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

# FORM 10-Q

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

**For the quarterly period ended March 31, 2022.**
**OR**

☐ **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.) |

**29222 Rancho Viejo Road, Suite 127**
**San Juan Capistrano, CA 92675**
(Address of Principal Executive Offices and Zip Code)
**(949) 487-9500**
(Registrant's Telephone Number, Including Area Code)

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

| Title of each class | Trading Symbol(s) | Name of each exchange on which registered |
|---|---|---|
| **Common Stock, par value $0.001 per share** | **ENSG** | **NASDAQ Global Select Market** |

| **Indicate by check mark:** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. | | | | | ☑ | **Yes** | ☐ | No |
| whether the registrant has submitted electronically, every Interactive Data File required to be submitted 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 such files). | | | | | ☑ | **Yes** | ☐ | No |
| whether the registrant is a large accelerated filer, an accelerated filer, non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act: | | | | | | | | |
| **Large accelerated filer** ☑ | Accelerated filer ☐ | Non-accelerated filer ☐ | Smaller reporting company ☐ | Emerging growth company ☐ | | | | |
| If an emerging growth company, indicate if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act. | | | | | ☐ | Yes | ☐ | No |
| whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). | | | | | ☐ | Yes | ☑ | **No** |

As of April 25, 2022, 55,477,077 shares of the registrant's common stock, $0.001 par value, were outstanding.

**THE ENSIGN GROUP, INC.**
**QUARTERLY REPORT ON FORM 10-Q**
**FOR THE THREE MONTHS ENDED MARCH 31, 2022**
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PART I.

## Item 1. FINANCIAL STATEMENTS

### THE ENSIGN GROUP, INC.
### UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| | *(In thousands, except par values)* | |
| **Assets** | | |
| Current assets: | | |
| Cash and cash equivalents | $ 248,546 | $ 262,201 |
| Accounts receivable—less allowance for doubtful accounts of $13,212 and $11,213 at March 31, 2022 and December 31, 2021, respectively | 339,886 | 328,731 |
| Investments—current | 12,093 | 13,763 |
| Prepaid income taxes | — | 5,452 |
| Prepaid expenses and other current assets | 32,586 | 29,562 |
| Total current assets | 633,111 | 639,709 |
| Property and equipment, net | 906,777 | 888,434 |
| Right-of-use assets | 1,294,931 | 1,138,872 |
| Insurance subsidiary deposits and investments | 38,024 | 36,567 |
| Escrow deposits | 400 | — |
| Deferred tax assets | 32,883 | 33,147 |
| Restricted and other assets | 55,172 | 47,046 |
| Intangible assets, net | 2,665 | 2,652 |
| Goodwill | 76,869 | 60,469 |
| Other indefinite-lived intangibles | 3,727 | 3,727 |
| Total assets | $ 3,044,559 | $ 2,850,623 |
| **Liabilities and equity** | | |
| Current liabilities: | | |
| Accounts payable | $ 56,850 | $ 58,116 |
| Accrued wages and related liabilities (Note 3) | 251,194 | 278,770 |
| Lease liabilities—current | 57,902 | 52,181 |
| Accrued self-insurance liabilities—current | 43,728 | 40,831 |
| Other accrued liabilities | 100,161 | 89,410 |
| Current maturities of long-term debt | 3,723 | 3,760 |
| Total current liabilities | 513,558 | 523,068 |
| Long-term debt—less current maturities | 152,010 | 152,883 |
| Long-term lease liabilities—less current portion | 1,207,104 | 1,056,515 |
| Accrued self-insurance liabilities—less current portion | 71,602 | 69,308 |
| Other long-term liabilities | 28,272 | 27,135 |
| Total liabilities | $ 1,972,546 | $ 1,828,909 |
| Commitments and contingencies (Notes 16, 18 and 19) | | |
| **Equity** | | |
| Ensign Group, Inc. stockholders' equity: | | |
| Common stock: $0.001 par value; 100,000 shares authorized; 58,385 and 55,308 shares issued and outstanding at March 31, 2022, respectively, and 58,134 and 55,190 shares issued and outstanding at December 31, 2021, respectively | 58 | 58 |
| Additional paid-in capital | 383,181 | 369,760 |
| Retained earnings | 781,290 | 733,992 |
| Common stock in treasury, at cost, 3,077 and 2,944 shares at March 31, 2022 and December 31, 2021, respectively (Note 20) | (92,939) | (83,042) |
| Total Ensign Group, Inc. stockholders' equity | 1,071,590 | 1,020,768 |
| Non-controlling interest | 423 | 946 |
| Total equity | 1,072,013 | 1,021,714 |
| Total liabilities and equity | $ 3,044,559 | $ 2,850,623 |

See accompanying notes to condensed consolidated financial statements.

**THE ENSIGN GROUP, INC.**
**UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF INCOME**

| | Three Months Ended March 31, | |
|---|---|---|
| | **2022** | **2021** |
| | *(In thousands, except per share data)* | |
| Revenue: | | |
| Service revenue | **$ 709,156** | $ 623,276 |
| Rental revenue | **4,289** | 3,977 |
| Total revenue | **$ 713,445** | $ 627,253 |
| Expense: | | |
| Cost of services | **555,641** | 482,186 |
| Rent—cost of services | **35,762** | 33,456 |
| General and administrative expense | **38,256** | 34,273 |
| Depreciation and amortization | **14,676** | 13,659 |
| Total expenses | **644,335** | 563,574 |
| Income from operations | **69,110** | 63,679 |
| Other income (expense): | | |
| Interest expense | **(2,068)** | (1,641) |
| Other (expense) income | **(816)** | 748 |
| Other expense, net | **(2,884)** | (893) |
| Income before provision for income taxes | **66,226** | 62,786 |
| Provision for income taxes | **16,138** | 12,949 |
| Net income | **50,088** | 49,837 |
| Less: | | |
| Net (loss) income attributable to noncontrolling interests | **(252)** | 631 |
| Net income attributable to The Ensign Group, Inc. | **$ 50,340** | $ 49,206 |
| | | |
| Net income per share attributable to The Ensign Group, Inc.: | | |
| Basic | **$ 0.92** | $ 0.91 |
| Diluted | **$ 0.89** | $ 0.86 |
| Weighted average common shares outstanding: | | |
| Basic | **54,667** | 54,192 |
| Diluted | **56,871** | 56,891 |

See accompanying notes to condensed consolidated financial statements.

## THE ENSIGN GROUP, INC.
## UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

| (In thousands) | Common Stock Shares | Common Stock Amount | Additional Paid-In Capital | Retained Earnings | Treasury Stock Shares | Treasury Stock Amount | Non-Controlling Interest | Total |
|---|---|---|---|---|---|---|---|---|
| **Balance - January 1, 2022** | **55,190** | **$ 58** | **$ 369,760** | **$ 733,992** | **2,944** | **$ (83,042)** | **$ 946** | **$ 1,021,714** |
| Issuance of common stock to employees and directors resulting from the exercise of stock options | **147** | **—** | **2,768** | **—** | **—** | **—** | **—** | **2,768** |
| Issuance of restricted stock, net of forfeitures | **104** | **—** | **5,241** | **—** | **—** | **—** | **—** | **5,241** |
| Shares of common stock used to satisfy tax withholding obligations | **—** | **—** | **—** | **—** | **—** | **(15)** | **—** | **(15)** |
| Dividends declared ($0.0550 per share) | **—** | **—** | **—** | **(3,042)** | **—** | **—** | **—** | **(3,042)** |
| Employee stock award compensation | **—** | **—** | **5,167** | **—** | **—** | **—** | **—** | **5,167** |
| Repurchase of common stock (Note 20) | **(133)** | **—** | **—** | **—** | **133** | **(9,882)** | **—** | **(9,882)** |
| Acquisition of noncontrolling interest | **—** | **—** | **245** | **—** | **—** | **—** | **(271)** | **(26)** |
| Net loss attributable to noncontrolling interest | **—** | **—** | **—** | **—** | **—** | **—** | **(252)** | **(252)** |
| Net income attributable to the Ensign Group, Inc. | **—** | **—** | **—** | **50,340** | **—** | **—** | **—** | **50,340** |
| **Balance - March 31, 2022** | **55,308** | **$ 58** | **$ 383,181** | **$ 781,290** | **3,077** | **$ (92,939)** | **$ 423** | **$ 1,072,013** |

| (In thousands) | Common Stock Shares | Common Stock Amount | Additional Paid-In Capital | Retained Earnings | Treasury Stock Shares | Treasury Stock Amount | Non-Controlling Interest | Total |
|---|---|---|---|---|---|---|---|---|
| **Balance - January 1, 2021** | 54,626 | $ 58 | $ 338,177 | $ 551,055 | 2,791 | $ (71,213) | $ 150 | $ 818,227 |
| Issuance of common stock to employees and directors resulting from the exercise of stock options | 246 | — | 3,880 | — | — | — | — | 3,880 |
| Issuance of restricted stock, net of forfeitures | 81 | — | 3,725 | — | — | — | — | 3,725 |
| Shares of common stock used to satisfy tax withholding obligations | — | — | — | — | — | (9) | — | (9) |
| Dividends declared ($0.0525 per share) | — | — | — | (2,886) | — | — | — | (2,886) |
| Employee stock award compensation | — | — | 4,054 | — | — | — | — | 4,054 |
| Net income attributable to noncontrolling interest | — | — | — | — | — | — | 631 | 631 |
| Distribution to noncontrolling interest holder | — | — | — | — | — | — | (1,248) | (1,248) |
| Net income attributable to the Ensign Group, Inc. | — | — | — | 49,206 | — | — | — | 49,206 |
| **Balance - March 31, 2021** | 54,953 | $ 58 | $ 349,836 | $ 597,375 | 2,791 | $ (71,222) | $ (467) | $ 875,580 |

See accompanying notes to condensed consolidated financial statements.

## THE ENSIGN GROUP, INC.
## UNAUDITED CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS

| *(In thousands)* | Three Months Ended March 31, 2022 | 2021 |
|---|---|---|
| **Cash flows from operating activities:** | | |
| Net income | $ 50,088 | $ 49,837 |
| Adjustments to reconcile net income to net cash provided by operating activities: | | |
| Depreciation and amortization | 14,676 | 13,659 |
| Amortization of deferred financing fees | 223 | 210 |
| Non-cash leasing arrangement | 124 | 112 |
| Deferred income taxes | 264 | — |
| Provision for doubtful accounts | 2,142 | 2,560 |
| Stock-based compensation | 5,167 | 4,054 |
| Loss/(gain) on insurance claims, legal finding and asset disposals | 4,054 | (236) |
| Change in operating assets and liabilities | | |
| Accounts receivable | (14,117) | (15,449) |
| Prepaid income taxes | 5,452 | 1,224 |
| Prepaid expenses and other assets | (3,580) | (4,271) |
| Cash surrender value of life insurance policy premiums | (7,916) | (7,440) |
| Operating lease obligations | (162) | (133) |
| Deferred compensation liability | 7,801 | 7,459 |
| Accounts payable | (1,467) | 2,768 |
| Accrued wages and related liabilities | (28,989) | (34,562) |
| Income taxes payable | 10,416 | 11,791 |
| Other accrued liabilities | (3,031) | (1,737) |
| Accrued self-insurance liabilities | 4,740 | 4,615 |
| Other long-term liabilities | (11) | (167) |
| Net cash provided by operating activities | 45,874 | 34,294 |
| **Cash flows from investing activities:** | | |
| Purchase of property and equipment | (15,838) | (15,334) |
| Cash payments for business acquisitions (Note 9) | (16,400) | — |
| Cash payments for asset acquisitions (Note 9) | (17,010) | — |
| Escrow deposits | (400) | (250) |
| Cash from insurance proceeds | 431 | 6,250 |
| Cash proceeds from the sale of assets | — | 840 |
| Purchases of investments | (2,340) | (6,869) |
| Maturities of investments | 2,553 | 3,430 |
| Other restricted assets | 764 | (279) |
| Net cash used in investing activities | (48,240) | (12,212) |
| **Cash flows from financing activities:** | | |
| Payments on debt (Note 16) | (979) | (849) |
| Issuance of common stock upon exercise of options | 2,768 | 3,880 |
| Repurchase of shares of common stock to satisfy tax withholding obligations | (15) | (9) |
| Repurchase of shares of common stock (Note 20) | (9,882) | — |
| Dividends paid | (3,035) | (2,868) |
| Non-controlling interest distribution | — | (1,248) |
| Purchase of non-controlling interest | (26) | — |
| Payments of deferred financing costs | (120) | — |
| Proceeds from CARES Act Provider Relief Fund and Medicare Advance Payment Program (Note 3) | — | 9,139 |
| Repayments of CARES Act Provider Relief Fund and Medicare Advance Payment Program (Note 3) | — | (111,162) |
| Net cash used in financing activities | (11,289) | (103,117) |
| Net decrease in cash and cash equivalents | (13,655) | (81,035) |
| Cash and cash equivalents beginning of period | 262,201 | 236,562 |
| Cash and cash equivalents end of period | $ 248,546 | $ 155,527 |

| *(In thousands)* | Three Months Ended March 31, 2022 | 2021 |
|---|---|---|
| Supplemental disclosures of cash flow information: | | |
| Cash paid during the period for: | | |
| Interest | $ 2,107 | $ 1,427 |
| Lease liabilities | $ 35,972 | $ 33,339 |
| Non-cash financing and investing activity: | | |
| Accrued capital expenditures | $ 3,900 | $ 3,800 |
| Accrued dividends declared | $ 3,042 | $ 2,886 |
| Right-of-use assets obtained in exchange for new and modified operating lease obligations | $ 170,007 | $ 37,471 |

See accompanying notes to condensed consolidated financial statements.

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

## 1. DESCRIPTION OF BUSINESS

***The Company*** — The Ensign Group, Inc. (collectively, Ensign or the Company), is a holding company with no direct operating assets, employees or revenue. The Company, through its operating subsidiaries, is a provider of health care services across the post-acute care continuum, engaged in the ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare-related properties and other ancillary businesses. As of March 31, 2022, the Company operated 250 facilities and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. The Company's operating subsidiaries, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of skilled nursing, senior living and other ancillary services. The Company's operating subsidiaries have a collective capacity of approximately 25,500 operational skilled nursing beds and 2,700 senior living units. As of March 31, 2022, the Company operated 179 facilities under long-term lease arrangements, and had options to purchase 11 of those 179 facilities. The Company's real estate portfolio includes 102 owned real estate properties, which included 71 facilities operated and managed by the Company, 32 senior living operations leased to and operated by The Pennant Group, Inc. (Pennant) as part of the spin-off transaction that occurred in October 2019, and the Service Center location. Of those 32 senior living operations, two are located on the same real estate properties as skilled nursing facilities that the Company owns and operates.

Certain of the Company’s wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide specific 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 that provides some claims-made coverage to the Company’s operating subsidiaries for general and professional liabilities, as well as coverage for certain workers’ compensation insurance liabilities.

In January of 2022, the Company formed a captive real estate investment trust (REIT), which owns and manages its real estate business, called Standard Bearer Healthcare REIT, Inc. (Standard Bearer). The Company expects the REIT structure will provide it with an efficient vehicle for future acquisitions of properties that could be operated by Ensign affiliates or other third parties. Refer to Note 7, *Standard Bearer* for additional information on Standard Bearer.

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

***Other Information*** — The accompanying condensed consolidated financial statements as of March 31, 2022 and for the three months ended March 31, 2022 and 2021 (collectively, the Interim Financial Statements) are unaudited. Certain information and note disclosures normally included in annual consolidated financial statements have been condensed or omitted, as permitted under applicable rules and regulations. Readers of the Interim Financial Statements should refer to the Company’s audited consolidated financial statements and notes thereto for the year ended December 31, 2021 which are included in the Company’s Annual Report on Form 10-K, File No. 001-33757 (the Annual Report) filed with the Securities and Exchange Commission (SEC). Management believes that the Interim Financial Statements reflect all adjustments which are of a normal and recurring nature necessary to present fairly the Company’s financial position and results of operations in all material respects. The results of operations presented in the Interim Financial Statements are not necessarily representative of operations for the entire year.

## 2. 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 (GAAP). The Company is the sole member or stockholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing operations, senior living operations and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interests within the equity section of its condensed consolidated balance sheets and the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interest in its condensed consolidated statements of income.

The condensed consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest. Additionally, the accounts of any variable interest entities (VIEs) where the Company is subject to a majority of the risk of loss from the VIE's activities are entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impacts" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. On October 1, 2021, the Company deconsolidated its VIE, which was not material, as this entity no longer met the requirements for consolidation. At the end of fiscal year 2021, the Company had no VIEs.

***Reclassifications*** — Prior period results reflect reclassifications, for comparative purposes, related to the change in the Company's segment structure as a result of the formation of Standard Bearer. Refer to Note 8, *Business Segments*, for additional information related to segments.

***Estimates and Assumptions*** — The preparation of the Interim Financial Statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the Interim 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, acquired property and equipment, intangible assets and goodwill, right-of-use assets, impairment of long-lived assets, lease liabilities, general and professional liabilities, workers' compensation and healthcare claims included in accrued self-insurance liabilities, and income taxes. Actual results could differ from those estimates.

***Fair Value of Financial Instruments*** —The Company's financial instruments consist principally of cash and cash equivalents, debt security investments, accounts receivable, insurance subsidiary deposits, accounts payable and borrowings. The Company believes all of the financial instruments' recorded values approximate fair values because of their nature or respective short durations. Contracts insuring the lives of certain employees who are eligible to participate in non-qualified deferred compensation plans are held in a rabbi trust. Cash surrender value of the contracts is based on performance measurement funds that shadow the deferral investment allocations made by participants in the deferred compensation plan. The fair value of the pooled investment funds is derived using Level 2 inputs.

***Service Revenue Recognition*** — The Company recognizes revenue in accordance with Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC) Topic 606, *Revenue from Contracts with Customers* (ASC 606). See Note 4, *Revenue and Accounts Receivable.*

***Rental Revenue Recognition*** — The Company recognizes rental revenue for operating leases on a straight-line basis over the lease term when collectability of all minimum lease payments is probable in accordance with FASB ASC Topic 842, *Leases* (ASC 842). See Note 4, *Revenue and Accounts Receivable.*

***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, net of estimates for variable consideration.

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

***Leases and Leasehold Improvements*** — The Company leases skilled nursing facilities, senior living facilities and commercial office space. The Company determines if an arrangement is a lease at the inception of each lease. Leases commencing prior to the ASC 842 adoption date were classified as operating lease under historical guidance. As the Company has elected the package of practical expedients allowing it to not reassess lease classification, these leases are classified as operating leases under ASC 842 as well. For leases commencing subsequent to the ASC 842 adoption date, the Company performs an evaluation to determine whether the lease should be classified as an operating or finance lease at the inception of the lease. As of March 31, 2022, the Company does not have any leases that are classified as finance leases. Rights and obligations of operating leases are included as right-of-use assets, current lease liabilities and long-term lease liabilities on the Company's condensed consolidated balance sheet. As the Company's leases do not provide an implicit rate, the Company uses its incremental borrowing rate based on the information available at lease commencement date in determining the present value of future lease payments. The Company utilized a third-party valuation specialist to assist in estimating the incremental borrowing rate.

The Company records rent expense for operating leases on a straight-line basis over the term of the lease. The lease term used for straight-line rent expense is calculated from the date the Company is given control of the leased premises through the end of the lease term. Renewals are not assumed in the determination of the lease term unless they are deemed to be reasonably assured at the inception of the lease. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements.

The Company's real estate leases generally have initial lease terms of ten years or more and typically include one or more options to renew, with renewal terms that generally extend the lease term for an additional ten to 15 years. Exercise of the renewal options is generally subject to the satisfaction of certain conditions which vary by contract and generally follow payment terms that are consistent with those in place during the initial term. The Company reassesses the renewal option using a "reasonably certain" threshold, which is understood to be a high threshold. For leases where the Company is reasonably certain to exercise its renewal option, the option periods are included within the lease term and, therefore, the measurement of the right-of-use asset and lease liability. The Company's leases generally contain annual escalation clauses that are either fixed or variable in nature, some of which are dependent upon published indices. The Company recognizes lease expense for leases with an initial term of 12 months or less on a straight-line basis over the lease term. These leases are not recorded on the condensed consolidated balance sheet. Certain of the Company's lease agreements include rental payments that are adjusted periodically for inflation. The lease agreements do not contain any material residual value guarantees or material restrictive covenants. The Company does not have material subleases.

***Impairment of Long-Lived Assets*** — The Company reviews the carrying value of long-lived assets that are held and used in the Company's operating subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiaries to which the assets relate, utilizing management's best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and determined there was no impairment during the three months ended March 31, 2022 and 2021.

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

The Company's indefinite-lived intangible assets consist of trade names, and Medicare and Medicaid licenses. The Company tests indefinite-lived intangible assets for impairment on an annual basis or more frequently if events or changes in circumstances indicate that the carrying amount of the intangible asset may not be recoverable.

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances indicate that its carrying value may not be recoverable. The Company performs its annual test for impairment during the fourth quarter of each year. The Company did not identify any goodwill or intangible asset impairment during the three months ended March 31, 2022 and 2021.

***Self-Insurance*** — The Company is partially self-insured for general and professional liability claims up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. The combined self-insured retention is $500 per claim, subject to an additional one-time deductible of $1,000 for California affiliated operations and a separate, one-time, deductible of $1,250 for non-California operations. For all affiliated operations, except those located in Colorado, the third-party coverage above these limits is $1,000 per claim, $3,000 per operation, with a $5,000 blanket aggregate limit and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits is $1,000 per claim and $3,000 per operation, which is independent of the aforementioned blanket aggregate limits that apply outside of Colorado.

The majority of the self-insured retention and deductible limits for general and professional liabilities and workers' compensation liabilities are self-insured through the captive insurance subsidiary, the related assets and liabilities of which are included in the accompanying condensed consolidated balance sheets. The captive insurance subsidiary is subject to certain statutory requirements as an insurance provider.

The Company's policy is to accrue amounts equal to the actuarial 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. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued general liability and professional malpractice liabilities on an undiscounted basis, net of anticipated insurance recoveries, were $67,798 and $66,158 as of March 31, 2022 and December 31, 2021, respectively.

The Company's operating subsidiaries are self-insured for workers' compensation liabilities in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed $625 per occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers' compensation claims and the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 per occurrence. The Company's operating subsidiaries in all other states, with the exception of Washington, are under a loss sensitive plan that insures individual claims that exceed $350 per occurrence. In the state of Washington, the Company is self insured and has purchased individual specific excess insurance coverage that insures individual claims that exceed $500 per occurrence. For all of the self insured plans and retention, 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 $28,116 and $27,335 as of March 31, 2022 and December 31, 2021, respectively.

In addition, the Company has recorded an asset and equal liability of $7,206 and $6,755 as of March 31, 2022 and December 31, 2021, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis. See Note 13, *Restricted and Other Assets.*

The Company self-funds medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $525 for each covered person for fiscal year 2022. The Company's accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $12,210 and $9,891 as of March 31, 2022 and December 31, 2021, 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. 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 liabilities exceed its estimates of losses, its future earnings, cash flows and financial condition would be adversely affected.

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

In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors with knowledge and expertise in certain fields. Due to certain risks associated with the Company's estimates and assumptions, actual results could differ.

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

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

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

**Recent Accounting Standards Adopted by the Company**

In November 2021, the FASB issued ASU 2021-10 "*Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance*," which created FASB ASC Topic 832, *Government Assistance* (ASC 832). ASC 832 requires business entities to disclose information about certain government assistance they receive. The Company adopted this standard on January 1, 2022 and determined there was no material impact on the Company's condensed consolidated financial statements.

**Accounting Standards Recently Issued but Not Yet Adopted by the Company**

In February 2020, the FASB issued ASU 2020-04 *"Reference Rate Reform (Topic 848),"* which provides temporary, optional practical expedients and exceptions to enable a smoother transition to reference rates which are expected to replace LIBOR reference rates. Adoption of the provisions of ASU 2020-04 is optional. The amendments are effective for all entities from the beginning of the interim period that includes the issuance date of the ASU. An entity may elect to apply the amendments prospectively through December 31, 2022. Subsequent to March 31, 2022, the Company and its subsidiaries including Standard Bearer, entered into the Second Amendment to Third Amended and Restated Credit Agreement (the Amended Credit Facility), which increased the revolving credit facility by $250,000 to an aggregate principal amount of up to $600,000. The amendment modifies the reference rate from LIBOR to Secured Overnight Financing Rate (SOFR). The Company is currently evaluating the impact of ASU 2020-04 on its financial position, results of operations and liquidity.

## 3. COVID-19 UPDATE

The COVID-19 pandemic has continued to impact the Company's affiliated operations. In prior years, as part of the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the CARES Act), the Company received cash distributions of relief fund payments (Provider Relief Funds) and funds authorized by U.S. Department of Health and Human Services (HHS) to be used to protect residents of nursing homes and long-term care (LTC) facilities from the impact of COVID-19. During the three months ended March 31, 2022, the Company did not receive Provider Relief Funds. During the three months ended March 31, 2021, the Company received and returned $9,139 in Provider Relief Funds. The Company may continue to receive additional funding in future periods.

In fiscal year 2020, the Company applied for and received $105,255 through the Medicare Accelerated and Advance Payment Program under the CARES Act. The purpose of the program is to assist in providing needed liquidity to care delivery providers. The Company repaid $3,232 of the funds in 2020. In March 2021, the Company repaid the remaining funds of $102,023.

The Family First Coronavirus Response Act was signed into law in 2020 to provide a temporary 6.2% increase to the Federal Medical Assistance Percentage (FMAP) effective January 1, 2020. The law permits states to retroactively change their state's Medicaid program rates effective as of January 1, 2020. The law provides discretion to each state and specifies the funds are to be used to reimburse the recipient for healthcare related expenses that are attributable to COVID-19 and associated with providing patient care. In addition, increases in Medicaid rates can come from other areas of the state's budget outside of FMAP funding. Revenues from these additional payments are recognized in accordance with ASC 606, subject to variable consideration constraints. In certain operations where the Company received additional payments that exceeded expenses incurred related to COVID-19, the Company characterized such payments as variable revenue that required additional consideration and accordingly, the amount of state relief revenue recognized is limited to the actual COVID-19 related expenses incurred. As of March 31, 2022 and December 31, 2021, the Company had $1,499 and $1,781 in unapplied state relief funds, respectively. During the three months ended March 31, 2022 and 2021, the Company received an additional $17,317 and $15,645 in state relief funding and recognized $17,599 and $16,465, respectively, as revenue.

The CARES Act also provides for deferred payment of the employer portion of social security taxes through the end of 2020, with 50% of the deferred amount due by December 31, 2021 and the remaining 50% due by December 31, 2022. The Company recorded $48,309 of deferred payments of social security taxes as a liability during 2020. The Company paid $24,154 during the year ended December 31, 2021 and the remaining short-term balance of $24,155 is included in accrued wages and related liabilities within the condensed consolidated balance sheets as of March 31, 2022.

## 4. REVENUE AND ACCOUNTS RECEIVABLE

### *Service Revenue*

The Company's service revenue is derived primarily from providing healthcare services to its patients. Revenue is recognized when services are provided to the patients at the amount that reflects the consideration to which the Company expects to be entitled from patients and third-party payors, including Medicaid, Medicare and insurers (private and Medicare replacement plans), in exchange for providing patient care. The healthcare services in skilled patient contracts include routine services in exchange for a contractual agreed-upon amount or rate. Routine services are treated as a single performance obligation satisfied over time as services are rendered. As such, patient care services represent a bundle of services that are not capable of being distinct. Additionally, there may be ancillary services which are not included in the daily rates for routine services, but instead are treated as separate performance obligations satisfied at a point in time, if and when those services are rendered.

Revenue recognized from healthcare services are adjusted for estimates of variable consideration to arrive at the transaction price. The Company determines the transaction price based on contractually agreed-upon amounts or rate on a per day basis, adjusted for estimates of variable consideration. The Company uses the expected value method in determining the variable component that should be used to arrive at the transaction price, using contractual agreements and historical reimbursement experience within each payor type. The amount of variable consideration which is included in the transaction price may be constrained, and is included in net revenue only to the extent that it is probable that a significant reversal in the amount of the cumulative revenue recognized will not occur in a future period. If actual amounts of consideration ultimately received differ from the Company’s estimates, the Company adjusts these estimates, which would affect net revenue in the period such variances become known.

Revenue from the Medicare and Medicaid programs accounted for 73.4% and 74.1% of all service revenue for the three months ended March 31, 2022 and 2021, respectively. Settlements with Medicare and Medicaid payors for retroactive adjustments due to audits and reviews are considered variable consideration and are included in the determination of the estimated transaction price. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Company’s historical settlement activity. Consistent with healthcare industry practices, any changes to these revenue estimates are recorded in the period the change or adjustment becomes known based on the final settlement. The Company recorded adjustments to revenue which were not material to the Company's condensed consolidated revenue for the three months ended March 31, 2022 and 2021.

***Rental Revenue***

The Company's rental revenues are primarily generated by leasing healthcare-related properties through triple-net lease arrangements, under which the tenant is solely responsible for the costs related to the property. Revenue is recognized on a straight-line basis over the lease term if it has been deemed probable of collection. The Company has elected the single component practical expedient, which allows a lessor, by class of underlying asset, not to allocate the total consideration to the lease and non-lease components based on their relative stand-alone selling prices where certain criteria are met. This single component practical expedient requires the Company to account for the lease component and non-lease components associated with that lease as a single component if (1) the timing and pattern of transfer of the lease component and the non-lease components associated with it are the same and (2) the lease component would be classified as an operating lease if it were accounted for separately. If the Company determines that the lease component is the predominant component, it accounts for the single component as an operating lease in accordance with the new lease standards. Conversely, the Company is required to account for the combined component under the revenue recognition standard if it determines that the non-lease component is the predominant component. As a result of this assessment, rental revenues from the lease of real estate assets that qualify for this expedient are accounted for as a single component under the new lease standards. The components of the Company's operating leases qualify for the single component presentation.

Tenant reimbursements related to property taxes and insurance are neither considered lease nor non-lease components under the new lease standards. Lessee payments for taxes and insurance paid directly to a third party, on behalf of the Company, are excluded from variable lease payments and rental revenue in the Company’s condensed consolidated statements of income. Otherwise, tenant reimbursements for taxes and insurance that are paid by the Company directly to a third party are classified as additional rental revenue and expense and recognized by the Company on a gross basis.

***Disaggregation of Revenue***

The Company disaggregates revenue from contracts with its patients by payors. The Company determines that disaggregating revenue into these categories achieves the disclosure objectives to depict how the nature, amount, timing and uncertainty of revenue and cash flows are affected by economic factors.

***Revenue by Payor***

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

Service revenue for the three months ended March 31, 2022 and 2021 is summarized in the following tables:

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2022 | | 2021 | |
| | Revenue | % of Revenue | Revenue | % of Revenue |
| Medicaid[1] | $ 266,348 | 37.6 % | $ 231,358 | 37.1 % |
| Medicare | 208,411 | 29.4 | 190,303 | 30.5 |
| Medicaid — skilled | 45,949 | 6.4 | 39,993 | 6.5 |
| Total Medicaid and Medicare | 520,708 | 73.4 | 461,654 | 74.1 |
| Managed care | 127,786 | 18.0 | 108,345 | 17.4 |
| Private and other[2] | 60,662 | 8.6 | 53,277 | 8.5 |
| Service revenue | $ 709,156 | 100.0 % | $ 623,276 | 100.0 % |

(1) Medicaid payor includes revenue for senior living operations and revenue related to FMAP.
(2) Private and other payors also includes revenue from senior living operations and all payors generated in other ancillary services.

In addition to the service revenue above, the Company's rental revenue derived from triple-net lease arrangements with third parties is $4,289 and $3,977, respectively, for the three months ended March 31, 2022 and 2021.

***Balance Sheet Impact***

Included in the Company's condensed consolidated balance sheets are contract balances, comprised of billed accounts receivable and unbilled receivables, which are the result of the timing of revenue recognition, billings and cash collections, as well as, contract liabilities, which primarily represent payments the Company receives in advance of services provided. The Company had no material contract liabilities and contract assets as of March 31, 2022 and December 31, 2021, or activity during the three months ended March 31, 2022 and 2021.

Accounts receivable as of March 31, 2022 and 2021, is summarized in the following table:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Medicaid | $ 128,574 | $ 123,647 |
| Managed care | 82,500 | 79,722 |
| Medicare | 61,884 | 59,797 |
| Private and other payors | 80,140 | 76,778 |
| | 353,098 | 339,944 |
| Less: allowance for doubtful accounts | (13,212) | (11,213) |
| Accounts receivable, net | $ 339,886 | $ 328,731 |

***Practical Expedients and Exemptions***

As the Company's contracts with its patients have an original duration of one year or less, the Company uses the practical expedient applicable to its contracts and does not consider the time value of money. Further, because of the short duration of these contracts, the Company has not disclosed the transaction price for the remaining performance obligations as of the end of each reporting period or when the Company expects to recognize this revenue. In addition, the Company has applied the practical expedient provided by ASC 340, *Other Assets and Deferred Costs*, and all incremental customer contract acquisition costs are expensed as they are incurred because the amortization period would have been one year or less.

## 5. COMPUTATION OF NET INCOME PER COMMON SHARE

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

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

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| **Numerator:** | | |
| Net income | $ 50,088 | $ 49,837 |
| Less: net (loss) income attributable to noncontrolling interests | (252) | 631 |
| Net income attributable to The Ensign Group, Inc. | $ 50,340 | $ 49,206 |
| **Denominator:** | | |
| Weighted average shares outstanding for basic net income per share | 54,667 | 54,192 |
| **Basic net income per common share:** | $ 0.92 | $ 0.91 |

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

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| **Numerator:** | | |
| Net income | $ 50,088 | $ 49,837 |
| Less: net (loss) income attributable to noncontrolling interests | (252) | 631 |
| Net income attributable to The Ensign Group, Inc. | $ 50,340 | $ 49,206 |
| **Denominator:** | | |
| Weighted average common shares outstanding | 54,667 | 54,192 |
| Plus: incremental shares from assumed conversion [1] | 2,204 | 2,699 |
| Adjusted weighted average common shares outstanding | 56,871 | 56,891 |
| **Diluted net income per common share:** | $ 0.89 | $ 0.86 |

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 647 and 28 for the three months ended March 31, 2022 and 2021, respectively.

