Other intangible assets	304	1,985
	$ 18,809	$ 22,133

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

its newly acquired facilities. The five businesses acquired during the six months ended June 30, 2010 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the June 30, 2010 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.

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

7. PROPERTY AND EQUIPMENT

Property and equipment consist of the following:

	June 30, 2010	December 31, 2009
Land	$ 46,330	$ 43,621
Buildings and improvements	173,068	158,803
Equipment	41,991	35,136
Furniture and fixtures	8,426	8,301
Leasehold improvements	20,774	17,978
Construction in progress	4,282	3,036
	294,871	266,875
Less accumulated depreciation	(43,551)	(36,101)
Property and equipment, net	$ 251,320	$ 230,774

8. INTANGIBLE ASSETS Net

	Weighted	June 30, 2010			December 31, 2009		
Intangible Assets	Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	15.5	$ 910	$ (562)	$ 348	$ 1,071	$ (694)	$ 377
Favorable lease	20.0	3,573	(378)	3,195	3,573	(274)	3,299
Patient base	0.6	738	(616)	122	1,202	(1,015)	187
Trade name	30.0	733	(110)	623	733	(98)	635
Total		$ 5,954	$ (1,666)	$ 4,288	$ 6,579	$ (2,081)	$ 4,498

Amortization expense was $186 and $514 for the three and six months ended June 30, 2010 and $227 and $524 for the three and six months ended June 30, 2009, respectively. Of the $514 in amortization expense incurred during the six months ended June 30, 2010, approximately $369 related to the amortization of patient base intangible assets at recently acquired facilities, which is typically amortized over a period of three 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
2010 (remainder)	$ 252
2011	308
2012	291
2013	291
2014	291
2015	268
Thereafter	2,587
	$ 4,288

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

9. RESTRICTED AND OTHER ASSETS

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

	June 30, 2010	December 31, 2009
Deposits with landlords	$ 732	$ 725
Capital improvement reserves with landlords and lenders	3,078	2,840
Debt issuance costs, net	2,226	2,085
Restricted and other assets	$ 6,036	$ 5,650

10. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	June 30, 2010	December 31, 2009
Quality assurance fee	$ 1,180	$ 5,071
Resident refunds payable	2,705	2,347
Deferred resident revenue	1,161	1,073
Cash held in trust for residents	1,492	1,748
Dividends payable	1,040	1,032
Property taxes	1,140	1,194
Income taxes payable	1,203	
Other	3,521	2,910
Other accrued liabilities	$ 13,442	$ 15,375

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

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

11. INCOME TAXES

The provision for income taxes for the six months ended June 30, 2010 and 2009 is summarized as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Current:				
Federal	$ 7,459	$ 6,267	$ 13,230	$ 9,702
State	1,196	1,161	2,266	2,030
	8,655	7,428	15,496	11,732
Deferred:				
Federal	(2,238)	(1,786)	(2,805)	(795)
State	(187)	(430)	(335)	(447)
	(2,425)	(2,216)	(3,140)	(1,242)
Expense for uncertain tax positions		70		70
Total	$ 6,230	$ 5,282	$ 12,356	$ 10,560

The Company s deferred tax assets and liabilities as of June 30, 2010 and December 31, 2009 are summarized as follows:

	June 30, 2010	December 31, 2009
Deferred tax assets (liabilities):		
Accrued expenses	$ 15,723	$ 12,498
Allowance for doubtful accounts	3,383	3,166
State taxes		324
Tax credits	1,161	1,180
Total deferred tax assets	20,267	17,168
State taxes	(276)	
Depreciation and amortization	(2,938)	(3,293)
Prepaid expenses	(1,525)	(1,487)
Total deferred tax liabilities	(4,739)	(4,780)
Net deferred tax assets	$ 15,528	$ 12,388

The Company is not currently under examination by any major income tax jurisdiction; however, its Federal tax returns for years beginning with 2006 and many of its state tax returns for years beginning with 2005 remain subject to potential examination. The statutes of limitations will lapse on the Company s 2005 and 2006 income tax years for state and Federal purposes in 2010, respectively. The Company does not believe these lapses will significantly impact

unrecognized tax benefits for any uncertain tax positions. The Company is not aware of any other event that might significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the six months ended June 30, 2010 or 2009.

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

12. Debt

On November 6, 2009, the Company finalized the Fourth Amended and Restated Loan Agreement (Amended Term Loan) with General Electric Capital Corporation (the Lender) which increased the borrowing capacity of the Amended Term Loan by $40,000, further referred to as the Six Project Loan. The Six Project Loan (as described below) will mature on September 30, 2014 and is secured by, among other things, a perfected first priority mortgage/deed of trust on the fee simple interest in six of the Company s skilled nursing facilities (the Property). The Amended Term Loan, which includes both the Ten Project Note (as described below) and the Six Project Loan, is cross collateralized and cross defaulted with the existing Second Amended and Restated Loan and Security Agreement (the Revolver). The interest rate on the loan is calculated at the current five year swap rate on the date of closing plus 585 basis points for half of the loan balance and the three year swap rate on the date of closing plus 585 basis points and therefore floating at 90-day LIBOR plus 575 basis points, reset monthly and subject to a LIBOR floor of 2.0% for the remaining half of the loan balance. The Amended Term Loan did not modify any of the existing terms of the Ten Project Note.

On October 1, 2009, four subsidiaries of The Ensign Group, Inc. entered into four separate promissory notes with Johnson Land Enterprises, LLC (the Seller), for an aggregate of $10,000, as a part of the Company s acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these notes is due on September 30, 2019. The notes bear interest at a rate of 6.0% per annum. As a part of this transaction, the Company recorded a discount to the debt balance in the form of imputed interest of $1,218. This amount will be amortized over the term of the promissory notes, or ten years.

In addition, on October 1, 2009, a subsidiary of The Ensign Group, Inc. in West Jordan, Utah assumed the obligation to pay the remaining principal and interest on bonds which were originally sold to finance the construction of the facility. These bonds were assumed as a part of the Company s acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these bonds is due on July 1, 2015. The bonds bear interest at an annual rate equal to sixty percent of the rate announced from time to time by Bank of America as its prime rate (Prime Rate), which was 2.1% on June 30, 2010.

The Company has the Revolver with the Lender under which the Company may borrow up to the lesser of $50,000 or 85% of the eligible accounts receivable. The Revolver will expire on February 21, 2013. At June 30, 2010 and December 31, 2009, there were no outstanding borrowings under the Revolver. As of June 30, 2010, the amount of borrowing capacity pledged to secure outstanding letters of credit and reserves against collateral for actual and contingent liabilities was $2,133 and $6,000, respectively. In addition, in the event of the Company s default under the Amended Term Loan, the Lender has the right to take control of the Company s facilities encumbered by the loan to the extent necessary to make such payments and perform such acts that are required under the loan.

Long-term debt consists of the following:

	June 30, 2010	December 31, 2009
Ten Project Note with the Lender, multiple-advance term loan, principal and interest payable monthly; interest is fixed at time of draw at 10-year treasury note rate plus 2.25% (rates in effect at June 30, 2010 range from 6.95% to 7.50%), balance due June 2016, collateralized by deeds of trust on real property, assignments of rents, security agreements and fixture financing statements.	$ 52,718	$ 53,200
Six Project Loan with the Lender, principal and interest payable monthly, interest defined above, balance due September 30, 2014, collateralized by deeds of trust on real property, assignments of rents, security agreements and fixture financing statements.	39,733	39,970
Promissory notes, principal, and interest of $69 payable monthly and continuing through September 2019, interest at fixed rate of 6.0%,	9,845	9,962

collateralized by deed of trust on real property, assignment of rents and security agreement.				
Bond, principal and interest of $20 payable monthly and continuing through July 2015, interest at a fixed rate of 60% of the Prime Rate (as defined by the agreement).		1,137		1,232
Mortgage note, principal, and interest of $54 payable monthly and continuing through February 2027, interest at fixed rate of 7.5%, collateralized by deed of trust on real property, assignment of rents and security agreement.		6,182		6,290
		109,615		110,654
Less current maturities		(2,125)		(2,065)
Less debt discount		(1,127)		(1,188)
	$	106,363	$	107,401

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

The Company is subject to standard reporting requirements and other typical covenants for loans of these types. As of June 30, 2010, the Company was in compliance with such loan covenants.

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

13. 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. Stock-based compensation expense recognized in the Company s condensed consolidated statements of income for the six months ended June 30, 2010 and 2009 does not include compensation expense for share-based payment awards granted prior to, but not yet vested as of, January 1, 2006, but does include compensation expense for the share-based payment awards granted on or subsequent to January 1, 2006 based on the grant date fair value. As stock-based compensation expense recognized in the Company s condensed consolidated statements of income for the six months ended June 30, 2010 and 2009 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.

The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan) all of which have been approved by the stockholders. In the 2001 Plan and the 2005 Plan, options may be exercised for unvested shares of common stock, which have full stockholder rights including voting, dividend and liquidation rights. The Company retains the right to repurchase any or all unvested shares at the exercise price paid per share of any or all unvested shares should the optionee cease to remain in service while holding such unvested shares. The total number of shares available under all of the Company s stock incentive plans was 1,351 as of June 30, 2010.

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 113 options during the six month period ended June 30, 2010. The Company used the following assumptions for stock options granted during the six months ended June 30, 2010 and 2009:

Grant Year	Plan	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2010	2007	113	2.36 2.82%	6.5 years	55%	1.08%
2009	2007	306	2.17 2.39%	6.5 years	55%	1.08%

The Company used the following assumptions for stock options granted during the three months ended June 30, 2010 and 2009:

Grant Year	Plan	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2010	2007	7	2.36%	6.5 years	55%	1.08%
2009	2007	137	2.36 2.39%	6.5 years	55%	1.08%

In addition to the above, on May 25, 2010, the Company granted 36 restricted stock awards at an exercise price of $0 which vest over five years. The fair value of restricted stock awards was $18.03 at the grant date. As of June 30, 2010,

no restricted stock awards had vested or been forfeited. The Company had not previously granted restricted stock awards.

For the six months ended June 30, 2010 and 2009, the following represents the Company s weighted average exercise price, grant date intrinsic value and fair value displayed at grant date:

Grant Year	Granted	Weighted Average Exercise Price of Common Stock	Weighted Average Fair Value of Options
2010	113	$ 17.51	$ 8.87
2009	306	$ 16.14	$ 8.05

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

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended June 30, 2010 and 2009 and therefore, the intrinsic value was $0.

The following table represents the employee stock option activity during the six months ended June 30, 2010:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2010	2,025	$ 10.68	709	$ 7.29
Granted	113	17.51		
Forfeited	(72)	10.57		
Exercised	(100)	5.07		
June 30, 2010	1,966	$ 11.36	739	$ 8.68

The following summary information reflects stock options outstanding, vested and related details as of June 30, 2010:

	Stock Options Outstanding					Stock Options Vested
Year of Grant	**Exercise Price**		**Number Outstanding**	**Black-Scholes Fair Value**	**Remaining Contractual Life (Years)**	**Number Vested and Exercisable**
2003	$ 0.67	0.81	9	$ *	3	9
2004	$ 1.96	2.46	38	*	4	38
2005	$ 4.99	5.75	199	*	5	155
2006	$ 7.05	7.50	444	4,256	6	254
2008	$ 9.38	14.87	685	3,682	8	228
2009	$ 14.92	16.70	478	3,779	9	55
2010	$ 17.47	18.03	113	1,004	10	
Total			1,966	$ 12,721		739

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

awards are
modified.

Total share-based compensation expense recognized for the three and six months ended June 30, 2010 and 2009 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Share-based compensation expense related to stock options	$ 607	$ 476	$ 1,256	$ 992
Share-based compensation expense related to restricted stock awards	10		10	
Total	$ 617	$ 476	$ 1,266	$ 992

In future periods, the Company expects to recognize approximately $7,402 in stock-based compensation expense over the next 3.2 weighted average years for unvested options that were outstanding as of June 30, 2010. There were 1,227 unvested and outstanding options at June 30, 2010, of which 1,121 are expected to vest. The weighted average contractual life for options vested at June 30, 2010 was 7.4 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of June 30, 2010 and December 31, 2009 is as follows:

Options	**June 30, 2010**	**December 31, 2009**
Outstanding	$ 10,273	$ 9,779
Vested	5,799	5,732
Expected to vest	3,968	3,806
Exercised	4,578	625

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

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

14. COMMITMENTS AND CONTINGENCIES

Leases The Company leases certain facilities and its administrative offices under non-cancelable operating leases, 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 $3,715 and $7,385 for the three and six months ended June 30, 2010, respectively, and $3,839 and $7,656 for the three and six months ended June 30, 2009, 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 June 30, 2010.

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. Although the Company is not aware of any significant future rate changes, significant changes to the reimbursement rates could have a material effect on the Company s operations.

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

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

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.

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

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.

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

Medicare Revenue Recoupments The Company is subject to reviews relating to Medicare services, billings and potential overpayments. The Company had two operations subject to probe review during the six months ended June 30, 2010. 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.

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

On December 17, 2007, the Company was informed by Deloitte & Touche LLP, its independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of its operating subsidiaries. The subpoena confirmed the Company s previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of the Company s operating subsidiaries. All together, the March 2007 authorized investigative demand and the

December 2007 subpoena specifically covered information from a total of 18 of the Company s 81 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. Based on these events, the Company believes that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group, Inc. and one or more of its skilled nursing facilities.

