ENSIGN GROUP, INC
Form 10-K
February 13, 2013
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UNITED STATES SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

R	ANNUAL REPORT PURSUANT TO SECTION 13(a) OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934. For the fiscal year ended December 31, 2012
OR	
o	TRANSITION REPORT PURSUANT TO SECTION 13(a) 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 (State or Other Jurisdiction of Incorporation or Organization)	33-0861263 (I.R.S. Employer Identification No.)
27101 Puerta Real, Suite 450, Mission Viejo, CA (Address of Principal Executive Offices)	92691 (Zip Code)

Registrant's Telephone Number, Including Area Code:
(949) 487-9500

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

Title of Each Class	Name of Each Exchange on Which Registered
Common Stock, par value $0.001 per share	NASDAQ Global Select Market

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

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

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

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. R 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). R Yes o No

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

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

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

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

The aggregate market value of the registrant's common stock held by non-affiliates of the registrant, computed by reference to the closing price as of the last business day of the registrant's most recently completed second fiscal quarter, June 30, 2012, was approximately $490,500,000.

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On February 11, 2013, The Ensign Group, Inc. had 21,756,540 shares of Common Stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE:

Part III of this Form 10-K incorporates information by reference from the Registrant's definitive proxy statement for the Registrant's 2013 Annual Meeting of Stockholders to be filed within 120 days after the close of the fiscal year covered by this annual report.

THE ENSIGN GROUP, INC.

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For the Fiscal Year Ended December 31, 2012

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CAUTIONARY NOTE REGARDING FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K 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,” “estimates,” “may,” “will,” “should,” “would,” “could,” “potential,” “continue,” “ongoing,” similar expres variations or negatives of these words. These statements are subject to the safe harbors created under the Securities Act of 1933 and the Securities and Exchange Act of 1934. 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” in Part I, Item 1A of this Annual Report on Form 10-K. Accordingly, you should not rely upon forward-looking statements as predictions of future events. 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 Annual Report on Form 10-K, the words, “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our facilities, operations, the Service Center (defined below) and our wholly-owned captive insurance subsidiary (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 annual report is not meant to imply that any of our facilities, business operations, the Service Center or the Captive are operated by the same entity.

The Ensign Group, Inc. is a holding company with no direct operating assets, employees or revenues. All of our skilled nursing and assisted living facilities, home health and hospice operations, urgent care centers and majority owned subsidiaries are operated by separate, wholly-owned, independent subsidiaries, each of which have their own management, employees and assets. In addition, one of our wholly-owned independent 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. 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.

Like our operations, the Service Center and Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. Reference herein to the consolidated “Company” and “its” assets and activities, as well as the use of the terms “we,” “us,” “our” and similar verbiage in this annual 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. We were incorporated in 1999 in Delaware. Our corporate address is 27101 Puerta Real, Suite 450, Mission Viejo, CA 92691, and our telephone number is (949) 487-9500. Our corporate website is located at www.ensigngroup.net. The information contained in, or that can be accessed through, our website does not constitute a part of this annual report.

Ensign™ is our United States trademark. All other trademarks and trade names appearing in this annual report are the property of their respective owners.

PART I.

Item 1. Business

Overview

We are a provider of skilled nursing and rehabilitative care services through the operation of 108 facilities, seven home health and six hospice operations, located in Arizona, California, Colorado, Idaho, Iowa, Nebraska, Nevada, Oregon, Texas, Utah and Washington. Our operations, each of which strives to be the service of choice in the community it serves, provide a broad spectrum of skilled nursing, assisted living, home health and hospice services, including physical, occupational and speech therapies, and other rehabilitative and healthcare services, for both long-term residents and short-stay rehabilitation patients. In addition, we own and operate urgent care centers in the Seattle, Washington area and an urgent care franchise system with locations in several states. These walk-in clinics will offer daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. As of December 31, 2012, we owned 86 of our 108 facilities and operated an additional 22 facilities under long-term lease arrangements, and had options to purchase two of those 22 facilities.

We encourage and empower our leaders and staff to make their facility the “facility of choice” in the community it serves. This means that our 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.