## 6. FAIR VALUE MEASUREMENTS

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

The fair value of cash and cash equivalents of $248,546 and $262,201 as of March 31, 2022 and December 31, 2021, respectively, is derived using Level 1 inputs. The Company's other financial assets include contracts insuring the lives of certain employees who are eligible to participate in non-qualified deferred compensation plans which are held in a rabbi trust. The cash surrender value of these contracts is based on performance measurement funds that shadow the deferral investment allocations made by participants in the deferred compensation plan. As of March 31, 2022, and December 31, 2021, the fair value of the pooled investment funds of $25,446 and $17,530, respectively, is derived using Level 2 inputs. The pooled investment funds are included in restricted and other assets in the condensed consolidated balance sheets. See Note 13, *Restricted and Other Assets.*

The Company's non-financial assets, which includes goodwill, intangible assets, property and equipment and right-of-use assets, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, the Company assesses its long-lived assets for impairment. When impairment has occurred, such long-lived assets are written down to fair value.

### *Debt Security Investments - Held to Maturity*

As of March 31, 2022 and December 31, 2021, the Company had approximately $50,117 and $50,330, respectively, in debt security investments which were classified as held to maturity and carried at amortized cost. The carrying value of the debt securities approximates fair value based on Level 1 inputs. The Company has the intent and ability to hold these debt securities to maturity. Further, as of March 31, 2022, the debt security investments were held in AA, A and BBB rated debt securities. The Company believes its debt security investments that were in an unrealized loss position as of March 31, 2022 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date that would indicate any other-than-temporary impairment.

## 7. STANDARD BEARER

Standard Bearer's real estate portfolio consists of 95 of the Company's 102 owned real estate properties, of which 67 are operated and managed by the Company and 30 are leased to and operated by Pennant. Standard Bearer intends to qualify and elect to be taxed as a REIT, for U.S. federal income tax purposes, commencing with its taxable year ending December 31, 2022. During the three months ended March 31, 2022, Standard Bearer acquired the real estate of two skilled nursing facilities for a purchase price of $17,010, of which both are operated and managed by Ensign's affiliated operations. Refer to Note 9, *Operation Expansions* for additional information.

As part of the formation of Standard Bearer, certain of the Company's operating subsidiaries and Standard Bearer and its subsidiaries entered into several agreements which include leasing, management services and debt arrangements between the operations. As these intercompany arrangements were entered into when Standard Bearer was formed in January 2022, the transactions related to these agreements are reflected in the Standard Bearer's segment income during three months ended March 31, 2022. All intercompany transactions have been eliminated in consolidation. Refer to Note 8, *Business Segments*, for additional information related to these intercompany eliminations as well as Standard Bearer as a reportable segment.

***Intercompany master lease agreements***

Certain of the Company's operating subsidiaries and the 67 Standard Bearer subsidiaries entered into five "triple-net" master lease agreements (collectively, the Standard Bearer Master Leases) in January 2022. The lease periods range from 15 to 19 years with three five-year renewal option beyond the initial term, on the same terms and conditions. The rent structure under the Standard Bearer Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the operating subsidiaries are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The two real estate properties acquired during three months ended March 31, 2022 were added to the Standard Bearer Master Leases. Rental revenue generated from Ensign affiliated operations for the three months ended March 31, 2022 and 2021 was $13,425 and $10,591, respectively.

***Intercompany management agreement***

The Service Center provides services to Standard Bearer pursuant to the management agreement between Standard Bearer and the Service Center. The management agreement provides for a base management fee that is equal to 5% of total rental revenue and an incentive management fee that is equal to 5% of funds from operations (FFO) and is capped at 1% of total rental revenue. Management fee generated between Standard Bearer and the Service Center for the three months ended March 31, 2022 was $1,022 or 6.0% of total Standard Bearer rental revenue.

***Intercompany debt arrangements***

Standard Bearer obtains its funding through various sources including operating cash flows, access to debt arrangements and intercompany loans. The intercompany debt arrangements include mortgage loans and a credit revolver between the Ensign Group, Inc., the real estate properties and Standard Bearer to fund acquisitions and working capital needs. The interest rate under the credit revolver is a base rate plus a margin ranging from 0.50% to 1.50% per annum or LIBOR (or an alternative reference rate) plus a margin range from 1.50% to 2.50% per annum.

In addition, as the Department of Housing and Urban Development (HUD) mortgage loans and promissory notes are entered into by real estate subsidiaries held by Standard Bearer, the interest expense incurred from these debts are included in Standard Bearer's segment income. Refer to Note 16, *Debt*, for additional information related to these debts.

***Equity Instrument Denominated in the Shares of a Subsidiary***

As part of the formation of Standard Bearer in January of 2022, the Company implemented the Standard Bearer Healthcare REIT, Inc. 2022 Omnibus Incentive Plan (Standard Bearer Equity Plan). The Company may grant stock options and restricted stock awards under the Standard Bearer Equity Plan to employees and management of the Company's affiliated subsidiaries. These awards generally vest over a period of five years or upon the occurrence of certain prescribed events. The value of the stock options and restricted stock awards is tied to the value of the common stock of Standard Bearer, which is determined based on an independent valuation of Standard Bearer. The awards can be put to the Company at various prescribed dates, which in no event is earlier than six months after vesting of the restricted awards or exercise of the stock options. The Company can also call the awards, generally upon employee termination. During the three months ended March 31, 2022, the Company did not grant any stock options nor restricted shares.

## 8. BUSINESS SEGMENTS

In conjunction with the formation Standard Bearer in January 2022, the Company's Chief Executive Officer, who is its chief operating decision maker, or CODM, began reviewing the results of Standard Bearer instead of all real estate properties. Accordingly, the Company revised its former real estate segment to include only real estate properties that are part of Standard Bearer. This change in organizational structure demonstrates that Standard Bearer's real estate is a core part of the Company's expansion of its real estate investment strategy. As of the first quarter of 2022, the Company has two reportable segments: (1) skilled services, which includes the operation of skilled nursing facilities and rehabilitation therapy services and (2) Standard Bearer, which is comprised of selected real estate properties owned by Standard Bearer and leased to skilled nursing and senior living operators. Segment information for prior period has been recast to reflect the change of the Company's segment structure.

As of March 31, 2022, the skilled services segment includes 217 skilled nursing operations and 23 campus operations that provide both skilled nursing and rehabilitative care services and senior living services. The Company's Standard Bearer segment consists of 95 owned real estate properties. These properties include 67 operations the Company operated and managed and 30 senior living operations that are leased to and operated by third parties. Of the 30 real estate operations leased to third parties, two senior living operations are located on the same real estate properties as skilled nursing facilities that the Company owns and operates. The Company also reports an "All Other" category that includes results from its senior living operations, which includes ten stand-alone senior living operations and 23 campus operations that provide both skilled nursing and rehabilitative care services and senior living services, mobile diagnostics, medical transportation, other real estate and other ancillary operations. Services included in the "All Other" category are insignificant individually, and therefore do not constitute a reportable segment.

The Company's reportable segments are significant operating segments that offer differentiated services. The Company's CODM reviews financial information for each operating segment to evaluate performance and allocate capital resources. This structure reflects its current operational and financial management and provides the best structure to maximize the quality of care and investment strategy provided, while maintaining financial discipline. The Company's CODM does not review assets by segment in his resource allocation and therefore assets by segment are not disclosed below.

The accounting policies of the reportable segments are the same as those described in Note 2, *Summary of Significant Accounting Policies*. Intercompany revenue is eliminated in consolidation, along with corresponding intercompany expenses. Segment income and loss is defined as profit or loss from operations before provision for income taxes, excluding gain or loss from sale of real estate, insurance recoveries and impairment charges from operations. Included in segment income for Standard Bearer is expense for intercompany services provided by the Service Center as described in Note 7, *Standard Bearer*, as it is part of the CODM financial information.

The following tables set forth financial information for the segments:

| | Three Months Ended March 31, 2022 | | | | |
|---|---|---|---|---|---|
| | Skilled Services | Standard Bearer | All Other[1] | Intercompany Elimination | Total |
| Service revenue[2] | $ 686,771 | $ — | $ 25,467 | $ (3,082) | $ 709,156 |
| Rental revenue[3] | — | 17,193 | 1,863 | (14,767) | 4,289 |
| Total revenue | $ 686,771 | $ 17,193 | $ 27,330 | $ (17,849) | $ 713,445 |
| Segment income (loss) | 98,256 | 6,900 | (38,930) | — | 66,226 |
| Depreciation and amortization | 7,901 | 5,021 | 1,754 | — | 14,676 |
| Interest expense[4] | $ — | $ 3,562 | $ 358 | $ (1,852) | $ 2,068 |

(1) All other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's affiliated wholly-owned healthcare facilities and management service revenue generated by the Service Center with Standard Bearer. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with Company's affiliated wholly-owned healthcare facilities. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. The intercompany interest expense is eliminated in the "Intercompany Elimination" column.

| | Three Months Ended March 31, 2021 | | | | |
|---|---|---|---|---|---|
| | Skilled Services | Standard Bearer | All Other(1) | Intercompany Elimination | Total |
| Service revenue(2) | $ 601,036 | $ — | $ 23,919 | $ (1,679) | $ 623,276 |
| Rental revenue(3) | — | 14,069 | 1,810 | (11,902) | 3,977 |
| Total revenue | $ 601,036 | $ 14,069 | $ 25,729 | $ (13,581) | $ 627,253 |
| Segment income (loss) | 88,931 | 7,713 | (34,298) | — | 62,346 |
| Gain on sale of real estate | — | — | — | — | 440 |
| Income before provision for income taxes | — | — | — | — | $ 62,786 |
| Depreciation and amortization | 7,475 | 4,155 | 2,029 | — | 13,659 |
| Interest expense(4) | $ — | $ 1,641 | $ — | $ — | $ 1,641 |

(1) All other primarily includes all ancillary operations, stand-alone senior living operations and the Service Center.
(2) Intercompany service revenue represents service revenue generated by ancillary operations provided to the Company's affiliated wholly-owned healthcare facilities. Intercompany service revenue is eliminated in consolidation along with corresponding intercompany cost of service.
(3) Intercompany rental revenue represents rental income generated by both Standard Bearer and other real estate properties with the Company's affiliated wholly-owned healthcare facilities. Intercompany rental revenue is eliminated in consolidation along with corresponding intercompany rent expense.
(4) Included in interest expense in Standard Bearer is interest expense incurred from intercompany debt arrangements between Standard Bearer and The Ensign Group, Inc. The intercompany interest expense is eliminated in the "Intercompany Elimination" column.

Service revenue by major payor source were as follows:

| | Three Months Ended March 31, 2022 | | | |
|---|---|---|---|---|
| | Skilled Services | Other Service Revenue | Total Service Revenue | Revenue % |
| Medicaid(1) | **$ 261,587** | **$ 4,761** | **$ 266,348** | **37.6 %** |
| Medicare | **208,411** | **—** | **208,411** | **29.4** |
| Medicaid-skilled | **45,949** | **—** | **45,949** | **6.4** |
| Subtotal | **515,947** | **4,761** | **520,708** | **73.4** |
| Managed care | **127,786** | **—** | **127,786** | **18.0** |
| Private and other(2) | **43,038** | **17,624** | **60,662** | **8.6** |
| Total service revenue | **$ 686,771** | **$ 22,385** | **$ 709,156** | **100.0 %** |

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to FMAP.
(2) Private and other payors also includes revenue from senior living operations and all payors generated in other ancillary services.

| | Three Months Ended March 31, 2021 | | | |
|---|---|---|---|---|
| | Skilled Services | Other Service Revenue | Total Service Revenue | Revenue % |
| Medicaid(1) | $ 227,741 | $ 3,617 | $ 231,358 | 37.1 % |
| Medicare | 190,303 | — | 190,303 | 30.5 |
| Medicaid-skilled | 39,993 | — | 39,993 | 6.5 |
| Subtotal | 458,037 | 3,617 | 461,654 | 74.1 |
| Managed care | 108,345 | — | 108,345 | 17.4 |
| Private and other(2) | 34,654 | 18,623 | 53,277 | 8.5 |
| Total service revenue | $ 601,036 | $ 22,240 | $ 623,276 | 100.0 % |

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to FMAP.
(2) Private and other payors also includes revenue from senior living operations and all payors generated in other ancillary services.

In addition to the service revenue above, the Company's rental revenue derived from triple-net lease arrangements with third parties is $4,289 and $3,977, respectively, for the three months ended March 31, 2022 and 2021. This revenue is included in both Standard Bearer and the all other category.

## 9. OPERATION EXPANSIONS

The Company's subsidiaries expansion focus is to purchase or lease operations that are complementary to the current affiliated operations, accretive to the business, or otherwise advance the Company's strategy. The results of all operating subsidiaries are included in the Interim Financial Statements subsequent to the date of acquisition. Acquisitions are accounted for using the acquisition method of accounting. The Company's affiliated operations also enter into long-term leases that may include options to purchase the facilities. As a result, from time to time, a real estate affiliated subsidiary will acquire the property of facilities that have previously been operated under third-party leases.

FASB ASC Topic 805, *Clarifying the Definition of a Business* (ASC 805) defined the definition of a business to assist entities with evaluating when a set of transferred assets and activities is deemed to be a business. Determining whether a transferred set constitutes a business is important because the accounting for a business combination differs from that of an asset acquisition. The definition of a business also affects the accounting for dispositions. When substantially all of the fair value of assets acquired is concentrated in a single asset, or a group of similar assets, the assets acquired would not represent a business and business combination accounting would not be required.

### *2022 Expansions*

During the three months ended March 31, 2022, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of four stand-alone skilled nursing operations. Of these additions, two are related to purchases of real estate properties, further expanding the Company's real estate portfolio. Refer to Note 7, *Standard Bearer*, for additional information on the purchase of real estate properties. In addition, the Company added two senior living operations that were transferred from Pennant, one of which is part of a campus operated by the Company's affiliated operating subsidiaries. These new operations added a total of 453 operational skilled nursing beds and 403 operational senior living units to be operated by the Company's affiliated operating subsidiaries. The aggregate purchase price for these expansions during the three months ended March 31, 2022 was $33,410.

In connection with the new operations made through long-term leases, the Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company entered into a separate operations transfer agreement with the prior operator as part of each transaction.

The aggregate purchase price for the two real estate properties acquired during the three months ended March 31, 2022 was $17,010 and was classified as asset acquisitions. The remaining aggregate purchase price during the three months ended March 31, 2022 of $16,400 is concentrated in goodwill and accordingly, the transactions were classified as business combinations.

Subsequent to March 31, 2022, the Company expanded its operations through long-term leases, which added three senior living operations that were transferred from Pennant, two of which are part of healthcare campuses operated by the Company's affiliated operating subsidiaries. These new operations added 281 operational senior living units to be operated by the Company's affiliated operating subsidiaries. The Company also invested in new ancillary services that are complementary to its existing businesses.

### *2021 Expansions*

During the three months ended March 31, 2021, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of four stand-alone skilled nursing operations. These new operations added a total of 447 operational skilled nursing beds operated by the Company's affiliated operating subsidiaries. The Company did not acquire any material assets or assume any liabilities other than the tenant's post-assumption rights and obligations under the long-term lease. The Company entered into a separate operations transfer agreement with the prior operator as part of each transaction.

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. The operations added by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operations, is often inadequate, inaccurate or unavailable. Consequently, the Company believes that prior operating results are not a meaningful representation of the Company's current operating results or indicative of the integration potential of its newly acquired operating subsidiaries. The assets added during the three months ended March 31, 2022 were not material operations to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These additions have been included in the March 31, 2022 condensed consolidated balance sheets of the Company, and the operating results have been included in the condensed consolidated statements of operations of the Company since the date the Company gained effective control.

## 10. PROPERTY AND EQUIPMENT - NET

Property and equipment, net consists of the following:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Land | $ 123,068 | $ 121,164 |
| Buildings and improvements | 667,053 | 646,221 |
| Leasehold improvements | 142,747 | 140,012 |
| Equipment | 269,917 | 262,246 |
| Furniture and fixtures | 4,339 | 4,305 |
| Construction in progress | 9,523 | 10,253 |
| | 1,216,647 | 1,184,201 |
| Less: accumulated depreciation | (309,870) | (295,767) |
| Property and equipment, net | $ 906,777 | $ 888,434 |

See also Note 7, *Standard Bearer* and Note 9, *Operation Expansions* for information on acquisitions during the three months ended March 31, 2022 and 2021.

## 11. INTANGIBLE ASSETS - NET

| | | March 31, 2022 | | | December 31, 2021 | | |
|---|---|---|---|---|---|---|---|
| Intangible Assets | Weighted Average Life (Years) | Gross Carrying Amount | Accumulated Amortization | Net | Gross Carrying Amount | Accumulated Amortization | Net |
| Assembled occupancy | 0.4 | $ 196 | $ (125) | $ 71 | $ 68 | $ (68) | $ — |
| Facility trade name | 30.0 | 733 | (397) | 336 | 733 | (391) | 342 |
| Customer relationships | 18.4 | 4,582 | (2,324) | 2,258 | 4,582 | (2,272) | 2,310 |
| Total | | $ 5,511 | $ (2,846) | $ 2,665 | $ 5,383 | $ (2,731) | $ 2,652 |

During the three months ended March 31, 2022 and 2021, amortization expense was $404 and $361, respectively, of which $289 and $290 was related to the amortization of right-of-use assets, respectively.

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

| Year | Amount |
|---|---|
| 2022 (remainder) | $ 247 |
| 2023 | 234 |
| 2024 | 234 |
| 2025 | 234 |
| 2026 | 234 |
| 2027 | 234 |
| Thereafter | 1,248 |
| | $ 2,665 |

## 12. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The Company tests goodwill during the fourth quarter of each year or more often if events or circumstances indicate there may be impairment. The Company performs its analysis for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment, in accordance with the provisions of FASB ASC Topic 350, *Intangibles—Goodwill and Other* (ASC 350). This guidance provides the option to first assess qualitative factors to determine whether it is more likely than not that the fair value of a reporting unit is less than its carrying value. If, based on a review of qualitative factors, it is more likely than not that the fair value of a reporting unit is less than its carrying value, the Company performs a goodwill impairment test by comparing the carrying value of each reporting unit to its respective fair value. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. The fair value of the reporting unit is the implied fair value of goodwill. In the event a reporting unit's carrying value exceeds its fair value, an impairment loss will be recognized. An impairment loss is measured by the difference between the carrying value of the reporting unit and its fair value.

The Company anticipates that the majority of total goodwill recognized will be fully deductible for tax purposes as of March 31, 2022.

Provided that goodwill corresponds to the acquisition of a business and not merely the acquisition of real estate property, the Company's Standard Bearer segment appropriately does not carry a goodwill balance. The following table represents the goodwill value by skilled service segment and "all other" category, which includes other ancillary services, as of March 31, 2022 and December 31, 2021:

| | Goodwill | | |
|---|---|---|---|
| | Skilled Services | All Other | Total |
| **January 1, 2022** | $ 51,486 | $ 8,983 | $ 60,469 |
| Additions | 16,400 | — | 16,400 |
| **March 31, 2022** | $ 67,886 | $ 8,983 | $ 76,869 |

Other indefinite-lived intangible assets consist of the following:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Trade name | $ 889 | $ 889 |
| Medicare and Medicaid licenses | 2,838 | 2,838 |
| | $ 3,727 | $ 3,727 |

## 13. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Debt issuance costs, net | $ 1,776 | $ 1,953 |
| Long-term insurance losses recoverable asset | 7,206 | 6,755 |
| Deposits with landlords | 14,429 | 13,705 |
| Capital improvement reserves with landlords and lenders | 6,315 | 7,103 |
| Deferred compensation plan investments | 25,446 | 17,530 |
| Restricted and other assets | $ 55,172 | $ 47,046 |

Included in restricted and other assets as of March 31, 2022 and December 31, 2021 are anticipated insurance recoveries related to the Company's workers' compensation liabilities and general and professional liability claims that are recorded on a gross rather than net basis in accordance with GAAP.

The Company implemented a non-qualified deferred compensation plan (the DCP) that was effective in 2019 for certain executives and was expanded to highly compensated employees on January 1, 2020. The plan allows for the employee deferrals to be deposited into a rabbi trust and the funds are generally invested in individual variable life insurance contracts owned by the Company that are specifically designed to informally fund savings plans of this nature. Cash surrender value of the contracts is based on performance measurement funds that shadow the deferral investment allocations made by participants in the deferred compensation plan. The Company recorded a loss on the deferral investment of $1,202 and a gain on the deferral investment of $306, which is included in other expense, net and offsetting income of $1,211 and offsetting expense $351 between cost of services and general and administrative expenses in the accompanying condensed consolidated statements of income for the three months ended March 31, 2022 and 2021, respectively.

## 14. OTHER ACCRUED LIABILITIES

Other accrued liabilities consists of the following:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Quality assurance fee | $ 6,652 | $ 6,474 |
| Refunds payable | 36,074 | 34,814 |
| Resident advances | 6,936 | 9,337 |
| Unapplied state relief funds | 1,499 | 1,781 |
| Cash held in trust for patients | 5,952 | 6,430 |
| Dividends payable | 3,042 | 3,035 |
| Property taxes | 7,716 | 9,124 |
| Income tax payable | 10,416 | — |
| Legal finding accrued | 3,626 | — |
| Other | 18,248 | 18,415 |
| Other accrued liabilities | $ 100,161 | $ 89,410 |

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

## 15. INCOME TAXES

The Company recorded income tax expense of $16,138 and $12,949 during the three months ended March 31, 2022 and 2021, respectively, or 24.4% of earnings before income taxes for the three months ended March 31, 2022, compared to 20.6% for the three months ended March 31, 2021. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, offset by non-deductible expenses including non-deductible compensation.

The Company is not currently under examination by any major income tax jurisdiction. During 2022, the statutes of limitations will lapse on the Company's 2018 Federal tax year and certain 2017 and 2018 state tax years. The Company does not believe the Federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the three months ended March 31, 2022 and 2021.

## 16. DEBT

Debt consists of the following:

| | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Mortgage loans and promissory notes | $ 158,988 | $ 159,967 |
| Less: current maturities | (3,723) | (3,760) |
| Less: debt issuance costs, net | (3,255) | (3,324) |
| Long-term debt less current maturities | $ 152,010 | $ 152,883 |

***Credit Facility with a Lending Consortium Arranged by Truist***

The Company maintains a revolving credit facility between the Company and its subsidiaries, including Standard Bearer as co-borrowers, and Truist Securities (Truist) (the Credit Facility). The Credit Facility includes a revolving line of credit of up to $350,000 in aggregate principal amount. The maturity date of the Credit Facility is October 1, 2024. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.50% to 1.50% per annum or LIBOR plus a margin range from 1.50% to 2.50% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, the Company and Standard Bearer, as co-borrowers, pay a commitment fee on the unused portion of the commitments that ranges from 0.25% to 0.45% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

The Credit Facility is guaranteed, jointly and severally, by certain of the Company’s wholly-owned subsidiaries, and is secured by a pledge of stock of the Company's material operating subsidiaries as well as a first lien on substantially all of its personal property. The Credit Facility contains customary covenants that, among other things, restrict, subject to certain exceptions, the ability of the Company and its operating subsidiaries to grant liens on their assets, incur indebtedness, sell assets, make investments, engage in acquisitions, mergers or consolidations, amend certain material agreements and pay certain dividends and other restricted payments. Under the Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of (i) a maximum consolidated total net debt to consolidated EBITDA ratio (which shall not be greater than 3.00:1.00; provided that if the aggregate consideration for approved acquisitions in a six month period is greater than $50,000, then the ratio can be increased at the election of the Company with notice to the administrative agent to 3.50:1.00 for the first fiscal quarter and the immediately following three fiscal quarters), and (ii) a minimum interest/rent coverage ratio (which cannot be less than 1.50:1.00). As of March 31, 2022, and April 26, 2022, there was no outstanding debt under the Credit Facility. The Company was in compliance with all loan covenants as of March 31, 2022.

Subsequent to March 31, 2022, the Company and its subsidiaries, including Standard Bearer, entered into the Amended Credit Facility with a revolving line of credit of up to $600,000 in aggregate principal. The maturity date of the Amended Credit Facility is April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Amended Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or Secured Overnight Financing Rate (SOFR) plus a margin range from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, the Company and its subsidiaries, including Standard Bearer, will pay a commitment fee on the unused portion of the commitments that will range from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio. Except as set forth in the Amended Credit Facility, all other terms and conditions of the Credit Facility remained in full force and effect as described below.

***Mortgage Loans and Promissory Notes***

As of March 31, 2022, the Company's operating subsidiaries had $158,988 outstanding under the mortgage loans and notes, of which $3,723 is classified as short-term and the remaining $155,265 is classified as long-term. The Company was in compliance with all loan covenants as of March 31, 2022.

As of March 31, 2022, 23 of the Company's subsidiaries have mortgage loans insured with HUD in the aggregate amount of $155,858, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates in a range of 3.1% to 4.2%, including fixed interest rates in a range of 2.4% to 3.3% per annum. In addition to the interest rate, we incur other fees for HUD placement, including but not limited to audit fees. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees based on the principal balance on the date of prepayment. For the majority of the loans, during the first three years, the prepayment fee is 10.0% and is reduced by 3.0% in the fourth year of the loan, and reduced by 1.0% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The terms for all the mortgage loans are 25 to 35 years.

In addition to the HUD mortgage loans above, the Company has a promissory note that was put in place in connection with an acquisition. The note bears a fixed interest rate of 5.3% per annum and the term of the note is 12 years. The note, which was used for an acquisition, is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

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

***Off-Balance Sheet Arrangements***

As of March 31, 2022, the Company had approximately $6,710 on the Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

## 17. OPTIONS AND AWARDS

Stock-based compensation expense consists of stock-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company’s condensed consolidated statements of income for the three months ended March 31, 2022 and 2021 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.

*2017 Omnibus Incentive Plan* - The Company has one active stock incentive plan, the 2017 Omnibus Incentive Plan (the 2017 Plan). The 2017 Plan provided for the issuance of 6,881 shares of common stock which are to be proportionally adjusted in the event of any Equity Restructuring. The number of shares available to be issued under the 2017 Plan were adjusted to 8,118 shares of common stock in order to reflect the proportional adjustments as part of the spin-off transaction that occurred in October 2019. The number of shares available to be issued under the 2017 Plan will be reduced by (i) one share for each share that relates to an option or stock appreciation right award and (ii) 2.5 shares for each share which relates to an award other than a stock option or stock appreciation right award (a full-value award). Granted non-employee director options vest and become exercisable in three equal annual installments, or the length of the term if less than three years, on the completion of each year of service measured from the grant date. All other options generally vest over five years at 20% per year on the anniversary of the grant date. Options expire ten years from the date of grant. As of March 31, 2022, there were approximately 1,723 unissued shares of common stock available for issuance under this plan.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for stock option awards. Determining the appropriate fair-value model and calculating the fair value of stock option awards at the grant date requires judgment, including estimating stock price volatility, expected option life, and forfeiture rates. The fair-value of the restricted stock awards at the grant date is based on the market price on the grant date, adjusted for forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time.

***Stock Options***

The Company granted 164 stock options during the three months ended March 31, 2022. The Company used the following assumptions for stock options granted during the three months ended March 31, 2022 and 2021:

| Grant Year | Options Granted | Weighted Average Risk-Free Rate | Expected Life | Weighted Average Volatility | Weighted Average Dividend Yield |
|---|---|---|---|---|---|
| **2022** | **164** | **1.8%** | **6.1 years** | **42.3%** | **0.3%** |
| 2021 | 136 | 0.8% | 6.3 years | 42.2% | 0.2% |

For the three months ended March 31, 2022 and 2021, the following represents the exercise price and fair value displayed at grant date for stock option grants:

| Grant Year | Granted | Weighted Average Exercise Price | Weighted Average Fair Value of Options |
|---|---|---|---|
| **2022** | **164** | **$ 79.79** | **$ 33.56** |
| 2021 | 136 | $ 83.64 | $ 33.99 |

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the three months ended March 31, 2022 and 2021 and therefore, the intrinsic value was $0 at the date of grant.

The following table represents the employee stock option activity during the three months ended March 31, 2022:

| | Number of Options Outstanding | Weighted Average Exercise Price | Number of Options Vested | Weighted Average Exercise Price of Options Vested |
|---|---|---|---|---|
| **January 1, 2022** | **4,038** | **$ 36.60** | **2,183** | **$ 21.02** |
| Granted | **164** | **79.79** | **—** | **—** |
| Forfeited | **(31)** | **52.39** | **—** | **—** |
| Exercised | **(147)** | **18.86** | **—** | **—** |
| **March 31, 2022** | **4,024** | **$ 38.89** | **2,172** | **$ 22.57** |

The following summary information reflects stock options outstanding, vested and related details as of March 31, 2022:

| | Stock Options Outstanding | | | | Stock Options Vested |
|---|---|---|---|---|---|
| **Year of Grant** | **Exercise Price** | **Number Outstanding** | **Black-Scholes Fair Value** | **Remaining Contractual Life (Years)** | **Vested and Exercisable** |
| 2012 | $5.56 - $6.75 | 29 | $ 89 | 0 | 29 |
| 2013 | 6.76 - 9.74 | 140 | 538 | 1 | 140 |
| 2014 | 8.94 - 16.05 | 582 | 2,795 | 2 | 582 |
| 2015 | 18.20 - 21.39 | 260 | 2,018 | 3 | 260 |
| 2016 | 15.93 - 16.86 | 242 | 1,430 | 4 | 242 |
| 2017 | 15.80 - 19.41 | 288 | 1,692 | 5 | 228 |
| 2018 | 22.49 - 32.71 | 499 | 4,834 | 6 | 287 |
| 2019 | 41.07 - 45.76 | 633 | 9,934 | 7 | 253 |
| 2020 | 44.84 - 59.49 | 589 | 11,600 | 8 | 126 |
| 2021 | 73.47 - 83.64 | 598 | 19,614 | 9 | 25 |
| 2022 | $79.79 | 164 | 5,509 | 10 | — |
| Total | | 4,024 | $ 60,053 | | 2,172 |

The aggregate intrinsic value of options outstanding, vested and expected to vest as of March 31, 2022 and December 31, 2021 is as follows:

| Options | March 31, 2022 | December 31, 2021 |
|---|---|---|
| Outstanding | **$ 205,704** | $ 191,242 |
| Vested | **146,474** | 137,382 |
| Expected to vest | **53,305** | 48,548 |

The intrinsic value is calculated as the difference between the market value of the underlying common stock and the exercise price of the options. The aggregate intrinsic value of options that vested during the three months ended March 31, 2022 and 2021 was $6,351 and $8,545, respectively. The total intrinsic value of options exercised during the three months ended March 31, 2022 and 2021 was $9,502 and $17,241, respectively.

***Restricted Stock Awards***

The Company granted 112 and 90 restricted stock awards during the three months ended March 31, 2022 and 2021, respectively. All awards were granted at an issue price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the three months ended March 31, 2022 and 2021 ranged from $73.17 to $79.79 and $83.64 to $84.70, respectively. The fair value per share includes quarterly stock awards to non-employee directors.

A summary of the status of the Company's non-vested restricted stock awards as of March 31, 2022 and changes during the three months ended March 31, 2022 is presented below:

| | Non-Vested Restricted Awards | Weighted Average Grant Date Fair Value |
|---|---|---|
| **Nonvested at January 1, 2022** | **549** | **$ 52.16** |
| Granted | **112** | **75.46** |
| Vested | **(110)** | **64.99** |
| Forfeited | **(8)** | **51.13** |
| **Nonvested at March 31, 2022** | **543** | **$ 54.39** |

During the three months ended March 31, 2022, the Company granted four automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards was $77.39 based on the market price on the grant date.

***Long-Term Incentive Plan***

On August 27, 2019, the Board approved the Long-Term Incentive Plan (the 2019 LTI Plan). The 2019 LTI Plan provides that certain employees of the Company who assisted in the consummation of the spin-off transaction that occurred in October 2019 are granted shares of restricted stock upon the successful completion of the spin-off. The 2019 LTI Plan provides for the issuance of 500 shares of Pennant restricted stock. The shares are vested over five years at 20% per year on the anniversary of the grant date. If a recipient is terminated or voluntarily leaves the Company, all shares subject to restriction or not yet vested shall be entirely forfeited. The total stock-based compensation related to the 2019 LTI Plan was approximately $195 and $201 for the three months ended March 31, 2022 and 2021, respectively.

Stock-based compensation expense recognized for the Company's equity incentive plans and long-term incentive plan for the three months ended March 31, 2022 and 2021 was as follows:

| | Three Months Ended March 31, | |
|---|---|---|
| | **2022** | **2021** |
| Stock-based compensation expense related to stock options | **$ 2,520** | $ 1,733 |
| Stock-based compensation expense related to restricted stock awards | **2,302** | 1,838 |
| Stock-based compensation expense related to stock options and restricted stock awards to non-employee directors | **345** | 483 |
| Total | **$ 5,167** | $ 4,054 |

In future periods, the Company expects to recognize approximately $37,341 and $28,325 in stock-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of March 31, 2022. Future stock-based compensation expense will be recognized over 3.7 and 3.4 weighted average years for unvested options and restricted stock awards, respectively. There were 1,852 unvested and outstanding options as of March 31, 2022, of which 1,746 shares are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest as of March 31, 2022 was 6.0 years.

## 18. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 96 affiliated skilled nursing and senior living facilities used in the Company's operations, 95 of which are under nine "triple-net" master lease agreements (collectively, the Master Leases), which range in terms from 13 to 20 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and being continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases is subject to termination prior to the expiration of the then current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases. If the Company elects to renew the term of a Master Lease, the renewal will be effective to all, but not less than all, of the leased property then subject to the Master Lease. Additionally, four of the 96 facilities leased from CareTrust include an option to purchase that the Company can exercise starting on December 1, 2024.

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

The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The terms and conditions of the one stand-alone lease are substantially the same as those for the master leases described above. Total rent expense under the Master Leases was approximately $15,645 and $14,080 for the three months ended March 31, 2022 and 2021, respectively.

Among other things, under the Master Leases, the Company must maintain compliance with specified financial covenants measured on a quarterly basis, including a portfolio coverage ratio and a minimum rent coverage ratio. The Master Leases also include certain reporting, legal and authorization requirements. The Company is in compliance with requirements of the Master Leases as of March 31, 2022.

In connection with the spin-off transaction that occurred in October 2019, the Company guaranteed certain leases of Pennant based on the underlying terms of the leases. The Company does not consider these guarantees to be probable and the likelihood of Pennant defaulting is remote, and therefore no liabilities have been accrued.

The Company also leases certain affiliated operations and certain administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company has entered into multiple lease agreements with various landlords to operate newly constructed state-of-the-art, full-service healthcare resorts. The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, the Company leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $35,785 and $33,476 for the three months ended March 31, 2022 and 2021, respectively.