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

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

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

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

As a byproduct of its investigation, the Company identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. The Company, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, the Company treated the claims as overpayments. Consistent with healthcare industry accounting practices, the Company records any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

From time to time our systems and controls highlight potential compliance issues, which the Company investigates as they arise. As a result of the detection by management at one of the Company s facilities, and its Service Center support personnel, of possible recordkeeping and related irregularities at that facility, the Company initiated an internal inquiry in the second quarter of 2010.

The Company concluded the investigatory phase of this inquiry in the third quarter of 2010, and commenced a billing review of potentially affected claims. The Company made observations at the facility regarding areas of potential improvement in some of its historical recordkeeping and billing practices and have identified measures, some of which had already been implemented before the inquiry began, that the Company believes have strengthened, and can strengthen further, its recordkeeping and billing processes. The issues detected appear to be isolated to one facility and one department within that facility. The Company continues to evaluate the measures it has implemented for effectiveness, and are continuing to seek ways to improve these processes.

As a result of its billing reviews, the Company identified a limited number of selected Medicare claims for which adequate backup documentation could not be located, or for which other billing deficiencies existed. Where accepted procedures and necessary data for reviewing and calculating potential overpayments were available, the Company followed such procedures and completed a billing review. Where such procedures and/or data were not available the Company developed a methodology for making a good faith estimate of potential overpayments with the assistance of independent consultants experienced in Medicare billing. The Company has accrued a liability for estimated overpayments resulting from insufficient or missing documentation or other billing deficiencies. To the extent that sufficient documentation is subsequently located, the amount the Company ultimately reimbursed will be reduced.

Consistent with healthcare industry accounting practices, the Company records any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the quarter ended June 30, 2010, the Company accrued for a revenue adjustment of approximately $553, plus interest, for the estimated overpayments described above, with a resulting impact to net income of approximately $251. At the conclusion of the Company s review it intends to submit the potential overpayment for settlement with the Medicare Fiscal Intermediary.

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 is significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company s receivables from Medicare and Medicaid payor programs accounted for approximately 60% and 59% of its total accounts receivable as of June 30, 2010 and December 31, 2009, respectively. Revenue from reimbursements under the Medicare and Medicaid programs accounted for approximately 76% of the Company s revenue for both periods during the three and six months ended June 30, 2010 and 75% for both periods during the three and six months ended June 30, 2009.

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.

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

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

This Report contains forward-looking statements, which include, but are not limited to the Company s expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities and plans and objectives of management. Forward-looking statements can often be identified by words such as anticipates, expects, intends, plans, predicts, believes, seeks, estimat should, would, could, potential, continue, ongoing, similar expressions, and variations or negatives of these w These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Therefore, our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section Risk Factors contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management s beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law. As used in this Management s Discussion and Analysis of Financial Condition and Results of Operations, the words, we, our and us refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our facilities, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of we, us, our and similar verbiage in this quarterly report is not meant to imply that any of our facilities, 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 81 facilities located in California, Arizona, Texas, Washington, Utah, Colorado and Idaho and one home health and hospice operation located in Idaho as of June 30, 2010. All of these facilities are skilled nursing facilities, other than three stand-alone assisted living facilities in Arizona, Texas and Colorado and five campuses that offer both skilled nursing and assisted living services in California, Arizona and Utah. Our facilities provide a broad spectrum of skilled nursing and assisted living services, physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. We encourage and empower our facility leaders and staff to make their facility the facility of choice in the community it serves. This means that our facility leaders and staff are generally free to discern and address the unique needs and priorities of healthcare professionals, customers and other stakeholders in the local community or market, and then work to create a superior service offering and reputation for that particular community or market to encourage prospective customers and referral sources to choose or recommend the facility. As of June 30, 2010, we owned 51 of our 81 facilities and operated an additional 30 facilities under long-term lease arrangements, and had options to purchase 8 of those 30 facilities. The following table summarizes our facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of June 30, 2010:

	Leased	Leased

	Owned	(with a Purchase Option)	(without a Purchase Option)	Total
Number of facilities	51	8	22	81
Percent of total	63.0%	9.9%	27.1%	100%
Operational skilled nursing, assisted living and independent living beds	5,686	1,042	2,616	9,344
Percent of total	60.9%	11.1%	28.0%	100%

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

Recent Developments

On January 1, 2010, we purchased two skilled nursing facilities in Idaho for approximately $7.6 million, which was paid in cash. This acquisition added 158 operational beds to our operations. We also entered into a separate operations transfer agreement with the prior owner as part of this transaction.

On May 1, 2010, we purchased two skilled nursing facilities in Texas for approximately $8.5 million, which was paid in cash. This acquisition added approximately 277 operational beds to our operations. We also entered into a separate operations transfer agreement with the prior owner as part of this transaction.

On May 1, 2010, we purchased a home health and hospice operation in Idaho for approximately $2.7 million, which was paid in cash. This acquisition did not impact our total operational bed count. We also entered into a separate operations transfer agreement with the prior owner as part of this transaction.

See further discussion of facility acquisitions in Note 6 in Notes to Condensed Consolidated Financial Statements.

Facility Acquisition History

	December 31,					June 30,
	2005	2006	2007	2008	2009	2010
Cumulative number of facilities	46	57	61	63	77	81
Cumulative number of operational skilled nursing, assisted living and independent living beds	5,585	6,667	7,105	7,324	8,948	9,344

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of June 30, 2010:

	CA	AZ	TX	UT	CO	WA	ID	Total
Number of facilities	33	12	17	9	4	3	3	81
Operational skilled nursing, assisted living and independent living beds	3,702	1,815	2,088	967	248	278	246	9,344

Key Performance Indicators

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

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

Skilled revenue: The amount of routine revenue generated from patients in our skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement

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

Skilled mix: The amount of our skilled revenue as a percentage of our total routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving services at our skilled nursing facilities divided by the total number of days patients (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 June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Skilled Mix:				
Days	24.8%	24.3%	25.4%	24.8%
Revenue	48.2%	48.0%	49.0%	48.3%
Quality Mix:				
Days	36.8%	36.8%	37.2%	37.4%
Revenue	57.3%	57.5%	57.8%	57.8%

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 June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Occupancy:				
Operational beds at end of period	9,344	7,986	9,344	7,986
Available patient days	841,994	726,636	1,658,834	1,436,636
Actual patient days	667,858	576,738	1,316,942	1,143,357
Occupancy percentage (based on operational beds)	79.3%	79.4%	79.4%	79.6%

Revenue Sources

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

	Three Months Ended June 30,				Six Months Ended June 30,			
	2010		2009		2010		2009	
	$	%	$	%	$	%	$	%
Revenue:								
Medicaid	$ 64,002	40.5%	$ 53,603	40.6%	$ 125,656	40.3%	$ 105,839	40.3%
Medicare	50,589	32.1	43,156	32.7	101,711	32.6	86,362	32.9
Medicaid-skilled	4,624	2.9	2,705	2.0	9,041	2.9	4,988	1.9
Total	119,215	75.5	99,464	75.3	236,408	75.8	197,189	75.1
Managed Care	20,222	12.8	17,182	13.0	40,791	13.0	34,679	13.2
Private and Other(1)	18,511	11.7	15,532	11.7	34,923	11.2	30,595	11.7
Total revenue	$ 157,948	100.0%	$ 132,178	100.0%	$ 312,122	100.0%	$ 262,463	100.0%

(1) Includes revenue from assisted living facilities and home health and hospice operations.

Critical Accounting Policies Update

There have been no significant changes during the three month period ended June 30, 2010 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.

Industry Trends

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

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

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

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

Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to U.S. Census Bureau Interim Projections, there will be 46 million people in the United States in 2010 that are over 65 years old. The U.S. Census Bureau estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

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

The Deficit Reduction Act of 2005 (DRA) 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 as part of the Patient Protection and Affordable Care Act, which extended the exception from January 1, 2010, to December 31, 2010.

On July 16, 2010, Centers for Medicare and Medicaid Services (CMS) released its proposed rule on the fiscal year 2011 PPS reimbursement rates for skilled nursing facilities, which would result in a net increase in payments to skilled nursing facilities of 1.7%. This net increase includes a 2.3% market basket increase, partially offset by a correction of a FY 2010 forecast error which would result in a 0.6% rate reduction.

Federal Health Care Reform. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act (the Affordable Care Act), which contained several sweeping changes to America s health insurance system. Among other reforms contained in the Affordable Care Act, many Medicare providers received reductions in their market basket updates. Unlike for some other Medicare providers, the Affordable Care Act makes no reduction to the market basket update for skilled nursing facilities in fiscal years 2010 or 2011. However, under the Affordable Care Act, the skilled nursing facility market basket update will be subject to a full productivity adjustment beginning in fiscal year 2012. In addition, the Affordable Care Act enacted several reforms with respect to skilled nursing facilities and hospice organizations, including payment measures to realize significant savings of federal and state funds by deterring and prosecuting fraud and abuse in both the Medicare and Medicaid programs. While many of the provisions of the Affordable Care Act will not take effect for several years or are subject to further refinement through the promulgation of regulations, some key provisions of the Affordable Care Act are effective immediately or

within six to twelve months of the Affordable Care Act s enactment date.

Enhanced CMPs and Escrow Provisions Effective March 23, 2010, the Affordable Care Act includes expanded civil monetary penalty (CMP) provisions applicable to all Medicare and Medicaid providers. The Affordable Care Act provides 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, the Affordable Care Act imposes substantial new transparency requirements for Medicare-participating nursing facilities. Existing law requires 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. The Affordable Care Act expands 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. Beginning March 23, 2010, facilities must have this information available for submission to the Secretary of Health & Human Services, the OIG, the state in which the facility is located, and the state long-term care ombudsman upon request.

Suspension of Payments During Pending Fraud Investigations The Affordable Care Act also provides the federal government with expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud. The Affordable Care Act provides that Medicare and Medicaid payments may be suspended pending a credible investigation of fraud, unless the Secretary of Health and Human Services determines that good cause exists not to suspend payments. This suspension authority creates a new mechanism for the federal government to suspend both Medicare and Medicaid payments for allegations of fraud, independent of whether a state exercises its authority to suspend Medicaid payments pending a fraud investigation.

Overpayment Reporting and Repayment; Expanded False Claims Act Liability The Affordable Care Act also enacted several important changes that expand potential liability under the federal False Claims Act. Effective March 23, 2010, the Affordable Care Act provides 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.

The provisions of the Affordable Care Act discussed above are examples of recently-enacted 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 the Affordable Care Act. It is possible that other provisions of the Affordable Care Act 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.

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.

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Results of Operations

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Revenue	100.0%	100.0%	100.0%	100.0%
Expenses:				
Cost of services (exclusive of facility rent and depreciation and amortization shown separately below)	79.7	79.7	79.8	79.8
Facility rent cost of services	2.3	2.8	2.3	2.8
General and administrative expense	4.0	4.1	3.9	4.0
Depreciation and amortization	2.5	2.4	2.5	2.4
Total expenses	88.5	89.0	88.5	89.0
Income from operations	11.5	11.0	11.5	11.0
Other income (expense):				
Interest expense	(1.5)	(0.9)	(1.5)	(1.0)
Interest income	0.1	0.1	0.1	0.1
Other expense, net	(1.4)	(0.8)	(1.4)	(0.9)
Income before provision for income taxes	10.1	10.2	10.1	10.1
Provision for income taxes	4.0	4.0	4.0	4.0
Net income	6.1%	6.2%	6.1%	6.1%

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2010	2009	2010	2009
Consolidated Statement of Income Data:				
Net income	$ 9,619	$ 8,184	$ 18,967	$ 16,107
Interest expense, net	2,245	1,072	4,458	2,330
Provision for income taxes	6,230	5,282	12,356	10,560
Depreciation and amortization	4,023	3,209	7,978	6,174
EBITDA(1)	$ 22,117	$ 17,747	$ 43,759	$ 35,171
Facility rent cost of services	3,616	3,724	7,191	7,425
EBITDAR(1)	$ 25,733	$ 21,471	$ 50,950	$ 42,596

(1)

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

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

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

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

We use EBITDA and EBITDAR:

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

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

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

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

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

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

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Three Months Ended June 30, 2010 Compared to Three Months Ended June 30, 2009

	Three Months Ended June 30, 2010	2009	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Revenue	$ 157,948	$ 132,178	$ 25,770	19.5%
Number of facilities at period end	81	70	11	15.7%
Actual patient days	667,858	576,738	91,120	15.8%
Occupancy percentage Operational beds	79.3%	79.4%		(0.1)%
Skilled mix by nursing days	24.8%	24.3%		0.5%
Skilled mix by nursing revenue	48.2%	48.0%		0.2%

	Three Months Ended June 30, 2010	2009	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Revenue	$ 120,899	$ 116,296	$ 4,603	4.0%
Number of facilities at period end	56	56		%
Actual patient days	488,508	495,981	(7,473)	(1.5)%
Occupancy percentage Operational beds	82.5%	81.6%		0.9%
Skilled mix by nursing days	28.6%	25.9%		2.7%
Skilled mix by nursing revenue	52.9%	50.1%		2.8%

	Three Months Ended June 30, 2010	2009	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Revenue	$ 8,753	$ 7,924	$ 829	10.5%
Number of facilities at period end	6	6		%
Actual patient days	40,901	39,249	1,652	4.2%
Occupancy percentage Operational beds	70.6%	67.7%		2.9%
Skilled mix by nursing days	18.5%	18.2%		0.3%
Skilled mix by nursing revenue	39.7%	41.7%		(2.0)%

	Three Months Ended June 30, 2010	2009	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Revenue	$ 28,296	$ 7,958	$ 20,338	NM%
Number of facilities at period end	19	7	12	NM%
Actual patient days	138,449	41,508	96,941	NM%
Occupancy percentage Operational beds	72.2%	68.1%		4.1%
Skilled mix by nursing days	13.5%	10.8%		2.7%
Skilled mix by nursing revenue	29.5%	23.3%		6.2%

(1) Same Facility results represent all facilities purchased prior to January 1, 2007. Same Facility results for 2009 include the results of operations through June 30, 2009 of our assisted living facility in Arizona where we decided not to exercise our renewal option on the lease which expired on September 30, 2009. The reduction in the number of actual patient days primarily relates to the non-renewal of this lease.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2007 to December 31, 2008.