Our organizational structure is centered upon local leadership. We believe our organizational structure, which empowers leaders and staff at the local level, is unique within the skilled nursing industry. Each of our operations is led by highly dedicated individuals who are responsible for key operational decisions at their facilities. Leaders and staff are trained and motivated to pursue superior clinical outcomes, high patient and family satisfaction, operating efficiencies and financial performance at their facilities. In addition, our leaders are enabled and motivated to share real-time operating data and otherwise benchmark clinical and operational performance against their peers in other facilities in order to improve clinical care, maximize patient satisfaction and augment operational efficiencies, promoting the sharing of best practices.

We view skilled nursing primarily as a local business, influenced by personal relationships and community reputation. We believe our success is largely dependent upon our ability to build strong relationships with key stakeholders from the local healthcare community, based upon a solid foundation of reliably superior care. Accordingly, our brand strategy is focused on encouraging the leaders and staff of each facility to focus on clinical excellence, and promote their facility independently within their local community.

Much of our historical growth can be attributed to our expertise in acquiring under-performing facilities and transforming them into market leaders in clinical quality, staff competency, employee loyalty and financial performance. We plan to continue to grow our revenue and earnings by:

•continuing to grow our talent base and develop future leaders;

•increasing the overall percentage or “mix” of higher-acuity residents;

•focusing on organic growth and internal operating efficiencies;

•continuing to acquire additional facilities in existing and new markets; and

•expanding and renovating our existing facilities, and potentially constructing new facilities.

Company History

Our company was formed in 1999 with the goal of establishing a new level of quality care within the skilled nursing industry. The name “Ensign” is synonymous with a “flag” or a “standard,” and refers to our goal of setting the standard by which all others are measured. We believe that through our efforts and leadership, we can foster a new level of patient care and professional competence at our facilities, and set a new industry standard for quality skilled nursing and rehabilitative care services.

We organize our facilities into portfolio companies, which we believe has enabled us to maintain a local, field-driven organizational structure and attract additional qualified leadership talent, and to identify, acquire, and improve facilities at a generally faster rate. Each of our portfolio companies has its own president. These presidents, who are experienced and proven leaders that are generally taken from the ranks of facility CEOs, serve as leadership resources within their own portfolio companies, and have the primary responsibility for recruiting qualified talent, finding potential acquisition targets, and identifying other internal and external growth opportunities. We believe this reorganization has improved the quality of our recruiting and will continue to facilitate successful acquisitions.

Cumulative Facility Growth

We have an established track record of successful acquisitions. Many of our earliest acquisitions were completed at a time when the skilled nursing industry was undergoing a major restructuring. From 2001 to 2003, we acquired a number of underperforming facilities, as several long-term care providers disposed of troubled facilities from their portfolios. We then applied our core operating expertise to turn these facilities around, both clinically and financially. In 2004 and 2005, we focused on the integration and improvement of our existing operations while limiting our acquisitions to strategically situated properties, acquiring five facilities over that period.

With the introduction in early 2006 of the portfolio companies and our New Market CEO program, described above, our acquisition activity accelerated, allowing us to add 15 facilities between January 1, 2006 and July 31, 2007. We then effectively suspended our acquisition program while we effected our initial public offering, which was completed in November 2007. From January 1, 2008 through December 31, 2011, we acquired 41 facilities which added 4,597 operational beds to our operations.
During the year ended December 31, 2012, the Company acquired five stand alone skilled nursing facilities, one of which also offers assisted living services, one stand alone assisted living facility, two home health operations and one hospice operation. The following table summarizes our growth from our formation in 1999 through December 31, 2012:

	December 31,													
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Cumulative number of facilities	5	13	19	24	41	43	46	57	61	63	77	82	102	108
Cumulative number of operational skilled nursing, assisted living and independent living beds	665	1,571	2,155	2,751	4,959	5,213	5,585	6,667	7,105	7,324	8,948	9,539	11,702	12,198

New Market CEO and New Ventures Programs. In order to broaden our reach to new markets, and in an effort to provide existing leaders in our company with the entrepreneurial opportunity and challenge of entering a new market and starting a new business, we established our New Market CEO program in 2006. Supported by our Service Center and other resources, a New Market CEO evaluates a target market, develops a comprehensive business plan, and relocates to the target market to find talent and connect with other providers, regulators and the healthcare community in that market, with the goal of ultimately acquiring facilities and establishing an operating platform for future growth. In addition, this program was expanded to broaden our reach to other lines of business closely related to the skilled nursing industry through our New Ventures program. The New Ventures program encourages facility CEOs to evaluate new lines of business with the goal of establishing an operating platform in new markets. We believe that this

program will not only continue to drive growth, but will also provide a valuable training ground for our next generation of leaders, who will have experienced the challenges of growing and operating a new business.