Forty-four of the Company's affiliated facilities, excluding the facilities that are operated under the Master Leases with CareTrust, are operated under eight separate master lease arrangements. In the first quarter of 2022, the Company added an operation and extended the term for one of the master leases for an additional 14 years. As a result, the lease liabilities and right-of-use assets increased by $120,349 to reflect the new lease obligations. 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.

The components of operating lease expense are as follows:

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| Rent - cost of services[1] | $ 35,762 | $ 33,456 |
| General and administrative expense | 23 | 20 |
| Depreciation and amortization[2] | 289 | 290 |
| Variable lease costs[3] | 5,363 | 3,443 |
| | $ 41,437 | $ 37,209 |

(1) Rent- cost of services includes deferred rent expense adjustments of $124 and $112 for the three months ended March 31, 2022 and 2021, respectively. Additionally, rent- cost of services includes other variable lease costs such as CPI increases and short-term leases of $937 and $584 for the three months ended March 31, 2022 and 2021, respectively.
(2) Depreciation and amortization is related to the amortization of favorable and direct lease costs.
(3) Variable lease costs, including property taxes and insurance, are classified in cost of services in the Company's condensed consolidated statements of income.

Future minimum lease payments for all leases as of March 31, 2022 are as follows:

| Year | Amount |
|---|---|
| 2022 (remainder) | $ 106,273 |
| 2023 | 139,958 |
| 2024 | 138,965 |
| 2025 | 138,854 |
| 2026 | 138,749 |
| 2027 | 137,931 |
| Thereafter | 1,224,452 |
| Total lease payments | 2,025,182 |
| Less: present value adjustment | (760,176) |
| Present value of total lease liabilities | 1,265,006 |
| Less: current lease liabilities | (57,902) |
| Long-term operating lease liabilities | $ 1,207,104 |

Operating lease liabilities are based on the net present value of the remaining lease payments over the remaining lease term. In determining the present value of lease payments, the Company used its incremental borrowing rate based on the information available at the lease commencement date. As of March 31, 2022, the weighted average remaining lease term is 15.2 years and the weighted average discount rate used to determine the operating lease liabilities is 6.8%.

Subsequent to March 31, 2022, the Company expanded its operations through long-term leases with the addition of a stand-alone senior living operation and a senior living operation, both of which were transferred from Pennant.

***Lessor Activities***

In connection with the spin-off transaction that occurred in October 2019, Ensign affiliates retained ownership of the real estate at 29 senior living operations that were contributed to Pennant. Between October 2019 and March 31, 2022, the Company transferred three senior living operations to Pennant. Ensign affiliates retained ownership of the real estate for these 32 senior living communities. All of these properties are leased to Pennant on a triple-net basis, whereas the respective Pennant affiliates are responsible for all costs at the properties including: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. The initial terms range between 14 to 16 years.

Total rental income from all third-party sources for the three months ended March 31, 2022 and 2021 is as follows:

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| Pennant[1] | $ 3,815 | $ 3,488 |
| Other third-party | 474 | 489 |
| | $ 4,289 | $ 3,977 |

(1) Pennant rental income includes variable rent such as property taxes of $330 and $314 for the three months ended March 31, 2022 and 2021, respectively.

Future annual rental income for all leases as of March 31, 2022 were as follows:

| Year | Amount[1] |
|---|---|
| 2022 (remainder) | $ 12,519 |
| 2023 | 16,380 |
| 2024 | 15,670 |
| 2025 | 15,275 |
| 2026 | 15,064 |
| 2027 | 15,064 |
| Thereafter | 81,486 |
| Total | $ 171,458 |

(1) Annual rental income includes base rents and variable rental income pursuant to existing leases as of March 31, 2022.

## 19. COMMITMENTS AND CONTINGENCIES

***Regulatory Matters*** — Laws and regulations governing Medicare and Medicaid programs are complex and subject to review and interpretation. Compliance with such laws and regulations is evaluated regularly, the results of which can be subject to future governmental review and interpretation, and can include significant regulatory action including fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations is monitoring performed by the Office of Civil Rights which covers the Health Insurance Portability and Accountability Act of 1996, the terms of which require healthcare providers (among other things) to safeguard the privacy and security of certain patient protected health information.

***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 to the Company's independent operating subsidiary, (iii) certain lending agreements, under which the Company may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with the Company's officers, directors and others, under which the Company may be required to indemnify such persons for liabilities arising out of the nature of their relationship to the Company. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. 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 condensed consolidated balance sheets for any of the periods presented.

In connection with the spin-off transaction that occurred in October 2019, certain landlords required, in exchange for their consent to the transaction, that the Company's lease guarantees remain in place for a certain period of time following the spin-off. These guarantees could result in significant additional liabilities and obligations for the Company if Pennant were to default on their obligations under their leases with respect to these properties.

***U.S. House of Representatives Select Subcommittee Request*** — In 2020, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis launched a nation-wide investigation into the COVID-19 pandemic, which included the impact of the coronavirus on residents and employees in nursing homes. In June 2020, the Company received a document and information request from the House Select Subcommittee in connection with its investigation. The Company has cooperated in responding to this inquiry. However, it is not possible to predict the ultimate outcome of any such investigation or whether and what other investigations or regulatory responses may result from the investigation, which could have a material adverse effect on our reputation, business, financial condition, and results of operations.

***Litigation*** — The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents served by the Company's independent operating subsidiaries. The Company, its independent operating subsidiaries, and others in the industry are subject to an increasing number of claims and lawsuits, including professional liability claims, alleging that services provided have resulted in personal injury, elder abuse, wrongful death or other related claims. In addition, the Company, its independent operating subsidiaries, and others in the industry are subject to claims and lawsuits in connection with COVID-19 and a facility's preparation for and/or response to COVID-19. The defense of these lawsuits may result in significant legal costs, regardless of the outcome, and can result in large settlement amounts or damage awards.

In addition to the potential lawsuits and claims described above, the Company and its independent operating subsidiaries are 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 Medicaid) or other 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. Under the *qui tam* or "whistleblower" provisions of the False Claims Act, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the Federal Government and receive a percentage of the Federal Government's recovery. Due to these whistleblower incentives, *qui tam* lawsuits have become more frequent. For example, and despite the decision of the U.S. Department of Justice to decline to participate in litigation based on the subject matter of its previously issued Civil Investigative Demand, the involved *qui tam* relator has continued on with the lawsuit and is pursuing claims that the Company and certain of its independent operating subsidiaries have allegedly violated the False Claims Act and/or the Anti-Kickback Statute.

In addition to the Federal False Claims Act, some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. Further, 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 and its independent operating subsidiaries could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which its independent operating subsidiaries do business.

In May 2009, Congress passed the Fraud Enforcement and Recovery Act (FERA) which made significant changes to the Federal False Claims Act and expanded 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 Federal False Claims Act violation can occur without any affirmative fraudulent action or statement, as long as the action or statement is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and the Company's independent operating subsidiaries are routinely subjected to varying types of claims, including class action "staffing" suits where the allegation is understaffing at the facility level. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements, and may result in significant legal costs. The Company expects the plaintiffs' bar to continue to be aggressive in their pursuit of these staffing and similar claims. While the Company has been able to settle these claims without an ongoing material adverse effect on its business, future claims could be brought that may materially affect its business, financial condition and results of operations.

Other claims and suits, including class actions, continue to be filed against the Company and other companies in its industry. The Company and its independent operating subsidiaries have been subjected to, and are currently involved in, class action litigation alleging violations (alone or in combination) of state and federal wage and hour laws as related to the alleged failure to pay wages, to timely provide and authorize meal and rest breaks, and related causes of action. The Company does not believe that the ultimate resolution of these actions will have an ongoing material adverse effect on the Company’s business, cash flows, financial condition or results of operations.

The Company and its independent operating subsidiaries have been, and continue to be, subject to claims, findings and legal actions that arise in the ordinary course of the various businesses, including healthcare and non-healthcare services. These claims include, but are not limited to, potential claims filed by residents, customers, patients and responsible parties related to patient care and treatment (professional negligence claims); to non-care based activities of certain of the subsidiaries; and to employment related claims filed by current or former employees. A significant increase in the number of these claims, or an increase in the amounts owing should plaintiffs be successful in their prosecution of these claims, could materially adversely affect the Company's business, financial condition, results of operations and cash flows. In addition, these claims could impact the Company's ability to procure insurance to cover its exposure related to the various services provided by its independent operating subsidiaries to their residents, customers and patients.

The Company and its independent subsidiaries are also subject to requests for information and investigations by other State and Federal governmental entities (e.g., offices of the attorney general and offices of the inspector general). The Company cannot predict or provide any assurance as to the possible outcome of any inquiry, investigation or litigation. If any such inquiry, investigation or litigation were to proceed, and the Company and its independent operating subsidiaries 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, or if the Company or its independent operating subsidiaries are alleged or found to be liable on theories of general or professional negligence or wage and hour violations, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged violations, and may also include the assumption of specific procedural and financial obligations by the Company or its independent operating subsidiaries under a corporate integrity agreement and/or other such arrangement.

***Medicare Revenue Recoupments*** — The Company's independent operating entities are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments as a result of Recovery Audit Contractors (RAC), Program Safeguard Contractors, and Medicaid Integrity Contractors programs (collectively referred to as Reviews). For several months during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) suspended its Targeted Probe and Educate Program. Beginning in August 2020, CMS resumed Targeted Probe and Educate Program activity. If an operation fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. The Company anticipates that these Reviews could increase in frequency in the future. As of March 31, 2022 and since, 19 of the Company's independent operating subsidiaries had Reviews scheduled, on appeal, or in a dispute resolution process.

### *Concentrations*

***Credit Risk*** — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company's receivables from Medicare and Medicaid payor programs accounted for 53.9% and 54.0% of its total accounts receivable as of March 31, 2022 and December 31, 2021, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 73.4% and 74.1% of the Company's revenue for the three months ended March 31, 2022 and 2021, respectively.

***Cash in Excess of FDIC Limits*** — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of April 26, 2022, the Company had approximately $1,512 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

## 20. COMMON STOCK REPURCHASE PROGRAM

On February 9, 2022, the Board of Directors approved the Company to enter into a stock repurchase program pursuant to which the Company may repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months that started on February 10, 2022. Under this program, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. During the three months ended March 31, 2022, the Company did not purchase any shares pursuant to this stock repurchase program.

As approved by the Board of Directors on October 21, 2021, the Company entered into a stock repurchase program pursuant to which the Company may repurchase up to $20,000 of its common stock under the program for a period of approximately 12 months that started on October 29, 2021. Under this program, the Company is authorized to repurchase its issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. During the three months ended March 31, 2022, the Company repurchased 133 shares of its common stock for $9,882. During the fourth quarter of 2021, the Company repurchased 132 shares of its common stock for $10,118. This repurchase program expired upon the repurchase of the full authorized amount under the plan.

## Item 2. MANAGEMENT'S DISCUSSION AND ANALYSIS OF FINANCIAL CONDITION AND RESULTS OF OPERATIONS

*The following discussion should be read in conjunction with the condensed consolidated financial statements and accompanying notes, which appear elsewhere in this Quarterly Report on Form 10-Q. We urge you to carefully review and consider the various disclosures made by us in this Quarterly Report and in our other reports filed with the Securities and Exchange Commission (SEC), including our Annual Report on Form 10-K for the year ended December 31, 2021 (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 Form 10-Q and Form 8-K, for additional information. The section entitled "Risk Factors" contained in Part II, Item 1A of this Quarterly Report on Form 10-Q, 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 Quarterly Report on Form 10-Q and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.*

*This Quarterly Report on Form 10-Q contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to our 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 expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Additionally, our business and operations for 2022 continue to be impacted by the COVID-19 pandemic. Because of the unprecedented nature of the pandemic, we are unable to predict the full extent and duration of the financial impact of COVID-19 on our business, financial condition and results of operations. Our actual results could differ materially 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 Quarterly Report on Form 10-Q. These forward-looking statements speak only as of the date of this Quarterly Report on Form 10-Q, 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, "Ensign," "Company," "we," "our" and "us" refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our affiliated operations, the Service Center, our wholly-owned captive insurance subsidiary and our captive real estate investment trust (REIT) called Standard Bearer Healthcare REIT, Inc. (Standard Bearer) are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of "Ensign," "Company," "we," "us," "our" and similar verbiage in this Quarterly Report on Form 10-Q is not meant to imply that any of our affiliated operations, the Service Center, the captive insurance subsidiary or Standard Bearer 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 the Annual Report.*

### Overview

We are a provider of health care services across the post-acute care continuum, engaged in the ownership, acquisition, development and leasing of skilled nursing, senior living and other healthcare related properties and other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the operation of choice in the community it serves, provide a broad spectrum of skilled nursing, senior living and other ancillary services. As of March 31, 2022, we offered skilled nursing, senior living and rehabilitative care services through 250 skilled nursing and senior living facilities. Of the 250 facilities, we operated 179 facilities under long-term lease arrangements and have options to purchase 11 of those 179 facilities. Our real estate portfolio includes 102 owned real estate properties, which included 71 facilities operated and managed by us, 32 senior living operations leased to and operated by The Pennant Group, Inc., or Pennant, as part of the spin-off transaction that occurred in October 2019 (Spin-Off), and the Service Center location. Of the 32 real estate operations leased to Pennant, two senior living operations are located on the same real estate properties as skilled nursing facilities that we own and operate.

The following table summarizes our affiliated facilities and operational skilled nursing beds and senior living units by ownership status as of March 31, 2022:

| | Owned and Operated | Leased (with a Purchase Option) | Leased (without a Purchase Option) | Total for Facilities Operated |
|---|---|---|---|---|
| Number of facilities | 71 | 11 | 168 | 250 |
| Percentage of total | 28.4 % | 4.4 % | 67.2 % | 100.0 % |
| Operational skilled nursing beds | 6,963 | 1,145 | 17,405 | 25,513 |
| Percentage of total | 27.3 % | 4.5 % | 68.2 % | 100.0 % |
| Senior living units | 1,600 | 178 | 958 | 2,736 |
| Percentage of total | 58.5 % | 6.5 % | 35.0 % | 100.0 % |

Ensign is a holding company with no direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly-owned subsidiaries, referred to collectively as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. We also have a wholly-owned captive insurance subsidiary that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as coverage for certain workers' compensation insurance liabilities and our captive real estate trust owns and operates our real estate portfolio. Our captive real estate investment trust, Standard Bearer, owns and manages our real estate business. References herein to the consolidated "Company" and "its" assets and activities, as well as the use of the terms "we," "us," "our" and similar terms in this Quarterly Report, are not meant to imply, nor should they be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries are operated by The Ensign Group.

### Recent Activities

***Revolving Credit Facility Amendment*** — On April 8, 2022, we entered into the Second Amendment to Third Amended and Restated Credit Facility (the Amended Credit Facility), which increased the revolving credit facility by $250.0 million to an aggregate principal amount of up to $600.0 million. The maturity date of the Amended Credit Facility is April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist Securities (Truist). The interest rates applicable to loans under the Amended Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or Secured Overnight Financing Rate (SOFR) plus a margin range from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, we will pay a commitment fee on the unused portion of the commitments that will range from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

***Captive Real Estate Investment Trust*** — In January of 2022, we formed Standard Bearer Healthcare REIT, Inc. or Standard Bearer, a captive REIT. Standard Bearer is a holding company with subsidiaries that own most of our real estate portfolio. We expect the REIT structure will allow us to better demonstrate the growing value of our owned real estate and provides us with an efficient vehicle for future acquisitions of properties that could be operated by Ensign affiliates or other third parties. We believe this structure will give us new pathways to growth with transactions we would not have considered in the past. Standard Bearer intends to qualify and elects to be taxed as a REIT, for U.S. federal income tax purposes, commencing with its taxable year ending December 31, 2022.

The real estate portfolio in Standard Bearer consists of a select 95 of our 102 owned real estate properties. Of the 95 owned real estate properties in Standard Bearer, 67 facilities are operated by Ensign operating subsidiaries and 30 facilities are leased to and operated by Pennant. Of the 30 real estate operations leased to Pennant, two senior living operations are located on the same real estate properties as skilled nursing facilities that we own and operate.

The fair value of Standard Bearer's real estate portfolio is more than $1.0 billion. The fair value was determined by a third party independent valuation specialist and incorporated each property's rental income, capitalization rate, rental yield rate and discount rate as appropriate.

In January of 2022, as part of the formation of Standard Bearer, certain of our operating subsidiaries and the 67 Standard Bearer subsidiaries entered into five "triple-net" master lease agreements (collectively, the Standard Bearer Master Leases). The lease period ranges from 15 to 19 years with three five-year renewal option beyond the initial term, on the same terms and conditions. The rent structure under the Standard Bearer Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the operating subsidiaries are required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. During the three months ended March 31, 2022, we acquired the real estate of two skilled nursing facilities for a purchase price of $17.0 million and leased these facilities to certain of our operating subsidiaries through the Standard Bearer Master Leases. Total annual rental income under the Standard Bearer Master Lease is approximately $56 million. In addition, as we expand our real estate portfolio through our acquisition strategy, we anticipate that the acquired real estate will be included in Standard Bearer.

Standard Bearer has no employees. Personnel and services provided to Standard Bearer by the Service Center are pursuant to the management agreement between Standard Bearer and the Service Center. The management agreement provides for a base management fee and an incentive management fee, payable in cash, among other terms. The base management fee for each applicable period is equal to 5.0% of the total revenue of Standard Bearer. The incentive management fee is equal to 5.0% of funds from operations (FFO) and is capped at 1.0% of total revenue. In addition, operating expenses incurred by the Service Center on Standard Bearer's behalf, which includes the cost of legal, tax, consulting, accounting and other similar services rendered by the Service Center, its advisers or other third parties, are reimbursed by Standard Bearer. During the three months ended March 31, 2022, management fee was $1.0 million or 6.0% of total revenue of Standard Bearer.

Standard Bearer will obtain its funding through various sources including operating cash flows, access to debt arrangements and intercompany loans. The intercompany debt arrangements include mortgage loans and a credit revolver between the Ensign Group, Inc., the real estate properties and Standard Bearer and will fund acquisitions and working capital needs. The interest rate under the credit revolver is a base rate plus a margin ranging from 0.50% to 1.50% per annum or LIBOR (or an alternative reference rate) plus a margin range from 1.50% to 2.50% per annum. The intercompany mortgage loan amount is $93.0 million. As of March 31, 2022, there is $16.8 million outstanding under the intercompany credit revolver. In addition, third party debt held by Department of Housing and Urban Development (HUD) mortgage loans and promissory notes are outstanding in an aggregate amount of $159.0 million, are included in Standard Bearer.

***Coronavirus Update*** — We are continuing to closely monitor the impact of the global COVID-19 pandemic on our business as evidenced by the extension of the public health emergency (PHE) through July 14, 2022. Our primary focus throughout the COVID-19 pandemic has remained ensuring the health and safety of our patients, residents, employees and their respective families. We continue to implement measures necessary to provide the safest possible environment within our sites of service, taking into consideration the vulnerable nature of our patients and the unique exposure risks of our staff.

We continue to execute on key initiatives to rebuild occupancy lost due to the pandemic. During the first quarter of 2022, our combined Same Facilities and Transitioning Facilities occupancy increased by 3.4% compared to first quarter of 2021 and 0.2% compared to the fourth quarter of 2021.

The improvements in occupancy were due to our operations developing innovative approaches to confront the occupancy declines, including strategic partnerships with upstream and downstream continuum partners and increasing clinical competencies to treat high-acuity patients, including those that are COVID-19 positive. Additionally, we have seen increases in hospital volumes for surgeries. Even with COVID-19 demands waning, the partnerships developed during the pandemic will continue to benefit us into the future. By strengthening existing partnerships, creating new partnerships and most importantly, demonstrating clinical capabilities and favorable outcomes, our census has continued to stabilize. We believe our operations are primed to rebuild occupancies and continue to gain additional market share as a result of relationships with acute care providers and other health care partners.

We did not receive any provider relief fund distributions (Provider Relief Fund) from the Coronavirus Aid, Relief and Economic Security Act of 2020 (the CARES Act) from the federal government during the three months ended March 31, 2022. To date, we have returned all Provider Relief Funds that we received and repaid all of the Medicare Accelerated and Advance Payment Program funds received.

During the three months ended March 31, 2022 and March 31, 2021, we received state relief funding of $17.3 million and $15.6 million and recognized $17.6 million and $16.5 million, respectively, as revenue. Our unapplied state funding as of December 31, 2021 and 2020 was $1.5 million and $1.8 million, respectively. See Note 3, *COVID-19 Update* in the Notes to the Unaudited Condensed Consolidated Financial Statements.

The CARES Act also provides for deferred payment of the employer portion of social security taxes through the end of 2020, with 50% of the deferred amount due by December 31, 2021 and the remaining 50% due by December 31, 2022. We recorded $48.3 million of deferred payments of social security taxes as a liability in 2020, of which $24.2 million was paid out in the fourth quarter of 2021 and the remaining liabilities will be paid in the fourth quarter of 2022.

***Common Stock Repurchase Program*** — On October 21, 2021, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that follow October 29, 2021. During the three months ended March 31, 2022, the Company repurchased 0.1 million shares of our common stock for $9.9 million. This repurchase program expired upon the repurchase of the full authorized amount under the plan. On February 9, 2022, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that follow February 10, 2022. During the three months ended March 31, 2022, we did not purchase any shares pursuant to this stock repurchase program.

### Facility Information

The following table sets forth the location of our operated and owned facilities by type as well as the number of beds and units located at operated and owned facilities as of March 31, 2022:

| | TX | CA | AZ | UT | CO | WA | ID | NE | IA | SC | WI | NV | KS | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Number of operated facilities** | | | | | | | | | | | | | | |
| Skilled nursing operations | 65 | 52 | 29 | 18 | 14 | 13 | 11 | 4 | 4 | 4 | 2 | 1 | — | 217 |
| Senior living operations | 1 | — | 1 | 2 | 5 | — | — | 1 | — | — | — | — | — | 10 |
| Campuses[1] | 4 | 1 | 4 | 1 | 1 | — | 1 | 2 | 2 | — | — | — | 7 | 23 |
| **Number of operated beds/units** | | | | | | | | | | | | | | |
| Operational skilled nursing beds | 8,350 | 5,296 | 4,364 | 1,991 | 1,303 | 1,227 | 984 | 413 | 368 | 424 | 100 | 92 | 601 | 25,513 |
| Senior living units | 505 | 65 | 718 | 163 | 725 | — | 21 | 302 | 31 | — | — | — | 206 | 2,736 |
| **Number of owned and operated facilities** | | | | | | | | | | | | | | |
| Skilled nursing properties | 16 | 8 | 8 | 7 | 4 | 2 | 5 | 1 | — | 4 | 2 | — | — | 57 |
| Senior living communities | 1 | — | — | — | 3 | — | — | 1 | — | — | — | — | — | 5 |
| Campuses[1] | 2 | — | 3 | — | — | — | — | — | — | — | — | — | 4 | 9 |
| **Number of owned and operated beds/units** | | | | | | | | | | | | | | |
| Owned skilled nursing beds | 2,012 | 848 | 1,443 | 684 | 346 | 204 | 454 | 88 | — | 424 | 100 | — | 360 | 6,963 |
| Owned Senior living units | 439 | — | 315 | — | 461 | — | — | 263 | — | — | — | — | 122 | 1,600 |
| **Number of owned and not operated facilities** | | | | | | | | | | | | | | |
| Senior living properties | 6 | 3 | 1 | — | — | — | 2 | 1 | — | — | 19 | — | — | 32 |

(1) Campuses represent facilities that offer both skilled nursing and senior living services.

During the three months ended March 31, 2022, we expanded our operations and real estate portfolio through a combination of long-term leases and real estate purchases, with the addition of four stand-alone skilled nursing operations. Of these additions, two include purchases of real estate properties, further expanding our Standard Bearer real estate portfolio. In addition, we added two senior living operations that were transferred from Pennant, one of which is part of a campus operated by our affiliated operating subsidiaries. These new operations added a total of 453 operational skilled nursing beds and 403 operational senior living units to be operated by our affiliated operating subsidiaries.

Subsequent to March 31, 2022, we expanded our operations and real estate portfolio through a real estate purchase, which added one stand-alone senior living operation. In addition, we added three senior living operation that were transferred from Pennant, two of which are part of healthcare campuses operated by our affiliated operating subsidiaries. These new operations added 281 operational senior living units to be operated by our affiliated operating subsidiaries. We also invested in new ancillary services that are complementary to our existing businesses

For further discussion of our acquisitions, see *Note 7, Standard Bearer* and *Note 9, Operation Expansions* in the Notes to the Unaudited Condensed Consolidated Financial Statements.

### Key Performance Indicators

We manage the fiscal aspects of our business by monitoring key performance indicators that affect our financial performance. Revenue associated with these metrics is generated based on contractually agreed-upon amounts or rate, excluding the estimates of variable consideration under the revenue recognition standard, ASC 606. These indicators and their definitions include the following:

***Skilled Services***

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

- ***Skilled revenue*** - The amount of routine revenue generated from patients in the skilled nursing facilities who are receiving higher levels of care under Medicare, managed care, Medicaid, or other skilled reimbursement programs. The other skilled patients who are included in this population represent very high acuity patients who are receiving high levels of nursing and ancillary services which are reimbursed by payors other than Medicare or managed care. Skilled revenue excludes any revenue generated from our senior living services.

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

- ***Average daily rates*** — The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period. These rates exclude additional state relief funding, which includes payments we recognized as part of The Family First Coronavirus Response Act.

- ***Occupancy percentage (operational beds)*** — The total number of patients occupying a bed in a skilled nursing 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 facilities that we own or operate and the total number of operational beds associated with these facilities.

***Skilled 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 from our skilled nursing services for the periods indicated as a percentage of our total skilled nursing routine revenue and as a percentage of total skilled nursing patient days:

| | Three Months Ended March 31, | |
|---|---|---|
| **Skilled Mix:** | **2022** | **2021** |
| Days | **33.7 %** | 34.4 % |
| Revenue | **54.3 %** | 55.6 % |

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

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

| | Three Months Ended March 31, | |
|---|---|---|
| **Occupancy for skilled services:** | **2022** | **2021** |
| Operational beds at end of period | **25,513** | 23,619 |
| Available patient days | **2,285,046** | 2,122,096 |
| Actual patient days | **1,695,964** | 1,509,600 |
| Occupancy percentage (based on operational beds) | **74.2 %** | 71.1 % |

***Segments***

We have two reportable segments: (1) skilled services, which includes the operation of skilled nursing facilities and rehabilitation therapy services and (2) Standard Bearer, which is comprised of selected properties owned by us through our captive REIT and leased to skilled nursing and senior living operations, including our own operating subsidiaries and third party operators.

We also reported an “all other” category that includes operating results from our senior living operations, mobile diagnostics, transportation, other real estate and other ancillary operations. These businesses are neither significant individually, nor in aggregate and therefore do not constitute a reportable segment. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

***Revenue Sources***

The following table sets forth our total service revenue by payor source generated by our skilled services segment and other service revenue and as a percentage of total revenue for the periods indicated (dollars in thousands):

| | Three Months Ended March 31, | | | | | |
|---|---|---|---|---|---|---|
| | Skilled Services | | Other Service Revenue | | Total Service Revenue | |
| | **2022** | **2021** | **2022** | **2021** | **2022** | **2021** |
| Medicaid[1] | **$ 261,587** | $ 227,741 | **$ 4,761** | $ 3,617 | **$ 266,348** | $ 231,358 |
| Medicare | **208,411** | 190,303 | **—** | — | **208,411** | 190,303 |
| Medicaid-skilled | **45,949** | 39,993 | **—** | — | **45,949** | 39,993 |
| Subtotal | **515,947** | 458,037 | **4,761** | 3,617 | **520,708** | 461,654 |
| Managed care | **127,786** | 108,345 | **—** | — | **127,786** | 108,345 |
| Private and other[2] | **43,038** | 34,654 | **17,624** | 18,623 | **60,662** | 53,277 |
| Total service revenue | **$ 686,771** | $ 601,036 | **$ 22,385** | $ 22,240 | **$ 709,156** | $ 623,276 |

| | Three Months Ended March 31, | | | | | |
|---|---|---|---|---|---|---|
| | Skilled Services | | Other Service Revenue | | Total Service Revenue | |
| | **2022** | **2021** | **2022** | **2021** | **2022** | **2021** |
| Medicaid[1] | **38.1 %** | 37.9 % | **21.3 %** | 16.3 % | **37.6 %** | 37.1 % |
| Medicare | **30.3** | 31.7 | **—** | — | **29.4** | 30.5 |
| Medicaid-skilled | **6.7** | 6.6 | **—** | — | **6.4** | 6.5 |
| Subtotal | **75.1** | 76.2 | **21.3** | 16.3 | **73.4** | 74.1 |
| Managed care | **18.6** | 18.0 | **—** | — | **18.0** | 17.4 |
| Private and other[2] | **6.3** | 5.8 | **78.7** | 83.7 | **8.6** | 8.5 |
| Total service revenue | **100.0 %** | 100.0 % | **100.0 %** | 100.0 % | **100.0 %** | 100.0 % |

(1) Medicaid payor includes revenue generated from senior living operations and revenue related to FMAP.
(2) Private and other payors also includes revenue from senior living operations and all payors generated in other ancillary services.

### *Skilled Services*

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

We are participating in supplemental payment programs in various states that provide supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as city and county hospital districts. Several of our operating subsidiaries entered into transactions with several such hospital districts providing for the transfer of the licenses for those skilled nursing facilities to the hospital districts. Each affected operating subsidiary agreement between the hospital district and our subsidiary is terminable by either party to fully restore the prior license status.

### *Standard Bearer*

We generate rental revenue primarily by leasing post-acute care properties we acquired to healthcare operators under triple-net lease arrangements, whereby the tenant is solely responsible for the costs related to the property, including property taxes, insurance, and maintenance and repair costs, subject to certain exceptions. As of March 31, 2022, our real estate portfolio within Standard Bearer comprised of 95 real estate properties. Of these properties, 67 are leased to affiliated skilled nursing facilities wholly-owned and managed by us and 30 are leased to senior living operations wholly owned and managed by Pennant. Of the 30 real estate operations leased to Pennant, two senior living operations are located on the same real estate properties as skilled nursing facilities that the Company owns and operates. During the three months ended March 31, 2022, we generated rental revenues of $17.2 million, of which $13.4 million was derived from affiliated wholly-owned healthcare operators, and therefore eliminated in consolidation.

### *Other*

Within our senior living operations, we generate revenue primarily from private pay sources, with a portion earned from Medicaid payors or through other state-specific programs. In addition, we hold majority membership interests in our other ancillary operations. Payment for these services varies and is based upon the service provided. The payment is adjusted for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk.

## *Critical Accounting Estimates*

Our condensed consolidated financial statements included in this report have been prepared in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP). The preparation of these financial statements requires management to make judgments, estimates and assumptions that affect the reported amounts of assets, liabilities, cash flows, revenues and expenses, and related disclosure of contingent assets and liabilities.

See Item 2., *Management's Discussion and Analysis of Financial Condition and Results of Operations*, in our Annual Report on Form 10-K for the fiscal year ended December 31, 2021 for further discussion of critical accounting estimates. There were no material changes to our critical accounting policies with which the estimates are developed since December 31, 2021.

## *Industry Trends*

The post-acute care 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 patient care to lower cost settings. The 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 U.S. 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 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. Due to the increasing demands from hospitals and insurance carriers to implement sophisticated and expensive reporting systems, we believe this fragmentation provides us with significant acquisition and consolidation opportunities.
- ***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*** — As seniors account for an increasing percentage of the total U.S. population, we believe the demand for skilled nursing and senior living services will continue to increase. According to the census projection released by the U.S. Census Bureau in early 2020, between 2016 and 2030, the number of individuals over 65 years old is projected to be one of the fastest growing segments of the United States population, growing from 16% to 21%. The Bureau expects this segment to increase nearly 50% to 73 million, as compared to the total U.S. population which is projected to increase by 10% over that time period. Furthermore, the generation currently retiring has accumulated less savings than prior generations, creating demand for more affordable senior housing and skilled nursing services. As a high-quality provider in lower cost settings, we believe we are well-positioned to benefit from this trend.
- ***Transition to Value-Based Payment Models*** — In response to rising healthcare spending in the United States, commercial, government and other payors are generally shifting away from fee-for-service payment models towards value-based models, including risk-based payment models that tie financial incentives to quality, efficiency and coordination of care. We believe that patient-centered outcomes driven reimbursement models will continue to grow in prominence. Many of our operations already receive value-based payments, and as valued-based payment systems continue to increase in prominence, it is our view that our strong clinical outcomes will be increasingly rewarded.
- ***Accountable Care Organizations and Reimbursement Reform*** — A significant goal of U.S. federal health care reform is to transform the delivery of health care by changing reimbursement to reflect and support the quality and safety of care that providers deliver, increase efficiency, and reduce growth in spending. Reimbursement models that provide financial incentives to encourage efficiency, affordability, and high-quality care have been developed and implemented by government and commercial third-party payers. The most prolific of these models, the Accountable Care Organization (ACO) model, incentivizes groups of providers to share in savings that are achieved through the coordination of care and chronic disease management of an assigned patient population. Reimbursement methodology reform includes Value-Based Purchasing (VBP), in which a portion of provider reimbursement is redistributed based on relative performance, or improvement on designated economic, clinical quality, and patient satisfaction metrics. In addition, the Centers for Medicare and Medicaid Services (CMS) has implemented Episode-based demonstration, voluntary and mandatory payment initiatives that bundle acute care and post-acute care reimbursement. These bundled payment models incentivize cross-continuum care coordination and include financial and performance accountability for episodes of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in government and commercial health plans. Many of our operations already participate in ACOs. With our focus on quality care and strong clinical outcomes, Ensign is well-positioned to benefit from these outcome-based payment models.

We believe the post-acute industry has been and will continue to be impacted by several other trends. The use of long-term care (LTC) 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 residents are looking for alternatives outside the family for their care.

## GOVERNMENT REGULATION

### *General*

Healthcare is an area of extensive and frequent regulatory change. Changes in the law or new interpretations of existing laws may have a significant impact on revenue, costs and business operations. Our independent operating subsidiaries that provide healthcare services are subject to federal, state and local laws relating to, among other things, licensure, quality and adequacy of care, physical plant requirements, life safety, personnel and operating policies. In addition, these same subsidiaries are subject to federal and state laws that govern billing and reimbursement, relationships with vendors and business relationships with physicians, and workplace protection for healthcare staff. Such laws include the Anti-Kickback Statue, the federal False Claims Act (FCA), the Stark Law, the Health Care Emergency Temporary Standard, and state corporate practice of medicine statutes.