(3) Recently Acquired Facility (or Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2009.

Revenue. Revenue increased $25.7 million, or 19.5%, to $157.9 million for the three months ended June 30, 2010 compared to $132.2 million for the three months ended June 30, 2009. Of the $25.7 million increase, Medicare and managed care revenue increased $10.4 million, or 17.4%, Medicaid revenue increased $10.4 million, or 19.4%, other skilled revenue increased $1.9 million, or 70.9%, and private and other revenue increased $3.0 million, or 19.2%. Approximately $20.3 million of the total revenue increase was due to revenue generated by Recently Acquired Facilities. Since January 1, 2009, the Company has acquired nineteen facilities and one home health and hospice operation in six states. Each group of facilities experienced an increase in operational occupancy. However, the overall occupancy was negatively weighted by the higher concentration of facilities in the Recently Acquired category, operating at generally lower occupancy percentages, causing consolidated occupancy to decrease slightly. Revenue generated by Same Facilities increased $4.6 million, or 4.0%, for the three months ended June 30, 2010 as compared to the three months ended June 30, 2009. This increase was primarily due to an increase in skilled mix of 2.8% to 52.9%, which was the result of higher acuity levels and skilled occupancy. Same Facility revenue in 2009 included approximately $0.5 million in revenue from our assisted living facility in Arizona where the lease expired on September 30, 2009 due to our decision not to exercise our renewal option on the lease. The reduction in the number of actual patient days primarily relates to the non-renewal of this lease.
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 June 30,								
	Same Facility		Transitioning		Acquisitions		Total		%
	2010	2009	2010	2009	2010	2009	2010	2009	Change
Skilled Nursing Average Daily Revenue Rates:									
Medicare	$ 551.53	$ 552.06	$ 473.28	$ 472.55	$ 429.87	$ 452.51	$ 527.95	$ 542.05	(2.6)%
Managed care	343.52	340.15	387.44	402.17	403.17	393.82	348.56	342.94	1.6%
Other skilled	543.60	620.88			622.49		546.03	620.88	(12.1)%
Total skilled revenue	469.43	470.83	443.46	457.40	428.44	440.92	463.57	469.18	(1.2)%
Medicaid	163.44	160.44	155.73	142.87	155.92	166.29	161.22	159.60	1.0%
Private and other payors	189.80	185.21	147.24	138.37	174.66	194.98	180.74	180.64	0.1%
Total skilled nursing revenue	$ 253.53	$ 243.42	$ 207.19	$ 199.02	$ 195.48	$ 203.31	$ 238.54	$ 237.40	0.5%

Transitional Facility Medicare daily rates increased by 0.2%, due to increased acuity levels. However, the overall average Medicare daily rate decreased by approximately 2.6% in the three months ended June 30, 2010 as compared to the three months ended June 30, 2009 as a result of the impact of lower acuity levels at Recently Acquired Facilities. The average Medicaid rate increased 1.0% in the three months ended June 30, 2010 relative to the same period in the prior year, primarily due to increases in reimbursement rates in the state of Texas. In addition, we have experienced continued growth in our managed care rates. We have and will continue to enhance our relationships with these organizations to appropriately service resident needs in their respective communities.
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. In the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we anticipate our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our

portfolio.

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

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2010	2009	2010	2009	2010	2009	2010	2009
Percentage of Skilled Nursing Revenue:								
Medicare	33.8%	33.3%	27.6%	33.8%	24.3%	19.2%	31.8%	32.5%
Managed care	15.2	14.3	12.1	7.9	4.6	4.1	13.2	13.3
Other skilled	3.9	2.5			0.6		3.2	2.2
Skilled mix	52.9	50.1	39.7	41.7	29.5	23.3	48.2	48.0
Private and other payors	7.6	8.1	15.5	15.0	13.7	25.0	9.1	9.5
Quality mix	60.5	58.2	55.2	56.7	43.2	48.3	57.3	57.5
Medicaid	39.5	41.8	44.8	43.3	56.8	51.7	42.7	42.5
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2010	2009	2010	2009	2010	2009	2010	2009
Percentage of Skilled Nursing Days:								
Medicare	15.5%	14.7%	12.1%	14.3%	11.1%	8.7%	14.4%	14.2%
Managed care	11.2	10.2	6.4	3.9	2.2	2.1	9.0	9.2
Other skilled	1.9	1.0			0.2		1.4	0.9
Skilled mix	28.6	25.9	18.5	18.2	13.5	10.8	24.8	24.3
Private and other payors	10.1	10.7	21.8	21.6	15.3	26.1	12.0	12.5
Quality mix	38.7	36.6	40.3	39.8	28.8	36.9	36.8	36.8
Medicaid	61.3	63.4	59.7	60.2	71.2	63.1	63.2	63.2
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $20.5 million, or 19.5%, to $125.8 million for the three months ended June 30, 2010 compared to $105.3 million for the three months ended June 30, 2009. Cost of services remained consistent as a percent of total revenue at 79.7% for the three months ended June 30, 2010 and 2009. Of the $20.5 million increase, Same Facilities increased $3.8 million, or 4.2% and Recently Acquired Facilities increased $16.4 million.

Facility Rent Cost of Services. Facility rent cost of services decreased $0.1 million, or 2.9%, to $3.6 million for the three months ended June 30, 2010 compared to $3.7 million for the three months ended June 30, 2009. Facility rent-cost of services as a percent of total revenue was 2.3% for the three months ended June 30, 2010 as compared to 2.8% for the three months ended June 30, 2009. The decrease in total facility rent was primarily a result of the non-renewal of one leased assisted living facility in Arizona in the third quarter of 2009.

General and Administrative Expense. General and administrative expense increased $1.0 million, or 18.3%, to $6.4 million for the three months ended June 30, 2010 compared to $5.4 million for the three months ended June 30, 2009. General and administrative expense decreased as a percent of total revenue to 4.0% for the three months ended June 30, 2010 as compared to 4.1% for the three months ended June 30, 2009. The $1.0 million increase was primarily due to increases in wages, benefits and professional fees.

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

Depreciation and Amortization. Depreciation and amortization expense increased $0.8 million, or 25.4%, to $4.0 million for the three months ended June 30, 2010 compared to $3.2 million for the three months ended June 30, 2009. Depreciation and amortization expense increased as a percent of total revenue to 2.5% for the three months ended June 30, 2010 as compared to 2.4% for the three months ended June 30, 2009. This increase was primarily related to the additional depreciation of Recently Acquired Facilities, as well as an increase in Same Facility depreciation expense due to recent renovations.

Other Income (Expense). Other expense, net increased $1.1 million, or 109.4%, to $2.2 million for the three months ended June 30, 2010 compared to $1.1 million for the three months ended June 30, 2009. Other expense, net increased as a percent of total revenue to 1.4% for the three months ended June 30, 2010 as compared to 0.8% for the three months ended June 30, 2009. This increase was primarily the result of interest expense on an additional $40.0 million added to the Term Loan in November 2009.

Provision for Income Taxes. Provision for income taxes increased $0.9 million, or 17.9%, to $6.2 million for the three months ended June 30, 2010 compared to $5.3 million for the three months ended June 30, 2009. This increase resulted from the increase in income before income taxes of $2.4 million, or 17.7%. Our effective tax rate was 39.3% for the three months ended June 30, 2010 as compared to 39.2% for the three months ended June 30, 2009.

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Six Months Ended June 30, 2010 Compared to Six Months Ended June 30, 2009

	Six Months Ended June 30,			
	2010	2009	Change	% Change
	(Dollars in thousands)			
Total Facility Results:				
Revenue	$ 312,122	$ 262,463	$ 49,659	18.9%
Number of facilities at period end	81	70	11	15.7%
Actual patient days	1,316,942	1,143,357	173,585	15.2%
Occupancy percentage Operational beds	79.4%	79.6%		(0.2)%
Skilled mix by nursing days	25.4%	24.8%		0.6%
Skilled mix by nursing revenue	49.0%	48.3%		0.7%

	Six Months Ended June 30,			
	2010	2009	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Revenue	$ 242,049	$ 232,600	$ 9,449	4.1%
Number of facilities at period end	56	56		%
Actual patient days	974,009	992,838	(18,829)	(1.9)%
Occupancy percentage Operational beds	82.6%	82.0%		0.6%
Skilled mix by nursing days	29.0%	26.3%		2.7%
Skilled mix by nursing revenue	53.5%	50.2%		3.3%

	Six Months Ended June 30,			
	2010	2009	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Revenue	$ 16,917	$ 16,164	$ 753	4.7%
Number of facilities at period end	6	6		%
Actual patient days	80,878	78,041	2,837	3.6%
Occupancy percentage Operational beds	70.2%	67.7%		2.5%
Skilled mix by nursing days	18.7%	18.7%		%
Skilled mix by nursing revenue	40.0%	43.2%		(3.2)%

	Six Months Ended June 30,			
	2010	2009	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Revenue	$ 53,156	$ 13,699	$ 39,457	NM%
Number of facilities at period end	19	7	12	NM%
Actual patient days	262,055	72,478	189,577	NM%
Occupancy percentage Operational beds	71.8%	65.9%		5.9%
Skilled mix by nursing days	14.2%	9.6%		4.6%
Skilled mix by nursing revenue	30.6%	20.8%		9.8%

(1) Same Facility results represent all facilities purchased prior to January 1, 2007. Same Facility results for 2009 include the results of operations through June 30, 2009 of our assisted living facility in Arizona where we decided not to exercise our renewal option on the lease which expired on September 30, 2009. The reduction in the number of actual patient days primarily relates to the non-renewal of this lease.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2007 to December 31, 2008.

(3) Recently Acquired Facility (or Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2009.

Revenue. Revenue increased $49.6 million, or 18.9%, to $312.1 million for the six months ended June 30, 2010 compared to $262.5 million for the six months ended June 30, 2009. Of the $49.6 million increase, Medicare and managed care revenue increased $21.4 million, or 17.7%, Medicaid revenue increased $19.8 million, or 18.7%, other skilled revenue increased $4.0 million, or 81.3%, and private and other revenue increased $4.3 million, or 14.1%. Approximately $39.5 million of the total revenue increase was due to revenue generated by Recently Acquired Facilities. Since January 1, 2009, the Company has acquired nineteen facilities and one home health and hospice operation in six states. Each group of facilities experienced an increase in operational occupancy. However, the overall occupancy was negatively weighted by the higher concentration of facilities in the Recently Acquired category, operating at generally lower occupancy percentages, causing consolidated occupancy to decrease slightly. Revenue generated by Same Facilities increased $9.4 million, or 4.1%, for the six months ended June 30, 2010 as compared to the six months ended June 30, 2009. This increase was primarily due to increase in skilled mix of 3.3% to 53.5%, which was the result of higher acuity levels. Same Facility revenue in 2009 included approximately $0.9 million in revenue from our assisted living facility in Arizona where the lease expired on September 30, 2009, due to our decision not to exercise our renewal option on the lease. The reduction in the number of actual patient days primarily relates to the non-renewal of this lease.

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:

	Six Months Ended June 30,								
	Same Facility		**Transitioning**		**Acquisitions**		**Total**		**%**
	2010	**2009**	**2010**	**2009**	**2010**	**2009**	**2010**	**2009**	**Change**
Skilled Nursing Average Daily Revenue Rates:									
Medicare	$ 553.30	$ 543.66	$ 469.03	$ 475.85	$ 431.42	$ 438.09	$ 529.91	$ 535.15	(1.0)%
Managed care	341.68	334.46	380.60	448.10	403.16	387.98	346.62	338.73	2.3%
Other skilled	547.19	632.38			623.46		549.62	632.38	(13.1)%
Total skilled revenue	469.74	463.42	435.11	469.71	429.84	428.99	463.68	462.96	0.2%
Medicaid	163.86	160.95	149.65	142.82	158.35	165.56	161.75	159.95	1.1%
Private and other payors	187.63	183.81	152.83	140.27	173.81	191.78	179.91	179.43	0.3%
Total skilled nursing revenue	$ 254.99	$ 243.14	$ 203.76	$ 203.40	$ 199.17	$ 197.68	$ 240.63	$ 237.43	1.3%

Same Facility Medicare daily rates increased by 1.8% due to higher acuity levels. However, the overall average Medicare daily rate decreased by approximately 1.0% in the six months ended June 30, 2010 as compared to the six months ended June 30, 2009, as a result of the impact of lower acuity levels at Transitioning and Recently Acquired Facilities. The average Medicaid rate increase of 1.1% in the six months ended June 30, 2010 relative to the same period in the prior year was primarily due to increases in reimbursement rates in the state of Texas and retroactive revenue adjustments in the state of Washington in the first quarter of 2010. In addition, we have experienced continued growth in our managed care rates. We have and will continue to enhance our relationships with these organizations to appropriately service resident needs in their respective communities.