Recent Developments

U.S. Government Inquiries — We, through the special committee and our outside counsel, continue to work cooperatively with the U.S Department of Justice (DOJ). Ensign anticipates that this ongoing dialogue will continue in 2013 as part of our effort to resolve this matter. Based on information gathered by us in connection with the work of the special committee, our outside counsel and their experts, we recorded an estimated liability in the amount of $15.0 million in the fourth quarter of 2012 related to our efforts to achieve a global, company-wide, resolution of any claims connected to the investigation. Active settlement discussions with the DOJ are ongoing and, until concluded, the outcome remains uncertain and the amount related to the resolution of any claims connected to this pending investigation could differ materially from our estimates. At this time, we cannot estimate the possible range of loss that may result from any such proceedings or discussions.

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

Board of Directors — Effective June 15, 2012, Mr. Daren J. Shaw was appointed by the board of directors, at the recommendation of the nomination and corporate governance committee, to serve on the audit committee with Mr. John Nackel and Mr. Thomas Maloof (Chair). Mr. Shaw has also been appointed by the board of directors to serve on the nomination and corporate governance committee and the compensation committee. On July 26, 2012, the board of directors appointed Mr. Shaw to serve as the chair of the audit committee effective September 1, 2012.

On October 31, 2012, Van R. Johnson informed the board of directors that he intends to retire from the board of directors at the close of the Annual Meeting of the Shareholders for 2013. Mr. Johnson's resignation is due to his acceptance of a full-time volunteer assignment from his church that will require him to step away from all outside business engagements, including the board of directors. Mr. Johnson has served on the board of directors since 2009 and is currently serving as the Chairman of the Nomination and Corporate Governance Committee.

Senior Credit Facility — On February 1, 2013, we entered into the third amendment to the senior credit facility with a six-bank lending consortium arranged by SunTrust and Wells Fargo (the Senior Credit Facility) (the Third Amendment), which amends our existing Senior Credit Facility agreement, dated as of July 15, 2011. The Third Amendment revises the Senior Credit Facility agreement to, among other things, (i) increase the revolving credit portion of the Senior Credit Facility by $75.0 million to an aggregate principal amount of $150.0 million, and (ii) extend the maturity date from July 15, 2016 to February 1, 2018. Except as set forth in the Third Amendment, all other terms and conditions of the Senior Credit Facility remain in full force and effect.

Urgent Care

Immediate Clinic (IC) — On January 10, 2012, we announced a joint venture to develop and operate urgent care facilities and related businesses. Immediate Clinic (IC) will offer daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. Design and construction planning for several new locations is currently underway, and IC is also seeking opportunities to acquire existing urgent care operations across the United States. As of December 31, 2012, IC was operating three urgent care centers, and anticipates opening two additional centers during the first quarter of 2013.

Our joint venture partner and IC's Chief Executive Officer, Dr. John Shufeldt resigned on September 12, 2012. On October 4, 2012, we invested an additional $6.0 million to IC in exchange for senior preferred stock which resulted in our holding approximately 96% of the outstanding interests in the joint venture on a fully-diluted basis. The proceeds of such investment will be used to continue the development of additional clinics in the Northwest. In addition, on December 20, 2012, IC redeemed all remaining minority interests in IC.

On February 15, 2012, IC purchased an equity investment in an urgent care software service provider for $1.4 million. In addition, on March 1, 2012, DRX Urgent Care LLC (DRX), a newly formed subsidiary of IC, purchased substantially all of the assets and assumed certain liabilities of Doctors Express Franchising LLC, a national urgent care franchise system for $2.0 million, adjusted for certain items at the time of close and redeemable noncontrolling interest of $11.6 million. We recognized intangible assets of $7.9 million in trade name, $3.0 million in franchise relationships and $2.7 million in goodwill as part of this transaction. On December 31, 2012, IC purchased the

remaining ownership interest in DRX for approximately $5.3 million.