Governmental and other authorities periodically inspect the skilled nursing facilities, senior living facilities and outpatient rehabilitation agencies of our independent operating subsidiaries to verify continued compliance with applicable regulations and standards. The operations must pass these inspections to remain licensed under state laws and to comply with Medicare and Medicaid provider agreements. The operations can only participate in these third-party payment programs if inspections by regulatory authorities reveal that the operations are in substantial compliance with applicable state and federal requirements. In the ordinary course of business, federal or state regulatory authorities may issue notices to the operations alleging deficiencies in certain regulatory practices. These statements of deficiency may require corrective action to regain and maintain compliance. In some cases, federal or state regulators may impose other remedies including imposition of civil monetary penalties, temporary payment bans, loss of certification as a provider in the Medicare or Medicaid program, or revocation of a state operating license.

We believe that the regulatory environment surrounding the healthcare industry subjects providers to intense scrutiny. In the ordinary course of business, providers are subject to inquiries, investigations and audits by federal and state agencies related to compliance with participation and payment rules under government payment programs. These inquiries may originate from the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG), state Medicaid agencies, state Attorney Generals, local and state ombudsman offices and CMS Recovery Audit Contractors, among other agencies. In response to the inquiries, investigations and audits, federal and state agencies continue to impose citations for regulatory deficiencies and other regulatory penalties, including demands for refund of overpayments, expanded civil monetary penalties that extend over long periods of time and date back to incidents prior to surveyor visits, Medicare and Medicaid payment bans and terminations from the Medicare and Medicaid programs, which may be temporary or permanent in nature. We vigorously contest each such regulatory outcome when appropriate; however, there are significant legal and other expenses involved that consume our financial and personnel resources. Expansion of enforcement activity could adversely affect our business, financial condition or the results of operations.

### *Coronavirus*

In an effort to promote efficient care delivery and to decrease the spread of COVID-19, federal, state and local regulators have implemented new regulations and waived (in some cases, temporarily) certain existing regulations, including those set forth below.

***Temporary suspension of certain patient coverage criteria and documentation and care requirements*** - The Coronavirus Aid, Relief, and Economic Security Act of 2020 (the CARES Act) and a series of temporary waivers and guidance issued by CMS suspended various Medicare patient coverage criteria to ensure patients continue to have adequate access to care, notwithstanding the burdens placed on healthcare providers as related to the COVID-19 pandemic. Many of these regulatory waivers were issued pursuant to Section 1135 of the Social Security Act, which authorizes the HHS Secretary to temporarily waive or modify Medicare and Medicaid requirements for affected health care providers and facilities following the declaration of a PHE (Section 1135 Waivers). HHS also waived requirements specific to skilled nursing facilities pursuant to its authority under Section 1812(f) of the Social Security Act (Section 1812(f) Waiver, and together with the Section 1135 Waivers, the Emergency Waivers). While many of the Emergency Waivers are expected to last throughout the duration of the COVID-19 PHE, CMS ended several Emergency Waivers effective May 10, 2021. Due to the prevalence of waves of COVID-19 variants in 2021 and continuing into 2022, it is unclear when the remaining Emergency Waivers will expire, or whether previously expired Emergency Waivers will be reinstated. Effective April 16, 2022, the COVID-19 PHE was extended until at least July 14, 2022. HHS has reported that it will provide at least 60 days' advance notice prior to the expiration or termination of the PHE.

Examples of the Emergency Waivers include, but are not limited to the following: (1) approving temporary expansion sites to ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients (e.g. CMS Hospital Without Walls); (2) removing barriers to practice for physicians, nurses, and other clinicians from the community or from other states to allow healthcare systems to provide clinical and workforce support where needed; (3) increasing access to telehealth and corresponding reimbursement through Medicare to ensure patients have access to healthcare while remaining safe at home; (4) expanding in-place COVID-19 testing to allow for more testing at home or in community based settings; (5) waiving the requirement for LTC facilities' directors of food and nutrition services to have specified higher education or other credentials in the areas of food service and management and safety; and (6) temporarily waiving certain documentation, reporting and audit requirements to allow providers, health care facilities, Medicare Advantage (MA) and Part D plans, and states to focus on the provision of care (e.g., Patients Over Paperwork). Many states have also waived regulations to ease regulatory burdens on the healthcare industries. It remains uncertain when federal and state regulators will resume enforcement of those regulations, which remain waived or are otherwise not being enforced during the PHE. We believe these regulatory actions could contribute to changes in skilled mix, which may have been different without the existence of the Emergency Waivers.

Pursuant to the Emergency Waivers, CMS also authorized temporary waivers on medical review requirements, effective March 1, 2020, for the duration of the PHE. In addition, CMS is re-prioritizing scheduled program audits and contract-level Risk Adjustment Data Validation audits for MA organizations, Part D sponsors, Medicare-Medicaid Plans, and Programs of All-Inclusive Care for the Elderly organizations. Re-prioritizing these audit activities allows providers, CMS and organizations to focus on patient care.

In July 2020, CMS updated its COVID-19 Provider Burden Relief Frequently Asked Questions (FAQ) related to claim audit waivers for multiple services. On March 30, 2020, CMS suspended most Medicare FFS medical reviews because of the COVID-19 pandemic. This included pre-payment medical reviews conducted by Medicare Administrative Contractors (MACs) under the Targeted Probe and Educate program and post-payment reviews conducted by the MACs, Supplemental Medical Review Contractors (SMRC), and Recovery Audit Contractors (RAC). CMS authorized MACs to resume these audit activities beginning on August 3, 2020, regardless of the status of the PHE. All reviews would be conducted in accordance with statutory and regulatory provisions, as well as related billing and coding requirements. Available waivers and flexibilities for the claims selected for review would also be applied. In December of 2021, CMS issued a 2019 Novel Coronavirus Medicare Provider Enrollment Relief FAQ document, which addressed Medicare enrollment and re-enrollment during the ongoing PHE. Within this December 2021 FAQ, CMS indicated that it would resume collecting application fees in 2021 and revalidating enrollees in 2022.

Under the Emergency Waivers, CMS is also allowing skilled nursing facilities to provide a skill-in-place program for Medicare beneficiaries who are residents of the skilled nursing facilities that meet the skill-in-place criteria, foregoing the usual three-day qualifying hospital stay. This waiver remains valid for the duration of the COVID-19 PHE. As patients qualify for skill-in-place for Medicare Part A stays, we could see a decrease in LTC Medicare Part B programs.

On August 24, 2020, CMS released a Medicaid Informational Bulletin providing guidance to states on flexibilities that are available to increase reimbursement for nursing facilities implementing specific infection control practices. On September 8, 2021, CMS clarified that CMS's waivers do not waive or change other requirements for SNF coverage under Medicare, including the SNF level of care criteria, which is unchanged by the PHE. CMS used this update of its March 16, 2021 Medicare FFS Response to the PHE on COVID-19 article to further clarify that CMS will review and take action in connection with SNF admissions that do not satisfy SNF level of care criteria that existed prior to the PHE and CMS's institution of applicable waivers that facilitated payment for SNF services.

On April 7, 2022, CMS issued a memorandum that identified 16 Emergency Waivers that would expire for SNFs and LTC facilities during the next 60 days. CMS stated that the Emergency Waivers would expire in two groups. The first group of Emergency Waivers to expire within 30 days of CMS’s memorandum, on May 7, 2022, contains seven Emergency Waivers. The second group of Emergency Waivers to expire 60 days after the memorandum’s issuance, on June 6, 2022, contains nine Emergency Waivers. The Emergency Waivers expiring on May 7, 2022 are: (1) waiver of the requirement that residents participate in-person during resident groups; (2) physicians’ ability to delegate tasks that otherwise would need to be personally performed by a physician within a SNF; (3) waiver of the requirement for physicians to make personal visits to patients, which the Emergency Waivers allow physicians to delegate to other clinicians; (4) waiver of the requirement for physicians and non-physician providers to conduct in-person visits to nursing home residents (and allowing those visits to be made via telemedicine as appropriate); (5) reducing LTC facilities’ requirements to develop, implement and maintain a QAPI program that satisfies federal standards; (6) waiver of LTC facilities’ obligation to participate in discharge planning for residents ending their care at the facility; and (7) waiver of the requirement for LTC facilities to provide residents with a copy of their records within two working days of a resident’s request for those records.

The Emergency Waivers that will expire on June 6, 2022 are: (1) waivers of SNF physical environment conditions for temporary use facilities (including COVID-19 treatment locations) and use of interior or non-residential space within a SNF to accommodate residents; (2) waivers of requirements for timely preventative maintenance for certain equipment, including dialysis equipment; (3) the waiver of inspection, testing and maintenance for the facilities and medical equipment used within ICFs and SNFs; (4) the waiver of inspection, testing, and maintenance for compliance with applicable life safety codes and health care facility codes for intermediate care facilities (ICFs) and SNFs; (5) the waiver of CMS’s requirement for ICFs and SNFs to have an exterior door or window in every room used for sleeping; (6) life safety code waivers of quarterly fire drills and allowing SNFs to erect temporary walls and barriers between patients; (7) waiving CMS’s minimum training requirements for paid feeding assistants in LTC facilities; (8) CMS’s waiver of its requirement for nurse aides within SNFs to receive at least 12 hours of annual in-service training; and (9) the waiver of an SNF’s normal obligation not to employ any nursing aid longer than 4 months if he or she does not satisfy federal training and certification requirements.

Select waivers including the three-day qualifying stay will remain in effect, however there may be additional or other Emergency Waivers that will be terminated or allowed to expire in coming weeks or days. CMS's memorandum may also exacerbate the care differential between hospitals and non-hospital facilities. Notably, CMS's April 7, 2022, memorandum specified that the Emergency Waivers will remain in effect for hospitals and critical access hospitals, but the specified Emergency Waivers will expire for SNFs, LTC facilities, and inpatient hospices, among other facility types. The expiration or termination of Emergency Waivers are determined at the agency level and may occur quickly as well as with little public notice.

***Resuming visitation and resident rights*** — CMS has issued guidance to facilities throughout the PHE regarding patients' rights to visitation. While the CMS guidance issued in March 2020 directed facilities to severely restrict visitation, CMS has subsequently provided guidance through the course of the pandemic (and most recently updated in November 2021 and January 2022) that broadens visitation and provides guidance on visitation procedures.

***Testing requirements*** — Beginning in April 2020, authorities in several states in which our independent operating subsidiaries are located began to mandate widespread COVID-19 testing at all nursing home and LTC facilities. This came after the Centers for Disease Control and Prevention (CDC) stated that older adults are at a higher risk for serious illness from the coronavirus and issued updated testing guidelines for nursing homes. Some of these states were also publicly reporting COVID-19 outbreaks in facilities. On July 22, 2020, CMS announced that nursing homes in states with a 5% or greater positivity rate for COVID-19 will be required to test all nursing home staff each week. On August 26, 2020, CMS issued new parameters for testing, requiring routine monthly testing of all facility staff if the facility's county positivity rate is less than 5%; weekly testing if the county positivity rate is between 5% and 10%; and twice weekly testing if the county positivity rate exceeds 10%. On April 27, 2021, CMS again issued revised parameters for testing, specifying that the requirement for routine testing of staff applies only to those staff members that are unvaccinated - fully vaccinated staff do not have to be routinely tested.

***Federal and state COVID-19 vaccination requirements*** — On December 11, 2020, the U.S. Food and Drug Administration (FDA) issued the first emergency use authorization (EUA) for the Pfizer-BioNTech vaccine for the prevention of COVID-19, followed by the second EUA for the use of the Moderna COVID-19 vaccine on December 28, 2020, and the third EUA for the Johnson & Johnson vaccine on February 27, 2021. Pfizer and Moderna's COVID-19 vaccines have since received full FDA approval. Vaccine distribution, including the administration of first vaccine booster shots, is now widespread in all 50 states. Through a series of amendments to the EUA beginning in 2021 through March 2022, the FDA authorized and the CDC recommended the use of first a single booster dose, and then a second booster dose, to be administered to qualifying individuals. First boosters were approved and recommended at least six months after completing the primary vaccination series of Pfizer-BioNTech or Moderna, or two months after completing the primary Johnson & Johnson vaccination. Second boosters of either the Pfizer-BioNTech or Moderna vaccines were approved and recommended to be administered to qualifying individuals at least four months after receipt of their first vaccine booster injection.

On August 18, 2021, the Administration announced that CMS was developing an emergency regulation requiring all workers within Medicare and Medicaid-participating nursing homes to be vaccinated against COVID-19 as a condition of participation in the Medicare and Medicaid programs. The Administration expanded the scope of this forthcoming emergency regulation on September 9, 2021, and on the same day the Administration announced that OSHA would introduce an emergency temporary standard (ETS) requiring employers with more than 100 employees to mandate that its employees be fully vaccinated against COVID-19 or submit to weekly testing for the virus. Both CMS's IFR and OSHA's ETS for vaccination were challenged in court and halted from enforcement in certain states.

On November 5, 2021, CMS issued the Omnibus COVID-19 Health Care Staff Vaccination interim final rule (IFR), requiring all eligible staff in certain Medicare and Medicaid participating health facilities to complete their one- or two-injection vaccination sequences by or before January 13, 2022. CMS's enforcement of this IFR was temporarily blocked in certain states pending appeal to the United States Supreme Court. By January 20, 2022, decisions of the United States Supreme Court and other courts affirmed CMS's authority to enforce the IFR in all states, with the last among them, Texas, subject to a deadline of March 21, 2022 for full compliance with the IFR's vaccination requirements. Additionally, facilities must test any staff or resident, regardless of vaccination status, who has signs or symptoms of COVID-19. In the event of a COVID-19 outbreak in the facility, all staff and residents must be tested at regular intervals until repeat testing identifies no new cases of COVID-19 infection among staff or residents for a 14-day period. Additional guidance may be issued in connection with this IFR. In addition to CMS's testing mandates, some states have imposed their own testing requirements for residents and staff, or are enforcing testing mandates under existing or expanded workplace safety regulations.

In addition to the IFR mandating vaccinations for health facility workers, several states where our independent operating facilities are located have issued vaccine mandates that apply to facility staff. California, the most populous state, issued an order on August 5, 2021 (and expanded on September 28, 2021), requiring adult care facilities and direct care workers to be vaccinated as well, and for all affected workers to be fully vaccinated by November 30, 2021. On February 22, 2022, California's Department of Public Health updated its directive to allow workers who had completed their primary vaccination series and contracted COVID-19 since becoming fully vaccinated to defer the receipt of a vaccine booster dose by up to 90 days after infection with COVID-19; otherwise, booster vaccine doses were required to be completed by March 1, 2022. On August 20, 2021, the State of Washington required workers (including employees, contractors, and volunteers) in LTC facilities and healthcare settings to be fully vaccinated against COVID-19 by October 2021. On August 30, 2021, the Colorado Board of Health approved (and extended by 120 days on December 15, 2021) a COVID-19 vaccine requirement for employees, contractors, and other individuals working in certain health care facilities including nursing homes and senior living facilities to be fully vaccinated by October 2021. None of these states have been enjoined from enforcing their respective mandates. Non-compliance with state or federal mandates may result in imposition of fines or other administrative action, and compliance with these laws may be difficult due to legal challenges and changes in the applicable laws, regulations, or directives.

***Reporting requirements*** — Effective May 8, 2020, CMS published an IFR requiring skilled nursing facilities to report information related to COVID-19 cases among facility residents and staff directly to the CDC National Health Safety Network no less than weekly; the reported information is made publicly available on a dedicated website. In addition, skilled nursing facilities are required to inform residents, their families and representatives of confirmed or suspected COVID-19 cases in their facilities. This resident/family/representative notification is required to take place by 5:00 p.m. (local time) the next calendar day following the occurrence of: (1) a single confirmed infection of COVID-19, or (2) three or more residents or staff with new-onset of respiratory symptoms that occur within 72 hours of one another.

Effective May 21, 2021, CMS published an IFR requiring LTC facilities to report weekly COVID-19 vaccination data of both residents and staff to the CDC National Healthcare Safety Network. Facilities are also required to provide residents and staff with vaccine education and offer vaccines, when available, to residents and staff. CMS may initiate enforcement activities and assess civil monetary penalties for not meeting any of these COVID-19 related requirements.

Effective June 11, 2021, HHS revised the Post-Payment Notice of Reporting Requirements which are applicable to recipients of Provider Relief Funds. The revised requirements provide additional information on the data elements that recipients are required to report as part of the post-payment reporting process, as well as the timing of such reporting.

Effective August 23, 2021, CMS published an IFR incorporating comments on its May 21, 2021 IFR which continued the obligation for LTC and intermediate care facilities to report COVID-19 vaccination data for both residents and staff to the CDC National Healthcare Safety Network. This new IFR requires facilities to develop policies and procedures to ensure the availability of the COVID-19 vaccine to residents and staff, and to educate residents and staff concerning the benefits, risks, and potential side effects associated with the vaccine. This IFR also addresses responses to vaccination refusal by residents and staff in compliance with U.S. Equal Employment Opportunity Commission guidance. CMS may initiate enforcement activities and assess civil monetary penalties for not meeting any of these COVID-19 related reporting requirements under this IFR. We do not believe these COVID-19 related requirements will have a material impact on our condensed consolidated financial statements.

***Survey Activity and Enforcement*** — On March 20, 2020, CMS announced the initiation of focused infection control surveys intended to assess LTC facility compliance with infection control requirements in connection with the COVID-19 pandemic. CMS prioritized infection control surveys over annual recertification and complaint surveys at the non-immediate jeopardy level, confirming its commitment to infection prevention and control in the skilled nursing industry. Effective August 17, 2020, CMS provided guidance authorizing resumption of traditional survey activity.

On June 1, 2020 (and most recently updated in January 2021), CMS introduced an enhanced enforcement program with respect to infection control deficiencies. The program contemplates more significant remedies against facilities with a prior history of infection control deficiencies and imposes more stringent penalties with deficiencies identified at a higher scope and severity. The spectrum of remedies available to CMS for imposition on skilled nursing facilities in connection with this enhancement includes increased monetary fines, shortened time periods to return to compliance, and other administrative penalties.

### *Medicare*

Medicare presently accounts for approximately 30.3% of our skilled nursing services revenue year-to-date, being our second-largest payor. The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins.

### *Patient-Driven Payment Model (PDPM)*

The Skilled Nursing Facility Prospective Payment System (SNF PPS) Rule became effective October 1, 2019. The SNF PPS Rule includes a new case-mix model that focuses on the patient's condition (clinically relevant factors) and resulting care needs, rather than on the volume of care provided, to determine Medicare reimbursement. The case mix-model is called the Patient-Driven Payment Model (PDPM), which utilizes clinically relevant factors for determining Medicare payment by using International Classification of Diseases, Tenth Revision diagnosis codes and other patient characteristics as the basis for patient classification. PDPM utilizes five case-mix adjusted payment components: physician therapy, occupational therapy, speech language pathology, nursing and social services and non-therapy ancillary services. It also uses a sixth non-case mix component to cover utilization of skilled nursing facilities resources that do not vary depending on resident characteristics.

PDPM replaces the existing case-mix classification methodology, Resource Utilization Groups, Version IV. The structure of PDPM moves Medicare towards a more value-based, unified post-acute care payment system. For example, PDPM adjusts Medicare payments based on each aspect of a resident's care, thereby more accurately addressing costs associated with medically complex patients. PDPM also removes therapy minutes as the basis for therapy payment. Finally, PDPM adjusts the skilled nursing facilities per diem payments to reflect varying costs throughout the stay, through the physician therapy, occupational therapy and non-therapy ancillary services components.

In addition, PDPM is intended to reduce paperwork requirements for performing patient assessments. Under the SNF PPS PDPM system, the payment to skilled nursing facilities and nursing homes is based heavily on the patient's condition rather than the specific services provided by each skilled nursing facility. On August 4, 2021, CMS published the SNF PPS final rule for fiscal year 2022, which included a 1.2% net market basket increase in payment to SNFs, and reduced the negative impact of readmissions for providers with more than 25 stays by returning 60% of the 2% withheld by CMS regardless of that provider's performance measures. Providers with lower volume and fewer than 25 stays will not have any adjustments made to their payment.

### *Skilled Nursing Facility - Quality Reporting Program (SNF QRP)*

The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act) imposed new data reporting requirements for certain Post-Acute-Care (PAC) providers. The IMPACT Act requires that each skilled nursing facility submit their quality measures data. Beginning with fiscal year 2018, and each subsequent year, if a skilled nursing facility does not submit required quality data, their payment rates are reduced by 2.0% for each such fiscal year. Application of the 2.0% reduction may result in payment rates for a fiscal year being less than the preceding fiscal year. In addition, reporting-based reductions to the market basket increase factor will not be cumulative; they will only apply for the fiscal year involved. A skilled nursing facility's MAC will issue the facility a notice of non-compliance if it does not satisfy its Quality Reporting Program reporting requirements.

Updated performance measures mandated for the SNF QRP for fiscal year 2020 were established in the final SNF PPS rule adopted on August 8, 2019 (fiscal year 2020 SNF PPS Rule). The final rule continues implementation of the SNF QRP measures to improve program interoperability, operational quality and safety. Specifically, the rule adopts a number of standardized patient assessment data elements. The SNF QRP applies to freestanding skilled nursing facilities, skilled nursing facilities affiliated with acute care facilities, and all non-critical access hospital swing-bed rural hospitals.

On July 29, 2021, CMS issued a final rule for the SNF QRP that adopted two new reporting measures and updated the specifications for another measure. Starting with the FY 2023 SNF QRP, SNFs are required for the first time to report the SNF Healthcare-Associated Infections (HAI) measure, which tracks the number of infections requiring hospitalization following a medical intervention, and the COVID-19 Vaccination Coverage among Healthcare Personnel (HCP) measure, which tracks vaccination of staff in order to assess whether SNFs are taking steps to limit the spread of COVID-19. The Transfer of Healthcare (TOH) information data SNFs must report, which is included in the Patient-Post-Acute Care measurement, will be changed to exclude SNF patients discharged to their homes under the care of either a home health service or hospice. The elimination of this information will change how the TOH is used in calculating Patient-Post-Acute Care measurement, and may have an impact on our quality ratings and reimbursement from Medicare and Medicaid on a prospective basis.

Beginning in March 2020, due to the COVID-19 pandemic, CMS issued a temporary suspension of SNF QRP reporting requirements effective until June 30, 2020. This effectively gave skilled nursing facilities discretion as to whether to report data from the fourth quarter (October 1, 2019 – December 31, 2019), and removed reporting requirements entirely for the first and second quarters of 2020 (January 1, 2020 – June 30, 2020). Skilled nursing facilities were required to resume timely quality data collection and submission of measure and patient assessment data effective June 30, 2020. In January 2022, SNF ratings based on the resumed data reporting were recalculated for publication on the SNF Care Compare website. SNF Care Compare website ratings based on SNF QRP data reporting were refreshed in April of 2022.

***Medicare Annual Payment Rule***

CMS is required to calculate an annual Medicare market-basket update to the payment rates. On July 31, 2020, CMS issued a final rule for fiscal year 2021 that updates the Medicare payment rates and the quality programs for skilled nursing facilities. Under the final rule, effective October 1, 2020, the aggregate payments to skilled nursing facilities increased by 2.2% for fiscal year 2021, compared to fiscal year 2020. This estimated increase is attributable to a 2.2% market basket increase factor.

On July 29, 2021, CMS issued a final rule for fiscal year 2022 that updates the Medicare payment rates and the quality programs for skilled nursing facilities. Under the final rule, effective October 1, 2021, the aggregate net market basket rate increased by 1.2% for fiscal year 2022, compared to fiscal year 2021. This increase is attributable to a 2.7% market basket increase factor with a 0.8% point reduction for forecast error adjustment and a 0.7% point reduction for multifactor productivity adjustment.

On April 11, 2022, CMS issued a proposed rule that would decrease the aggregate net payment by 0.7% which is comprised of a net market basket increase of 2.8% for fiscal year 2023 plus a 1.5% market basket forecast error adjustment for a 0.4% reduction for productivity adjustment, as well as a 4.6% decrease in the SNF PPS rates as a result of the proposed recalibrated parity adjustment.

*Proposed Recalibration of the PDPM Parity Adjustment* - Based on the prior year aggregate spending, CMS has conducted a data analysis to recalibrate the parity adjustment in order to achieve budget neutrality under PDPM. CMS is proposing a PDPM parity adjustment using a combined methodology of a subset population that excludes those patients whose stays utilized a COVID-19 PHE-related waiver or who were diagnosed with COVID-19 and control period data using months with low COVID-19 prevalence from fiscal year 2020 and 2021. As a result of this methodology, CMS is proposing a parity adjustment that would reduce SNF spending by 4.6%, or $1.7 billion, in fiscal year 2023 to achieve budget neutrality.

***Sequestration of Medicare Rates***

The Budget Control Act of 2011 requires a mandatory, across the board reduction in federal spending, called a sequestration. Medicare FFS claims with dates of service or dates of discharge on or after April 1, 2013 incur a 2.0% reduction in Medicare payments. All Medicare rate payments and settlements have incurred this mandatory reduction and it will continue to be in place through at least 2023, unless Congress takes further action. In response to COVID-19, the CARES Act temporarily suspended the automatic 2.0% reduction of Medicare claim reimbursements for the period of May 1, 2020 through December 31, 2020. On December 27, 2020, the Consolidated Appropriations Act further suspended the 2.0% payment adjustment through March 31, 2021. On April 14, 2021, Congress extended the suspension of the 2.0% payment adjustment through December 31, 2021. On December 10, 2021, President Biden signed into law a bill to postpone the 2.0% payment adjustment through April 1, 2022; from April 1, 2022 through June 30, 2022, the 2.0% payment adjustment is reduced from 2.0% to 1.0%. To pay for the change, Congress would increase the sequester cuts by one year to fiscal year 2030.

***Skilled Nursing Facility Value-Based Purchasing (SNF-VBP) Program***

The SNF-VBP Program rewards skilled nursing facilities with incentive payments based on the quality of care they provide to Medicare beneficiaries, as measured by a hospital readmissions measure. CMS annually adjusts its payment rules for skilled nursing facilities using the SNF-VBP Program. Effective October 1, 2018, CMS began withholding 2.0% to fund the SNF-VBP Program incentive payment pool and will redistribute 60% of the withheld payments back to skilled nursing facilities through the program. The fiscal year 2020 SNF PPS Rules estimate the economic impact of the SNF-VBP Program to be a reduction of $213.6 million in aggregate payments to skilled nursing facilities during fiscal year 2020. The Rule also introduced two new quality measures to assess how health information is shared and adopted a number of standardized patient assessment data elements that assess factors such as cognitive function and mental status, special services, and social determinants of health. The fiscal year 2021 SNF PPS rule updated the deadlines for baseline period quality measure quarterly reporting and announced performance periods and standards for the fiscal year 2023 program year, but otherwise made no changes to the measures, scoring or payment policies. In the fiscal year 2022 program, CMS proposed changes to account for COVID-19 impacting readmission rates and SNF admissions during the performance periods of fiscal year 2020. These proposed changes would impact the SNF-VBP Program rate adjustment. On July 29, 2021, CMS published its final rule for the fiscal year 2022 program in the Federal Register, adopting the proposed changes for measuring the performance period and amending the data to be reported to CMS, which impacted the SNF-VBP Program rate adjustment.

On February 28, 2022, the Administration published a fact sheet stating its priorities for making changes to senior care, including potential changes to regulations affecting LTCs and SNFs. The SNF-VBP Program was identified as an area for change, with staffing levels, retention and resident experience affecting reimbursement. Following studies by CMS, proposed rules that may affect the SNF-VBP Program are expected in approximately one year, with final rules to follow after a notice-and-comment period.

On April 11, 2022, CMS issued a proposed rule where VBP adjustments will not be applied. Instead, all locations will have the same reduction, except for those locations that have a small population. This proposed rule also requested information to evaluate potential changes to the VBP program, but those changes would not take effect in fiscal year 2023 and thus not apply to the annual reimbursement rates that take effect on October 1, 2022.

***Part B Rehabilitation Requirements***

Some of our revenue is paid by the Medicare Part B program under a fee schedule. Part B services are limited with a payment cap by combined speech-language pathology services (SLP) and physical therapy (PT) services and a separate annual cap for occupational therapy (OT) services. These caps were implemented under the authority of the Balanced Budget Amendments of 1997. These amounts were previously associated with the financial limitation amounts. The Bipartisan Budget Act of 2018 (BBA) repealed those caps while retaining and adding additional limitations to ensure appropriate therapy services. This policy does not limit the amount of medically necessary Medicare Part B therapy services a beneficiary may receive. The BBA establishes coding modifier requirements to obtain payments beyond the updated KX modifier thresholds, discussed below, and reaffirms the specific $3,000 claim audit threshold requirements for the Medicare Administrative Contractors. For PT and SLP combined the threshold for coding modifier requirements is $2,110 for 2021, compared to $2,080 for 2020. The KX Modifier Threshold is set at $2,150 for CY 2022. The threshold is the same for OT services.

Consistent with CMS's "Patients over Paperwork" initiative, the agency has also been moving toward eliminating burdensome claims-based functional reporting requirements. Beginning in 2021, CMS rescinded 21 problematic National Correct Coding Initiative edits impacting outpatient therapy services, including services furnished under Medicare Part B primarily related to PT and OT services, removing a coding burden caused by requirements for additional documentation and claim modifier coding.

On December 1, 2020, CMS issued the calendar year 2021 Physician Fee Schedule (PFS) Final Rule, which reduced the conversion factor (i.e. the number by which CMS determine all current procedural terminology code payments) by 10.2%. These changes lowered the reimbursement rate for therapy Medicare Part B specialty providers by 9% for PT and OT and by 6% for SLP Codes. These reductions were mitigated by the Consolidated Appropriations Act of 2021 (CAA, also referred to as The Omnibus Appropriations Law), which was signed into law on December 27, 2020. The CAA includes three components relevant to the Medicare Part B PFS. First, the CAA incorporates a rate relief of approximately 3.75% for fiscal year 2021. Additionally, the CAA incorporates a freeze to the payment for the physician add-on code for three years which would effectively create relief on the initial cuts through 2023. Finally, the relief calls for the 2% sequester to not be applied to the Medicare Part B program for the first quarter of 2021. CMS incorporated the first and second components of the CAA relief into the fiscal year 2021 PFS files which were published on January 5, 2021. While the 2021 PFS Final Rule reduced the fiscal year 2021 factor to $32.4085 (calendar year conversion factor was $36.0896), the CAA restored part of the reductions resulting in the final fiscal year 2021 conversion factor of $34.8931. This conversion factor rate does not include the 2% sequester which has been suspended until April 1, 2022 and then will be implemented as a 1% sequestration until June 30, 2022.

On November 19, 2021, CMS published the 2022 PFS, which required the use of new modifiers (the CO modifier) to identify and make payments at 85% of the otherwise applicable Part B payment amount for PT and OT services furnished in whole, or in part by PT and OT assistants. On December 10, 2021, President Biden signed the Protecting Medicare and American Farmers from Sequester Cuts Act into law, which restored funding for Medicare payments that was removed in the 2022 PFS. Following passage of this law, CMS announced payment changes to the 2022 PFS on December 16, 2021, which would result in Medicare payments not being reduced from January 1, 2022 through March 31, 2022. Thereafter, FFS Medicare payments would then be adjusted by 1% from April 1, 2022 through June 30, 2022, and further adjusted by a total of 2% from July 1, 2022 through December 31, 2022. Under the recalculated 2022 PFS announced by CMS in December of 2021, the applicable conversion factor was reduced from the 2021 conversion factor of $34.8931 by 0.82% to $34.6062, a smaller reduction than the those found in the proposed rule or 2022 PFS.

The Multiple Procedure Payment Reduction (MPPR) continues at a 50% reduction, which is applied to therapy procedures by reducing payments for practice expense of the second and subsequent procedures when services provided beyond one unit of one procedure are provided on the same day. The implementation of MPPR includes (1) facilities that provide Medicare Part B speech-language pathology, occupational therapy, and physical therapy services and bill under the same provider number; and (2) providers in private practice, including speech-language pathologists, who perform and bill for multiple services in a single day.

On May 27, 2020, pursuant to its authority under the Emergency Waivers, CMS added physical therapy, occupational therapy and speech-language pathology to list of approved telehealth Providers for the Medicare Part B programs provided by a skilled nursing facility. Subsequently, the calendar year 2021 and 2022 PFS Final Rules added certain of these PT and OT services to the list of Medicare telehealth services on a temporary basis through at least the end of calendar year 2023. On December 31, 2020, CMS announced its 2021 update to the list of codes that describe Medicare Part B outpatient therapy services, making permanent existing and new codes introduced during the COVID-19 PHE for use under PT, OT, or SLP, including several telehealth codes as “sometimes therapy,” to permit physicians and certain non-physician practitioners to render these services outside a therapy plan of care when appropriate. “Sometimes therapy” codes will not have the MPPR applied. On November 19, 2021, CMS expanded these “sometimes therapy” codes further for the 2022 PFS, including five new codes for remote therapeutic monitoring treatment, which are broader than pre-existing monitoring codes and include measuring and evaluating adherence and response to medication and therapy.

Pursuant to the Emergency Waivers, CMS allowed for the facility to bill an originating site fee to CMS for telehealth services provided to Medicare Part B beneficiary residents of the facility when the services are provided by a physician from an alternate location, effective March 6, 2020 and ending on May 7, 2022 as part of the Emergency Waivers CMS announced it was terminating within 30 days from April 7, 2022. Our Facilities will cease using these telemedicine Emergency Waivers upon their termination.

***Programs of All-Inclusive Care for the Elderly***

CMS issued a final rule on June 3, 2019, which updates the requirements for the Programs of All-Inclusive Care for the Elderly (PACE) under the Medicare and Medicaid programs. The regulation is intended to provide greater operational flexibility, remove redundancies and outdated information and codify existing programs. Such flexibility includes: (i) more lenient standards applicable to the current requirement that the PACE organization be monitored for compliance with the PACE program requirements during and after a 3-year trial period and (ii) relieving certain restrictions placed upon the interdisciplinary team that comprehensively assesses and provides for the individual needs of each PACE participant by allowing one person to fill two roles and permitting secondary participation in the PACE program. Further, non-physician primary care providers can provide certain services in place of primary care physicians. On October 21, 2021, CMS published an extension of the timeline to complete further final rulemaking for the PACE program until November 1, 2022, based on a proposed rule published on November 1, 2018, regarding policy and technical changes to Medicare Advantage, Medicare Prescription Drug Benefit, PACE, Medicaid FFS, and Medicaid managed care programs for 2020 and 2021. Based on completed studies, public comments, and the intervening COVID-19 pandemic that required CMS's focus, CMS extended the timeline to issue a final rule regarding new policy and technical changes to the PACE program until November of 2022. The November 2018 proposed rule suggests changes to payment and appeals of disputes within the PACE program which may affect our business.