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. In the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we

anticipate our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio.

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

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2010	2009	2010	2009	2010	2009	2010	2009
Percentage of Skilled Nursing Revenue:								
Medicare	34.3%	33.5%	26.6%	34.1%	25.3%	17.4%	32.5%	32.8%
Managed care	15.3	14.4	13.4	9.1	4.6	3.4	13.4	13.5
Other skilled	3.9	2.3			0.7		3.1	2.0
Skilled mix	53.5	50.2	40.0	43.2	30.6	20.8	49.0	48.3
Private and other payors	7.4	8.3	16.5	14.6	13.1	25.4	8.8	9.5
Quality mix	60.9	58.5	56.5	57.8	43.7	46.2	57.8	57.8
Medicaid	39.1	41.5	43.5	42.2	56.3	53.8	42.2	42.2
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2010	2009	2010	2009	2010	2009	2010	2009
Percentage of Skilled Nursing Days:								
Medicare	15.8%	15.0%	11.5%	14.6%	11.7%	7.9%	14.7%	14.5%
Managed care	11.4	10.5	7.2	4.1	2.3	1.7	9.3	9.5
Other skilled	1.8	0.8			0.2		1.4	0.8
Skilled mix	29.0	26.3	18.7	18.7	14.2	9.6	25.4	24.8
Private and other payors	10.1	11.0	22.0	21.2	15.0	26.1	11.8	12.6
Quality mix	39.1	37.3	40.7	39.9	29.2	35.7	37.2	37.4
Medicaid	60.9	62.7	59.3	60.1	70.8	64.3	62.8	62.6
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Cost of Services (exclusive of facility rent and depreciation and amortization shown separately). Cost of services increased $39.5 million, or 18.9%, to $249.0 million for the six months ended June 30, 2010 compared to $209.5 million for the six months ended June 30, 2009. Cost of services remained consistent as a percent of total revenue at 79.8% for the six months ended June 30, 2010 and 2009. Of the $39.5 million increase, Same Facilities increased $7.7 million, or 4.2% and Recently Acquired Facilities increased $31.7 million.

Facility Rent Cost of Services. Facility rent cost of services decreased $0.2 million, or 3.2%, to $7.2 million for the six months ended June 30, 2010 compared to $7.4 million for the six months ended June 30, 2009. Facility rent-cost of services as a percent of total revenue was 2.3% for the six months ended June 30, 2010 as compared to 2.8% for the six months ended June 30, 2009. The decrease in total facility rent was primarily a result of the non-renewal of one leased assisted living facility in Arizona in the third quarter of 2009.

General and Administrative Expense. General and administrative expense increased $1.8 million, or 17.4%, to $12.2 million for the six months ended June 30, 2010 compared to $10.4 million for the six months ended June 30, 2009. General and administrative expense decreased as a percent of total revenue to 3.9% for the six months ended June 30, 2010 as compared to 4.0% for the six months ended June 30, 2009. The $1.8 million increase was primarily due to an increase in wages, benefits and professional fees.

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

Depreciation and Amortization. Depreciation and amortization expense increased $1.8 million, or 29.2%, to $8.0 million for the six months ended June 30, 2010 compared to $6.2 million for the six months ended June 30, 2009. Depreciation and amortization expense increased as a percent of total revenue to 2.5% for the six months ended June 30, 2010 as compared to 2.4% for the six months ended June 30, 2009. This increase was primarily related to the additional depreciation of Recently Acquired Facilities, as well as an increase in Same Facility depreciation expense due to recent renovations.

Other Income (Expense). Other expense, net increased $2.1 million, or 91.4%, to $4.4 million for the six months ended June 30, 2010 compared to $2.3 million for the six months ended June 30, 2009. Other expense, net increased as a percent of total revenue to 1.4% for the six months ended June 30, 2010 as compared to 0.9% for the six months ended June 30, 2009. This increase was primarily the result of interest expense on an additional $40.0 million added to the Term Loan in November 2009.

Provision for Income Taxes. Provision for income taxes increased $1.8 million, or 17.0%, to $12.4 million for the six months ended June 30, 2010 compared to $10.6 million for the six months ended June 30, 2009. This increase resulted from the increase in income before income taxes of $4.7 million, or 17.5%. Our effective tax rate was 39.4% for the six months ended June 30, 2010 as compared to 39.6% for the six months ended June 30, 2009.

Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flow from operations, long term debt secured by our real property and our Second Amended and Restated Loan and Security Agreement (the Revolver) with General Electric Capital Corporation (the Lender). As of June 30, 2010, the maximum available for borrowing under the Revolver was approximately $50.0 million, subject to available collateral limits. As of June 30, 2010, the amount of borrowing capacity pledged to secure outstanding letters of credit and reserves against collateral for actual and contingent liabilities was $2.1 million and $6.0 million, respectively.

Since 2004, we have financed the majority of our facility acquisitions primarily through refinancing of existing facilities, and cash generated from operations or proceeds from our IPO. Cash paid for business acquisitions was $18.8 million and $22.1 million for the six months ended June 30, 2010 and 2009, respectively. Where we enter into a facility lease agreement, we typically do not pay any material amount to the prior facility operator, nor do we acquire any assets or assume any liabilities, other than our rights and obligations under the new lease and operations transfer agreement, as part of the transaction. Leases are included in the contractual obligations section below. Total capital expenditures for property and equipment were $13.8 million and $11.7 million for the six months ended June 30, 2010 and 2009, respectively. We currently have a combined $16.8 million budgeted for capital expenditure projects for 2010.

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

Our cash and cash equivalents as of June 30, 2010 consisted of bank term deposits, money market funds and treasury bill related investments. In addition, as of June 30, 2010, we held debt security investments of approximately $12.1 million, which are guaranteed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program upon maturity. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

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

	Six months ended June 30,	
	2010	2009
	(In thousands)	
Net cash provided by operating activities	$ 14,903	$ 18,700
Net cash used in investing activities	(25,153)	(24,072)
Net cash used in financing activities	(2,252)	(2,267)

Net decrease in cash and cash equivalents	(12,502)	(7,639)
Cash and cash equivalents at beginning of period	38,855	41,326
Cash and cash equivalents at end of period	$ 26,353	$ 33,687

Six months ended June 30, 2010 Compared to Six months ended June 30, 2009

Net cash provided by operations for the six months ended June 30, 2010 was $14.9 million compared to $18.7 million for the six months ended June 30, 2009, a decrease of $3.8 million. This decrease was primarily due to increases in outstanding accounts receivable balances of $13.0 million as compared to $6.4 million for the six month period ended June 30, 2009, an increase of $6.6 million. This increase was partially offset by our improved operating results, which contributed $28.3 million in 2010 after adding back depreciation and amortization, deferred income taxes, provision for doubtful accounts, stock-based compensation, excess tax benefits from share based compensation and loss on disposition of property and equipment (non-cash charges), as compared to $24.1 million for 2009, an increase of $4.2 million.

Net cash used in investing activities for the six months ended June 30, 2010 was $25.2 million compared to $24.1 million for the six months ended June 30, 2009, an increase of $1.1 million. The increase was primarily the result of $25.0 million in cash paid for business acquisitions and purchased property and equipment in the six months ended June 30, 2010 compared to $23.7 million in the six months ended June 30, 2009.

Net cash used in financing activities for the six months ended June 30, 2010 remained consistent at $2.3 million.

Principal Debt Obligations and Capital Expenditures

Total long-term debt obligations outstanding as of June 30, 2010 and the years ended December 31, 2009, 2008 and 2007 were as follows:

	December 31,			June 30,
	2007	2008	2009	2010
	(in thousands)			
Amended Term Loan with GE Capital	$ 54,929	$ 54,102	$ 93,170	$ 92,451
Mortgage Loan and Promissory Notes	8,641	6,449	15,064	14,900
Bond payable			1,232	1,137
Total	$ 63,570	$ 60,551	$ 109,466	$ 108,488

The following table represents the Company s cumulative facility growth from 2004 to the present:

	December 31,				June 30,
	2006	2007	2008	2009	2010
Cumulative number of facilities	57	61	63	77	81

Term Loan with General Electric Capital Corporation

On December 29, 2006, a number of our independent real estate holding subsidiaries jointly entered into the Third Amended and Restated Loan Agreement, with General Electric Capital Corporation (the Lender), which consists of an approximately $55.7 million multiple-advance term loan, further referred to as the Ten Project Note. The Ten Project Note matures in June 2016, and is currently secured by the real and personal property comprising the ten facilities owned by these subsidiaries.

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

On November 6, 2009, we finalized the Fourth Amended and Restated Loan Agreement (Amended Term Loan) with the Lender which increased the borrowing capacity of the loan by $40.0 million, further referred to as the Six Project Loan. The Six Project Loan will mature on September 30, 2014 and is secured by, among other things (a) a perfected first priority mortgage/deed of trust on the fee simple interest in six of our skilled nursing facilities (the Property), (b) an assignment of all related leases, rents, deposits, letters of credit, income and profits, (c) an assignment and/or a perfected security interest in all assignable licenses, permits, general intangibles, contracts, agreements and personal property relating to the Property and (d) a perfected first priority security interest in all reserve accounts. The

Amended Term Loan, which includes both the Ten Project Note and Six Project Loan, is cross collateralized and cross defaulted with the existing Revolver. We paid approximately $0.8 million upon closing of the Amended Term Loan. The interest rate on the loan is calculated at the current five year swap rate on the date of closing plus 585 basis points for half of the loan balance and the three year swap rate on the date of closing plus 585 basis points and thereafter floating at 90-day LIBOR plus 575 basis points, reset monthly and subject to a LIBOR floor of 2.0% for the remaining half of the loan balance. The Amended Term Loan did not modify any of the existing terms of the Ten Project Note.

In connection with the Amended Term Loan, we have guaranteed the payment and performance of all the obligations of our real estate holding subsidiaries under the loan documents. In the event of our default under the Amended Term Loan, all amounts owed by our subsidiaries and guaranteed by us under the Amended Term Loan and any other loan with the Lender, including the Revolver discussed above, would become immediately due and payable. In addition, in the event of our default under the Amended Term Loan, the Lender has the right to take control of our facilities encumbered by the loan to the extent necessary to make such payments and perform such acts required under the loan. Under the Amended Term Loan, we are subject to standard reporting requirements and other typical covenants for a loan of this type. Effective October 1, 2006 and continuing each calendar quarter thereafter, we are subject to restrictive financial covenants, including average occupancy, Debt Service (as defined in the agreement) and Project Yield (as defined in the agreement). As of June 30, 2010, we were in compliance with all loan covenants. As of June 30, 2010, our borrowing subsidiaries had $92.5 million outstanding on the Amended Term Loan.

Revolving Credit Facility with General Electric Capital Corporation

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

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

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

- certain indebtedness;
- certain investments, loans, advances and acquisitions;
- certain sales or other dispositions of our assets;
- certain liens and negative pledges;
- financial covenants;
- changes of control (as defined in the loan agreement);
- certain mergers, consolidations, liquidations and dissolutions;
- certain sale and leaseback transactions without the Lender s consent;
- dividends and distributions during the existence of an event of default;
- guarantees and other contingent liabilities;
- affiliate transactions that are not in the ordinary course of business; and

certain changes in capital structure.

A violation of these or other representations or covenants of ours could result in a default under the Revolver and could possibly cause the entire amount outstanding under the Revolver and a cross-default of all amounts owed by us, including amounts due under the Term Loan, to be declared immediately due and payable.
In connection with the Revolver, the majority of our subsidiaries granted a first priority security interest to the Lender in, among other things: (1) all accounts, accounts receivable and rights to payment of every kind, contract rights, chattel paper, documents and instruments with respect thereto, and all of our rights, remedies, securities and liens in, to, and in respect of our accounts, (2) all moneys, securities, and other property and the proceeds thereof under the control of the Lender and its affiliates, (3) all right, title and interest in, to and in respect of all goods relating to or resulting in accounts, (4) all deposit accounts into which our accounts are deposited, (5) general intangibles and other property of every kind relating to our accounts, (6) all other general intangibles, including, without limitation, proceeds from insurance policies, intellectual property rights, and goodwill, (7) inventory, machinery, equipment, tools, fixtures, goods, supplies, and all related attachments, accessions and replacements, and (8) proceeds, including insurance proceeds, of all of the foregoing. In the event of our default, the Lender has the right to take possession of the foregoing with or without judicial process.

Promissory Notes with Johnson Land Enterprises, Inc.

On October 1, 2009, four subsidiaries of The Ensign Group, Inc. entered into four separate promissory notes with Johnson Land Enterprises, LLC (the Seller), for an aggregate of $10.0 million, as a part of the Company s acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these notes is due on September 30, 2019. The notes bear interest at a rate of 6.0% per annum. As of June 30, 2010, our subsidiaries had $9.8 million outstanding on the Promissory Notes.