Mobile X-Ray and Diagnostics

On December 31, 2012, the Company purchased 80% of the membership interest of a mobile x-ray and diagnostic company for $5.8 million, plus preliminary net working capital of approximately $1.3 million for total consideration of approximately $7.1 million, which was paid in cash. The mobile diagnostic company is a leader in providing mobile diagnostic services, including digital x-ray, ultrasound, electrocardiograms, ankle-brachial index, and phlebotomy services to people in their homes or at long-term care facilities. The Company believes the acquisition is strategic given the mobile diagnostic company's experienced management team. This acquisition will provide the Company with a broad set of services to its customers in the markets it serves.

The Company recognized intangible assets of approximately $0.9 million in trade name, $4.2 million in customer relationship and $2.1 million in goodwill as part of this transaction. See additional details in Note 9 Goodwill and Other Indefinite-Lived Intangible Assets-Net in Notes to Consolidated Financial Statements. The Company's preliminary determination of the fair value of the tangible and intangible assets acquired and liabilities assumed is based on estimates and assumptions that are subject to change. During the measurement period, when information becomes available which would indicate adjustments are required to the purchase price allocation, such adjustment will be included in the purchase price allocation retrospectively. The measurement period is expected to extend as long as one year from the date of acquisition.

Facility Acquisition History

The following table sets forth the location and number of licensed and independent living beds located at our skilled nursing and assisted living facilities as of December 31, 2012:

	CA	AZ	TX	UT	CO	WA	ID	NV	NE	IA	Total
Number of facilities	35	13	23	11	5	3	6	3	4	5	108
Operational skilled nursing, assisted living and independent living beds	3,864	1,902	2,918	1,344	463	274	477	304	296	356	12,198

On January 1, 2013, we acquired one home health operation in Washington and two hospice operations in California and Arizona, respectively, for an aggregate purchase price of approximately $4.5 million, which was paid in cash. These acquisitions did not impact our overall bed count.

During the fourth quarter of 2012, we purchased a skilled nursing facility in Texas for $2.6 million, which was paid in cash. This acquisition added 92 operational skilled nursing beds to our operations.

During the third quarter of 2012, we purchased two skilled nursing facilities in Idaho for $4.5 million in one transaction, which was paid in cash. One of the skilled nursing facilities acquired also offers assisted living services. This acquisition added 94 operational skilled nursing beds and 24 assisted living units to our operations.

During the second quarter of 2012, we purchased a home health and hospice business with operations in Utah and Arizona and a skilled nursing facility in Texas in two separate transactions for an aggregate purchase price of $11.0 million. All second quarter acquisitions were paid for in cash. The skilled nursing facility acquisition added 150 operational skilled nursing beds, while the home health operations did not impact our overall bed count.

During the first quarter of 2012, we purchased one assisted living facility in Nevada, one home health operation in Oregon and one skilled nursing facility in Idaho in three separate transactions for an aggregate purchase price of $5.4 million. All first quarter acquisitions were paid for in cash. These acquisitions added an aggregate of 113 operational skilled nursing beds and 60 assisted living units to our operations, while the home health operation acquisition did not impact our overall bed count.

We also entered into separate operations transfer agreements with the prior operator as part of each of the above noted transactions.

In addition, during the year ended December 31, 2012, we purchased the underlying assets of three of our skilled nursing facilities in California which we previously operated under long-term lease agreements, which contained options to purchase, for $11.4 million, which was paid in cash. These acquisitions did not impact our operational bed count.

Industry Trends

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

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

- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.
- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.