***Preadmission Screening and Resident Review***

On February 20, 2020, CMS published a proposed rule which would modernize requirements for the Preadmission Screening and Resident Review process. This process assesses the needs of individuals with mental illness or intellectual disability that are applying to or residing in Medicaid-certified nursing facilities. The proposed rule, if enacted as currently drafted, would impose additional resident review requirements that are not reflected in current regulations, authorize the use of telehealth, and simplify the list of information that must be collected during evaluations.

***Decisions Regarding Skilled Nursing Facility Payment***

Medicare reimbursement rates and rules are subject to frequent change. Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. 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.

These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past, and could in the future, result in substantial reductions in our revenue and operating margins. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates, see Part I, Item 1A *Risk Factors* under the headings Risks Related to Our Business and Industry

***Patient Protection and Affordable Care Act***

Various healthcare reform provisions became law upon enactment of the Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, the ACA). The reforms contained in the ACA have affected our operating subsidiaries in some manner and are directed in large part at increased quality and cost reductions. Several of the reforms are very significant and could ultimately change the nature of our services, the methods of payment for our services and the underlying regulatory environment. These reforms include modifications to the conditions of qualification for payment, bundling of payments to cover both acute and post-acute care and the imposition of enrollment limitations on new providers. The upcoming Congressional elections in the United States and policies implemented by the current and former Presidential administration have resulted in significant changes in legislation, regulation, implementation of Medicare, Medicaid, and government policy. The 2022 midterm elections may significantly alter the current regulatory framework and impact our business and the health care industry. We continually monitor these developments so we can respond to the changing regulatory environment impacting our business.

***Requirements of Participation***

CMS has requirements that providers, including SNFs and other LTC facilities must meet in order to participate in the Medicare and Medicaid Programs. Some requirements can be burdensome and costly, and in recent years, CMS has modified these requirements. For example, beginning in 2016, skilled nursing facilities were required to comply with emergency preparedness requirements, which requirements have since been strengthened via promulgation of additional rules.

Another relevant change is a 2019 final rule that removed the prohibition on the use of pre-dispute, binding arbitration agreements by LTC facilities. The rule imposed specific requirements on the use of these agreements, including requiring the use of plain language in drafting; that facilities post a notice in plain language that describes the policy on the use of agreements for binding arbitration in an area that is visible to residents and visitors; that admission to the facility not be conditioned on the signing of an arbitration agreement; and that the facility expressly inform the resident or his/her representative of the right not to sign the agreement as a condition of admission. Congress has routinely introduced, but not passed, legislation addressing the issue of arbitration agreements used by LTC facilities. While legislative action is possible in the future, federal and state regulations remain our primary source of authority over the use of pre-dispute binding arbitration agreements.

As discussed under the “Coronavirus” heading above, the Administration announced that CMS and OSHA would implement emergency rules requiring all workers within all Medicare and Medicaid-participating nursing homes, and all employees of companies with more than 100 employees, to be fully vaccinated against COVID-19. Significant litigation followed, including enforcement of both the CMS and OSHA vaccination mandates being halted by certain courts. On January 13, 2022, the United States Supreme Court held that the OSHA vaccination mandate could not be enforced against large employers, but that the CMS vaccination mandate could be enforced upon Medicare- and Medicaid-participating facilities. Those states except Texas where the CMS rule had been halted against enforcement then had to enforce the rule. On January 20, 2022, the United States District Court for the Northern District of Texas dismissed the block of the CMS's vaccination IFR in Texas. That same day, CMS became empowered to enforce the IFR in Texas and set a deadline of March 21, 2022 for full compliance with its vaccination requirements. Since CMS became empowered to enforce the IFR in Texas, there has not been any administrative or legislative action to change the applicability or enforcement of this IFR.

***Civil and Criminal Fraud and Abuse Laws and Enforcement***

Various complex federal and state laws exist which govern a wide array of referrals, relationships and arrangements, and prohibit fraud by healthcare providers. Governmental agencies are devoting increasing attention and resources to such anti-fraud efforts. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the Balanced Budget Act of 1997 expanded the penalties for healthcare fraud. Additionally, in connection with our involvement with federal healthcare reimbursement programs, the government or those acting on its behalf may bring an action under the FCA, alleging that a healthcare provider has defrauded the government by submitting a claim for items or services not rendered as claimed, which may include coding errors, billing for services not provided, and submitting false or erroneous cost reports. The Fraud Enforcement and Recovery Act of 2009 (FERA) expanded the scope of the FCA by, among other things, creating liability for knowingly and improperly avoiding repayment of an overpayment received from the government and broadening protections for whistleblowers. The FCA clarifies that if an item or service is provided in violation of the Anti-Kickback Statute, the claim submitted for those items or services is a false claim that may be prosecuted under the FCA as a false claim. Civil monetary penalties under the FCA range from approximately $11 thousand to $23 thousand per violation and are adjusted annually for inflation. Under the qui tam or “whistleblower” provisions of the FCA, a private individual with knowledge of fraud may bring a claim on behalf of the federal government and receive a percentage of the federal government’s recovery. Due to these whistleblower incentives, lawsuits have become more frequent. Many states also have a false claim prohibition that mirrors or closely tracks the federal FCA. Federal law also provides that the OIG has the authority to exclude individuals and entities from federally funded health care programs on a number of grounds, including, but not limited to, certain types of criminal offenses, licensure revocations or suspensions, and exclusion from state or other federal healthcare programs. CMS can recover overpayments from health care providers up to five years following the year in which payment was made. On February 28, 2022, the Administration published a fact sheet regarding nursing home care, which identified the Administration’s priorities of further funding for SNF and LTC facility inspections, enhancing civil penalties on poor-performing facilities and increasing the scrutiny of companies that operate more than one facility. Proposed rules based on these directives and studies are expected in approximately one year, with final rules to follow after a notice-and-comment period.

In November 2019, the OIG released a report of its investigation into overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. Hospitals violating this policy transferred patients to certain post-acute-care settings, such as skilled nursing facilities, but claimed the higher reimbursements associated with discharges to homes. A similar OIG audit report, released in February 2019, focused on improper payments for skilled nursing facility services when the Medicare three-day inpatient hospital stay requirement was not met. In 2021, the OIG released the result of an audit finding that Medicare overpaid millions of dollars of chronic care management (CCM) services. The OIG's 2021 report found that in calendar years 2017 and 2018, Medicare overpaid millions of dollars in CCM claims. These investigatory actions by OIG demonstrate its increased scrutiny into post-hospital skilled nursing facility care provided to beneficiaries and may encourage additional oversight or stricter compliance standards.

On numerous occasions, CMS has indicated its intent to vigilantly monitor overall payments to skilled nursing facilities, paying particular attention to facilities that have high reimbursements for ultra-high therapy, therapy resource utilization groups with higher activities of daily living scores, and long average lengths of stay. The OIG recognizes that there is a strong financial incentive for facilities to bill for higher levels of therapies, even when not needed by patients. We cannot predict the extent to which the OIG's recommendations to CMS will be implemented and, what effect, if any, such proposals would have on us. Our business model, like those of some other for-profit operators, is based in part on seeking out higher-acuity patients whom we believe are generally more profitable, and over time our overall patient mix has consistently shifted to higher-acuity in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording services in order to, among other things, increase reimbursement to levels appropriate for the care actually delivered. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

***Federal Healthcare Reform***

In 2015, CMS released a final rule addressing, among other things, implementation of certain provisions of Medicare Access and CHIP Reauthorization Act of 2015, which changes the way physicians are paid who participate in Medicare through implementation of the Quality Payment Program, which created new paths for payment based on the Merit-based Incentive Payment System (MIPS) or the use of Alternative Payment Models (APM). A measure to ascertain provider quality is the Five-Star Quality Rating system, which includes a rating of one to five in various categories. In 2018 and 2019, these calculations changed to reflect new and additional data that affected rankings, including freezing information regarding health inspection information, and including data to reflect the ranking of staffing (including emphasizing the level of registered nurse staffing), stay durations, spending, discharge outcomes and readmissions.

As of January 1, 2020, CMS assigned ratings to SNFs under its Five Star Quality reporting system and displayed those ratings on its consumer-based Nursing Home Compare website. CMS's assignment of ratings under its Five Star Quality for a SNF measure is based upon numerous quality measures, which as of January 1, 2020 included staffing levels (and staffing composition, focusing on the use of registered nurses), the use of antipsychotic medications, rate of hospitalization, emergency department use, community discharge, improvements in function, independently worsened and anxiety or hypnotic medication use, payroll based journals, and Medicare spending by beneficiary. Additionally, this data is segregated and rated separately for short-term and long-term stays in the SNF. These measures were subject to thresholds for stars assigned based on both staffing and quality components, with standards for score assignment that restricted the number of 4- and 5-star ratings that could be given. This resulted in a reduction in the number of 4- and 5-star facilities compared to their prior ranking, including certain of our own facilities. CMS also displays a consumer alert icon next to nursing homes that had been cited for incidents of abuse, neglect, or exploitation on the Nursing Home Compare website, which is updated monthly with CMS's refresh of survey inspection results on that website. In February 2020, CMS announced that part of its Enhancing Enforcement efforts would include improved oversight of state survey agencies (SSA) and revisions to the State Performance Standards System, which is the program used to access SSA performance.

In 2020, in response to the COVID-19 pandemic, a temporary freeze was placed on Skilled Nursing Facilities Quality Reporting Program data, Staffing data, and Health Inspection data on the Nursing Home Compare website to account for the suspended reporting and inspection obligations due to the COVID-19 pandemic. The information reported to CMS and used in these quality calculations changed over the period of 2020. Beginning in August of 2020, and in response to the COVID-19 pandemic, CMS announced a new, targeted inspection plan to focus on urgent patient safety threats and infection control, therefore causing a shift in the number of nursing homes inspected and the manner in which the inspections are conducted. As this change would disrupt the inspections and data collection CMS and state surveyors conducted as part of the Nursing Home Five Star Quality Rating System, results of these inspections conducted on or after March 4, 2020 were not initially used to calculate a nursing home's health inspection star ratings. By December of 2020, CMS and state surveyors had resumed inspections of nursing homes to include inspection data, including surveys that occurred on March 4, 2020 and afterward, in its star rankings calculated for January 2021. CMS resumed calculating nursing homes' health inspection ratings on January 27, 2021. Similarly, although staff reporting requirements were waived for the first and second quarters of 2020, this waiver ended on June 25, 2020. Thereafter, nursing homes were required to report staffing data to CMS, which was incorporated into CMS's Five Star Quality rating for those nursing homes beginning in January 2021. The January 2021 calculation of Five Star Quality ratings for nursing homes reflected nursing home-provided quarterly updates of most quality measures for the period beginning June 2019 and ending June 2020 due to interruptions in data collection. The quality measures that are specific to SNFs but not included in CMS's Five Star Quality ratings for January 2021 were the measures for percentages of new or worsening pressure injuries, and the rate of residents who successfully return to home from a SNF. These measures may be included in future Five Star Quality ratings and the delay may not reveal improvements in previously low-rated facilities, or declines in performance within highly rated facilities. When the anticipated January 2022 refresh of Five Star Quality ratings occurs, SNF quality reporting measures will be calculated based on the data reported from July 1, 2020 through March 31, 2021, due to the ongoing COVID-19 PHE. When these Five Star Quality ratings are updated, they may not contain or reflect the latest or most accurate data regarding our facilities, including improvements in previously low-rated facilities, or declines in performance within higher-rated facilities.

Another impact of the COVID-19 pandemic to the Nursing Home Five-Star Quality Rating System is CMS's decision to make submission of the minimum data set assessment data optional for the fourth quarter of 2019 and excepted for the first and second quarters of 2020. Due to the gap in reported data, CMS did not include the two quality measures that are reflected in the minimum data set assessment-based data in its quality measure ratings in January 2021.

On August 10, 2021, the Nursing Home Improvement and Accountability Act of 2021 (Nursing Home Improvement Act) was introduced in the U.S. Senate and is intended to update federal nursing home policy to improve quality of care and oversight. The proposed legislation reduces SNF payments by two percentage points beginning in fiscal year 2025 for inaccurate submission of certain data, provides federal funding of $50 million to carry out data validation tasks for SNF data and provides federal funding of $250 million to ensure accuracy of information on cost reports. The Nursing Home Improvement Act also proposes to establish nurse staffing requirements, including the requirement for the use of a 24-hour registered professional nurse and other provisions intended to increase transparency and accuracy of reported data regarding nursing activities, improve accountability and enhance quality of care. If passed in its current form, however, this bill would provide participating states with a temporary enhanced federal Medicaid match to fund improvements in nursing home workforce and care. This match would last six years and states would be responsible for showing CMS that Medicaid reimbursement increases were used to increase worker wages and yield new training resources and opportunities for nursing home staff. As of December 31, 2021, no action has been taken on this bill since its introduction to the Senate on August 10, 2021 and referral to the Senate Finance Committee that same day.

In January of 2022, CMS issued a bulletin stating that the Nursing Home Compare website would begin reporting nursing home weekend staffing that same month, as nursing homes previously had been required to submit this information to CMS. Within the same bulletin, CMS announced that it would begin reporting information about nursing home staff tenure and other staffing data reported to CMS beginning in January of 2022. By July of 2022, CMS will not only disclose weekend staffing and staff turnover data on the Nursing Home Compare website, but also begin incorporating it into CMS's Five Star Quality ratings for nursing homes, including SNFs and LTC facilities.

On February 28, 2022, the Administration published a fact sheet stating its priorities for making changes to senior care, including potential changes to regulations affecting LTC and SNF facilities. The Administration identified three core aims of its proposed changes: (1) providing adequate staffing with appropriate training to deliver care; (2) holding poorly performing facilities accountable by requiring improvement as a condition of receiving federal funds; and (3) providing the public with more information about facility conditions and operations.

Specifically, the Administration expressed its desires to study the appropriate levels of staffing required for SNF and LTC facilities and issue proposed rules within one year of its study. The SNF-VBP Program was also identified as an area for change, with staffing levels, retention and resident experience affecting reimbursement. The Administration's priorities also include transparency and public disclosure for nursing home owners and operators, with information to be made more readily available to the public, including through the Nursing Home Care Compare website that will report new measures with regard to staffing, retention and data to be collected in the future. The President's priorities also include a proposed examination of the role private equity investment, real estate investment trusts (REITs) and other investment interests play in the nursing home sector, and their relation to the best interests of residents. Additional enforcement authority and resources, including enhanced scrutiny of poorly performing facilities, is another Administration priority, along with providing enhanced tools for facilities to use in improving their performance. The Administration also seeks to improve accessibility to nurse aide training, tie Medicaid payments to staff wages and benefits, and to enhance the recruitment and career paths for care workers. Finally, the Administration wishes to incorporate the lessons learned from the COVID-19 pandemic to impose new requirements for infection control, emergency preparedness and safety.

Proposed rules are expected to be issued within one year, with final rules to follow after a notice-and-comment period required by federal law. Based on the Administration's fact sheet and calls for studies regarding certain topics, it is expected that these changes will be enacted through proposed rules and later-enacted final rules following a notice-and-comment period, rather than through immediately effective interim final rules. On April 11, 2022, the CMS issued a proposed rule that requested information to be used in potentially changing the SNF-VBP Program, setting SNF and LTC facility staffing levels, and creating new measures relevant to reimbursement consistent with the Administration's February 28, 2022 fact sheet.

***Monitoring Compliance in Our Facilities***

Governmental agencies and other authorities periodically inspect our independent operating facilities to assess compliance with various standards, rules and regulations. The robust regulatory and enforcement environment continues to impact healthcare providers, especially in connection with responses to any alleged noncompliance identified in periodic surveys and other inspections by governmental authorities. Unannounced surveys or inspections generally occur at least annually and may also follow a government agency's receipt of a complaint about a facility. Facilities must pass these inspections to maintain licensure under state law, to obtain or maintain certification under the Medicare and Medicaid programs, to continue participation in the Veterans Administration program at some facilities, and to comply with provider contracts with managed care clients at many facilities. From time to time, our independent operating subsidiaries, like others in the healthcare industry, may receive notices from federal and state regulatory agencies of an alleged failure to substantially comply with applicable standards, rules or regulations. These notices may require corrective action, may impose civil monetary penalties for noncompliance, and may threaten or impose other operating restrictions on skilled nursing facilities such as admission holds, provisional skilled nursing license, or increased staffing requirements. If our independent operating subsidiaries fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, the facility could lose its certification as a Medicare or Medicaid provider, or lose its license permitting operation in the State.

Facilities with otherwise acceptable regulatory histories generally are normally given an opportunity to correct deficiencies and continue their participation in the Medicare and Medicaid programs by a certain date, usually within nine months; however, 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, may not be 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 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 acquisition by our independent operating subsidiaries and that develop new deficiencies after acquisition 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 or sustained quality of care problems through the special focus facility (SFF) initiative. A facility's administrators and owners are notified when it is identified as a SFF. This information is also provided to the general public. The SFF 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. SFFs receive 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 a defined period of time.

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 our independent subsidiaries, 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. In the past and from time to time, some of our independent operating subsidiaries have been or will be 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, could include various remedies up to and including decertification.

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, HHS 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. On February 28, 2022, the Administration published a fact sheet regarding nursing home care, which identified the Administration’s priorities of further funding for SNF and LTC facility inspections, as well as enhanced penalties and other tools to use against non-compliant facilities. Proposed rules based on these directives and studies are expected in approximately one year, with final rules to follow a notice-and-comment period required by law. On April 11, 2022, the CMS issued a proposed rule that requested information to be used for study and potential rulemaking consistent with the Administration’s February 28, 2022 fact sheet.

***Regulations Regarding Financial Arrangements***

We are also subject to federal and state laws that regulate financial arrangement by and between healthcare providers, such as the federal and state anti-kickback laws, the Stark laws, and various state anti-referral laws.

The Anti-Kickback Statute, Section 1128B of the Social Security Act (Anti-Kickback Statute) prohibits the knowing and willful offer, payment, solicitation, or receipt of any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to induce the referral of an individual, in return for recommending, or to arrange for, the referral of an individual for any item or service payable under any federal healthcare program, including Medicare or Medicaid. The OIG has issued regulations that create “safe harbors” for certain conduct and business relationships that are deemed protected under the Anti-Kickback Statute. In order to receive safe harbor protection, all of the requirements of a safe harbor must be met. The fact that a given business arrangement does not fall within one of these safe harbors, however, does not render the arrangement per se illegal. Business arrangements of healthcare service providers that fail to satisfy the applicable safe harbor criteria, if investigated, will be evaluated based upon all facts and circumstances and risk increased scrutiny and possible sanctions by enforcement authorities.

Violations of the Anti-Kickback Statute can result in criminal penalties of up to $100 thousand and ten years imprisonment. Violations of the Anti-Kickback Statute can also result in civil monetary penalties of up to $100 thousand per violation and an assessment of up to three times the total amount of remuneration offered, paid, solicited, or received. Violation of the Anti-Kickback Statute may also result in an individual's or organization's exclusion from future participation in federal healthcare programs. State Medicaid programs are required to enact an anti-kickback statute. Many states in which our independent operating subsidiaries operate have adopted or are considering similar legislative proposals, some of which extend beyond the Medicaid program, to prohibit the payment or receipt of remuneration for the referral of patients regardless of the source of payment for the care. We believe that business practices of providers and financial relationships between providers have become subject to increased scrutiny as healthcare reform efforts continue on the federal and state levels.

Additionally, Section 1877 of the Social Security Act, commonly known as the “Stark Law,” provides that a physician may not refer a Medicare or Medicaid patient for a “designated health service” to an entity with which the physician or an immediate family member has a financial relationship unless the financial arrangement meets an exception under the Stark Law or its regulations. Designated health services include inpatient and outpatient hospital services, PT, OT, SLP, durable medical equipment, prosthetics, orthotics and supplies, diagnostic imaging, enteral and parenteral feeding and supplies and home health services. Under the Stark Law, a “financial relationship” is defined as an ownership or investment interest or a compensation arrangement. If such a financial relationship exists and does not meet a Stark Law exception, the entity is prohibited from submitting or claiming payment under the Medicare or Medicaid programs or from collecting from the patient or other payor. Many of the compensation arrangements exceptions permit referrals if, among other things, the arrangement is set forth in a written agreement signed by the parties, the compensation to be paid is set in advance, is consistent with fair market value and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties. Exceptions may have other requirements. Any funds collected for an item or service resulting from a referral that violates the Stark Law are not eligible for payment by federal healthcare programs and must be repaid to Medicare or Medicaid, any other third-party payor, and the patient. Violations of the Stark Law may result in the imposition of civil monetary penalties, including, treble damages. Individuals and organizations may also be excluded from participation in federal healthcare programs for Stark Law violations. Many states have enacted healthcare provider referral laws that go beyond physician self-referrals or apply to a greater range of services than just the designated health services under the Stark Law.

***Regulations Regarding Patient Record Confidentiality***

Health care providers are also subject to laws and regulations enacted to protect the confidentiality of patient health information. For example, HHS has issued rules pursuant to HIPAA, including the Health Information Technology for Economic and Clinical Health (HITECH) Act which governs our use and disclosure of protected health information of patients. We have established policies and procedures to comply with HIPAA privacy and security requirements at our independent operating subsidiaries. Our independent operating subsidiaries have adopted and implemented HIPAA compliance plans, which we believe comply with the HIPAA privacy and security regulations. The HIPAA privacy and security regulations have and will continue to impose significant costs on our independent operating subsidiaries in order to comply with these standards. There are numerous other laws and legislative and regulatory initiatives at the federal and state levels addressing privacy and security concerns. Our independent operating subsidiaries are also subject to any federal or state privacy-related laws that are more restrictive than the privacy regulations issued under HIPAA. These laws vary and could impose additional penalties for privacy and security breaches. Healthcare entities are also required to afford patients with certain rights of access to their health information under HIPAA and the 21st Century Cures Act (Cures Act). Recently, the Office of Civil Rights, the agency responsible for HIPAA enforcement, has targeted investigative and enforcement efforts on violations of patients’ rights of access, including denial of access to medical records, imposing significant fines for violations largely initiated from patient complaints. The Office of the National Coordinator for Health Information Technology can also investigate and impose separate penalties for information blocking violations under the Cures Act.

***Antitrust Laws***

We are also subject to federal and state antitrust laws. Enforcement of the antitrust laws against healthcare providers is common, and antitrust liability may arise in a wide variety of circumstances, including third party contracting, physician relations, joint venture, merger, affiliation and acquisition activities. In some respects, the application of federal and state antitrust laws to healthcare is still evolving, and enforcement activity by federal and state agencies appears to be increasing. At various times, healthcare providers and insurance and managed care organizations may be subject to an investigation by a governmental agency charged with the enforcement of antitrust laws, or may be subject to administrative or judicial action by a federal or state agency or a private party. Violators of the antitrust laws could be subject to criminal and civil enforcement by federal and state agencies, as well as by private litigants.

***Americans with Disabilities Act***

Our independent operating subsidiaries must also comply with the ADA, and similar state and local laws to the extent that the facilities are "public accommodations" as defined in those laws. The obligation to comply with the ADA and other similar laws is an ongoing obligation, and the independent operating subsidiaries continue to assess their facilities relative to ADA compliance and make appropriate modifications as needed.

## REGULATIONS SPECIFIC TO SENIOR LIVING COMMUNITIES

As previously mentioned, senior living services revenue is primarily derived from private pay residents, with a small portion of senior living revenue (approximately 1.9% of total revenue) derived from Medicaid funds. Thus, some of the regulations discussed above applicable to Medicaid providers, also apply to senior living. However, the following provides a brief overview of the regulatory framework applicable specifically to senior living.

A majority of states provide, or are approved to provide, Medicaid payments for personal care and medical services to some residents in licensed senior living communities under waivers granted by or under Medicaid state plans approved by CMS. State Medicaid programs control costs for senior living and other home and community-based services by various means such as restrictive financial and functional eligibility standards, enrollment limits and waiting lists. Because rates paid to senior living community operators are generally lower than rates paid to skilled nursing facility operators, some states use Medicaid funding of senior living services as a means of lowering the cost of services for residents who may not need the higher level of health services provided in skilled nursing facilities. States that administer Medicaid programs for services in senior living communities are responsible for monitoring the services at, and physical conditions of, the participating communities. As a result of the growth of senior living in recent years, states have adopted licensing standards applicable to senior living communities. Most state licensing standards apply to senior living communities regardless of whether they accept Medicaid funding.

Since 2003, CMS has commenced a series of actions to increase its oversight of state quality assurance programs for senior living communities, and has provided guidance and technical assistance to states to improve their ability to monitor and improve the quality of services paid through Medicaid waiver programs. CMS is encouraging state Medicaid programs to expand their use of home and community-based services as alternatives to facility-based services, pursuant to provisions of the ACA, and other authorities, through the use of several programs. As noted above, the Administration issued a fact sheet regarding nursing home care priorities and reforms that it intends to seek in the coming year. The Administration’s desired changes are multi-faceted, concerning payment to facilities, staffing level requirements, training and retention of staff, standards of care offered to residents, increased transparency and public disclosure of ownership, and enhanced civil remedies and other authority to exercise upon facilities that do not satisfy CMS’s standards. Proposed rules based on these directives are expected in approximately one year, with final rules to follow a notice-and-comment period required by law. On April 11, 2022, the CMS issued a proposed rule that requested information to be used for study and potential rulemaking consistent with the Administration’s February 28, 2022 fact sheet.

The types of laws and statutes affecting the regulatory landscape of the post-acute industry continue to expand. In addition to this changing regulatory environment, federal, state and local officials are increasingly focusing their efforts on the enforcement of these laws. In order to operate our businesses, we must comply with federal, state and local laws relating to licensure, delivery and adequacy of medical care, distribution of pharmaceuticals, equipment, personnel, operating policies, fire prevention, rate-setting, billing and reimbursement, building codes and environmental protection. Additionally, we must also adhere to anti-kickback statues, physician referral laws, the ADA, and safety and health standards set by the OSHA Administration. Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

Our independent operating subsidiaries are also subject to various regulations and licensing requirements promulgated by state and local health and social service agencies and other regulatory authorities. Requirements vary from state to state and these requirements can affect, among other things, personnel education and training, patient and personnel records, services, staffing levels, monitoring of patient wellness, patient furnishings, housekeeping services, dietary requirements, emergency plans and procedures, certification and licensing of staff prior to beginning employment, and patient rights. These laws and regulations could limit our ability to expand into new markets and to expand the services provided by independent operating subsidiaries in existing markets.

## Results of Operations

We believe we exist to dignify and transform post-acute care. We set out a strategy to achieve our goal of ensuring our patients are receiving the best possible care through our ability to acquire, integrate and improve our operations. Our results serve as a strong indicator that our strategy is working and our transformation is underway. We saw a recovery in our census starting in the first quarter of 2021 and has continued into 2022. Despite the emergence of COVID-19 variants in the first quarter of 2022, which has led to spikes in COVID-19 caseloads and slowed down our census recoveries, we continue to experience healthy growth in both revenue and operational earnings.

Our net revenue for the three months ended March 31, 2022 continued to be impacted by COVID-19. The Emergency Waivers issued by CMS, including a waiver of the requirement to have a three-day stay in a hospital to get Medicare coverage of a skilled nursing stay as well as the authorization of renewed skilled nursing facility coverage without having to start a new benefit period for certain beneficiaries who recently exhausted their skilled nursing facility benefits, remained in effect in the first quarter of 2022. In addition, we continued to receive state relief funding in selected states, which has been designed to enhance reimbursement to provide additional funding to cover COVID-19 related expenses. For the three months ended March 31, 2022, we recorded state relief revenue of $17.6 million which directly offset against COVID-19 related expenses we incurred in those states. See *Recent Activities* for further information.

Our total revenue for the quarter increased $86.2 million, or 13.7% while our diluted GAAP earning per share grew by 3.5%, from $0.86 to $0.89, compared to the first quarter in 2021. We have continued to make progress on targeted initiatives, including our foundational structure of local operations that are the centers of excellence in the communities they serve. As part of this focus, we have been able to expand our relationships with doctors, hospitals and managed care plans. Revenue from our skilled services collectively increased by 14.3%. We have also strengthened our collection process and identified non-clinical areas where we can manage spending. These operational fundamentals coupled with the increase in occupancy, expansion to our operations and cash generated from strong first quarter.

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

| | Three Months Ended March 31, | |
|---|---|---|
| | **2022** | **2021** |
| Revenue: | | |
| Service revenue | **99.4 %** | 99.4 % |
| Rental revenue | **0.6** | 0.6 |
| Total revenue | **100.0 %** | 100.0 % |
| Expense: | | |
| Cost of services | **77.9** | 76.8 |
| Rent—cost of services | **5.0** | 5.3 |
| General and administrative expense | **5.3** | 5.5 |
| Depreciation and amortization | **2.1** | 2.2 |
| Total expenses | **90.3** | 89.8 |
| Income from operations | **9.7** | 10.2 |
| Other income (expense): | | |
| Interest expense | **(0.3)** | (0.3) |
| Other (expense) income | **(0.1)** | 0.1 |
| Other expense, net | **(0.4)** | (0.2) |
| Income before provision for income taxes | **9.3** | 10.0 |
| Provision for income taxes | **2.2** | 2.1 |
| Net income | **7.1** | 7.9 |
| Less: net income attributable to noncontrolling interests | **—** | 0.1 |
| Net income attributable to The Ensign Group, Inc. | **7.1 %** | 7.8 % |

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| **Segment Income**[1] | (In thousands) | |
| Skilled services | $ 98,256 | $ 88,931 |
| Real estate[2] | $ 6,900 | $ 7,713 |
| **Non-GAAP Financial Measures:** | | |
| **Performance Metrics** | | |
| EBITDA | $ 84,038 | $ 76,707 |
| Adjusted EBITDA | $ 92,729 | $ 80,879 |
| FFO for Standard Bearer | $ 11,921 | $ 11,868 |
| **Valuation Metric** | | |
| Adjusted EBITDAR | $ 128,491 | |

(1) Segment income represents operating results of the reportable segments excluding gain and loss on sale of assets, impairment charges and provision for income taxes. Included in segment income for Standard Bearer for the three months ended March 31, 2022 are expenses for intercompany management fee between Standard Bearer and the Service Center and intercompany interest expense. Segment income is reconciled to the Condensed Consolidated Statement of Income in Note 8, *Business Segments* in Notes to Unaudited Condensed Consolidated Financial Statements of this Quarterly Report on Form 10-Q.
(2) Standard Bearer segment income includes rental revenue from Ensign affiliated tenants and related expenses.

The following discussion includes references to EBITDA, Adjusted EBITDA, Adjusted EBITDAR and Funds from Operations (FFO) which are non-GAAP financial measures (collectively, the 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 (the Exchange Act), define and prescribe the conditions for use of certain non-GAAP financial information. 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 the presentation of certain Non-GAAP Financial Measures are useful to investors and other external users of our financial statements regarding our results of operations because:

- they are widely used by investors and analysts in our industry as a supplemental measure to evaluate the overall performance of companies in our industry without regard to items such as other 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 the Non-GAAP Financial Measures:

- 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 assess the value of a potential acquisition;
- to assess the value of a transformed operation's performance;
- to evaluate the effectiveness of our operational strategies; and
- to compare our operating performance to that of our competitors.

We use certain Non-GAAP Financial Measures to compare the operating performance of each operation. These measures are useful in this regard because they do not include such costs as other expense, income taxes, depreciation and amortization expense, which may vary from period-to-period depending upon various factors, including the method used to finance operations, the amount of debt that we have incurred, whether an operation is owned or leased, the date of acquisition of a facility or business, and the tax law of the state in which a business unit operates.

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

Despite the importance of these measures in analyzing our underlying business, designing incentive compensation and for our goal setting, the Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, certain of our Non-GAAP Financial 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 interest expense, or the cash requirements necessary to service interest or principal payments, on our debt;
- they do not reflect rent expenses, which are necessary to operate our leased operations, in the case of Adjusted EBITDAR;
- 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 do not reflect any cash requirements for such replacements; and
- other companies in our industry may calculate these measures differently than we do, which may limit their usefulness as comparative measures.

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

Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these Non-GAAP Financial Measures are not standardized, it may not be possible to compare these financial measures with other companies' Non-GAAP financial measures having the same or similar names. These Non-GAAP Financial Measures should not be considered a substitute for, nor superior to, financial results and measures determined or calculated in accordance with GAAP. We strongly urge you to review the reconciliation of income from operations to the Non-GAAP Financial Measures in the table below, along with our unaudited condensed consolidated financial statements and related notes included elsewhere in this document.

We use the following Non-GAAP financial measures that we believe are useful to investors as key valuation and operating performance measures:

**PERFORMANCE MEASURES:**

***EBITDA***

We believe EBITDA is useful to investors in evaluating our operating performance because it helps investors evaluate and compare the results of our operations from period to period by removing the impact of our asset base (depreciation and amortization expense) from our operating results.

We calculate EBITDA as net income, adjusted for net losses attributable to noncontrolling interest, before (a) other expense, net, (b) provision for income taxes, and (c) depreciation and amortization.

***Adjusted EBITDA***

We adjust EBITDA when evaluating our performance because we believe that the exclusion of certain additional items described below provides useful supplemental information to investors regarding our ongoing operating performance, in the case of Adjusted EBITDA. We believe that the presentation of Adjusted EBITDA, when combined with EBITDA and GAAP net income attributable to The Ensign Group, Inc., is beneficial to an investor's complete understanding of our operating performance.

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

- stock-based compensation expense;
- legal finding;
- acquisition related costs;
- costs incurred related to new systems implementation;
- results related to operations not at full capacity; and
- gain on sale of assets.

***Funds from Operations (FFO)***

We consider FFO to be a useful supplemental measure of the operating performance of Standard Bearer. Historical cost accounting for real estate assets in accordance with U.S. GAAP implicitly assumes that the value of real estate assets diminishes predictably over time as evidenced by the provision for depreciation. However, since real estate values have historically risen or fallen with market conditions, many real estate investors and analysts have considered presentations of operating results for real estate companies that use historical cost accounting to be insufficient. In response, the National Association of Real Estate Investment Trusts (NAREIT) created FFO as a supplemental measure of operating performance for REITs, which excludes historical cost depreciation from net income. We define (in accordance with the definition used by NAREIT) FFO to consist of Standard Bearer segment income, excluding depreciation and amortization related to real estate, gains or losses from sales of real estate, insurance recoveries related to real estate and impairment of depreciable real estate assets.

**VALUATION MEASURE:**

***Adjusted EBITDAR***

We use Adjusted EBITDAR as one measure in determining the value of prospective acquisitions. It is also a commonly used measure by our management, research analysts and investors, to compare the enterprise value of different companies in the healthcare industry, without regard to differences in capital structures and leasing arrangements. Adjusted EBITDAR is a financial valuation measure that is not specified in GAAP. This measure is not displayed as a performance measure as it excludes rent expense, which is a normal and recurring operating expense.