Bonds Payable to Lynn Family Partnership

On October 1, 2009, a subsidiary of The Ensign Group, Inc. located in West Jordan, Utah assumed the obligation to pay the remaining principal and interest on bonds which were originally sold to finance the construction of the facility. These bonds were assumed as a part of the Company s acquisition of three skilled nursing facilities in Utah. The unpaid balance of principal and accrued interest from these bonds is due on July 1, 2015. The bonds bear interest at an annual rate equal to sixty percent of the rate announced from time to time by Bank of America as its prime rate (Prime Rate), which was 2.1% on June 30, 2010. As of June 30, 2010, the balance outstanding on these bonds was $1.1 million.

Mortgage Loan with Continental Wingate Associates, Inc.

Ensign Southland LLC, a subsidiary of The Ensign Group, Inc., entered into a mortgage loan on January 30, 2001 with Continental Wingate Associates, Inc. The mortgage loan is insured with the U.S. Department of Housing and Development, or HUD, which subjects our Southland facility to HUD oversight and periodic inspections. As of June 30, 2010, the balance outstanding on this mortgage loan was approximately $6.2 million. The unpaid balance of principal and accrued interest from this mortgage loan is due on February 1, 2027. The mortgage loan bears interest at the rate of 7.5% per annum.
This mortgage loan is secured by the real property comprising the Southland Care Center facility and the rents, issues and profits thereof, as well as all personal property used in the operation of the facility.

Contractual Obligations, Commitments and Contingencies

We lease certain facilities and our Service Center office under operating leases, most of which have initial lease terms ranging from five to 20 years. Most of these leases contain options to renew or extend the lease term, some of which involve rent increases. We also lease a majority of our equipment under operating leases with initial terms ranging from three to five years. Total rent expense, inclusive of straight-line rent adjustments, was $3.7 million and $7.4 million for the three and six months ended June 30, 2010, respectively and $3.8 million and $7.7 million for the three and six months ended June 30, 2009, respectively.
In March 2007, we and certain of our officers received a series of notices from our bank indicating that the United States Attorney for the Central District of California had issued an authorized investigative demand, a request for records similar to a subpoena, to our bank. The U.S. Attorney subsequently rescinded that demand. The rescinded demand requested documents from our bank related to financial transactions involving us, ten of our operating subsidiaries, an outside investor group, and certain of our current and former officers. Subsequently, in June 2007, the

U.S. Attorney sent a letter to one of our current employees requesting a meeting. The letter indicated that the U.S. Attorney and the U.S. Department of Health and Human Services Office of Inspector General were conducting an investigation of claims submitted to the Medicare program for rehabilitation services provided at unspecified facilities. Although both we and the employee offered to cooperate, the U.S. Attorney later withdrew its meeting request.

On December 17, 2007, we were informed by Deloitte & Touche LLP, our independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of our operating subsidiaries. The subpoena confirmed our previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of our operating subsidiaries. All together, the March 2007 authorized investigative demand and the December 2007 subpoena specifically covered information from a total of 18 of our 81 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. We also continue to sporadically receive anecdotal reports of former employees who have been contacted by investigators from the U.S. Attorney s office. Based on these events, we believe that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group, Inc. and one or more of our skilled nursing facilities.

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

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

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

As a byproduct of our investigation we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. We, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, we treated the claims as overpayments. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. See additional description of our contingencies in Note 14 in Notes to Condensed Consolidated Financial Statements.

From time to time our systems and controls highlight potential compliance issues, which we investigate as they arise. As a result of the detection by management at one of our facilities, and their Service Center support personnel, of possible recordkeeping and related irregularities at that facility, we initiated an internal inquiry in the second quarter

of 2010.

We concluded the investigatory phase of this inquiry in the third quarter of 2010, and commenced a billing review of potentially affected claims. We made observations at the facility regarding areas of potential improvement in some of our historical recordkeeping and billing practices and have identified measures, some of which had already been implemented before the inquiry began, that we believe have strengthened, and can strengthen further, our recordkeeping and billing processes. The issues detected appear to be isolated to one facility and one department within that facility. We continue to evaluate the measures we have implemented for effectiveness, and we are continuing to seek ways to improve these processes.

As a result of our billing reviews, we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located, or for which other billing deficiencies existed. Where accepted procedures and necessary data for reviewing and calculating potential overpayments were available, we followed such procedures and completed a billing review. Where such procedures and/or data were not available we developed a methodology for making a good faith estimate of potential overpayments with the assistance of independent consultants experienced in Medicare billing. We have accrued a liability for estimated overpayments resulting from insufficient or missing documentation or other billing deficiencies. To the extent that sufficient documentation is subsequently located, the amount we ultimately reimburse will be reduced.

Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the quarter ended June 30, 2010, we accrued for a revenue adjustment of approximately $0.5 million, plus interest, for the estimated overpayments described above, with a resulting impact to net income of approximately $0.3 million. At the conclusion of our review we intend to submit the potential overpayment for settlement with the Medicare Fiscal Intermediary.

Inflation

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

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

Adoption of New Accounting Pronouncements

In February 2010, the FASB issued amendments to address certain implementation issues related to an entity s requirement to perform and disclose subsequent events procedures. The amendment requires (1) SEC filers and (2) conduit debt obligors for conduit debt securities that are traded in a public market to evaluate subsequent events through the date the financial statements are issued. All other entities are required to evaluate subsequent events through the date the financial statements are available to be issued. It further exempts SEC filers from disclosing the date through which subsequent events have been evaluated. For all entities (except conduit debt obligors), these requirements are effective immediately for financial statements that are (1) issued or available to be issued or (2) revised. For conduit debt obligors, the requirements are effective for interim and annual periods ending after June 15, 2010. The adoption of these requirements did not have an impact on our condensed consolidated financial statements.

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

Interest Rate Risk. We are exposed to interest rate changes in connection with the Revolver, which is available but is not regularly used to maintain liquidity and fund capital expenditures and operations. Our interest rate risk management objective is to limit the impact of interest rate changes on earnings and cash flows and to provide more predictability to our overall borrowing costs. To achieve this objective, we borrow primarily at fixed rates, although the Revolver is available and could be used for short-term borrowing purposes. At June 30, 2010, we had no outstanding floating rate debt.

Our cash and cash equivalents as of June 30, 2010 consisted of bank term deposits, money market funds and treasury bill related investments. In addition, as of June 30, 2010, we held debt security investments of approximately $12.1 million which are guaranteed by the Federal Deposit Insurance Corporation (FDIC) under the Temporary Liquidity Guarantee Program upon maturity. Our market risk exposure is interest income sensitivity, which is affected by changes in the general level of U.S. interest rates. The primary objective of our investment activities is to preserve principal while at the same time maximizing the income we receive from our investments without significantly increasing risk. Due to the low risk profile of our investment portfolio, an immediate 10% change in interest rates would not have a material effect on the fair market value of our portfolio. Accordingly, we would not expect our operating results or cash flows to be affected to any significant degree by the effect of a sudden change in market interest rates on our securities portfolio.

The above only incorporates those exposures that existed as of June 30, 2010, and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Item 4. *Controls and Procedures*

Disclosure Controls and Procedures

Under the supervision and with the participation of our management, including the Chief Executive Officer and Chief Financial Officer, we have evaluated the effectiveness of our disclosure controls and procedures (as such term is defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934, as amended (Exchange Act)), as of the end of the period covered by this report. Based on that evaluation, the Chief Executive Officer and Chief Financial Officer have concluded that these disclosure controls and procedures are effective.

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended June 30, 2010, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Part II. Other Information

Item 1. *Legal Proceedings*

Certain legal proceedings in which we are involved are discussed in Part I, Item 3, of our Annual Report on Form 10-K for the year ended December 31, 2009. In addition, for more information regarding our legal proceedings, please see Note 14 included in Part 1, Item 1 of this Form 10-Q.

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

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

Item 1A. *Risk Factors*

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

Risks Related to Our Business and Industry

Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare.

We derived approximately 44% and 43% of our revenue from the Medicaid program during the three and six months ended June 30, 2010, respectively, and approximately 42% of our revenue for both periods during the three and six months ended June 30, 2009, respectively. We derived approximately 32% and 33% of our revenue from the Medicare program during the three and six months ended June 30, 2010, respectively, and approximately 33% for both periods during the three and six months ended June 30, 2009, respectively. If reimbursement rates under these programs are reduced or fail to increase as quickly as our costs, or if there are changes in the way these programs pay for services, our business and results of operations would be adversely affected. The services for which we are currently reimbursed by Medicaid and Medicare may not continue to be reimbursed at adequate levels or at all. Further limits on the scope of services being reimbursed, delays or reductions in reimbursement or changes in other aspects of reimbursement could impact our revenue. For example, in the past, the enactment of the Deficit Reduction Act of 2005 (DRA), the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 and the Balanced Budget Act of 1997 (BBA) caused changes in government reimbursement systems, which, in some cases, made obtaining reimbursements more difficult and costly and lowered or restricted reimbursement rates for some of our residents.

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The Medicaid and Medicare programs are subject to statutory and regulatory changes affecting base rates or basis of payment, retroactive rate adjustments, annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) for rehabilitation therapy services rendered to Medicare beneficiaries, administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates and frequency at which these programs reimburse us for our services. For example, the Medicaid Integrity Contractor (MIC) program is increasing the scrutiny placed on Medicaid payments, and could result in recoupments of alleged overpayments in an effort to rein in Medicaid spending. The Mid-Session Review of the presidential budget submitted for federal fiscal year 2010 included, through federal fiscal year 2014, $490.0 million in savings from improving Medicare and Medicaid program integrity , and another $175.0 million in Medicaid savings through implementation of coding edits to ensure appropriate Medicaid payments. It is uncertain what proportion of these estimated cost savings will come from recoupments against long-term care facilities. However, despite the savings projected from effectively reducing payments to Medicaid providers, the Mid-Session Review of the presidential budget submitted for federal fiscal year 2010 also included an outlay of $1.5 billion for Medicaid spending through federal fiscal year 2010. The federal share of current law Medicaid outlays is expected to be $248.0 billion, a $26.0 billion increase over projected fiscal year 2009 spending. Some of the projected increases in Medicaid outlays are pursuant to the American Recovery and Reinvestment Act passed in February 2009, which contained several temporary measures expected to increase Medicaid expenditures. In order to qualify for increases in Medicaid matching funds from the federal government, states must refrain from implementing eligibility standards, methodologies or procedures that are more restrictive than those in effect as of July 1, 2008. Implementation of these and other measures to reduce or delay reimbursement could result in substantial reductions in our revenue and profitability. Payors may disallow our requests for reimbursement based on determinations that certain costs are not reimbursable or reasonable because either adequate or additional documentation was not provided or because certain services were not covered or considered reasonably necessary. Additionally, revenue from these payors can be retroactively adjusted after a new examination during the claims settlement process or as a result of post-payment audits. New legislation and regulatory proposals could impose further limitations on government payments to healthcare providers.

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

Medicaid, which is largely administered by the states, is a significant payor for our skilled nursing services. Rapidly increasing Medicaid spending, combined with slow state revenue growth, has led many states to institute measures aimed at controlling spending growth. For example, in February 2009, the California legislature approved a new budget to help relieve a $42 billion budget deficit. The budget package was signed after months of negotiation, during which time California s governor declared a fiscal state of emergency in California. The new budget implements spending cuts in several areas, including Medi-Cal spending. Some of the spending cuts are triggered only if an inadequate amount of federal funding is received from the American Recovery and Reinvestment Act of 2009 described above. Further, California initially had extended its cost-based Medi-Cal long-term care reimbursement system enacted through Assembly Bill 1629 (A.B.1629) through the 2009-2010 and 2010-2011 rate years with a growth rate of up to five percent for both years. However, due to California s severe budget crisis, in July 2009, the State passed a budget-balancing proposal that eliminated this five percent growth cap by amending the current statute to provide that, for the 2009-2010 and 2010-2011 rate years, the weighted average Medi-Cal reimbursement rate paid to long-term care facilities shall not exceed the weighted average Medi-Cal reimbursement rate for the 2008-2009 rate year. In addition, the budget proposal increased the amounts that California nursing facilities will pay to Medi-Cal in quality assurance fees for the 2009-2010 and 2010-2011 rate years by including Medicare revenue in the calculation of the quality assurance fee that nursing facilities pay under A.B. 1629. Although overall reimbursement from Medi-Cal remained stable, individual facility rates varied. Because state legislatures control the amount of state funding for Medicaid programs, cuts or delays in approval of such funding by legislatures could reduce the amount of, or cause a delay in, payment from Medicaid to skilled nursing facilities. We expect continuing cost containment pressures on Medicaid outlays for skilled nursing facilities, and any such decline could adversely affect our financial condition and results of operations.

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

Our hospice operations are subject to annual Medicare caps calculated by Medicare. If such caps were to be exceeded by any of our hospice providers, our business and consolidated financial condition, results of operations and cash flows could be materially adversely affected.