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

Effects of Changing Prices

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

In October 2011, the Centers for Medicare and Medicaid Services (CMS) announced a final rule reducing Medicare skilled nursing facility PPS payments in fiscal year 2012 by 11.1%. CMS recalibrated the case-mix indexes (CMIs) for fiscal year 2012 to restore overall payments to their intended levels on a prospective basis. This reduction was partially offset by the fiscal year 2012 update to Medicare payments to skilled nursing facilities. The update, a 1.7% or $600 million increase, reflected a 2.7% market basket increase, reduced by a 1.0% multi-factor productivity (MFP) adjustment mandated by the Patient Protection and Affordable Care Act (PPACA). The combined MFP-adjusted market basket increase and the fiscal year 2012 recalibration was projected to yield a net reduction of $3.87 billion, or 11.1%.

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

On January 2, 2013 the President signed the American Taxpayer Relief Act of 2012 into law. This statute delays significant cuts in Medicare rates for physician services until December 31, 2013. The statute also creates a Commission on Long Term Care, the goal of which is to develop a plan for the establishment, implementation, and financing of a comprehensive, coordinated, and high-quality system that ensures the availability of long-term care services and supports for individuals in need of such services and supports. Any implementation of recommendations from this commission may have an impact on coverage and payment for our services.

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

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

Additionally, there is further uncertainty on how Medicare will reimburse for home health services when rebasing of rates becomes effective in 2014; when Medicare will reset the rates and change how CMS reimburses for home health services. The methodology for rebasing has yet to be determined, but we expect it will result in further reimbursement reductions.

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

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

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

The therapy cap exception was reauthorized in a number of subsequent laws, most recently in the American Taxpayer Relief Act of 2012 which extends the exceptions process through December 31, 2013. The statutory Medicare Part B outpatient therapy cap for occupational therapy and the combined cap for physical therapy and speech-language pathology services are $1,880, respectively, for 2012. These amounts represent annual per beneficiary therapy caps determined for each calendar year. These cap amounts will increase to $1,900 in 2013. Similar to the therapy cap, Congress established a threshold of $3,700 for physical therapy and speech-language pathology services combined and a separate threshold of $3,700 for occupational therapy services. All therapy services rendered above this limit are subject to medical review and beginning October 1, 2012, CMS rolled out a pilot program requiring some therapy providers to submit pre-approval requests for exceptions. Prior to October 1, 2012 there was no requirement for an exception request to be pre-approved when the threshold was exceeded. The pilot program was rolled out to our facilities in groups beginning in October 2012.

In addition, the Multiple Procedure Payment Reduction (MPPR) will be increased to 50% and applied to therapy by reducing payments for practice expense of the second and subsequent therapies when therapies are provided on the same day, instead of the existing 25% discount. The change from 25% of the practice expense to a 50% reduction is expected to take effect on April 1, 2013.

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

Medicare Coverage Settlement Agreement — A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved

on January 24, 2013, which tasked CMS with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS must also develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve. At the conclusion of the CMS education campaign, the members of the class will have the opportunity for re-review of their claims, and a two- or three-year monitoring period will commence. Implementation of the provisions of this settlement agreement could favorably impact reimbursement for our services.

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

Payor Sources

Total Revenue by Payor Sources. We derive revenue primarily from the Medicaid and Medicare programs, private pay patients and managed care payors. Medicaid typically covers patients that require standard room and board services, and provides reimbursement rates that are generally lower than rates earned from other sources. We monitor our quality mix, which is the percentage of non-Medicaid revenue from each of our facilities, to measure the level received from each payor across each of our business units. We intend to continue to focus on enhancing our care offerings to accommodate more high acuity patients.

Medicaid. Medicaid is a state-administered program financed by state funds and matching federal funds. Medicaid programs are administered by the states and their political subdivisions, and often go by state-specific names, such as Medi-Cal in California and the Arizona Healthcare Cost Containment System in Arizona. Medicaid programs generally provide health benefits for qualifying individuals, and may supplement Medicare benefits for financially needy persons aged 65 and older. Medicaid reimbursement formulas are established by each state with the approval of the federal government in accordance with federal guidelines. Seniors who enter skilled nursing facilities as private pay clients can become eligible for Medicaid once they have substantially depleted their assets. Medicaid is the largest source of funding for nursing home facilities.

Private and Other Payors. Private and other payors consist primarily of individuals, family members or other third parties who directly pay for the services we provide.