The adjustments made and previously described in the computation of Adjusted EBITDA are also made when computing Adjusted EBITDAR. We calculate Adjusted EBITDAR by excluding rent-cost of services from Adjusted EBITDA.

We believe the use of Adjusted EBITDAR allows the investor to compare operational results of companies who have operating and capital leases. A significant portion of capital lease expenditures are recorded in interest, whereas operating lease expenditures are recorded in rent expense.

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

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| **Condensed consolidated statements of income data:** | (In thousands) | |
| Net income | $ 50,088 | $ 49,837 |
| Less: net (loss) income attributable to noncontrolling interests | (252) | 631 |
| Add: Other expense, net | 2,884 | 893 |
| Provision for income taxes | 16,138 | 12,949 |
| Depreciation and amortization | 14,676 | 13,659 |
| EBITDA | $ 84,038 | $ 76,707 |
| Stock-based compensation | 5,167 | 4,054 |
| Legal finding(a) | 3,353 | — |
| Gain on sale of assets | — | (540) |
| Results related to operations not at full capacity | — | 584 |
| Acquisition related costs(b) | 106 | 36 |
| Costs incurred related to new systems implementation | 65 | — |
| Rent related to items above | — | 38 |
| Adjusted EBITDA | $ 92,729 | $ 80,879 |
| Rent—cost of services | 35,762 | 33,456 |
| Less: rent related to items above | — | (38) |
| Adjusted rent | 35,762 | 33,418 |
| Adjusted EBITDAR | $ 128,491 | |

(a) Legal finding against our non-emergent transportation subsidiary.
(b) Costs incurred to acquire operations which are not capitalizable.

## Results of Operations

### Three Months Ended March 31, 2022 Compared to the Three Months Ended March 31, 2021

The following table sets forth details of operating results for our revenue and earnings, and their respective components, by our reportable segment for the periods indicated:

| | Three Months Ended March 31, 2022 | | | | |
|---|---|---|---|---|---|
| | Skilled services | Standard Bearer | All Other | Eliminations | Consolidated |
| Total revenue | 686,771 | 17,193 | 27,330 | (17,849) | $ 713,445 |
| Total expenses, including other expense, net | 588,515 | 10,293 | 66,260 | (17,849) | 647,219 |
| Segment income (loss) | 98,256 | 6,900 | (38,930) | — | 66,226 |
| Income before provision for income taxes | | | | | $ 66,226 |

| | Three Months Ended March 31, 2021 | | | | |
|---|---|---|---|---|---|
| | Skilled services | Standard Bearer | All Other | Eliminations | Consolidated |
| Total revenue | $ 601,036 | $ 14,069 | $ 25,729 | $ (13,581) | $ 627,253 |
| Total expenses, including other expense, net | 512,105 | 6,356 | 60,027 | (13,581) | 564,907 |
| Segment income (loss) | 88,931 | 7,713 | (34,298) | — | 62,346 |
| Loss from sale of real estate and impairment charges | | | | | 440 |
| Income before provision for income taxes | | | | | $ 62,786 |

Our total revenue increased $86.2 million, or 13.7%, compared to the three months ended March 31, 2021. The increase in revenue was primarily driven by an increase in our patient days and occupancy from our skilled services operations, along with the impact of acquisitions. Total revenue from operations acquired on or subsequent to January 1, 2021 increased our consolidated revenue by $41.6 million during the three months ended March 31, 2022, when compared to the same period in 2021. In addition, we recorded $17.6 million of state relief revenue in the first quarter of 2022 compared to $16.5 million in the same period in 2021, which correlated directly to the additional COVID-19 related expenses incurred. All state relief revenue is included in Medicaid revenue.

### *Skilled Services*

*Revenue*

The following table presents the skilled services revenue and key performance metrics by category during the three months ended March 31, 2022 and 2021:

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2022 | 2021 | Change | % Change |
| **Total Facility Results:** | (Dollars in thousands) | | | |
| Skilled services revenue | $ 686,771 | $ 601,036 | $ 85,735 | 14.3 % |
| Number of facilities at period end | 217 | 200 | 17 | 8.5 % |
| Number of campuses at period end* | 23 | 23 | — | — % |
| Actual patient days | 1,695,964 | 1,509,600 | 186,364 | 12.3 % |
| Occupancy percentage — Operational beds | 74.2 % | 71.1 % | | 3.1 % |
| Skilled mix by nursing days | 33.7 % | 34.4 % | | (0.7) % |
| Skilled mix by nursing revenue | 54.3 % | 55.6 % | | (1.3) % |

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2022 | 2021 | Change | % Change |
| **Same Facility Results(1):** | (Dollars in thousands) | | | |
| Skilled services revenue | $ 545,185 | $ 510,659 | $ 34,526 | 6.8 % |
| Number of facilities at period end | 169 | 169 | — | — % |
| Number of campuses at period end* | 18 | 18 | — | — % |
| Actual patient days | 1,321,682 | 1,268,254 | 53,428 | 4.2 % |
| Occupancy percentage — Operational beds | 75.1 % | 72.2 % | | 2.9 % |
| Skilled mix by nursing days | 35.2 % | 35.2 % | | — % |
| Skilled mix by nursing revenue | 55.6 % | 56.3 % | | (0.7)% |

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2022 | 2021 | Change | % Change |
| **Transitioning Facility Results(2):** | (Dollars in thousands) | | | |
| Skilled services revenue | $ 91,796 | $ 80,400 | $ 11,396 | 14.2 % |
| Number of facilities at period end | 27 | 27 | — | — % |
| Number of campuses at period end* | 5 | 5 | — | — % |
| Actual patient days | 239,912 | 218,823 | 21,089 | 9.6 % |
| Occupancy percentage — Operational beds | 72.6 % | 66.4 % | | 6.2 % |
| Skilled mix by nursing days | 29.3 % | 28.7 % | | 0.6 % |
| Skilled mix by nursing revenue | 50.3 % | 49.7 % | | 0.6 % |

| | Three Months Ended March 31, | | | |
|---|---|---|---|---|
| | 2022 | 2021 | Change | % Change |
| **Recently Acquired Facility Results(3):** | **(Dollars in thousands)** | | | |
| Skilled services revenue | **$ 49,790** | $ 9,977 | $ 39,813 | NM |
| Number of facilities at period end | **21** | 4 | 17 | NM |
| Number of campuses at period end* | **—** | — | — | NM |
| Actual patient days | **134,370** | 22,523 | 111,847 | NM |
| Occupancy percentage — Operational beds | **69.1 %** | 63.3 % | | NM |
| Skilled mix by nursing days | **27.2 %** | 39.2 % | | NM |
| Skilled mix by nursing revenue | **47.4 %** | 65.0 % | | NM |

* Campus represents a facility that offers both skilled nursing and senior living services. Revenue and expenses related to skilled nursing and senior living services have been allocated and recorded in the respective operating segment.
(1) Same Facility results represent all facilities purchased prior to January 1, 2019.
(2) Transitioning Facility results represent all facilities purchased from January 1, 2019 to December 31, 2020.
(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2021.

Skilled services revenue increased $85.7 million, or 14.3%, compared to the three months ended March 31, 2021. Of the $85.7 million increase, the primary changes were from an increase in Medicaid revenue of $39.8 million, or 14.9%, an increase in managed care revenue $19.4 million, or 17.9%, an increase in Medicare revenue of $18.1 million, or 9.5% and an increase in private revenue of $8.4 million or 24.2%.

The increase in revenue was primarily driven by strong performance across our skilled services operations as our census continued to recover in the first quarter of 2022. Our consolidated occupancy increased by 3.1%, which includes operations acquired at lower occupancy compared to the same period in the prior year. As COVID-19 cases declined from the same period in the previous year, there was a shift in Medicare patients to LTC patients, resulting in a decline in skilled mix days and skilled mix revenue.

Revenue in our Same Facilities increased $34.5 million, or 6.8% due to increased occupancy and total patient days. Our diligent efforts to strengthen our partnership with various managed care organizations, hospitals and the local communities we operate in, increased our occupancy by 2.9% to 75.1%. Managed care skilled days increased by 9.6%, resulting in an increase in Managed Care revenue of $9.2 million.

Revenue generated by our Transitioning Facilities increased $11.4 million, or 14.2%, primarily due to improved occupancy growth of 6.2% to 72.6% and an increase in our total patient days and skilled mix days compared to the three months ended March 31, 2021, demonstrating our ability to transition these healthcare operations toward higher acuity patients.

Skilled services revenue generated by facilities purchased on or subsequent to January 1, 2021 (Recently Acquired Facilities) increased by approximately $39.8 million compared to the three months ended March 31, 2021. We acquired seventeen operations between April 1, 2021 and March 31, 2022 across six states.

In the future, if we acquire additional turnaround or start-up operations, we expect to see lower occupancy rates and skilled mix, and these metrics are expected to vary from period to period based upon the maturity of the facilities within our portfolio. Historically, we have generally experienced lower occupancy rates, lower skilled mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth.

The following table reflects the change in skilled nursing average daily revenue rates by payor source, excluding services that are not covered by the daily rate [(1)]:

| | Three Months Ended March 31, | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Same Facility | | Transitioning | | Acquisitions | | Total | |
| | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 |
| **Skilled Nursing Average Daily Revenue Rates:** | | | | | | | | |
| Medicare | $ 693.89 | $ 689.44 | $ 694.73 | $ 686.64 | $ 683.23 | $ 806.10 | $ 693.28 | $ 691.34 |
| Managed care | 508.30 | 505.67 | 474.35 | 455.78 | 506.42 | 543.34 | 504.23 | 500.13 |
| Other skilled | 578.80 | 543.43 | 463.69 | 377.66 | 492.14 | 544.87 | 562.51 | 533.43 |
| Total skilled revenue | 598.41 | 593.20 | 588.91 | 577.94 | 587.83 | 683.70 | 596.57 | 592.90 |
| Medicaid | 260.45 | 252.21 | 241.36 | 235.65 | 243.03 | 237.98 | 255.97 | 249.38 |
| Private and other payors | 253.91 | 240.56 | 235.00 | 238.07 | 259.89 | 220.36 | 251.36 | 240.06 |
| Total skilled nursing revenue | $ 378.76 | $ 371.30 | $ 342.36 | $ 334.22 | $ 338.20 | $ 412.16 | $ 370.39 | $ 366.53 |

(1) These rates exclude additional FMAP we recognized and include sequestration reversal of 2%.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 0.6% and 1.2%, respectively, compared to the three months ended March 31, 2021. The increase is attributable to the 1.2% net market basket increase that became effective in October 2021.

Our average Medicaid rates increased 2.6% due to state reimbursement increases and our participation in supplemental Medicaid payment programs and quality improvement programs in various states. Medicaid rates exclude the amount of state relief revenue we recorded.

***Payor Sources as a Percentage of Skilled Nursing Services.*** We use our skilled mix as measures of the quality of reimbursements we receive at our affiliated 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 March 31, | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Same Facility | | Transitioning | | Acquisitions | | Total | |
| | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 |
| **Percentage of Skilled Nursing Revenue:** | | | | | | | | |
| Medicare | 27.6 % | 29.1 % | 31.1 % | 32.7 % | 26.3 % | 40.8 % | 27.9 % | 29.7 % |
| Managed care | 19.8 | 19.1 | 15.8 | 14.5 | 12.3 | 6.2 | 18.8 | 18.3 |
| Other skilled | 8.2 | 8.1 | 3.4 | 2.5 | 8.8 | 18.0 | 7.6 | 7.6 |
| Skilled mix | 55.6 | 56.3 | 50.3 | 49.7 | 47.4 | 65.0 | 54.3 | 55.6 |
| Private and other payors | 6.7 | 6.0 | 7.4 | 7.0 | 5.5 | 1.9 | 6.7 | 6.1 |
| Medicaid | 37.7 | 37.7 | 42.3 | 43.3 | 47.1 | 33.1 | 39.0 | 38.3 |
| Total skilled nursing | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % |

| | Three Months Ended March 31, | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Same Facility | | Transitioning | | Acquisitions | | Total | |
| | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 | 2022 | 2021 |
| **Percentage of Skilled Nursing Days:** | | | | | | | | |
| Medicare | 15.1 % | 15.6 % | 15.3 % | 15.9 % | 13.0 % | 20.9 % | 14.9 % | 15.8 % |
| Managed care | 14.8 | 14.0 | 11.4 | 10.6 | 8.2 | 4.7 | 13.8 | 13.4 |
| Other skilled | 5.3 | 5.6 | 2.6 | 2.2 | 6.0 | 13.6 | 5.0 | 5.2 |
| Skilled mix | 35.2 | 35.2 | 29.3 | 28.7 | 27.2 | 39.2 | 33.7 | 34.4 |
| Private and other payors | 10.0 | 9.4 | 10.7 | 9.9 | 7.3 | 3.4 | 9.9 | 9.3 |
| Medicaid | 54.8 | 55.4 | 60.0 | 61.4 | 65.5 | 57.4 | 56.4 | 56.3 |
| Total skilled nursing | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % | 100.0 % |

*Cost of Services*

The following table sets forth total cost of services for our Skilled services segment for the periods indicated (dollars in thousands):

| | Three Months Ended March 31, | | Change | |
|---|---|---|---|---|
| | 2022 | 2021 | $ | % |
| Cost of service | $ 534,174 | $ 462,960 | $ 71,214 | 15.4 % |
| Revenue percentage | 77.8 % | 77.0 % | | 0.8 % |

Cost of services related to our Skilled services segment increased $71.2 million, or 15.4%, primarily due to additional costs related to new acquisitions, which accounted for $32.0 million of the increase to cost of services with additional increases mainly due to higher staffing expenses. Cost of services as a percentage of revenue increased to 77.8% from 77.0%, an increase of 0.8%.

***Standard Bearer***

| | Three Months Ended March 31, | | Change | |
|---|---|---|---|---|
| | 2022 | 2021 | $ | % |
| | (In thousands) | | | |
| Rental revenue generated from third-party tenants | $ 3,768 | $ 3,478 | $ 290 | 8.3 % |
| Rental revenue generated from Ensign affiliated operations | 13,425 | 10,591 | 2,834 | 26.8 |
| Total rental revenue | $ 17,193 | $ 14,069 | $ 3,124 | 22.2 % |
| Segment income | 6,900 | 7,713 | (813) | (10.5) |
| Depreciation and amortization | 5,021 | 4,155 | 866 | 20.8 |
| FFO | $ 11,921 | $ 11,868 | $ 53 | 0.4 % |

*Rental revenue*. Our rental revenue, including revenue generated from our affiliated facilities, increased by $3.1 million, or 22.2%, to $17.2 million, compared to the three months ended March 31, 2021. The increase in revenue is primarily attributable to eight real estate purchases as well as annual rent increases since the three months ended March 31, 2021.

*FFO*. Our FFO increased $0.1 million, or 0.4% to $11.9 million, compared to the three months ended March 31, 2021. The increase in expenses are offset against the increase in rental revenue of $3.1 million. Included in FFO for the three months ended March 31, 2022 is interest expense of $1.9 million as well as management fee expense of $1.0 million associated with the intercompany agreements between Standard Bearer and the Service Center starting in January of 2022. As noted in Item 2., under *Recent Activities*, Ensign Group, Inc., the real estate properties and Standard Bearer entered into intercompany debt arrangements including mortgage loans and a credit revolver with the formation of Standard Bearer in January of 2022.

***All Other Revenue***

Our other revenue increase by $1.6 million, or 6.2%, to $27.3 million, compared to the three months ended March 31, 2021. Other revenue for 2022 includes senior living revenue of $13.6 million and revenue from other ancillary services of $11.8 million and rental income of $1.9 million. The increase in other revenue is attributable to our senior living acquisitions as our senior living occupancy recovers from COVID-19.

**Consolidated Financial Expenses**

***Rent — cost of services.*** Our rent — cost of services as a percentage of total revenue decreased by 0.3% to 5.0%, primarily due the growth in revenue outpacing the increase in rent expense.

***General and administrative expense —*** General and administrative expense increased $4.0 million or 11.6%, to $38.3 million. This increase was primarily due to increases in wages and benefits due to enhanced performance and growth. General and administrative expense as a percentage of revenue decreased by 0.2% to 5.3%.

***Depreciation and amortization —*** Depreciation and amortization expense increased $1.0 million, or 7.4%, to $14.7 million. This increase was primarily related to the additional depreciation and amortization incurred as a result of our newly acquired operations. Depreciation and amortization decreased 0.1%, to 2.1%, as a percentage of revenue.

***Other expense, net —*** Other expense, net as a percentage of revenue increased by 0.2% to 0.4%. Other expense primarily includes interest expense related to new debt and gain or loss on the investments mirrored to our deferred compensation program. During the three months ended March 31, 2022, we recorded a loss of $1.2 million compared to a gain of $306 during the three months ended March 31, 2021. There is an offsetting income and offsetting expense split between cost of services and general and administrative expenses for both periods.

***Provision for income taxes —*** Our effective tax rate was 24.4% for the three months ended March 31, 2022, compared to 20.6% for the same period in 2021. The effective tax rate for both periods is driven by the impact of excess tax benefits from stock-based compensation, partially offset by non-deductible expenses. The higher effective tax rate reflects a decrease in tax benefit from stock-based payment awards. See Note 15, *Income Taxes*, in the Notes to the Unaudited Condensed Consolidated Financial Statements for further discussion.

## Liquidity and Capital Resources

Our primary sources of liquidity have historically been derived from our cash flows from operations and long-term debt secured by our real property and our Credit Facility. Our liquidity as of March 31, 2022 is impacted by cash generated from strong operational performance and the repayment of Medicare Accelerated and Advance Payment Program funds and deferral of the employer portion of social security taxes.

Historically, we have primarily financed the majority of our acquisitions through the financing of our operating subsidiaries through mortgages, our Credit Facility, and cash generated from operations. Total capital expenditures for property and equipment were $15.8 million and $15.3 million for the three months ended March 31, 2022 and 2021, respectively. We currently have approximately $70.0 million budgeted for renovation projects for 2022. We believe our current cash balances, our cash flow from operations and the amounts available under our Credit Facility 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 March 31, 2022 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of March 31, 2022, we held debt security investments of approximately $50.1 million, which were split between AA, A and BBB rated securities. We believe our debt security investments that were in an unrealized loss position as of March 31, 2022 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date that would indicate any other-than-temporary impairment.

As mentioned above, our primary sources of cash is from our ongoing operations. Our positive cash flows have supported our business and have allowed us to pay regular dividends to our stockholders. We currently anticipate that existing cash and total investments as of March 31, 2022, along with projected operating cash flows and available financing, will support our normal business operations for the foreseeable future.

On October 21, 2021, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that follow October 29, 2021. During the three months ended March 31, 2022, we repurchased approximately 0.1 million shares of our common stock for $9.9 million. This repurchase program expired upon the repurchase of the full authorized amount under the plan. On February 9, 2022, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that follow February 10, 2022. During the three months ended March 31, 2022, we did not purchase any shares pursuant to this stock repurchase program. The share repurchase programs do not obligate us to acquire any specific number of shares.

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

| | Three Months Ended March 31, | |
|---|---|---|
| | 2022 | 2021 |
| Net cash provided by/(used in): | (In thousands) | |
| Operating activities | $ 45,874 | $ 34,294 |
| Investing activities | (48,240) | (12,212) |
| Financing activities | (11,289) | (103,117) |
| Net decrease in cash and cash equivalents | (13,655) | (81,035) |
| Cash and cash equivalents beginning of period | 262,201 | 236,562 |
| Cash and cash equivalents at end of period | $ 248,546 | $ 155,527 |

***Operating Activities***

Cash provided by operating activities is net income adjusted for certain non-cash items and changes in operating assets and liabilities.

The $11.6 million increase in cash provided by operating activities for the three months ended March 31, 2022 compared to the same period in 2021, was primarily due to higher net income and changes in working capital. Changes in working capital were driven by a decrease in accrued wages and related liabilities and prepaid income taxes as a result of timing, partially offset by the timing of accounts payable and other accrued liabilities.

***Investing Activities***

Investing cash flows consist primarily of capital expenditures, investment activities, insurance proceeds and cash used for acquisitions.

The $36.0 million increase in cash used in investing activities for the three months ended March 31, 2022, compared to the same period in 2021, was primarily due to an increase in cash used for expansions and capital expenditures of $34.1 million.

***Financing Activities***

Financing cash flows consist primarily of payment of dividends to stockholders, issuance and repayment of short-term and long-term debt, payment for share repurchases, repayment of the Medicare Accelerated and Advance Payment Program funds and sale of shares of common stock through employee equity incentive plans.

The $91.8 million decrease in cash used in financing activities for the three months ended March 31, 2022, compared to the same period in 2021, was primarily due to the $102.0 million of net proceeds and repayment of the Medicare Accelerated and Advance Payment Program funds in 2021, offset by $9.9 million of share repurchases as part of our stock repurchase program in 2022.

***Credit Facility with a Lending Consortium Arranged by Truist***

We maintain the Credit Facility with a lending consortium arranged by Truist, which includes a revolving line of credit of up to $350.0 million in aggregate principal amount. The maturity date of the Credit Facility is October 1, 2024. The interest rates applicable to loans under the Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.50% to 1.50% per annum or LIBOR plus a margin range from 1.50% to 2.50% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, we pay a commitment fee on the unused portion of the commitments that ranges from 0.25% to 0.45% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

Subsequent to March 31, 2022, on April 8, 2022, we entered into the Amended Credit Facility, with a revolving line of credit of up to $600.0 million in aggregate principal. The maturity date of the Amended Credit Facility is April 8, 2027. Borrowings are supported by a lending consortium arranged by Truist. The interest rates applicable to loans under the Amended Credit Facility are, at our option, equal to either a base rate plus a margin ranging from 0.25% to 1.25% per annum or SOFR plus a margin range from 1.25% to 2.25% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, we will pay a commitment fee on the unused portion of the commitments that will range from 0.20% to 0.40% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio.

### *Mortgage Loans and Promissory Notes*

As of March 31, 2022, 23 of our subsidiaries have mortgage loans insured with HUD for an aggregate amount of $155.9 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear effective interest rates range of 3.1% to 4.2%, including fixed interest rates range of 2.4% to 3.3% per annum. Amounts borrowed under the mortgage loans may be prepaid, subject to prepayment fees of the principal balance on the date of prepayment. For the majority of the loans, the prepayment fee is 10% during the first three years and is reduced by 3% in the fourth year of the loan, and reduced by 1% per year for years five through ten of the loan. There is no prepayment penalty after year ten. The term of the mortgage loans are 25 to 35 years.

In addition to the HUD mortgage loans above, we have a promissory note that was put in place in connection with an acquisition. The note bears a fixed interest rate of 5.3% per annum and the term of the note is 12 years. The year note which was used for an acquisition is secured by the real property comprising the facility and the rent, issues and profits thereof, as well as all personal property used in the operation of the facility.

### *Operating Leases*

As of March 31, 2022, 179 of our facilities are under long-term lease arrangements, of which 95 of the operations are under nine triple-net Master Leases and one stand-alone lease with CareTrust REIT, Inc. (CareTrust). The Master Leases consist of multiple leases, each with its own pool of properties, that have varying maturities and diversity in property geography. Under each master lease, our individual subsidiaries that operate those properties are the tenants and CareTrust's individual subsidiaries that own the properties subject to the Master Leases are the landlords. The rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of the percentage change in the Consumer Price Index (but not less than zero) or 2.5%. At our option, we can extend the Master Leases for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. If we elect to renew the term of a Master Lease, the renewal will be effective as to all, but not less than all, of the leased property then subject to the Master Lease. Additionally, four of the 96 facilities leased from CareTrust include an option to purchase that we can exercise starting on December 1, 2024.

We also lease certain affiliated facilities and our administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, we lease certain of our 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.

Forty-four of our affiliated facilities, excluding the facilities that are operated under the Master Leases from CareTrust, are operated under eight separate master lease arrangements. Under these master leases, a breach at a single facility could subject one or more of the other affiliated 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 our 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 our 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.

### *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. There can be no assurance that we will be able to anticipate fully or otherwise respond to any future inflationary pressures.

### Recent Accounting Pronouncements

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

### Recent Accounting Standards Adopted by the Company

In November 2021, the FASB issued ASU 2021-10 "*Government Assistance (Topic 832): Disclosures by Business Entities about Government Assistance*," which created FASB ASC Topic 832, *Government Assistance* (ASC 832). ASC 832 requires business entities to disclose information about certain government assistance they receive. We adopted this standard on January 1, 2022 and determined there was no material impact on the our condensed consolidated financial statements.

### Accounting Standards Recently Issued but Not Yet Adopted by the Company

In February 2020, the FASB issued ASU 2020-04 *"Reference Rate Reform (Topic 848)"* which provides temporary, optional practical expedients and exceptions to enable a smoother transition to reference rates which are expected to replace LIBOR reference rates. Adoption of the provisions of ASU 2020-04 is optional. The amendments are effective for all entities from the beginning of the interim period that includes the issuance date of the ASU. An entity may elect to apply the amendments prospectively through December 31, 2022. Subsequent to March 31, 2022, we entered into the Second Amendment to Third Amended and Restated Credit Agreement (Amended Credit Facility), which increased the revolving credit facility by $250,000 to an aggregate principal amount of up to $600,000. The amendment modifies the reference rate from LIBOR to SOFR. We are currently evaluating the impact of ASU 2020-04 on our financial position, results of operations and liquidity.

## Item 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

***Interest Rate Risk.*** We are exposed to risks associated with market changes in interest rates through our borrowing arrangements and investments. In particular, our Credit Facility exposes us to variability in interest payments due to changes in LIBOR interest rates. We manage our exposure to this market risk by monitoring available financing alternatives. Our mortgages and promissory notes require principal and interest payments through maturity pursuant to amortization schedules.

Our mortgages generally contain provisions that allow us to make repayments earlier than the stated maturity date. In some cases, we are not allowed to make early repayment prior to a cutoff date. Where prepayment is permitted, we are generally allowed to make prepayments only at a premium which is often designed to preserve a stated yield to the note holder. These prepayment rights may afford us opportunities to mitigate the risk of refinancing our debts at maturity at higher rates by refinancing prior to maturity.

As of March 31, 2022, there was no outstanding debt under our Credit Facility. We have outstanding indebtedness under mortgage loans insured with HUD and one promissory note to third parties of $159.0 million all of which are at fixed interest rates.

Subsequent to March 31, 2022, we entered into the Amended Credit Facility, with a revolving line of credit of up to $600.0 million in aggregate principal. The Amended Credit Facility amended the reference rate from LIBOR to SOFR. We have no outstanding debt under our Amended Credit Facility as of April 26, 2022.

Our cash and cash equivalents as of March 31, 2022 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of March 31, 2022, we held debt security investments of approximately $50.1 million which were split between AA, A, and BBB rated securities. We believe our debt security investments that were in an unrealized loss position as of March 31, 2022 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date that would indicate any other-than-temporary impairment. 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 10.0% 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 exist as of March 31, 2022 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 Exchange Act as of the end of the period covered by this Quarterly Report on Form 10-Q. 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 March 31, 2022, that have materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

# PART II.

## Item 1. LEGAL PROCEEDINGS

***Regulatory Matters*** — Laws and regulations governing Medicare and Medicaid programs are complex and subject to review and interpretation. Compliance with such laws and regulations is evaluated regularly, the results of which can be subject to future governmental review and interpretation, and can include significant regulatory action with fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations are rules requiring vaccination of employees and HIPAA, the terms of which require healthcare providers (among other things) to safeguard the privacy and security of certain patient protected health information.

***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 us.

***Indemnities*** — From time to time, we enter into certain types of contracts that contingently require us to indemnify parties against third-party claims. These contracts primarily include (i) certain real estate leases, under which we may be required to indemnify property owners or prior facility operators for post-transfer environmental or other liabilities and other claims arising from our use of the applicable premises, (ii) operations transfer agreements, in which we agree to indemnify past operators of facilities we acquire against certain liabilities arising from the transfer of the operation and/or the operation thereof after the transfer to the Company's independent operating subsidiary, (iii) certain lending agreements, under which we may be required to indemnify the lender against various claims and liabilities, and (iv) certain agreements with our officers, directors and others, under which we may be required to indemnify such persons for liabilities arising out of the nature of their relationship to the Company. The terms of such obligations vary by contract and, in most instances, do not expressly state or include a specific or maximum dollar amount. 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 our balance sheets for any of the periods presented.

In connection with the spin-off transaction, certain landlords required, in exchange for their consent to the transaction, that our lease guarantees remain in place for a certain period of time following the spin-off. These guarantees could result in significant additional liabilities and obligations for us if Pennant were to default on their obligations under their leases with respect to these properties.

***Litigation*** — We and our independent operating entities 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 services provided to patients by our independent operating entities have resulted in injury or death, and claims related to employment and commercial matters. Although we intend to vigorously defend against these claims, there can be no assurance that the outcomes of these matters will not have a material adverse effect on operational results and financial condition. In certain states in which we have or have had independent operating entities, insurance coverage for the risk of punitive damages arising from general and professional liability litigation may not be available due to state law and/or public policy prohibitions. There can be no assurance that our independent operating entities will not be liable for punitive damages awarded in litigation arising in states for which punitive damage insurance coverage is not available.

The skilled nursing and post-acute care industry is heavily regulated. As such, we and our independent operating subsidiaries are continuously subject to state and federal regulatory scrutiny, supervision and control in the ordinary course of business. 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 from state and federal agencies, the skilled nursing and post-acute care industry is also subject to regulatory requirements which could result in 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 programs. We believe that there has been, and will continue to be, an increase in governmental investigations of LTC providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse determinations 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.

Additionally, and in 2020, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis launched a nation-wide investigation into the COVID-19 pandemic, which included the impact of the coronavirus on residents and employees in nursing homes. In June 2020, the Company received a document and information request from the House Select Subcommittee. The Company is cooperating in responding to this inquiry. However, it is not possible to predict the ultimate outcome of any such investigation, or whether and what other investigations or regulatory responses may result from the investigation, which could have a material adverse effect on our reputation, business, financial condition and results of operations.

In addition to the potential lawsuits and claims described above, we and our independent operating subsidiaries are 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 Medicaid) or other payor. A violation may provide the basis for exclusion from Federally funded healthcare programs. Such exclusions could have a correlative negative impact on our financial performance. Under the *qui tam* or "whistleblower" provisions of the False Claims Act, a private individual with knowledge of fraud or potential fraud may bring a claim on behalf of the Federal Government and receive a percentage of the Federal Government's recovery. Due to these whistleblower incentives, *qui tam* lawsuits have become more frequent. For example, and despite the decision of the U.S. Department of Justice to decline to participate in litigation based on the subject matter of its previously issued Civil Investigative Demand, the involved *qui tam* relator is continuing on with the lawsuit and pursuing claims that one or more of the Company's independent operating entities have allegedly violated the False Claims Act and/or the Anti-Kickback Statute.

In addition to the Federal False Claims Act, some states, including California, Arizona and Texas, have enacted similar whistleblower and false claims laws and regulations. Further, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. As such, we and our independent operating subsidiaries could face increased scrutiny, potential liability, and legal expenses and costs based on claims under state false claims acts in markets where our independent operating subsidiaries do business.

In May 2009, Congress passed the FERA which made significant changes to the Federal False Claims Act (FCA) and expanded 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 an FCA violation can occur without any affirmative fraudulent action or statement, as long as the action or statement is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, an employment relationship is generally not required in order to qualify for protection against retaliation for whistleblowing.

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and our independent operating entities are routinely subjected to varying types of claims, including class action "staffing" suits where the allegation is understaffing at the facility level. These class-action “staffing” suits have the potential to result in large jury verdicts and settlements. We expect the plaintiffs' bar to continue to be aggressive in their pursuit of these staffing and similar claims.

We and our independent operating subsidiaries have been, and continue to be, subject to claims, findings and legal actions that arise in the ordinary course of the various businesses, including healthcare and non-healthcare services. These claims include, but are not limited to potential claims related to patient care and treatment (professional negligence claims) as well as employment related claims. In addition, we and our independent operating subsidiaries, and others in the industry, are subject to claims and lawsuits in connection with COVID-19 and facility preparation for and/or response to the COVID-19 pandemic. While we have been able to settle or otherwise resolve these types of claims without an ongoing material adverse effect on our business, a significant increase in the number of these claims, or an increase in the amounts owing should plaintiffs be successful in their prosecution of future claims, could materially adversely affect the Company’s business, financial condition, results of operations and cash flows. In addition, these claims could impact our ability to procure insurance to cover our exposure related to the various services provided by our independent operating subsidiaries to their residents, customers and patients.

Claims and suits, including class actions, continue to be filed against our independent operating subsidiaries and other companies in the post-acute care industry. We and our independent operating entities have been subjected to, and/or are currently involved in, class action litigation alleging violations (alone or in combination) of state and federal wage and hour law as related to the alleged failure to pay wages, to timely provide and authorize meal and rest breaks, and other such similar causes of action. We do not believe that the ultimate resolution of these actions will have a material adverse effect on our business, cash flows, financial condition or results of operations.

***Medicare Revenue Recoupments*** — We and our independent operating subsidiaries are subject to regulatory reviews relating to the provision of Medicare services, billings and potential overpayments resulting from reviews conducted via RAC, Program Safeguard Contractors, and Medicaid Integrity Contractors (collectively referred to as Reviews). For several months during the COVID-19 pandemic, CMS suspended its Targeted Probe and Educate Program. Beginning in August 2020, CMS resumed Targeted Probe and Educate Program activity. If an operation fails a Review and/or subsequent Reviews, the operation could then be subject to extended review or an extrapolation of the identified error rate to billings in the same time period. We anticipate that these Reviews could increase in frequency in the future. As of March 31, 2022 and since, 19 of our independent operating subsidiaries had Reviews scheduled, on appeal, or in a dispute resolution process.

## Item 1A. RISK FACTORS

We are providing the following summary of the risk factors contained in our Form 10-Q to enhance the readability and accessibility of our risk factor disclosures. We encourage our stockholders to carefully review the risk factors contained in this Form 10-Q in their entirety for additional information regarding the risks and uncertainties that could cause our actual results to vary materially from recent results or from our anticipated future results.