With respect to our hospice operations, overall payments made by Medicare to each provider number are subject to an inpatient cap amount and an overall payment cap, which are calculated and published by the Medicare fiscal intermediary on an annual basis covering the period from November 1 through October 31. If payments received by any one of our hospice provider numbers exceeds either of these caps, we may be required to reimburse Medicare for payments received in excess of the caps, which could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations.
Skilled nursing facilities are required to perform consolidated billing for certain items and services furnished to patients and residents. The consolidated billing requirement essentially confers on the skilled nursing facility itself the Medicare billing responsibility for the entire package of care that its residents receive in these situations. The BBA also affected skilled nursing facility payments by requiring that post-hospitalization skilled nursing services be bundled into the hospital s Diagnostic Related Group (DRG) payment in certain circumstances. Where this rule applies, the hospital and the skilled nursing facility must, in effect, divide the payment which otherwise would have been paid to the hospital alone for the patient s treatment, and no additional funds are paid by Medicare for skilled nursing care of the patient. At present, this provision applies to a limited number of DRGs, but already is apparently having a negative effect on skilled nursing facility utilization and payments, either because hospitals are finding it difficult to place patients in skilled nursing facilities which will not be paid as before or because hospitals are reluctant to discharge the patients to skilled nursing facilities and lose part of their payment. This bundling requirement could be extended to more DRGs in the future, which would accentuate the negative impact on skilled nursing facility utilization and payments. We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations.
Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements.
The Patient Protection and Affordable Care Act (the Affordable Care Act) and the Health Care and Education Reconciliation Act of 2010 (the Reconciliation Act) were recently enacted as new laws. These new laws include sweeping changes to how health care is paid for and furnished in the United States.
The Affordable Care Act, as modified by the Reconciliation Act, is projected to expand access to Medicaid and thereby expand eligibility to approximately 16 million people. However, the Affordable Care Act will also reduce the projected growth of Medicare by $500 billion over ten years by tying payments to providers more closely to quality outcomes. The Affordable Care Act also imposes new obligations on skilled nursing facilities, requiring them to disclose information regarding ownership, expenditures and certain other accountability requirements. This information will be disclosed on a website for comparison by members of the public.
To address fraud and abuse of federal health care programs, including Medicare and Medicaid, the Affordable Care Act includes provider screening and enhanced oversight periods for new providers and suppliers, as well as enhanced penalties for submitting false claims and provide funding for enhanced anti-fraud activities. The new law imposes enrollment moratoria in elevated risk areas by requiring providers and suppliers to establish compliance programs.
In addition, on October 1, 2010, the next generation of the Minimum Data Set (MDS), MDS 3.0, will be implemented, creating significant changes in the methodology for calculating the RUG-IV category under Medicare Part A, most notably eliminating Section T. Because therapy does not necessarily begin upon admission, MDS 2.0 and the RUG-III system included a provision to capture therapy services that are scheduled to occur but have not yet been provided in order to calculate a RUG level that better reflects the intensity of care the resident would actually receive. This is eliminated with MDS 3.0 and RUG-IV, which create a new category of assessment called the Medicare Short Stay Assessment. This assessment provides for calculation of a rehabilitation RUG for residents discharged on or before day eight who received less than five days of therapy.
We cannot predict what effect these changes will have on our business, including the demand for our services or the amount of reimbursement available for those services. However, it is possible these new laws may lower reimbursement and adversely affect our business.
Increased competition for, or a shortage of, nurses and other skilled personnel could increase our staffing and labor costs and subject us to monetary fines.
Our success depends upon our ability to retain and attract nurses, Certified Nurse Assistants (CNAs) and therapists. Our success also depends upon our ability to retain and attract skilled management personnel who are responsible for the day-to-day operations of each of our facilities. Each facility has a facility leader responsible for the overall day-to-day operations of the facility, including quality of care, social services and financial performance. Depending upon the size of the facility, each facility leader is supported by facility staff that is directly responsible for day-to-day care of the patients and marketing and community outreach programs. Other key positions supporting each facility

may include individuals responsible for physical, occupational and speech therapy, food service and maintenance. We compete with various healthcare service providers, including other skilled nursing providers, in retaining and attracting qualified and skilled personnel.

We operate one or more skilled nursing facilities in the states of California, Arizona, Texas, Washington, Utah, Colorado and Idaho. With the exception of Utah, which follows federal regulations, each of these states has established minimum staffing requirements for facilities operating in that state. Failure to comply with these requirements can, among other things, jeopardize a facility s compliance with the conditions of participation under relevant state and federal healthcare programs. In addition, if a facility is determined to be out of compliance with these requirements, it may be subject to a notice of deficiency, a citation, or a significant fine or litigation risk. For example, we are aware of one company in our industry that is subject to a substantial judgment as a result of not complying with minimum staffing laws. Deficiencies may also result in the suspension of patient admissions and/or the termination of Medicaid participation, or the suspension, revocation or nonrenewal of the skilled nursing facility s license. If the federal or state governments were to issue regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.

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

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

As a result of our participation in the Medicaid and Medicare programs, we are subject to various governmental reviews, audits and investigations to verify our compliance with these programs and applicable laws and regulations. Private pay sources also reserve the right to conduct audits. We believe that billing and reimbursement errors and disagreements are common in our industry. We are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the process related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce. An adverse review, audit or investigation could result in:

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

In 2004, one of our Medicare fiscal intermediaries began to conduct selected reviews of claims previously submitted by and paid to some of our facilities. While we have always been subject to post-payment audits and reviews, more intensive probe reviews appear to be a permanent procedure with our fiscal intermediary. Although some of these probe reviews identified patient miscoding, documentation deficiencies and other errors in our recordkeeping and Medicare billing, these errors resulted in no Medicare revenue recoupment, net of appeal recoveries, to the federal government and related resident copayments during the six months ended June 30, 2010 and year ended December 31, 2009, respectively.

If the government or court were to conclude that such errors and deficiencies constituted criminal violations, or were to conclude that such errors and deficiencies resulted in the submission of false claims to federal healthcare programs, or if it were to discover other problems in addition to the ones identified by the probe reviews that rose to actionable

levels, we and certain of our officers might face potential criminal charges and/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we and/or some of our key personnel could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare. In any event, it is likely that a governmental investigation alone, regardless of its outcome, would divert material time, resources and attention from our management team and our staff, and could have a materially detrimental impact on our results of operations during and after any such investigation or proceedings.

In some cases, probe reviews can also result in a facility being temporarily placed on prepayment review of reimbursement claims, requiring additional documentation and adding steps and time to the reimbursement process for the affected facility. Failure to meet claim filing and documentation requirements during the prepayment review could subject a facility to an even more intensive targeted review, where a corrective action plan addressing perceived deficiencies must be prepared by the facility and approved by the fiscal intermediary. During a targeted review, additional claims are reviewed pre-payment to ensure that the prescribed corrective actions are being followed. Failure to make corrections or to otherwise meet the claim documentation and submission requirements could eventually result in Medicare decertification. None of our operations are currently on prepayment review, and others may be placed on prepayment review in the future. We have no operations that are currently undergoing targeted review. Separately, in 2006, the federal government introduced a program that utilizes independent contractors (other than the fiscal intermediaries) known as recovery audit contractors to identify and recoup Medicare overpayments. These recovery audit contractors are paid a contingent fee based on recoupments. In October 2008, this program was permanently implemented and requires the expansion of the program to all 50 states by no later than 2010. We anticipate that the number of overpayment reviews will increase in the future, and that the reviewers could be more aggressive in making claims for recoupment. In 2006, one of our facilities was subjected to review under this program, resulting in a recoupment to the federal government of approximately $12,000. If future Medicare reviews result in significant refund payments to the federal government, it would have an adverse effect on our financial results.

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

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

The DRA directs CMS to create a process to allow exceptions to therapy caps for certain medically necessary services provided on or after January 1, 2006 for patients with certain conditions or multiple complexities whose therapy services are reimbursed under Medicare Part B. A significant portion of the residents in our skilled nursing facilities and patients served by our rehabilitation therapy programs whose therapy is reimbursed under Medicare Part B have qualified for the exceptions to these reimbursement caps. 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 as part of the Affordable Care Act, which extended the exception from January 1, 2010, to December 31, 2010.

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, 2010, which could also have an adverse effect on our revenue after that date.

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

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

- facility and professional licensure, certificates of need, permits and other government approvals;
- adequacy and quality of healthcare services;

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

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

We are subject to federal and state laws, such as the Federal False Claims Act, state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal anti-kickback laws, state anti-kickback laws, and the federal Stark laws, that govern financial and other arrangements among healthcare providers, their owners, vendors and referral sources, and that are intended to prevent healthcare fraud and abuse. Among other things, these laws prohibit kickbacks, bribes and rebates, as well as other direct and indirect payments or fee-splitting arrangements that are designed to induce the referral of patients to a particular provider for medical products or services payable by any federal healthcare program, and prohibit presenting a false or misleading claim for payment under a federal or state program. They also prohibit some physician self-referrals. Possible sanctions for violation of any of these restrictions or prohibitions include loss of eligibility to participate in federal and state reimbursement programs and civil and criminal penalties. Changes in these laws could increase our cost of doing business. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations, refund payments to the government, enter into corporate integrity, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

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

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

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

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

The interpretation and enforcement of federal and state laws and regulations governing our operations, including, but not limited to the laws describe above, are subject to frequent change. Governmental authorities may interpret these laws in a manner inconsistent with our interpretation and application. If we fail to comply, even inadvertently, with any of these requirements, we could be required to alter our operations and reduce, forego or refund reimbursements to the government, or incur other significant penalties. We could also be compelled to divert personnel and other resources to responding to an investigation or other enforcement action under these laws or regulations, or to ongoing compliance with a corporate integrity agreement, deferred prosecution agreement, court order or similar agreement. The diversion of these resources, including our management team, clinical and compliance staff, and others, would take away from the time and energy these individuals devote to routine operations.

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

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

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

- cost reporting and billing practices;
- quality of care;
- financial relationships with referral sources; and
- medical necessity of services provided.

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

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

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

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

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

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

CMS has undertaken several initiatives to increase or intensify Medicaid and Medicare survey and enforcement activities, including federal oversight of state actions. CMS is taking steps to focus more survey and enforcement

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

In addition, CMS has adopted, and is considering additional regulations expanding federal and state authority to impose civil monetary penalties in instances of noncompliance. When a facility is found to be deficient under state licensing and Medicaid and Medicare standards, sanctions may be threatened or imposed such as denial of payment for new Medicaid and Medicare admissions, civil monetary penalties, focused state and federal oversight and even loss of eligibility for Medicaid and Medicare participation or state licensure. Sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance.

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Facilities with otherwise acceptable regulatory histories generally are given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within six months, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility s existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously-certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators. In addition, CMS has increased its focus on facilities with a history of serious quality of care problems through the special focus facility initiative. A facility s administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility s compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility graduates from the program once it demonstrates significant improvements in quality of care that are continued over time. We have had several facilities placed on special focus facility status, due largely or entirely to their respective regulatory histories prior to our acquisition of the operations, and have successfully graduated three facilities from the program to date. We currently have two facilities operating under special focus status, and the state survey agency has indicated that some or all of the historical non-compliance considered in placing one of these facilities on special focus status predated our late 2006 acquisitions of the facility. In addition, one facility was placed on special focus status prior to our acquisition of that facility on October 1, 2009.

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

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

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

In addition, other states that do not require certificates of need have effectively barred the expansion of existing facilities and the development of new ones by placing partial or complete moratoria on the number of new Medicaid beds they will certify in certain areas or in the entire state. Other states have established such stringent development standards and approval procedures for constructing new healthcare facilities that the construction of new facilities, or the expansion or renovation of existing facilities, may become cost-prohibitive or extremely time-consuming. Our ability to acquire or construct new facilities or expand or provide new services at existing facilities would be adversely affected if we are unable to obtain the necessary approvals, if there are changes in the standards applicable to those approvals, or if we experience delays and increased expenses associated with obtaining those approvals. We may not be able to obtain licensure, certificate of need approval, Medicaid certification, or other necessary approvals for future expansion projects. Conversely, the elimination or reduction of state regulations that limit the construction, expansion or renovation of new or existing facilities could result in increased competition to us or result in overbuilding of facilities in some of our markets. If overbuilding in the skilled nursing industry in the markets in which we operate were to occur, it could reduce the occupancy rates of existing facilities and, in some cases, might reduce the private rates that we charge for our services.