Medicare. Medicare is a federal program that provides healthcare benefits to individuals who are 65 years of age or older or are disabled. To achieve and maintain Medicare certification, a skilled nursing facility must meet the CMS, “Conditions of Participation”, on an ongoing basis, as determined in periodic facility inspections or “surveys” conducted primarily by the state licensing agency in the state where the facility is located. Medicare pays for inpatient skilled nursing facility services under the prospective payment system. The prospective payment for each beneficiary is based upon the medical condition of and care needed by the beneficiary. Medicare skilled nursing facility coverage is limited to 100 days per episode of illness for those beneficiaries who require daily care following discharge from an acute care hospital.

Managed Care and Private Insurance. Managed care patients consist of individuals who are insured by a third-party entity, typically a senior HMO plan, or who are Medicare beneficiaries who have assigned their Medicare benefits to a senior HMO plan. Another type of insurance, long-term care insurance, is also becoming more widely available to consumers, but is not expected to contribute significantly to industry revenues in the near term.

Billing and Reimbursement. Our revenue from government payors, including Medicare and state Medicaid agencies, is subject to retroactive adjustments in the form of claimed overpayments and underpayments based on rate adjustments and asserted billing and reimbursement errors. We believe billing and reimbursement errors, disagreements, overpayments and underpayments are common in our industry, and we are regularly engaged with government payors and their fiscal intermediaries in reviews, audits and appeals of our claims for reimbursement due to the subjectivity inherent in the processes related to patient diagnosis and care, recordkeeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce.

We take seriously our responsibility to act appropriately under applicable laws and regulations, including Medicare and Medicaid billing and reimbursement laws and regulations. Accordingly, we employ accounting, reimbursement and compliance specialists who train, mentor and assist our clerical, clinical and rehabilitation staffs in the preparation of claims and supporting documentation, regularly monitor billing and reimbursement practices within our facilities, and assist with the appeal of overpayment and recoupment claims generated by governmental, fiscal intermediary and other auditors and reviewers. In addition,

due to the potentially serious consequences that could arise from any impropriety in our billing and reimbursement processes, we investigate all allegations of impropriety or irregularity relative thereto, and sometimes do so with the aid of outside auditors, other than our independent registered public accounting firm, attorneys and other professionals.

Whether information about our billing and reimbursement processes is obtained from external sources or activities such as Medicare and Medicaid audits or probe reviews, internal investigations, or our regular day-to-day monitoring and training activities, we collect and utilize such information to improve our billing and reimbursement functions and the various processes related thereto. While, like other operators in our industry, we experience billing and reimbursement errors, disagreements and other effects of the inherent subjectivities in reimbursement processes on a regular basis, we believe that we are in substantial compliance with applicable Medicare and Medicaid reimbursement requirements. We continually strive to improve the efficiency and accuracy of all of our operational and business functions, including our billing and reimbursement processes.

The following table sets forth the payor sources of our total revenue for the periods indicated:

	Year Ended December 31,								
	2012			2011			2010		
	$	%		$	%		$	%	
	(Dollars in thousands)								
Revenue:									
Medicaid- custodial	$302,046	36.6	%	$277,736	36.6	%	$259,711	40.0	%
Medicare	278,578	33.8		272,283	35.9		219,217	33.7	
Medicaid-skilled	25,418	3.1		20,290	2.7		17,573	2.7	
Total	606,042	73.5		570,309	75.2		496,501	76.4	
Managed care	106,268	12.9		94,266	12.4		84,364	13.0	
Private and other payors[(1)]	112,409	13.6		93,702	12.4		68,667	10.6	
Total revenue	$824,719	100.0	%	$758,277	100.0	%	$649,532	100.0	%

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

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

	Year Ended December 31,					
	2012		2011		2010	
Percentage of Skilled Nursing Days:						
Medicare	15.3	%	15.2	%	14.5	%
Managed care	9.0		8.9		9.2	
Other skilled	1.6		1.4		1.3	
Skilled mix	25.9		25.5		25.0	
Private and other payors	13.2		12.6		11.7	
Quality mix	39.1		38.1		36.7	
Medicaid	60.9		61.9		63.3	
Total skilled nursing	100.0	%	100.0	%	100.0	%

Reimbursement for Specific Services