### Risks Related to our Business and Industry

- We face numerous risks related to the COVID-19 public health emergency (PHE), which could individually or in the aggregate have a material adverse effect on our business, financial condition, liquidity, results of operations and prospects.
- Changes to reimbursement rates and rules and other aspects of Medicare and Medicaid could have a material, adverse effect on our revenues, financial condition and results of operations.
- Our revenue could be impacted by a shift to value-based reimbursement models, such as PDPM, and changes to existing reimbursement models.
- Reforms to the U.S. healthcare system, including the ACA, continue to impose new requirements upon us and may increase our costs or lower our reimbursements, which could materially impact our business.
- The recent U.S. Presidential and Congressional elections and upcoming midterm elections in 2022, for which certain primary campaigns are already underway, may create significant changes to the regulatory framework, enforcements, and reimbursements.
- 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.
- Failure to comply with applicable laws and regulations, including state-specific mandates or proclamations regarding COVID-19, or if these laws and regulations change, could cause us to incur significant expenses and/or change our operations in order to bring our facilities and operations into compliance.
- Public and government calls for increased survey and enforcement efforts toward long-term care (LTC) facilities, and potential rulemaking that may result in enhanced enforcement and penalties, could result in increased scrutiny by state and federal survey agencies. Potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.
- Future cost containment initiatives undertaken by third-party payors may limit our revenue and profitability.
- Changes in Medicare reimbursements for physician and non-physician services could impact reimbursement for medical professionals, which could have a negative effect on our business, financial condition or results of operations.
- We may be subject to increased investigation and enforcement activities related to HIPAA violations if we fail to adopt and maintain business procedures and systems designed to protect the privacy, security and integrity of patients' individual health information.
- Security breaches and other cyber-security incidents could violate security laws and subject us to significant liability.
- If we are not fully reimbursed for all services for which each facility bills through consolidated billing, our revenue, financial condition and results of operations could be adversely affected.
- 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 resulting from a failure to maintain minimum staffing requirements, or may affect reimbursement.
- Annual caps and other cost-reductions for outpatient therapy services may reduce our future revenue and profitability or cause us to incur losses.
- Increased scrutiny of our billing practices by the Office of the Inspector General or other regulatory authorities may result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.
- 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.
- Changes to federal and state employment-related laws and regulations could increase our cost of doing business.
- Required regulatory approvals could delay or prohibit transfers of our healthcare operations, which could result in periods in which we are unable to receive reimbursement for such properties.
- Compliance with federal and state fair housing, fire, safety, staffing, and other regulations may require us to incur unexpected expenses, which could be costly to us.
- 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 affiliated facilities as well as payor mix and payment methodologies.
- We are subject to litigation that could result in significant legal costs and large settlement amounts or damage awards.

- If our regular internal investigations into the care delivery, recordkeeping and billing processes of our operating subsidiaries detect instances of noncompliance, efforts to correct such non-compliance could materially decrease our revenue.
- We may be unable to complete future facility or business acquisitions at attractive prices or at all, or may elect to dispose of underperforming or non-strategic operating subsidiaries, either of which could decrease our revenue.
- We may not be able to successfully integrate acquired facilities and businesses into our operations, or we may be exposed to costs, liabilities and regulatory issues that may adversely affect our operations.
- If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar monitoring activities, our business may be negatively affected.
- If we are unable to obtain insurance, or if insurance becomes more costly for us to obtain, our business may be adversely affected, and our self-insurance programs may expose us to significant and unexpected costs and losses.
- The geographic concentration of our affiliated facilities could leave us vulnerable to economic downturn, regulatory changes or acts of nature in those areas.
- 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 lease the majority of our affiliated facilities, and risks associated with leased property, could adversely affect our business, financial position or results of operations.
- 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 operating subsidiaries and cause us to lose facilities or experience foreclosures.
- Move-in and occupancy rates may remain unpredictable even after the COVID-19 pandemic is over.
- A housing downturn could decrease demand for senior living services.
- As we continue to acquire and lease real estate assets, we may not be successful in identifying and consummating these transactions.
- As we expand our presence in other relevant healthcare industries, we would become subject to risks in a market in which we have limited experience.
- 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 may need additional capital to fund our operating subsidiaries 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.
- The condition of the financial markets, could limit the availability of debt and equity financing sources to fund the capital and liquidity requirements of our business, as well as negatively impact or impair the value of our current portfolio of cash, cash equivalents and investments.
- Delays in reimbursement may cause liquidity problems.
- Compliance with the regulations of the Department of Housing and Urban Development may require us to make unanticipated expenditures which could increase our costs.
- Failure to safeguard our patient trust funds may subject us to citations, fines and penalties.
- 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 may incur operational difficulties or be exposed to claims and liabilities as a result of the separation of Pennant, including if the Spin-Off is not tax-free for U.S. federal income tax purposes.
- We may not achieve some or all of the anticipated benefits of the Spin-Off, which may adversely affect our business.
- The Spin-Off and related transactions may expose us to potential liabilities arising out of state and federal fraudulent conveyance laws and legal distribution requirements.
- Certain directors who serve on our Board of Directors also serve as directors of Pennant, and ownership of shares of Pennant common stock by our directors and executive officers may create, or appear to create, conflicts of interest.

**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 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.

## Risks Related to Our Business and Industry

***We face numerous risks related to the COVID-19 PHE, which could have a material adverse effect on our business, financial condition, liquidity, results of operations and prospects.***

The extent to which the COVID-19 PHE will continue impacting our operations will depend on future developments, which are highly uncertain and cannot be predicted with confidence, including the duration of the outbreak, federal vaccination program efforts, additional or modified government actions, new information which may emerge concerning the severity of the virus, variant outbreaks and efficacy of vaccinations, and the actions taken to contain the virus or treat its impact, among others. Effective on April 16, 2022, HHS's PHE was extended through at least July 14, 2022. HHS has reported it will provide at least sixty (60) days' advance notice prior to the end of the PHE. Some of the risks of COVID-19 are being mitigated as a result of the federal vaccination program, including vaccinations and vaccine booster injections of nursing facility staff and residents, but there remains uncertainty as to when the pandemic will subside and eventually end.

As discussed in Item 2., under *Government Regulation*, federal, state and local regulators have implemented new regulations and waived existing regulations to promote care delivery during the COVID-19 PHE. While the majority of these changes are beneficial by reducing regulatory burdens, these accommodations may also have an adverse effect through increased legal and operational costs related to compliance and monitoring. Additionally, most of the accommodations are limited in duration and tied to the COVID-19 PHE declaration, thus there may be significant operational change requirements on short notice. Other proposed changes, could include requirements for employees to be vaccinated as a condition of Medicare participation or in order to avoid fines or penalties under other laws, may be prospective in nature and affect the ability to retain and attract a qualified workforce. Also, the reinstatement of waived state and federal regulations may not occur simultaneously, requiring heightened monitoring to ensure compliance.

Other factors from the continuation of the COVID-19 pandemic that could have an adverse effect on our business, financial condition, liquidity, results of operations and prospects, include:

- potential for increased government regulations and restrictions to combat COVID-19;
- increased strain on employees and resources caused by different waves of COVID-19 variants with different infection and effects;
- significantly reduced occupancy as a result of government-imposed orders;
- lower census due to general decline in all hospital procedures, including elective/non-urgent procedures;
- increased costs and staffing requirements related to additional CDC protocols, federal and state workforce protection and related isolation procedures, including obligations to test patients and staff for COVID-19;
- limitations on availability of staff due to COVID-19 related illness or exposure;
- disruptions to supply chains which could negatively impact consistent and reliable delivery of personal protective equipment, sanitizing supplies, food, pharmaceuticals, utilities and other goods to our affiliated facilities, resulting in our inability to obtain on reasonable terms, or at all, personal protective equipment, sanitizing supplies, food, pharmaceuticals, utilities and other goods;
- incurrence of additional expenditures to comply with COVID-19 isolation procedures, including temporary construction or purchase of additional equipment;
- increased scrutiny by regulators of infection control and prevention measures, including increased reporting requirements related to suspected and confirmed COVID-19 diagnoses of residents and staff, which may result in fines or other sanctions related to non-compliance;
- new state requirements or pressure from state officials to accept post-discharge patients from hospitals facing overcrowding, which increases the potential spread of COVID-19 within our facilities;
- increased risk of litigation and related liabilities arising in connection with patient or staff illness, hospitalization and/or death;
- negative impacts on our patients' ability or willingness to pay for healthcare services and our third parties' ability or willingness to pay rents; and
- new regulations which will require that all of our workers be fully vaccinated against COVID-19 as a condition of participating in Medicare and Medicaid programs.

The extent and duration of the impact of the COVID-19 pandemic on our stock price is uncertain, our stock price may be more volatile, and our ability to raise capital could be impaired.

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

We derived 29.4% and 30.5% of our service revenue from the Medicare programs for the three months ended March 31, 2022 and 2021, respectively. In addition, many other payors may use published Medicare rates as a basis for reimbursements. Accordingly, if Medicare reimbursement rates are reduced or fail to increase as quickly as our costs, if there are changes in the rules governing the Medicare program that are disadvantageous to our business or industry, or if there are delays in Medicare payments, our business and results of operations will be adversely affected.

The Medicare program and its reimbursement rates and rules are subject to frequent change. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), annual caps that limit the amount that can be paid (including deductible and coinsurance amounts) administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which Medicare reimburses us for our services. Budget pressures often lead the federal government to reduce or place limits on reimbursement rates under Medicare. Implementation of these and other types of measures has in the past and could in the future result in substantial reductions in our revenue and operating margins. For example, see Item 2., under *Government Regulation*, *Sequestration of Medicare Rates.*

Additionally, Medicare payments can be delayed or declined due to 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 medically 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.

In addition, CMS often changes the rules governing the Medicare program, including those governing reimbursement. Changes to the Medicare program that could adversely affect our business include:

- administrative or legislative changes to base rates or the bases of payment;
- limits on the services or types of providers for which Medicare will provide reimbursement;
- changes in methodology for patient assessment and/or determination of payment levels;
- changes in staff requirements (i.e. requiring all workers to be vaccinated against COVID-19 and receive booster injections for those vaccinations) as a condition of payment or eligibility for Medicare reimbursement (See also, Item 2., under *Government Regulation*);
- the reduction or elimination of annual rate increases, or the end of the reduced payments deferment (See also, Item 2., under *Government Regulation*); or
- an increase in co-payments or deductibles payable by beneficiaries.

Among the important statutory changes that are being implemented by CMS are provisions of the IMPACT Act. This law imposes a stringent timeline for implementing benchmark quality measures and data metrics across post-acute care providers (long stay hospitals, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies). The enactment also mandates specific actions to design a unified payment methodology for post-acute providers. CMS continues to promulgate regulations to implement provisions of this enactment. Depending on the final details, the costs of implementation could be significant. The failure to meet implementation requirements could expose providers to fines and payment reductions.

Reductions in reimbursement rates or the scope of services being reimbursed could have a material, adverse effect on our revenue, financial condition and results of operations or even result in reimbursement rates that are insufficient to cover our operating costs. Loss of Medicare reimbursement entirely would also have a material adverse effect on our revenue. Medicare may rescind our certification and terminate its payor agreements if not all of our employees are fully vaccinated consistent with CMS's IFR requiring vaccination of SNF employees, which the United States Supreme Court has allowed enforcement of as of January 13, 2022. As of January 20, 2022, CMS’s IFR requiring vaccination of SNF employees is in effect in the State of Texas, with SNF staff required to be fully vaccinated or to have exemptions granted by March 21, 2022. There has been no further activity regarding this IFR since January of 2022 when CMS became empowered to enact and enforce it nationwide. Failure to comply with the CMS IFR in all states by their applicable deadlines stated by CMS may result in fines and other sanctions imposed by CMS. In addition, within California, Washington, and Colorado, if our employees are not fully vaccinated as required by those states’ vaccination mandates, we could incur a deficiency that could endanger our Medicaid certification and participation status for certain locations within those states where employees have not been vaccinated. Any penalty, suspension, termination, or other sanction under any state’s Medicaid program could lead to reciprocal and commensurate penalties being imposed under the Medicare program, up to termination or rescission of our Medicare participation and payor agreements as noted above. Additionally, any delay or default by the government in making Medicare reimbursement payments could materially and adversely affect our business, financial condition and results of operations.

***Reductions in Medicaid reimbursement rates or changes in the rules governing the Medicaid program could have a material, adverse effect on our revenue, financial condition and results of operations.***

A significant portion of reimbursement for skilled nursing services comes from Medicaid. In fact, Medicaid is our largest source of revenue, accounting for 44.0% and 43.6% of our service revenue for the three months ended March 31, 2022 and 2021, respectively. Medicaid is a state-administered program financed by both state funds and matching federal funds. Medicaid spending has increased rapidly in recent years, becoming a significant component of state budgets, which has led both the federal government and many states to institute measures aimed at controlling the growth of Medicaid spending, and in some instances reducing aggregate Medicaid spending. Since a significant portion of our revenue is generated from our skilled nursing operating subsidiaries in California, Texas and Arizona, any budget reductions or delays in these states could adversely affect our net patient service revenue and profitability. Despite present state budget surpluses in many of the states in which we operate, we can 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.

The Medicaid program and its reimbursement rates and rules are subject to frequent change at both the federal and state level. These include statutory and regulatory changes, rate adjustments (including retroactive adjustments), administrative or executive orders and government funding restrictions, all of which may materially adversely affect the rates at which our services are reimbursed by state Medicaid plans. To generate funds to pay for the increasing costs of the Medicaid program, many states utilize financial arrangements commonly referred to as provider taxes. Under provider tax arrangements, states collect taxes from healthcare providers and then use the revenue to pay the providers as a Medicaid expenditure, which allows the states to then claim additional federal matching funds on the additional reimbursements. Current federal law provides for a cap on the maximum allowable provider tax as a percentage of the provider's total revenue. There can be no assurance that federal law will continue to provide matching federal funds on state Medicaid expenditures funded through provider taxes, or that the current caps on provider taxes will not be reduced. Any discontinuance or reduction in federal matching of provider tax-related Medicaid expenditures could have a significant and adverse effect on states' Medicaid expenditures, and as a result could have a material and adverse effect on our business, financial condition or results of operations.

***Our revenue could be impacted by a shift to value-based reimbursement models, including PDPM, and changes to existing reimbursement models.***

As discussed in more detail in Item 2., under *Government Regulation*, CMS implemented a final rule in October 2019 to replace the existing case-mix classification system, Resource Utilization Groups, Version IV, with a new case-mix classification system, PDPM, that focuses more on the clinical condition of the patient and less on the volume of services provided. CMS may make future adjustments to reimbursement levels as it continues to monitor the impact of PDPM on patient outcomes and budget neutrality. As included in the proposed rule, CMS could remove the entire parity calculated adjustment and this would cause a drastic reduction in payments. In addition, the Administration continues to study the nursing home industry and for HHS to issue proposed rules based on those studies, including changes to SNF-VBP Program, may also adversely affect our reimbursement. On April 11, 2022, the CMS issued a proposed rule that requested information to be used for study and potential rulemaking consistent with the Administration’s February 28, 2022 fact sheet.

***Reforms to the U.S. healthcare system continue to impose new requirements upon us and may increase our costs or lower our reimbursements.***

The ACA included sweeping changes to how healthcare is paid for and furnished in the U.S. Applicable to our business, as discussed in greater detail in Item 2., under *Government Regulation*, the ACA has resulted in significant changes to our operations and reimbursement models for services we provide. CMS continues to issue rules to implement the ACA. Courts continue to interpret and apply the ACA’s provisions.

The efficacy of the ACA is the subject of much debate among members of Congress and the public. Additionally, a number of lawsuits have been filed challenging various aspects of the ACA and related regulations with inconsistent outcomes - some expand the ACA while others limit the ACA. In the event that the ACA is repealed or materially amended as a result of future challenges, particularly any elements of the ACA that are beneficial to our business or that cause changes in the health insurance industry, including reimbursement and coverage by private, Medicare or Medicaid payers, our business, operating results and financial condition could be harmed. Thus, the future impact of the ACA on our business is difficult to predict and its continued uncertain future may negatively impact our business. However, any material changes to the ACA or its implementing regulations may negatively impact our operations.

Similarly, the proposed Nursing Home Improvement Act may have an impact on our business due to the proposed two percent decrease in payments to skilled nursing facilities, as well as the staffing and reporting requirements contained within the bill. This bill primarily creates penalties such as reduced reimbursement and monetary penalties for submitting inaccurate cost reports or staffing data. If passed in its current form, however, this bill would provide participating states with a temporary enhanced federal Medicaid match to fund improvements in nursing home workforce and care. This match would last six years, and states would be responsible for showing CMS that Medicaid reimbursement increases were used to increase worker wages and yield new training resources and opportunities for nursing home staff. While it is difficult to determine whether the Nursing Home Improvement Act will be amended prior to adoption, or even passed into law, if passed, this bill may negatively impact our business, with the scope and nature of its consequences unknown. However, based on recent statements by the Administration in its February 28, 2022 fact sheet and President Biden's March 1, 2022 State of the Union Address, HHS and CMS are being instructed to study the nursing home industry, specifically with regard to staffing levels, and the Administration has called for greater oversight of LTC and SNF facilities—including greater penalties for non-compliance with federal laws and regulations. On April 11, 2022, the CMS issued a proposed rule that requested information to be used for study and potential rulemaking consistent with the Administration's February 28, 2022 fact sheet. Based upon this activity, HHS and CMS are expected to issue new rules that may subject our business to greater oversight, increase penalties that the Government may seek to impose upon us, and impose additional conditions and measurements to the reimbursement we receive from Medicare and Medicaid.

We cannot predict what effect future reforms to the U.S. healthcare system 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 or increase the cost of doing business and adversely affect our business.

***The results of recent U.S. Presidential and Congressional elections, and upcoming midterm elections in 2022, for which certain primary campaigns are already underway, may create significant changes to regulatory framework, enforcements and reimbursements.***

The recent Presidential and Congressional elections in the United States and upcoming midterm elections in 2022, could result in significant changes in, and uncertainty with respect to, legislation, regulation, implementation or repeal of laws and rules related to government health programs, including Medicare and Medicaid. Democratic proposals for Medicare for All or significant expansion of Medicare, could significantly impact our business and the healthcare industry if implemented. Further, if proposed policies specific to nursing facilities are implemented, these may result in significant regulatory changes, increased survey frequency and scope, and increased penalties for non-compliance.

We continually monitor these developments in order to respond to the changing regulatory environment impacting our business. While it is not possible to predict whether and when any such changes will occur, specific proposals discussed during and after the election, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

***Our business may be materially impacted if certain aspects of the ACA are amended, repealed, or successfully challenged.***

A number of lawsuits have been filed challenging various aspects of the ACA and related regulations. In addition, the efficacy of the ACA is the subject of much debate among members of Congress and the public. Cases challenging the ACA or related rules have had inconsistent outcomes - some expand the ACA while others limit the ACA. Thus, the future impact of the ACA on our business is difficult to predict. The uncertainty as to the future of the ACA may negatively impact our business, as will any material changes to the ACA.

Presidential and Congressional elections in the United States and the upcoming midterm elections of 2022 could result in significant changes to, and uncertainty with respect to, legislation, regulation, implementation or repeal of the ACA, and other federal health program policy that could significantly impact our business and the healthcare industry. In the event that legal challenges are successful or the ACA is repealed or materially amended, particularly any elements of the ACA that are beneficial to our business or that cause changes in the health insurance industry, including reimbursement and coverage by private, Medicare or Medicaid payers, our business, operating results and financial condition could be harmed. While it is not possible to predict whether and when any such changes will occur, specific proposals discussed during and after the election, including a repeal or material amendment of the ACA, could harm our business, operating results and financial condition. In addition, even if the ACA is not amended or repealed, the President and the executive branch of the federal government, as well as CMS and HHS have a significant impact on the implementation of the provisions of the ACA, and a new administration could make changes impacting the implementation and enforcement of the ACA, which could harm our business, operating results and financial condition. If we are slow or unable to adapt to any such changes, our business, operating results and financial condition could be adversely affected.

***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. We are subject to regulatory reviews relating to Medicare services, billings and potential overpayments resulting from Recovery Audit Contractors, Zone Program Integrity Contractors, Program Safeguard Contractors, Unified Program Integrity Contractors, Supplemental Medical Review Contractors and Medicaid Integrity Contractors programs, (collectively referred to as Reviews), in which third party firms engaged by CMS conduct extensive reviews of claims data and medical and other records to identify potential improper payments under the Medicare programs. As discussed above, the Administration has called for HHS and CMS to increase the scrutiny of these audits and has requested those agencies adopt rules that would impose greater penalties upon non-compliant LTC and SNF operators and CMS issued its first proposed rule seeking information regarding these priorities on April 11, 2022. 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;
- temporary or permanent 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, our Medicare administrative contractors began to conduct selected reviews of claims previously submitted by and paid to some of our affiliated 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 intermediaries. All findings of overpayment from CMS contractors are eligible for appeal through the CMS defined continuum. With the exception of rare findings of overpayment related to objective errors in Medicare payment methodology or claims processing, we utilize all defenses reasonably available to us to demonstrate that the services provided meet all clinical and regulatory requirements for reimbursement.

In cases where claim and documentation review by any CMS contractor results in repeated poor performance, an operation can be subjected to protracted oversight. This oversight may include repeat education and re-probe, extended pre-payment review, referral to recovery audit or integrity contractors, or extrapolation of an error rate to other reimbursement outside of specifically reviewed claims. Sustained failure to demonstrate improvement towards meeting all claim filing and documentation requirements could ultimately lead to Medicare decertification. As of March 31, 2022 and since, 19 of our independent operating subsidiaries had Reviews scheduled, on appeal, or in a dispute resolution process, either pre- or post-payment. We anticipate that these Reviews could increase in frequency in the future.

Additionally, 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 we should agree to a settlement of, claims or obligations under federal Medicare statutes, the federal FCA, 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 or other arrangement with the government.

If the government or court were to conclude that errors and deficiencies constitute criminal violations, concluded 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 civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we or some of the key personnel of our operating subsidiaries could be temporarily or permanently excluded from future participation in state and federal healthcare reimbursement programs such as Medicaid and Medicare.

If any of our affiliated 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 affiliated facilities could harm our reputation for quality care and lead to a reduction in the patient referrals of our operating subsidiaries and ultimately a reduction in occupancy at these facilities. Also, responding to auditing and enforcement efforts diverts 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.

***We are subject to extensive and complex laws and government regulations. If we are not operating in compliance with these laws and regulations or if these laws and regulations change, we could be required to make significant expenditures or change our operations in order to bring our facilities and operations into compliance.***

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:

- licensure and certification;
- adequacy and quality of healthcare services;
- qualifications and vaccination 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;
- addition of facilities and services; and
- billing 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. As noted above, the Administration has called upon HHS and CMS to study and propose new rules regarding staffing requirements and reimbursement for the nursing home industry, including tying reimbursement to staffing levels, salary, benefits, and retention and CMS issued its first proposed rule seeking information regarding these priorities on April 11, 2022. 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. Additionally, in the future, different interpretations or enforcement of these laws and regulations could subject our current or past practices to allegations of impropriety or illegality or could require us to make changes in our facilities, equipment, personnel, services, capital expenditure programs and operating expenses.

As discussed in greater detail in Item 2., under *Government Regulation*, we are subject to federal and state laws intended to prevent healthcare fraud and abuse, including the federal FCA, state false claims acts, the illegal remuneration provisions of the Social Security Act, the Anti-Kickback Statute, state anti-kickback laws, the Civil Monetary Penalties Law and the federal “Stark” Law. 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. 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 a corporate integrity agreement, deferred prosecution or similar agreements with state or federal government agencies, and become subject to significant civil and criminal penalties.

These anti-fraud and abuse laws and regulations are complex, and we do not always have the benefit of significant regulatory or judicial interpretation of these laws and regulations. While we do not believe we are in violation of these prohibitions, we cannot assure you that governmental officials charged with the responsibility for enforcing these prohibitions will not assert that we are violating the provisions of such laws and regulations. Our company is currently aware of another investigation by the DOJ related to allegations some of our California facilities may have violated the FCA or the Anti-Kickback Statute with respect to the relationships between certain of our skilled nursing facilities and persons who served as medical directors, advisory board participants or other referral sources. While our operating entities maintain policies and procedures to promote compliance with the FCA, the Anti-Kickback Statute, and other applicable regulatory requirements, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on our company.

We are unable to predict the future course of federal, state and local regulation or legislation, including Medicare and Medicaid statutes and regulations related to fraud and abuse, the intensity of federal and state enforcement actions or the extent and size of any potential sanctions, fines or penalties. Changes in the regulatory framework, 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 enforcement sanctions, fines or penalties could have a material adverse effect upon our business, financial condition or results of operations. Furthermore, should we lose licenses or certifications for a number of our facilities or other businesses as a result of regulatory action or legal proceedings, we could be deemed to be in default under some of our agreements, including agreements governing outstanding indebtedness.

***Public and government calls for increased survey and enforcement efforts toward LTC facilities, and potential rulemaking that may result in enhanced enforcement and penalties, could result in increased scrutiny by state and federal survey agencies. In addition, potential sanctions and remedies based upon alleged regulatory deficiencies could negatively affect our financial condition and results of operations.***

As CMS turns its attention to enhancing enforcement of LTC facilities, as discussed in Item 2., under *Government Regulation*, state survey agencies will have more accountability for their survey and enforcement efforts. As discussed in Item 2., under *Government Regulation*, 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 and state to state. 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 license to a conditional or provisional status, 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.

Furthermore, in some states, citations in one company facility could negatively impact other company facilities in the same 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 overall of operations results.

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. If we elect to voluntary close any operations in the future or to opt to stop accepting new patients pending completion of a state or federal survey, it could negatively impact our financial condition and results of operation.

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 affiliated facilities. We have had affiliated facilities placed on special focus facility status in the past, continue to have some facilities on this status currently and other operating subsidiaries may be identified for such status in the future. We currently have no facilities placed on special focus facility status.

***Future cost containment initiatives undertaken by private third-party payors may limit our revenue and profitability.***

Our non-Medicare and non-Medicaid revenue and profitability are affected by continuing efforts of third-party payors to maintain or reduce costs of healthcare by lowering payment rates, narrowing the scope of covered services, increasing case management review of services and negotiating pricing. In addition, sustained unfavorable economic conditions may affect the number of patients enrolled in managed care programs and the profitability of managed care companies, which could result in reduced payment rates. There can be no assurance that third party payors will make timely payments for our services, or that we will continue to maintain our current payor or revenue mix. We are continuing our efforts to develop our non-Medicare and non-Medicaid sources of revenue and any changes in payment levels from current or future third-party payors could have a material adverse effect on our business and consolidated financial condition, results of operations and cash flows.

***Changes in Medicare reimbursements for physician and non-physician services could impact reimbursement for medical professionals.***

As discussed in greater detail in Item 2., under *Government Regulation*, MACRA revised the payment system for physician and non-physician services. Section 1 of that law, the sustainable growth rate repeal and Medicare Provider Payment Modernization will impact payment provisions for medical professional services. That enactment also extended for two years provisions that permit an exceptions process from therapy caps imposed on Medicare Part B outpatient therapy. There was a combined cap for PT and SLP and a separate cap for OT services that apply subject to certain exceptions. On February 9, 2018, the BBA was signed into law, which provides for the repeal of all therapy caps retroactively to January 1, 2018. The law also reduced the monetary threshold that triggers a manual medical review (MMR), in certain instances (from $3,700 to $3,000). The reduction in the MMR threshold will likely result in increased number of reviews, which could in turn have a negative effect on our business, financial condition or results of operations. Additionally, potential changes in the SNF-VBP Program based on proposed rules may also reduce the reimbursement we receive.

***We may be subject to increased investigation and enforcement activities related to HIPAA violations.***

We are required to comply with numerous legislative and regulatory requirements at the federal and state levels addressing patient privacy and security of health information, as discussed in greater detail in Item 2., under *Government Regulation*. HIPAA, as amended by the HITECH Act, requires us to adopt and maintain business procedures and systems designed to protect the privacy, security and integrity of patients' individual health information. States also have laws that apply to the privacy of healthcare information. We must comply with these state privacy laws to the extent that they are more protective of healthcare information or provide additional protections not afforded by HIPAA. If we fail to comply with these state and federal laws, we could be subject to criminal penalties, civil sanctions, litigation, and be forced to modify our policies and procedures. Additionally, if a breach under HIPAA or other privacy laws were to occur, remediation efforts could be costly and damage to our reputation could occur.

In addition to breaches of protected patient information, under HIPAA and the 21st Century Cures Act (Cures Act), healthcare entities are also required to afford patients with certain rights of access to their health information. Recently, the Office of Civil Rights, the agency responsible for HIPAA enforcement, has targeted investigative and enforcement efforts on violations of patients' rights of access, imposing significant fines for violations largely initiated from patient complaints. If we fail to comply with our obligations under HIPAA, we could face significant fines. Likewise, if we fail to comply with our obligations under the Cures Act, we could face fines from the Office of the National Coordinator for Health Information Technology, the agency responsible for Cures Act enforcement.

***Security breaches and other cyber-security incidents could violate security laws and subject us to significant liability.***

Healthcare businesses are increasingly the target of cyberattacks whereby hackers disrupt business operations or obtain protected health information, often demanding large ransoms. Our business is dependent on the proper functioning and availability of our computer systems and networks. While we have taken steps to protect the safety and security of our information systems and the patient health information and other data maintained within those systems, we cannot assure you that our safety and security measures and disaster recovery plan will prevent damage, interruption or breach of our information systems and operations. Because the techniques used to obtain unauthorized access, disable or degrade service, or sabotage systems change frequently and may be difficult to detect, we may be unable to anticipate these techniques or implement adequate preventive measures. In addition, hardware, software or applications we develop or procure from third parties may contain defects in design or manufacture or other problems that could unexpectedly compromise the security of our information systems. Unauthorized parties may attempt to gain access to our systems or facilities, or those of third parties with whom we do business, through fraud or other forms of deceiving our employees or contractors.

On occasion, we have acquired additional information systems through our business acquisitions, and these acquired systems may expose us to risk. We also license certain third-party software to support our operations and information systems. Our inability, or the inability of third-party software providers, to continue to maintain and upgrade our information systems and software could disrupt or reduce the efficiency of our operations. In addition, costs and potential problems and interruptions associated with the implementation of new or upgraded systems and technology or with maintenance or adequate support of existing systems also could disrupt or reduce the efficiency of our operations.

A cyber-attack or other incident that bypasses our information systems security could cause a security breach which may lead to a material disruption to our information systems infrastructure or business and may involve a significant loss of business or patient health information. If a cyber-attack or other unauthorized attempt to access our systems or facilities were to be successful, it could result in the theft, destructions, loss, misappropriation or release of confidential information or intellectual property, and could cause operational or business delays that may materially impact our ability to provide various healthcare services. Any successful cyber-attack or other unauthorized attempt to access our systems or facilities also could result in negative publicity which could damage our reputation or brand with our patients, referral sources, payors or other third parties and could subject us to a number of adverse consequences, the vast majority of which are not insurable, including but not limited to disruptions in our operations, regulatory and other civil and criminal penalties, fines, investigations and enforcement actions (including, but not limited to, those arising from the SEC, Federal Trade Commission, Office of Civil Rights, the OIG or state attorneys general), fines, private litigation with those affected by the data breach, loss of customers, disputes with payors and increased operating expense, which either individually or in the aggregate could have a material adverse effect on our business, financial position, results of operations and liquidity.

***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 patients 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. Although this provision applies to a limited number of DRGs, it has 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.

***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 and other skilled personnel, such as Certified Nurse Assistants, social workers and speech, physical and occupational 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 affiliated 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 affiliated skilled nursing facilities in the states of Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. 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. Deficiencies (depending on the level) may also result in the suspension of patient admissions and the termination of Medicaid participation, or the suspension, revocation or non-renewal 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, including the increased scrutiny on staffing at the state and federal levels as a result of the COVID-19 virus. The broader labor market where we compete is in a unique state of disequilibrium where the needs of businesses such as ours outstrip the supply of available and willing workers. There is additional upward pressure on wages from different industries, some of which compete with us for labor and others that do not, which makes it difficult to make significant hourly wage and salary increases due to the fixed nature of our reimbursement under insurance contracts as well as Medicare and Medicaid, in addition to our increasing variable costs. Due to the limited supply of qualified applicants who seek or are willing to accept employment, these broader concerns, as well as those specific to both forthcoming federal COVID-19 vaccination mandates and existing state mandates, may increase our labor costs or lead to potential staffing shortages, reduced operations to comply with applicable laws and regulations, or difficulty complying with those laws and regulations at current operational levels.

Federal laws and regulations may increase our costs of maintaining qualified nursing and skilled personnel, or make it more difficult for us to attract or retain qualified nurses and skilled staff members. The proposed Nursing Home Improvement Act, if passed into law in substantially the same form as the proposed bill, may increase our responsibility to provide nursing coverage and the costs associated with that increased coverage. The Administration’s February 28, 2022 fact sheet regarding the nursing home industry demonstrates its desire to have HHS and CMS study staffing level requirements and to tie Medicare and Medicaid reimbursement to the salary, benefits, and retention of staff. On April 11, 2022, CMS issued a proposed rule that requested information regarding LTC staffing level requirements. These requirements may also increase our operating costs and require additional compensation to be paid to employees in the form of wages and benefits. We are monitoring our facilities for potential effects from CMS's IFR requiring employees of Medicare and Medicaid-participating medical facilities to be vaccinated, which may cause disruption to our affiliated facilities’ nursing staff and may additionally disrupt our operations if affected personnel decline to be vaccinated and replacement staffing cannot be located. On November 5, 2021, CMS issued the IFR discussed under Item 2, *Government Regulations*, requiring all eligible staff to receive their first dose of a two-dose primary vaccination series by December 5, 2021 and the second dose of a two-dose primary vaccination series by January 4, 2022. CMS’s enforcement of this IFR was temporarily blocked in certain states pending appeal to the United States Supreme Court. On January 13, 2022, the United States Supreme Court entered an order allowing CMS’s enforcement of the IFR and its vaccination requirements by March 15, 2022 for our operating subsidiaries in Arizona, Idaho, Iowa, Kansas, Nebraska, South Carolina and Utah and by February 28, 2022 for all of our other operating subsidiaries except those in Texas (which, as discussed below, is now subject to the IFR).

Similar state-level requirements in the states where our affiliated skilled nursing facilities operate, whether such requirements are passed by statute, regulation, or executive order, may result in a shortage or inability to obtain nurses and skilled staff. As noted above, California, Washington, and Colorado have all mandated vaccinations for workers in health care facilities that include nursing homes. These administrative mandates precede, may be more restrictive than and are not likely to be preempted by CMS's IFR. On October 11, 2021, Texas issued an executive order banning the practice of mandating vaccination, including by private employers. On January 20, 2022, the United States District Court for the Northern District of Texas dismissed the State of Texas’s lawsuit against CMS’s enforcement of the IFR’s vaccine mandate upon the request of the State of Texas. The District Court’s dismissal of the Texas's lawsuit ended the court’s injunction against CMS’s enforcement of the IFR's vaccine mandate in Texas. On January 20, 2022, CMS became empowered to enforce the IFR in Texas and set a deadline of March 21, 2022 for full compliance with its vaccination requirements.