Changes in federal and state employment-related laws and regulations could increase our cost of doing business.
Our operations are subject to a variety of federal and state employment-related laws and regulations, including, but not limited to, the U.S. Fair Labor Standards Act which governs such matters as minimum wages, overtime and other working conditions, the Americans with Disabilities Act (ADA) and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission, regulations of the Office of Civil Rights, regulations of state Attorneys General, family leave mandates and a variety of similar laws enacted by the federal and state governments that govern these and other employment law matters. Because labor represents such a large portion of our operating costs, changes in federal and state employment-related laws and regulations could increase our cost of doing business.
The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our facilities are required to comply with the ADA. The ADA has separate compliance requirements for public accommodations and commercial properties, but generally requires that buildings be made accessible to people with disabilities. Compliance with ADA requirements could require removal of access barriers and non-compliance could result in imposition of government fines or an award of damages to private litigants. Further legislation may impose additional burdens or restrictions with respect to access by disabled persons. In addition, federal proposals to introduce a system of mandated health insurance and flexible work time and other similar initiatives could, if implemented, adversely affect our operations. We also may be subject to employee-related claims such as wrongful discharge, discrimination or violation of equal employment law. While we are insured for these types of claims, we could experience damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.
Compliance with federal and state fair housing, fire, safety and other regulations may require us to make unanticipated expenditures, which could be costly to us.
We must comply with the federal Fair Housing Act and similar state laws, which prohibit us from discriminating against individuals if it would cause such individuals to face barriers in gaining residency in any of our facilities. Additionally, the Fair Housing Act and other similar state laws require that we advertise our services in such a way that we promote diversity and not limit it. We may be required, among other things, to change our marketing techniques to comply with these requirements.
In addition, we are required to operate our facilities in compliance with applicable fire and safety regulations, building codes and other land use regulations and food licensing or certification requirements as they may be adopted by governmental agencies and bodies from time to time. Like other healthcare facilities, our skilled nursing facilities are subject to periodic surveys or inspections by governmental authorities to assess and assure compliance with regulatory requirements. Surveys occur on a regular (often annual or biannual) schedule, and special surveys may result from a specific complaint filed by a patient, a family member or one of our competitors. We may be required to make substantial capital expenditures to comply with these requirements.
We depend largely upon reimbursement from third-party payors, and our revenue, financial condition and results of operations could be negatively impacted by any changes in the acuity mix of patients in our facilities as well as payor mix and payment methodologies.
Our revenue is affected by the percentage of our patients who require a high level of skilled nursing and rehabilitative care, whom we refer to as high acuity patients, and by our mix of payment sources. Changes in the acuity level of patients we attract, as well as our payor mix among Medicaid, Medicare, private payors and managed care companies, significantly affect our profitability because we generally receive higher reimbursement rates for high acuity patients and because the payors reimburse us at different rates. For the six months ended June 30, 2010, approximately 76% of our revenue was provided by government payors that reimburse us at predetermined rates. If our labor or other operating costs increase, we will be unable to recover such increased costs from government payors. Accordingly, if we fail to maintain our proportion of high acuity patients or if there is any significant increase in the percentage of our patients for whom we receive Medicaid reimbursement, our results of operations may be adversely affected.
Initiatives undertaken by major insurers and managed care companies to contain healthcare costs may adversely affect our business. These payors attempt to control healthcare costs by contracting with healthcare providers to obtain

services on a discounted basis. We believe that this trend will continue and may limit reimbursements for healthcare services. If insurers or managed care companies from whom we receive substantial payments were to reduce the amounts they pay for services, we may lose patients if we choose not to renew our contracts with these insurers at lower rates.

Compliance with state and federal employment, immigration, licensing and other laws could increase our cost of doing business.

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

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

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

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

In addition, plaintiffs attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers and other long-term care companies, and have employed a wide variety of advertising and publicity strategies. Among other things, these strategies include establishing their own Internet websites, paying for premium advertising space on other websites, paying Internet search engines to optimize their plaintiff solicitation advertising so that it appears in advantageous positions on Internet search results, including results from searches for our company and facilities, using newspaper, magazine and television ads targeted at customers of the healthcare industry generally, as well as at customers of specific providers, including us. From time to time, law firms claiming to specialize in long-term care litigation have named us, our facilities and other specific healthcare providers and facilities in their advertising and solicitation materials. These advertising and solicitation activities could result in more claims and litigation, which could increase our liability exposure and legal expenses, divert the time and attention of our personnel from day-to-day business operations, and materially and adversely affect our financial condition and results of operations. Furthermore, to the extent the frequency and/or severity of losses from such claims and suits increases, our liability insurance premiums could increase and/or available insurance coverage levels could decline, which could materially and adversely affect our financial condition and results of operations.

Certain lawsuits filed on behalf of patients of long-term care facilities for alleged negligence and/or alleged abuses have resulted in large damage awards against other companies, both in and related to our industry. In addition, there has been an increase in the number of class action suits filed against long-term and rehabilitative care companies. A class action suit was previously filed against us alleging, among other things, violations of certain California Health and Safety Code provisions and a violation of the California Consumer Legal Remedies Act at certain of our facilities. We settled this class action suit and this settlement was approved by the affected class and the Court in April 2007. However, we could be subject to similar actions in the future, which could subject us to large damage awards and settlements.

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

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

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

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

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

On December 17, 2007, we were informed by Deloitte & Touche LLP, our independent registered public accounting firm, that the U.S. Attorney served a grand jury subpoena on Deloitte & Touche LLP, relating to The Ensign Group, Inc., and several of our operating subsidiaries. The subpoena confirmed our previously reported belief that the U.S. Attorney was conducting an investigation involving facilities operated by certain of our operating subsidiaries. All together, the March 2007 authorized investigative demand and the December 2007 subpoena specifically covered information from a total of 18 of our 81 facilities. In February 2008, the U.S. Attorney contacted two additional current employees. We also continue to sporadically receive anecdotal reports of former employees who have been contacted by investigators from the U.S. Attorney s office. Based on these events, we believe that the U.S. Attorney may be conducting parallel criminal, civil and administrative investigations involving The Ensign Group, Inc. and one or more of our skilled nursing facilities.

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

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

decline.

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

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

As a byproduct of our investigation we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located or for which other billing deficiencies existed. We, with the assistance of independent consultants experienced in Medicare billing, completed a billing review on these claims. To the extent missing documentation was not located, we treated the claims as overpayments. Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known.

From time to time our systems and controls highlight potential compliance issues, which we investigate as they arise. As a result of the detection by management at one of our facilities, and their Service Center support personnel, of possible recordkeeping and related irregularities at that facility, we initiated an internal inquiry in the second quarter of 2010.

We concluded the investigatory phase of this inquiry in the third quarter of 2010, and commenced a billing review of potentially affected claims. We made observations at the facility regarding areas of potential improvement in some of our historical recordkeeping and billing practices and have identified measures, some of which had already been implemented before the inquiry began, that we believe have strengthened, and can strengthen further, our recordkeeping and billing processes. The issues detected appear to be isolated to one facility and one department within that facility. We continue to evaluate the measures we have implemented for effectiveness, and we are continuing to seek ways to improve these processes.

As a result of our billing reviews, we identified a limited number of selected Medicare claims for which adequate backup documentation could not be located, or for which other billing deficiencies existed. Where accepted procedures and necessary data for reviewing and calculating potential overpayments were available, we followed such procedures and completed a billing review. Where such procedures and/or data were not available we developed a methodology for making a good faith estimate of potential overpayments with the assistance of independent consultants experienced in Medicare billing. We have accrued a liability for estimated overpayments resulting from insufficient or missing documentation or other billing deficiencies. To the extent that sufficient documentation is subsequently located, the amount we ultimately reimburse will be reduced.

Consistent with healthcare industry accounting practices, we record any charge for refunded payments against revenue in the period in which the claim adjustment becomes known. During the quarter ended June 30, 2010, we accrued for a revenue adjustment of approximately $0.5 million, plus interest, for the estimated overpayments described above, with a resulting impact to net income of approximately $0.3 million. At the conclusion of our review we intend to submit the potential overpayment for settlement with the Medicare Fiscal Intermediary.

If additional reviews result in identification and quantification of additional amounts to be refunded, we would accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. If future investigations ultimately result in findings of significant billing and reimbursement noncompliance which could require us to record significant additional provisions or remit payments, our business, financial condition and results of operations could be materially and adversely affected and our stock price could decline.

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

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

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

We have also historically acquired a few facilities, either because they were included in larger, indivisible groups of facilities or under other circumstances, which were or have proven to be non-strategic or less desirable, and we may

consider disposing of such facilities or exchanging them for facilities which are more desirable. To the extent we dispose of such a facility without simultaneously acquiring a facility in exchange, our revenues might decrease.

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

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

In the six months ended June 30, 2010, we acquired four skilled nursing facilities and one home health and hospice operation with a total of 435 operational beds. In 2009 we acquired twelve skilled nursing facilities, one skilled nursing facility which also offers independent living and hospice services, one skilled nursing facility which also offers assisted living and independent living services and one assisted living facility with a total of 1,777 operational beds. This growth has placed and will continue to place significant demands on our current management resources. Our ability to manage our growth effectively and to successfully integrate new acquisitions into our existing business will require us to continue to expand our operational, financial and management information systems and to continue to retain, attract, train, motivate and manage key employees, including facility-level leaders and our local directors of nursing. We may not be successful in attracting qualified individuals necessary for future acquisitions to be successful, and our management team may expend significant time and energy working to attract qualified personnel to manage facilities we may acquire in the future. Also, the newly acquired facilities may require us to spend significant time improving services that have historically been substandard, and if we are unable to improve such facilities quickly enough, we may be subject to litigation and/or loss of licensure or certification. If we are not able to successfully overcome these and other integration challenges, we may not achieve the benefits we expect from any of our facility acquisitions, and our business may suffer.

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

In undertaking acquisitions, we also may be adversely impacted by unforeseen liabilities attributable to the prior providers who operated those facilities, against whom we may have little or no recourse. Many facilities we have historically acquired were underperforming financially and had clinical and regulatory issues prior to and at the time of acquisition. Even where we have improved operations and patient care at facilities that we have acquired, we still may face post-acquisition regulatory issues related to pre-acquisition events. These may include, without limitation, payment recoupment related to our predecessors prior noncompliance, the imposition of fines, penalties, operational restrictions or special regulatory status. Further, we may incur post-acquisition compliance risk due to the difficulty or impossibility of immediately or quickly bringing non-compliant facilities into full compliance. Diligence materials pertaining to acquisition targets, especially the underperforming facilities that often represent the greatest opportunity for return, are often inadequate, inaccurate or impossible to obtain, sometimes requiring us to make acquisition decisions with incomplete information. Despite our due diligence procedures, facilities that we have acquired or may acquire in the future may generate unexpectedly low returns, may cause us to incur substantial losses, may require unexpected levels of management time, expenditures or other resources, or may otherwise not meet a risk profile that our investors find acceptable. For example, in July of 2006 we acquired a facility that had a history of intermittent noncompliance. Although the facility had been already surveyed once by the local state survey agency after being acquired by us, and that survey would have met the heightened requirements of the special focus facility program, based upon the facility s compliance history prior to our acquisition, in January 2008, state officials nevertheless recommended to CMS that the facility be placed on special focus facility status. In addition, in October of 2006, we acquired a facility which had a history of intermittent non-compliance. This facility was surveyed by the local state survey agency during the third quarter of 2008 and passed the heightened survey requirements of the special focus facility program. Both facilities have successfully graduated from the Centers for Medicare and Medicaid Services Special Focus program. We currently have two facilities remaining on special focus facility status.

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

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

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

We have received notices of potential sanctions and remedies based upon alleged regulatory deficiencies from time to time, and such sanctions have been imposed on some of our facilities. CMS has included two of our facilities on its recently released list of special focus facilities, which are described above, and other facilities may be identified for such status in the future, the sanctions for which involve increased scrutiny in the form of more frequent inspection visits from state regulators. One of the facilities included on the special focus facility list was acquired by us on October 1, 2009. From time to time, we have opted to voluntarily stop accepting new patients pending completion of a new state survey, in order to avoid possible denial of payment for new admissions during the deficiency cure period, or simply to avoid straining staff and other resources while retraining staff, upgrading operating systems or making other operational improvements. In the past, some of our facilities have been in denial of payment status due to findings of continued regulatory deficiencies, resulting in an actual loss of the revenue associated with the Medicare and Medicaid patients admitted after the denial of payment date. Additional sanctions could ensue and, if imposed, these sanctions, entailing various remedies up to and including decertification, would further negatively affect our financial condition and results of operations.

The intensified and evolving enforcement environment impacts providers like us because of the increase in the scope or number of inspections or surveys by governmental authorities and the severity of consequent citations for alleged failure to comply with regulatory requirements. We also divert personnel resources to respond to federal and state investigations and other enforcement actions. The diversion of these resources, including our management team, clinical and compliance staff, and others take away from the time and energy that these individuals could otherwise spend on routine operations. As noted, from time to time in the ordinary course of business, we receive deficiency reports from state and federal regulatory bodies resulting from such inspections or surveys. The focus of these deficiency reports tends to vary from year to year. Although most inspection deficiencies are resolved through an agreed-upon plan of corrective action, the reviewing agency typically has the authority to take further action against a licensed or certified facility, which could result in the imposition of fines, imposition of a provisional or conditional license, suspension or revocation of a license, suspension or denial of payment for new admissions, loss of certification as a provider under state or federal healthcare programs, or imposition of other sanctions, including criminal penalties. In the past, we have experienced inspection deficiencies that have resulted in the imposition of a provisional license and could experience these results in the future. We currently have no facilities operating under provisional licenses which were the result of inspection deficiencies.

Furthermore, in some states, citations in one facility impact other facilities in the state. Revocation of a license at a given facility could therefore impair our ability to obtain new licenses or to renew existing licenses at other facilities, which may also trigger defaults or cross-defaults under our leases and our credit arrangements, or adversely affect our ability to operate or obtain financing in the future. If state or federal regulators were to determine, formally or otherwise, that one facility s regulatory history ought to impact another of our existing or prospective facilities, this could also increase costs, result in increased scrutiny by state and federal survey agencies, and even impact our expansion plans. Therefore, our failure to comply with applicable legal and regulatory requirements in any single facility could negatively impact our financial condition and results of operations as a whole. We currently have four facilities in Colorado whereby the provisional, or conditional, license status is not the result of inspection deficiencies, but the state s decision to issue a provisional license to us as a new operator in the state of Colorado. The state s granting of a provisional license in Colorado was the result of the Company not having prior operational compliance history in the state.

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

Overall operational occupancy across all of our facilities was 79.4% and 79.6% for the six months ended June 30, 2010 and 2009, respectively, leaving opportunities for internal growth without the acquisition or construction of new facilities. Because a large portion of our costs are fixed, a decline in our occupancy could adversely impact our financial performance. In addition, our profitability is impacted heavily by our patient mix. We generally generate greater profitability from non-Medicaid patients. If we are unable to maintain or increase the proportion of

non-Medicaid patients in our facilities, our financial performance could be adversely affected.

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

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

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

The skilled nursing and assisted living industries are highly competitive, and we expect that these industries may become increasingly competitive in the future. Our skilled nursing facilities compete primarily on a local and regional basis with many long-term care providers, from national and regional multi-facility providers that have substantially greater financial resources to small providers who operate a single nursing facility. We also compete with other skilled nursing and assisted living facilities, and with inpatient rehabilitation facilities, long-term acute care hospitals, home healthcare and other similar services and care alternatives. Increased competition could limit our ability to attract and retain patients, attract and retain skilled personnel, maintain or increase private pay and managed care rates or expand our business. Our ability to compete successfully varies from location to location depending upon a number of factors, including:

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

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

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

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

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

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

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In December 2008, CMS introduced the Five-Star Quality Rating System to help consumers, their families and caregivers compare nursing homes more easily. The Five-Star Quality Rating System gives each nursing home a rating of between one and five stars in various categories. In cases of acquisitions, the previous operator s clinical ratings are included in our overall Five-Star Quality Rating. The prior operator s results will impact our rating until we have sufficient clinical measurements subsequent to the acquisition date. If we are unable to achieve quality of care ratings that are comparable or superior to those of our competitors, our ability to attract and retain patients could be adversely affected.

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

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

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

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

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

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

Our self-insurance programs may expose us to significant and unexpected costs and losses.
Since 2002, we have maintained general and professional liability insurance and worker s compensation insurance since 2005 through a wholly-owned subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our SIR and deductibles as part of a continually evolving overall risk management strategy. We establish the premiums to be paid to Standardbearer, and the loss reserves set by that subsidiary, based on an estimation process that uses information obtained from both company-specific and industry data. The estimation process requires us to continuously monitor and evaluate the life cycle of the claims. Using data obtained from this monitoring and our assumptions about emerging trends, we, along with an independent actuary, develop information about the size of ultimate claims based on our historical experience and other available industry information. The most significant assumptions used in the estimation process include determining the trend in costs, the expected cost of claims incurred but not reported and the expected costs to settle or pay damages with respect to unpaid claims. It is possible, however, that the actual liabilities may exceed our estimates of loss. We may also experience an unexpectedly large number of successful claims or claims that result in costs or liability significantly in excess of our projections. For these and other reasons, our self-insurance reserves could prove to be inadequate, resulting in liabilities in excess of our available insurance and self-insurance. If a successful claim is made against us and it is not covered by our insurance or exceeds the insurance policy limits, our business may be negatively and materially impacted. Further, because our SIR under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.
In May 2006, we began self-insuring our employee health benefits. With respect to our health benefits self-insurance, we do not yet have a meaningful multi-year loss history by which to set reserves or premiums, and have consequently relied heavily on general industry data that is not specific to our own company to set reserves and premiums. Even with a combination of limited company-specific loss data and general industry data, our loss reserves are based on actuarial estimates that may not correlate to actual loss experience in the future. Therefore, our reserves may prove to be insufficient and we may be exposed to significant and unexpected losses.
The geographic concentration of our facilities could leave us vulnerable to an economic downturn, regulatory changes or acts of nature in those areas.
Our facilities located in California and Arizona account for the majority of our total revenue. As a result of this concentration, the conditions of local economies, changes in governmental rules, regulations and reimbursement rates or criteria, changes in demographics, state funding, acts of nature and other factors that may result in a decrease in demand and/or reimbursement for skilled nursing services in these states could have a disproportionately adverse effect on our revenue, costs and results of operations. Moreover, since approximately 40% of our facilities are located in California, we are particularly susceptible to revenue loss, cost increase or damage caused by natural disasters such as fires, earthquakes or mudslides. In addition, to the extent we acquire additional facilities in Texas, we become more susceptible to revenue loss, cost increase or damage caused by hurricanes or flooding. Any significant loss due to a natural disaster may not be covered by insurance or may exceed our insurance limits and may also lead to an increase in the cost of insurance.
The actions of a national labor union that has pursued a negative publicity campaign criticizing our business in the past may adversely affect our revenue and our profitability.
We continue to maintain our right to inform our employees about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staffs at our facilities that have been approached to unionize have uniformly rejected union organizing efforts. If employees decide to unionize, our cost of doing business could increase, and we could experience contract delays, difficulty in adapting to a changing regulatory and economic environment, cultural conflicts between unionized and non-unionized employees, strikes and work stoppages, and we may conclude that affected facilities or operations would be uneconomical to continue operating.
The unwillingness on the part of both our management and staff to accede to union demands for neutrality and other concessions has resulted in a negative labor campaign by at least one labor union, the Service Employees International Union. From 2002 to 2007, this union, and individuals and organizations allied with or sympathetic to this union

actively prosecuted a negative retaliatory publicity action, also known as a corporate campaign, against us and filed, promoted or participated in multiple legal actions against us. The union s campaign asserted, among other allegations, poor treatment of patients, inferior medical services provided by our employees, poor treatment of our employees, and health code violations by us. In addition, the union has publicly mischaracterized actions taken by the DHS against us and our facilities. In numerous cases, the union s allegations created the false impression that violations and other events that occurred at facilities prior to our acquisition of those facilities were caused by us. Since a large component of our business involves acquiring underperforming and distressed facilities, and improving the quality of operations at these facilities, we may have been associated with the past poor performance of these facilities. To the extent this union or another elects to directly or indirectly prosecute a corporate campaign against us or any of our facilities, our business could be negatively affected.

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

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

We currently occupy approximately 7% of our facilities under agreements that are structured as master leases. Under a master lease, we may lease a large number of geographically dispersed properties through an indivisible lease. With an indivisible lease, it is difficult to restructure the composition of the portfolio or economic terms of the lease without the consent of the landlord. Failure to comply with Medicare or Medicaid provider requirements is a default under several of our master lease and debt financing instruments. In addition, other potential defaults related to an individual facility may cause a default of an entire master lease portfolio and could trigger cross-default provisions in our outstanding debt arrangements and other leases, which would have a negative impact on our capital structure and our ability to generate future revenue, and could interfere with our ability to pursue our growth strategy.

In addition, we occupy approximately 14% of our facilities under individual facility leases that are held by the same or related landlords, the largest of which covers five of our facilities. These leases typically contain cross-default provisions that could cause a default at one facility to trigger a technical default with respect to one or more other locations, potentially subjecting us to the various remedies available to the landlords under each of the related leases.

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

At June 30, 2010, we had $109.6 million of outstanding indebtedness under our Fourth Amended and Restated Loan Agreement (the Amended Term Loan), our Second Amended and Restated Loan and Security Agreement (the Revolver) and mortgage notes, plus $138.6 million of operating lease obligations. We intend to continue financing our facilities through mortgage financing, long-term operating leases and other types of financing, including borrowings under our lines of credit and future credit facilities we may obtain.

We may not generate sufficient cash flow from operations to cover required interest, principal and lease payments. In addition, from time to time the financial performance of one or more of our mortgaged facilities may not comply with the required operating covenants under the terms of the mortgage. Any non-payment, noncompliance or other default under our financing arrangements could, subject to cure provisions, cause the lender to foreclose upon the facility or facilities securing such indebtedness or, in the case of a lease, cause the lessor to terminate the lease, each with a consequent loss of revenue and asset value to us or a loss of property. Furthermore, in many cases, indebtedness is secured by both a mortgage on one or more facilities, and a guaranty by us. In the event of a default under one of these scenarios, the lender could avoid judicial procedures required to foreclose on real property by declaring all amounts

outstanding under the guaranty immediately due and payable, and requiring us to fulfill our obligations to make such payments. If any of these scenarios were to occur, our financial condition would be adversely affected. For tax purposes, a foreclosure on any of our properties would be treated as a sale of the property for a price equal to the outstanding balance of the debt secured by the mortgage. If the outstanding balance of the debt secured by the mortgage exceeds our tax basis in the property, we would recognize taxable income on foreclosure, but would not receive any cash proceeds, which would negatively impact our earnings and cash position. Further, because our mortgages and operating leases generally contain cross-default and cross-collateralization provisions, a default by us related to one facility could affect a significant number of other facilities and their corresponding financing arrangements and operating leases.

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

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

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

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

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

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

We rely significantly on appropriate referrals from physicians, hospitals and other healthcare providers in the communities in which we deliver our services to attract appropriate residents and patients to our facilities. Our referral

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

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

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

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

Financial markets experienced significant disruptions in 2008, which continued in 2009 and 2010. These disruptions impacted liquidity in the debt markets, making financing terms for borrowers less attractive and, in certain cases, significantly reducing the availability of certain types of debt financing. As a result of these market conditions, the cost and availability of credit has been and may continue to be adversely affected by illiquid credit markets and wider credit spreads. Concern about the stability of the markets has led many lenders and institutional investors to reduce, and in some cases, cease to provide credit to borrowers. These factors have led to a decrease in spending by businesses and consumers alike. Continued turbulence in the U.S. and prolonged declines in business and consumer spending may adversely affect our liquidity and financial condition. Though we anticipate that the cash amounts generated internally, together with amounts available under the Revolver, will be sufficient to implement our business plan for the foreseeable future, we may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. We cannot assure you that additional capital will be available or available on terms favorable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our information systems or if issues arise with Medicare, Medicaid or other payors, we may encounter delays in our payment cycle. From time to time, we have experienced such delays as a result of government payors instituting planned reimbursement delays for budget balancing purposes or as a result of prepayment reviews. For example, in 2008, California delayed any reimbursement subsequent to the end of July until such time as the budget was enacted. Further, and independent to the budget impasse, the State of California delayed all August 2008 payments until September. We cannot predict whether similar reimbursement delays will continue in future fiscal years. Medi-Cal had also delayed the release of the reimbursement rates which were announced in January 2010. These rate increases were put in place on a retrospective basis, effective August 1, 2009. In January 2009, the State of California announced expected cash shortages in February which impacted payments to Medi-Cal providers from late March through April. Any future timing delay may cause working capital shortages. As a result, working capital management, including prompt and diligent billing and collection, is an important factor in our results of operations and liquidity. Our working capital management procedures may not successfully ameliorate the effects of any delays in our receipt of payments or reimbursements. Accordingly, such delays could have an adverse effect on our liquidity and financial condition.

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

Four of our facilities are currently subject to regulatory agreements with the Department of Housing and Urban Development (HUD) that give the Commissioner of HUD broad authority to require us to be replaced as the operator of those facilities in the event that the Commissioner determines there are operational deficiencies at such facilities under HUD regulations. In 2006, one of our HUD-insured mortgaged facilities did not pass its HUD inspection. Following an unsuccessful appeal of the decision, we requested a re-inspection. The re-inspection occurred in the fourth quarter of 2009 and the facility passed its HUD re-inspection. Compliance with HUD s requirements can often be difficult because these requirements are not always consistent with the requirements of other federal and state agencies. Appealing a failed inspection can be costly and time-consuming and, if we do not successfully remediate the failed inspection, we could be precluded from obtaining HUD financing in the future or we may encounter limitations or prohibitions on our operation of HUD-insured facilities.

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

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

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

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

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

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

In addition, because environmental laws vary from state to state, expansion of our operations to states where we do not currently operate may subject us to additional restrictions in the manner in which we operate our facilities.

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

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

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

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

Risks Related to Ownership of our Common Stock

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

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

While we do not have a formal dividend policy, we currently intend to continue to pay regular quarterly dividends to the holders of our common stock, but future dividends will continue to be at the discretion of our board of directors and will depend on many factors, including our results of operations, financial condition and capital requirements, earnings, general business conditions, restrictions imposed by financing arrangements including pursuant to the loan and security agreement governing our revolving line of credit, legal restrictions on the payment of dividends and other factors the board of directors deems relevant. From 2002 through 2009, we paid aggregate annual dividends equal to approximately 5% to 15% of our net income. We may not be able to pay or maintain dividends, and we may at any time elect not to pay dividends but to retain cash for other purposes. We also cannot assure you that the level of dividends will be maintained or increase over time or that increases in demand for our beds and monthly patient fees will increase our actual cash available for dividends to stockholders. It is possible that we may pay dividends in a future period that may exceed our net income for such period. The failure to pay or maintain dividends could adversely affect our stock price.

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

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

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

The trading market for our common stock is influenced by the research and reports that industry or securities analysts publish about us or our business. If one or more of these analysts cease coverage of our company or fail to publish reports on us regularly, we could lose visibility in the financial markets, which in turn could cause our stock price or trading volume to decline. Moreover, if one or more of the analysts who cover us downgrade our stock or if our operating results do not meet their expectations, our stock price could decline.

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

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

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

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

Any shares issued in connection with our acquisitions, the exercise of outstanding stock options or otherwise would dilute the holdings of the investors who purchase our shares.

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

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

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

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

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

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

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

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

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

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

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

common stock to decline.

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

None.

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

None.

Item 4. ***(Removed and Reserved)***

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Item 5. ***Other Information***

None.

Item 6. ***Exhibits***

EXHIBIT INDEX

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

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SIGNATURES

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

	THE ENSIGN GROUP, INC.
August 6, 2010	BY: /s/ SUZANNE D. SNAPPER Suzanne D. Snapper Chief Financial Officer and Duly Authorized Officer

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