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 the patients of our operating subsidiaries. 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 could be harmed.

***Annual caps and other cost-reductions for outpatient therapy services may reduce our future revenue and profitability or cause us to incur losses.***

As discussed in detail in Item 2., under *Government Regulation*, sub-heading *Part B Rehabilitation Requirements*, several government actions have been taken in recent years to try and contain the costs of rehabilitation therapy services provided under Medicare Part B, including the MPPR, institution of annual caps, mandatory medical reviews for annual claims beyond a certain monetary threshold, and a reduction in reimbursement rates for therapy assistant claim modifiers. Of specific concern is CMS's decision to lower Medicare Part B reimbursement rates for outpatient therapy services by 9%, beginning in January 1, 2021. Such cost-containment measures and ongoing payment changes could have an adverse effect on our revenue.

***The Office of the Inspector General or other regulatory authorities may choose to more closely scrutinize billing practices in areas where we operate or propose to expand, which could result in an increase in regulatory monitoring and oversight, decreased reimbursement rates, or otherwise adversely affect our business, financial condition and results of operations.***

As discussed in greater detail in Item 2., under Government Regulation, Civil and Criminal Fraud and Abuse Laws and Enforcement, the OIG regularly conducts investigations regarding certain payment or compliance issues within various healthcare sectors. Following these investigation, the OIG publishes reports, in part, to educate involved stakeholders and signal future enforcement focus. Reports published in 2019 and 2020 demonstrate the OIG's increased scrutiny on post-hospital skilled nursing facility care and billing. This may impact the skilled nursing facility industry by motivating additional reviews and stricter compliance in the areas outlined in the recent reports, expending material time and resources. Recent publications and statements by the Administration have also called for greater scrutiny of SNF and LTC facilities, and calling for more authorities to impose penalties and other remedies on facilities that violate federal laws and regulations.

Additionally, OIG reports published in 2010 and 2015 show the OIG's concerns related to the billing practices of skilled nursing facilities based on Medicare Part A claims and financial incentives for facilities to bill for higher levels of therapies, even when not needed by patients. In its fiscal year 2014 work plan, and again in 2017, OIG specifically stated that it will continue to study and report on questionable Part A and Part B billing practices amongst skilled nursing facilities. Recently, in its 2021 work plan, OIG stated it will evaluate whether payments to SNFs under PDPM complied with Medicare requirements. OIG's 2022 work plan states it will use a series of audits to confirm compliance with COVID-19 vaccination requirements for LTC facility staff and will study nursing home emergency preparedness—particularly with managing resident care and collaborating with other health care providers. The study findings of nursing home emergency preparedness will be used to develop a key performance indicator to track challenges faced by nursing homes over time.

Our business model, like those of some other for-profit operators, is based in part on seeking out higher-acuity patients whom we believe are generally more profitable, and over time our overall patient mix has consistently shifted to higher-acuity and higher-resource utilization patients in most facilities we operate. We also use specialized care-delivery software that assists our caregivers in more accurately capturing and recording activities of daily living services, among other things. These efforts may place us under greater scrutiny with the OIG, CMS, our fiscal intermediaries, recovery audit contractors and others.

***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: (i) the purchase, construction or expansion of healthcare facilities; (ii) capital expenditures exceeding a prescribed amount; or (iii) 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 establishment 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. In addition, some states require the approval of the state Attorney General for acquisition of a facility being operated by a non-profit organization.

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, state Attorney General approval 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 to federal and state employment-related laws and regulations could increase our cost of doing business.***

Our operating subsidiaries 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 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 EEOC, 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. On November 5, 2021, OSHA issued an ETS requiring employers with more than 100 employees to have employees who were not fully vaccinated to complete weekly testing to prove they were not infected with COVID-19 to remain in the workforce, which the United States Supreme Court blocked enforcement of on January 13, 2022 after nationwide litigation over the ETS. The uncertain environment regarding these mandates and potential attempts to enforce similar mandates in 2022 is one we are monitoring, as it represents a risk of uncertainty to the Company that may result in limitations on staff availability, disruption caused by staff departure, potential claims under the ADA and other laws and potential government sanctions which could cause disruptions to the operations of our subsidiaries, limit our ability to grow and otherwise adversely affect our business and financial results. Furthermore, the Administration has requested HHS and CMS study and issue proposed rules regarding the sustainability of care-based careers, including improving access to training, increasing the attractiveness of compensation in care-based positions, and improving the retention and career progression of care workers. The Administration has sought proposed rules that tie some of these issues, such as wages and retention, to Medicare reimbursement for facilities. Rising operating costs due to labor shortages, greater compensation and incentives required to attract and retain qualified personnel and higher-than-usual inflation on items including energy, utilities, food and other goods used in our facilities and the costs for transporting these items could increase our cost and decrease our profits.

The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our affiliated 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 be subject to 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.

***Required regulatory approvals could delay or prohibit transfers of our healthcare operations, which could result in periods in which we are unable to receive reimbursement for such properties.***

The operations of our operating subsidiaries must be licensed under applicable state law and, depending upon the type of operation, certified or approved as providers under the Medicare and/or Medicaid programs. In the process of acquiring or transferring operating assets, our operations must receive change of ownership approvals from state licensing agencies, Medicare and Medicaid as well as third party payors. The Administration has requested HHS and CMS issue proposed rules that may increase the scrutiny placed on companies that operate, directly or indirectly, multiple SNF and LTC facilities, and may subject our licensing and approval process to additional scrutiny or delays if such proposals are codified into regulations. If there are any delays in receiving regulatory approvals from the applicable federal, state or local government agencies, or the inability to receive such approvals, such delays could result in delayed or lost reimbursement related to periods of service prior to the receipt of such approvals, which could negatively impact our cash position.

***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 affiliated 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 affiliated 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 affiliated 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 affiliated facilities as well as payor mix and payment methodologies.***

Our revenue is affected by the percentage of the patients of our operating subsidiaries 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 three months ended March 31, 2022 and 2021, 73.4% and 74.1% of our service 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 the patients of our operating subsidiaries 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. Among other initiatives, 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.

On November 5, 2021, CMS issued the IFR discussed under Item 2, *Government Regulations*, subheading Coronavirus requiring all eligible staff to be fully vaccinated against COVID-19. CMS's enforcement of this IFR was temporarily blocked in certain states pending appeal to the United States Supreme Court. On January 13, 2022, the United States Supreme Court entered an order allowing CMS's enforcement of the IFR and its vaccination requirements by March 15, 2022 for our operating subsidiaries in Arizona, Idaho, Iowa, Kansas, Nebraska, South Carolina and Utah and by February 28, 2022 for all of our other operating subsidiaries except those in Texas. On January 20, 2022, CMS became empowered to enforce the IFR in Texas and set a deadline of March 21, 2022 for compliance with its vaccination requirements.

The IFR and its enforcement by CMS may cause disruption to our affiliated facilities' nursing staff and may further disrupt our operations if affected personnel decline to be vaccinated and replacement staff cannot be located. In the event we or our affiliated facilities do not comply with this requirement, our Medicare and Medicaid agreements could be terminated and the termination of those agreements may lead to other payors terminating their agreements with us or our affiliated facilities and operating subsidiaries. CMS terminating Medicare or Medicaid participation agreements and the loss of the payment agreements with private payors as a result of CMS terminating Medicare or Medicaid participation agreements with our affiliated facilities and operating subsidiaries would materially and adversely affect our business, financial condition and results of operations.

In addition to the IFR, the Administration has requested HHS and CMS conduct studies about additional requirements pertaining to staffing, data reporting, employee compensation and retention, and resident experience that may result in a reduction of our revenue from Medicare and Medicaid. CMS issued its first proposed rule seeking information regarding these priorities on April 11, 2022. These study results may result in additional conditions of participation within those programs. We anticipate that proposed rules regarding these issues will be issued in approximately one year, followed by a notice-and-comment period and the issuance of final rules. Until the proposed rules are issued, all that is known about their intended contents are the topics identified by the Administration and discussed under Item 2, *Government Regulations*.

***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 the patients and residents of our operating subsidiaries and the services we provide. The industry has experienced an increased trend in the number and severity of litigation claims, due in part to the number of large verdicts, including large punitive damage awards. These claims are filed based upon a wide variety of claims and theories, including deficiencies under conditions of participation under certain state and federal healthcare programs. Plaintiffs' attorneys have become increasingly more aggressive in their pursuit of claims against healthcare providers, including skilled nursing providers, employing a wide variety of advertising and solicitation activities to generate more claims. The defense of lawsuits has in the past, and may in the future, result in significant legal costs, regardless of the outcome. Additionally, increases to the frequency and/or severity of losses from such claims and suits may result in increased liability insurance premiums or a decline in available insurance coverage levels, which could materially and adversely affect our business, financial condition and results of operations.

We have in the past been subject to class action litigation involving claims of violations of various regulatory requirements. While we have been able to settle these claims without an ongoing material adverse effect on our business, future claims could be brought that may materially affect our business, financial condition and results of operations. Other claims and suits, including class actions, continue to be filed against us and other companies in our industry. For example, there has been a general increase in the number of wage and hour class action claims filed in several of the jurisdictions where we are present. Allegations typically include claimed failures to permit or properly compensate for meal and rest periods, or failure to pay for time worked. If there were a significant increase in the number of these claims against us or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could have a material adverse effect to our business, financial condition, results of operations and cash flows.

Beyond our skilled nursing business, we engage in numerous ancillary businesses through one or more of our subsidiaries. These ancillary businesses generally support and provide services complementary to our operations, including but not limited to non-emergent ground transportation for patients and residents of our facilities. Our ancillary businesses may also be the subject of claims, lawsuits, and regulatory oversight that are specific to the particular services they offer. Noncompliance with the laws and regulations that may apply to our ancillary businesses may result in fines, penalties, and civil claims paid by our affected independent subsidiaries. Specific to our non-emergent ground transportation business, the drivers employed by this business may be subject to additional state-specific regulations regarding working time allowed to be spent driving, waiting time, and break or rest periods, and violations of these rules may lead to regulatory fines, penalties, or claims to be paid to individual drivers, in addition to the general employment risks described above.

Our ancillary businesses also are susceptible to general liability claims based on facts and circumstances that are specific to their activities and operations. In the case of our non-emergent ground transportation business, this liability likely exists in the form of automobile-involved accidents, which may involve property, individuals, or other automobiles. The defense of automobile accident and general liability lawsuits relating to our ancillary businesses in the past, and may in the future, result in significant legal costs, regardless of the outcome. As our ancillary businesses grow, the independent subsidiaries may be subject to increased frequency and/or severity of losses from such claims and suits which may result in increased liability insurance premiums for those businesses or a decline in available insurance coverage levels, which could materially and adversely affect our business, financial condition and results of operations.

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.

If litigation is 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.

Congress has repeatedly considered, without passage, a bill that would require, among other things, that agreements to arbitrate nursing home disputes be made after the dispute has arisen rather than before prospective patients move in, to prevent nursing home operators and prospective patients from mutually entering into a pre-admission pre-dispute arbitration agreement. This bill, known as the Fairness in Nursing Home Arbitration Act, was introduced in the House of Representatives as a H.R. 5326 in 2019 and H.R. 2812 in 2021; neither bill made it out of the committees to which it was referred for discussion to be voted on by the entire House of Representatives. 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.

***We conduct regular internal investigations into the care delivery, recordkeeping and billing processes of our operating subsidiaries. These reviews sometimes detect instances of noncompliance which we attempt to correct, which can decrease our revenue.***

As an operator of healthcare facilities, we have a program to help us comply with various requirements of federal and private healthcare programs. Our compliance program includes, among other things, (i) policies and procedures modeled after applicable laws, regulations, government manuals and industry practices and customs that govern the clinical, reimbursement and operational aspects of our subsidiaries; (ii) training about our compliance process for all of the employees of our operating subsidiaries, our directors and officers, and training about Medicare and Medicaid laws, fraud and abuse prevention, clinical standards and practices, and claim submission and reimbursement policies and procedures for appropriate employees; and (iii) internal controls that monitor, for example, the accuracy of claims, reimbursement submissions, cost reports and source documents, provision of patient care, services, and supplies as required by applicable standards and laws, accuracy of clinical assessment and treatment documentation, and implementation of judicial and regulatory requirements (i.e., background checks, licensing and training).

From time to time our systems and controls highlight potential compliance issues, which we investigate as they arise. Historically, we have, and would continue to do so in the future, initiated internal inquiries into possible recordkeeping and related irregularities at our affiliated skilled nursing facilities, which were detected by our internal compliance team in the course of its ongoing reviews.

Through these internal inquiries, we have identified potential deficiencies in the assessment of and recordkeeping for small subsets of patients. We have also identified and, at the conclusion of such investigations, assisted in implementing, targeted improvements in the assessment and recordkeeping practices to make them consistent with the existing standards and policies applicable to our affiliated skilled nursing facilities in these areas. We continue to monitor the measures implemented for effectiveness and perform follow-up reviews to ensure compliance. 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.

If additional reviews result in identification and quantification of additional amounts to be refunded, we will accrue additional liabilities for claim costs and interest, and repay any amounts due in normal course. Furthermore, failure to refund overpayments within required time frames (as described in greater detail above) could result in FCA liability. 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 or business acquisitions at attractive prices or at all, which may adversely affect our revenue; we may also elect to dispose of underperforming or non-strategic operating subsidiaries, which would also decrease our revenue.***

To date, our revenue growth has been significantly impacted by our acquisition of new facilities and businesses. 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 and business acquisition opportunities that are consistent with our geographic, financial and operating objectives.

We face competition for the acquisition of facilities and businesses and expect this competition to increase. Based upon factors such as our ability to identify suitable acquisition candidates, future regulations affecting the ability to purchase facilities, 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, 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, either because they were included in larger, indivisible groups of facilities or under other circumstances. To the extent we dispose of such a facility without simultaneously acquiring a facility in exchange, our revenue may decrease.

***We may not be able to successfully integrate acquired facilities and businesses 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 of facilities and businesses with our existing operating subsidiaries, culture and systems. The process of integrating acquisitions 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 operations 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 acquisitions into our existing operations. We may not be able to recover the costs incurred to reposition or renovate newly operating subsidiaries. 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 operations 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 the operating subsidiaries we acquire, we will not realize the anticipated benefits and we may experience lower than anticipated profits, or even losses.

During the three months ended March 31, 2022, we expanded our operations through long-term leases and real estate purchases, with the addition of four stand-alone skilled nursing operations. In addition, the Company added two senior living operations that were transferred from Pennant, one of which is part of a campus operated by the Company's affiliated operating subsidiaries. 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 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 operating subsidiaries and patient care at affiliated 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.

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 determines 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. 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. Anticipated future regulations may cause delays in acquiring the required licenses and certifications, if it is possible to do so at all. 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.

***If we do not achieve or maintain competitive quality of care ratings from CMS or private organizations engaged in similar monitoring activities, our business may be negatively affected.***

CMS, as well as certain private organizations engaged in similar monitoring activities, provides comparative public data, rating every skilled nursing facility operating in each state based upon quality-of-care indicators. CMS's system is the Five-Star Quality Rating System, introduced in 2008, 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, and the ratings are available on a consumer-facing website, Nursing Home Compare. In cases of acquisitions, the previous operator's clinical ratings are included in our overall Five-Star Quality Rating. Over the years, the Five-Star Quality Rating System has been modified, with the most recent changes being implemented in 2018 and 2019. Additionally, as a result of the COVID-19 pandemic and CMS's suspension or modification of certain inspection and reporting requirements, the data used to calculate the star ratings of facilities was interrupted. CMS temporarily froze certain data on the Nursing Home Compare website through January 2021, and recalculated its Five Star Quality ratings with modified data used to calculate the nursing home's rating. Other data related to quality reporting measures, including new or worsened pressure-related injuries and discharges to home, are not presently factored into CMS's star calculations. This data is reflected on the Nursing Home Compare website based on the recalculation in January of 2022. The temporary adjustments due to COVID-19 could impact facilities that might have less favorable Five-Star Ratings from being able to demonstrate improvements on the public-facing website through mid-2022. The Administration has indicated that it wishes to collect more data to be reported on the Nursing Home Compare website, and to make the reported data more readily accessible and understandable for consumers. This may lead to more scrutiny in the marketplace and may adversely affect our scoring depending on the data to be reported and the manner in which it is displayed on the Nursing Home Compare website. For more information on these changes and proposed future alterations, see Item 2., under *Government Regulation.*

CMS continues to increase quality measure thresholds, making it more difficult to achieve upward ratings. CMS acknowledges that some facilities may see a decline in their overall five-star rating absent any new inspection information. This change could further affect star ratings across the industry. Additionally, on the Nursing Home Compare website, CMS recently began displaying a consumer alert icon next to nursing homes that have been cited on inspection reports for incidents of abuse, neglect, or exploitation. See Item 2., under *Government Regulation.*

Providing quality patient care is the cornerstone of our business. We believe that hospitals, physicians and other referral sources refer patients to us in large part because of our reputation for delivering quality care. If we should fail to achieve our internal rating goals or fail to exceed the national average rating on the Five-Star Quality Rating System, or have facilities displaying a consumer alert icon for incidents of abuse, neglect, or exploitation, it may affect our ability to generate referrals, which could have a material adverse effect upon our business and consolidated financial condition, results of operations and cash flows.

***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, automobile 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.

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.

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 and deductibles in connection with general and professional liability claims. We also have implemented a self-insurance program for workers compensation in all states, except Washington, and elected non-subscriber status for workers' compensation in Texas. In Washington, the insurance coverage is financed through premiums paid by the employers and employees. Due to the nature of our business and the residents we serve, including the risk of claims from residents as well as potential governmental action, it may be difficult to complete the underwriting process and obtain insurance at commercially reasonable rates. 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.***

We have maintained general and professional liability insurance since 2002 and workers' compensation insurance since 2005 through a wholly-owned captive insurance subsidiary to insure our self-insurance reimbursements and deductibles as part of a continually evolving overall risk management strategy. We establish the insurance loss reserves 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 self-insurance reimbursements 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.

We also self-insure our employee health benefits. With respect to our health benefits self-insurance, our reserves and premiums are computed based on a mix of company specific and general industry data that is not specific to our own company. 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 frequency and magnitude of claims and legal costs may increase due to the COVID-19 pandemic or our related response efforts.

***The geographic concentration of our affiliated facilities could leave us vulnerable to an economic downturn, regulatory changes or acts of nature in those areas.***

Our affiliated facilities located in Arizona, California, and Texas 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 over 21% of our affiliated 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, our affiliated facilities in Iowa, Nebraska, Kansas, South Carolina, Washington and Texas are more susceptible to revenue loss, cost increases or damage caused by natural disasters including hurricanes, tornadoes and flooding. These acts of nature may cause disruption to us, the employees of our operating subsidiaries and our affiliated facilities, which could have an adverse impact on the patients of our operating subsidiaries and our business. In order to provide care for the patients of our operating subsidiaries, we are dependent on consistent and reliable delivery of food, pharmaceuticals, utilities and other goods to our affiliated facilities, and the availability of employees to provide services at our affiliated facilities. If the delivery of goods or the ability of employees to reach our affiliated facilities were interrupted in any material respect due to a natural disaster or other reasons, it would have a significant impact on our affiliated facilities and our business. Furthermore, the impact, or impending threat, of a natural disaster may require that we evacuate one or more facilities, which would be costly and would involve risks, including potentially fatal risks, for the patients. The impact of disasters and similar events is inherently uncertain. Such events could harm the patients and employees of our operating subsidiaries, severely damage or destroy one or more of our affiliated facilities, harm our business, reputation and financial performance, or otherwise cause our business to suffer in ways that we currently cannot predict.

***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 the employees of our operating subsidiaries about our views of the potential impact of unionization upon the workplace generally and upon individual employees. With one exception, to our knowledge the staff at our affiliated facilities that have been approached to unionize have uniformly rejected union organizing efforts. Forthcoming proposed rules from HHS and CMS, which, based on the Administration's statements, are anticipated within the next year, may increase the likelihood of employee unionization. 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.

***Because we lease the majority of our affiliated facilities, we are subject to risks associated with leased real property, including risks relating to lease termination, lease extensions and special charges, any of which could adversely affect our business, financial position or results of operations.***

As of March 31, 2022, we leased 179 of our 250 affiliated facilities. Most of our leases are triple-net leases, which means that, in addition to rent, we are required to pay for the costs related to the property (including property taxes, insurance, and maintenance and repair costs). We are responsible for paying these costs notwithstanding the fact that some of the benefits associated with paying these costs accrue to the landlords as owners of the associated facilities.

Each lease provides that the landlord may terminate the lease for a variety of reasons, including the default in any payment of rent, taxes or other payment obligations or the breach of any other covenant or agreement in the lease. Termination of a lease could result in a default under our debt agreements and could adversely affect our business, financial position or results of operations. There can be no assurance that we will be able to comply with all of our obligations under the leases in the future.

***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 operating subsidiaries and cause us to lose facilities or experience foreclosures.***

Our Amended Credit Facility provides a revolving line of credit of up to $600.0 million in aggregate principal amount. As of April 26, 2022, we have no outstanding debt under our Amended Credit Facility. Twenty-three of our subsidiaries have mortgage loans insured with Department of Housing and Urban Development (HUD) for an aggregate amount of $155.9 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The terms of the mortgage loans range from 25- to 35-years.

We also have one outstanding promissory note with an aggregate principal amount of approximately $3.1 million as of March 31, 2022. The term of the note is 12 years. Because this mortgage loan is insured with HUD, our borrower subsidiary under the loan is subject to HUD oversight and periodic inspections.

In addition, we had $2.0 billion of future operating lease obligations as of March 31, 2022. We intend to continue financing our operating subsidiaries 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, our outstanding Credit Facility 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, project yield, net leverage ratios, minimum interest coverage ratios and minimum asset coverage ratios. These restrictions may interfere with our ability to obtain additional advances under our existing Credit Facility or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue.

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 term loans, promissory notes, bonds, mortgages 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 operating subsidiaries, 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.

***Move-in and occupancy rates may remain unpredictable even after the COVID-19 pandemic is over.***

Occupancy levels at skilled nursing facilities are likely to remain vulnerable to the effects of COVID-19 even after the pandemic is over. Facilities experiencing decreases in move-in rates in 2021 cite resident or family member concerns as the basis for such decreases. These and other similar concerns may continue to impact our ability to attract new residents and our ability to retain existing residents.

***A housing downturn could decrease demand for senior living services.***

Seniors often use the proceeds of home sales to fund their admission to senior living facilities. A downturn in the housing markets could adversely affect seniors' ability to afford our resident fees and entrance fees. If national or local housing markets enter a persistent decline, our occupancy rates, revenues, results of operations and cash flow could be negatively impacted.

***As we continue to acquire and lease real estate assets, we may not be successful in identifying and consummating these transactions.***

As part of, and subsequent to, the Spin-Off, we lease 32 of our properties to Pennant's senior living operations. In the future, we might expand our leasing property portfolio to additional Pennant operations or other unaffiliated tenants. We have very limited control over the success or failure of our tenants' and operators' businesses and, at any time, a tenant or operator may experience a downturn in its business that weakens its financial condition. If that happens, the tenant or operator may fail to make its payments to us when due. Although our lease agreements give us the right to exercise certain remedies in the event of default on the obligations owing to us, we may determine not to do so if we believe that enforcement of our rights would be more detrimental to our business than seeking alternative approaches.

An important part of our business strategy is to continue to expand and diversify our real estate portfolio through accretive acquisition and investment opportunities in healthcare properties. Our execution of this strategy by successfully identifying, securing and consummating beneficial transactions is made more challenging by increased competition and can be affected by many factors, including our relationships with current and prospective tenants, our ability to obtain debt and equity capital at costs comparable to or better than our competitors and our ability to negotiate favorable terms with property owners seeking to sell and other contractual counterparties. Our competitors for these opportunities include healthcare REITs, real estate partnerships, healthcare providers, healthcare lenders and other investors, including developers, banks, insurance companies, pension funds, government-sponsored entities and private equity firms, some of whom may have greater financial resources and lower costs of capital than we do. Potential regulations may affect the ability of these entities, as well as ourselves, to compete for these opportunities or enter into transactions for real estate related to our business. If we are unsuccessful at identifying and capitalizing on investment or acquisition opportunities, our growth and profitability in our real estate investment portfolio may be adversely affected.

Investments in and acquisitions of healthcare properties entail risks associated with real estate investments generally, including risks that the investment will not achieve expected returns, that the cost estimates for necessary property improvements will prove inaccurate or that the tenant or operator will fail to meet performance expectations. Income from properties and yields from investments in our properties may be affected by many factors, including changes in governmental regulation (such as licensing and government payment), general or local economic conditions (such as fluctuations in interest rates, senior savings, and employment conditions), the available local supply of and demand for improved real estate, a reduction in rental income as the result of an inability to maintain occupancy levels, natural disasters (such as hurricanes, earthquakes and floods) or similar factors. Furthermore, healthcare properties are often highly customized, and the development or redevelopment of such properties may require costly tenant-specific improvements. As a result, we cannot assure you that we will achieve the economic benefit we expect from acquisition or investment opportunities.

***As we expand our presence in other relevant healthcare industries, we would become subject to risks in a market in which we have limited experience.***

The majority of our affiliated facilities have historically been skilled nursing facilities. As we expand our presence in other relevant healthcare industries, our existing overall business model will continue to change and expose our company to risks in markets in which we have limited experience. We expect that we will have to adjust certain elements of our existing business model, which could have an adverse effect 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 affiliated 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.

***We may need additional capital to fund our operating subsidiaries 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 operating subsidiaries 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 affiliated 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, as well as negatively impact or impair the value of our current portfolio of cash, cash equivalents and investments, including U.S. Treasury securities and U.S.-backed investments.***

Our cash, cash equivalents and investments are held in a variety of interest-bearing instruments, including U.S. treasury securities. As a result of the uncertain domestic and global political, credit and financial market conditions, including an increase in the Consumer Price Index of seven percent in 2021, which is expected to continue for the foreseeable future in 2022, investments in these types of financial instruments pose risks arising from liquidity and credit concerns. Given that future deterioration in the U.S. and global credit and financial markets is a possibility, no assurance can be made that losses or significant deterioration in the fair value of our cash, cash equivalents, or investments will not occur. Uncertainty surrounding the trading market for U.S. government securities or impairment of the U.S. government's ability to satisfy its obligations under such treasury securities could impact the liquidity or valuation of our current portfolio of cash, cash equivalents, and investments, a substantial portion of which were invested in U.S. treasury securities. Further, continued domestic and international political uncertainty, along with credit, and financial market uncertainty, may make it difficult for us to liquidate our investments prior to their maturity without incurring a loss, which would have a material adverse effect on our consolidated financial position, results of operations or cash flows.

We may need additional capital if a substantial acquisition or other growth opportunity becomes available or if unexpected events occur or opportunities arise. U.S. capital markets can be volatile. We cannot assure you that additional capital will be available or available on terms acceptable 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 billing 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.

Some states in which we operate are operating with budget deficits or could have budget deficit in the future, which may delay reimbursement in a manner that would adversely affect our liquidity. In addition, from time to time, procedural issues require us to resubmit claims before payment is remitted, which contributes to our aged receivables. Unanticipated delays in receiving reimbursement from state programs due to changes in their policies or billing or audit procedures may adversely impact our liquidity and working capital.

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

Twenty-three of our affiliated facilities are currently subject to regulatory agreements with 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. 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.

***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 affiliated 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. 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.

***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 revenue. Each of our affiliated 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 stockholders, agreements of those subsidiaries, the terms of our financing arrangements and the terms of any future financing arrangements of our subsidiaries.

***We may incur operational difficulties or be exposed to claims and liabilities as a result of the separation of Pennant.***

On October 1, 2019, we distributed all of the outstanding shares of The Pennant Group, Inc. or Pennant, common stock to stockholders in connection with the separation of our home health and hospice business and substantially all of our senior living operations into a separate publicly traded company, or the Spin-Off. In connection with the Spin-Off, we entered into a separation agreement and various other agreements, including a tax matters agreement, an employee matters agreement and transition services agreements. These agreements govern the separation and distribution and the relationship between us and Pennant going forward, including with respect to potential tax-related losses associated with the separation and distribution. They also provide for the performance of services by each company for the benefit of the other for a period of time.

The separation agreement provides for indemnification obligations designed to make Pennant financially responsible for many liabilities that may exist relating to its business activities, whether incurred prior to or after the distribution, including any pending or future litigation, but we cannot guarantee that Pennant will be able to satisfy its indemnification obligations. It is also possible that a court would disregard the allocation agreed to between us and Pennant and require us to assume responsibility for obligations allocated to Pennant. Third parties could also seek to hold us responsible for any of these liabilities or obligations, and the indemnity rights we have under the separation agreement may not be sufficient to fully cover all of these liabilities and obligations. Even if we are successful in obtaining indemnification, we may have to bear costs temporarily. In addition, our indemnity obligations to Pennant, including those related to assets or liabilities allocated to us, may be significant. In addition, certain landlords required, in exchange for their consent to the Spin-Off, that our lease guarantees remain in place for a certain period of time following the Spin-Off. These guarantees could result in significant additional liabilities and obligations for us if Pennant were to default on their obligations under their leases with respect to these properties. These risks could negatively affect our business, financial condition or results of operations.

The separation of Pennant continues to involve a number of additional risks, including, among other things, the potential that management's and our employees' attention will be significantly diverted by the provision of skilled services or that we may incur other operational challenges or difficulties as a result of the separation. Certain of the agreements described above provide for the performance of services by each company for the benefit of the other for a period of time. If Pennant is unable to satisfy its obligations under these agreements, we could incur losses and may not have sufficient resources available for such services. These arrangements could also lead to disputes over rights to certain shared property and over the allocation of costs and revenues for products and operations. Our inability to effectively manage the transition activities and related events could adversely affect our business, financial condition or results of operations.

***If our Spin-Off fails to qualify as generally tax-free for U.S. federal income tax purposes, we and our stockholders could be subject to significant tax liabilities.***

The Spin-Off is intended to qualify for tax-free treatment to us and our stockholders for U.S. federal income tax purposes. Accordingly, completion of the transaction was conditioned upon, among other things, our receipt of opinions from outside tax advisors that the distributions would qualify as a transaction that is intended to be tax-free to both us and our stockholders for U.S. federal income tax purposes under Sections 355 and 368(a)(1)(D) of the Internal Revenue Code. The opinions were based on and relied on, among other things, certain facts and assumptions, as well as certain representations, statements and undertakings, including those relating to the past and future conduct. If any of these facts, assumptions, representations, statements or undertakings is, or becomes, inaccurate or incomplete, or if any of the parties breach any of their respective covenants relating to the transactions, the tax opinions may be invalid. Moreover, the opinions are not binding on the IRS or any courts. Accordingly, notwithstanding receipt of the opinion, the IRS could determine that the distribution and certain related transactions should be treated as taxable transactions for U.S. federal income tax purposes.

If the Spin-Off fails to qualify as a transaction that is generally tax-free under Sections 355 and 368(a)(1)(D) of the Internal Revenue Code, in general, for U.S. federal income tax purposes, we would recognize taxable gain with respect to the distributed securities and our stockholders who received securities in such distribution would be subject to tax as if they had received a taxable distribution equal to the fair market value of such shares.

We also have obligations to provide indemnification to a number of parties as a result of the transaction. Any indemnity obligations for tax issues or other liabilities related to the Spin-Off, could be significant and could adversely impact our business.

***Certain directors who serve on our Board of Directors also serve as directors of Pennant, and ownership of shares of Pennant common stock by our directors and executive officers may create, or appear to create, conflicts of interest.***

Certain of our directors who serve on our Board of Directors also serve on the board of directors of Pennant. This may create, or appear to create, conflicts of interest when our, or Pennant's management and directors face decisions that could have different implications for us and Pennant, including the resolution of any dispute regarding the terms of the agreements governing the Spin-Off and the relationship between us and Pennant after the Spin-Off or any other commercial agreements entered into in the future between us and the spun-off business and the allocation of such directors' time between us and Pennant.

All of our executive officers and some of our non-employee directors own shares of the common stock of Pennant. The continued ownership of such common stock by our directors and executive officers following the Spin-Off creates, or may create, the appearance of a conflict of interest when these directors and executive officers are faced with decisions that could have different implications for us and Pennant.

**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. The Credit Facility restricts our ability to pay dividends to stockholders if we receive notice that we are in default under this agreement. The failure to pay or maintain dividends could adversely affect our stock price.

***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.***

Our amended and restated certificate of incorporation and our amended and restated bylaws contain provisions that may enable our Board of Directors 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 our amended and restated bylaws include:

- our Board of Directors is 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 is 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.

We are also subject to the anti-takeover provisions of Section 203 of the General Corporation Law of the State of Delaware. Under these provisions, if anyone becomes an "interested stockholder," we may not enter into a "business combination" with that person for three years without special approval, which could discourage a third party from making a takeover offer and could delay or prevent a change of control. For purposes of Section 203, "interested stockholder" means, generally, someone owning more than 15% or more of our outstanding voting stock or an affiliate of ours that owned 15% or more of our outstanding voting stock during the past three years, subject to certain exceptions as described in Section 203.

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

### *Issuer Repurchases of Equity Securities*

A summary of the repurchase activity for the three months ended March 31, 2022 (dollars in millions, except per share amounts):

| Period | Total Number of Shares Repurchased | Average Price Per Share | Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs | Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs |
|---|---|---|---|---|
| January 1 to January 31, 2022[(1)] | 133,328 | $ 74.09 | 133,328 | $ — |
| February 1 to February 28, 2022 | — | $ — | — | $ — |
| March 1 to March 31, 2022 | — | $ — | — | $ — |

(1) These purchases were effectuated through a Rule 10b5-1 trading plan adopted by the Company on October 21, 2021.

*Stock Repurchase Programs.* As approved by the Board of Directors on October 21, 2021, we entered into a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that started on October 29, 2021. Under this program, we are authorized to repurchase our issued and outstanding common shares from time to time in open-market and privately negotiated transactions and block trades in accordance with federal securities laws. During the three months ended March 31, 2022, we repurchased 0.1 million shares of our common stock for $9.9 million. During the fourth quarter of 2021, we repurchased 0.1 million shares of our common stock for $10.1 million. This repurchase program expired upon the repurchase of the full authorized amount under the plan. On February 9, 2022, the Board of Directors approved a stock repurchase program pursuant to which we may repurchase up to $20.0 million of our common stock under the program for a period of approximately 12 months that started on February 10, 2022. During the three months ended March 31, 2022, we did not purchase any shares pursuant to this stock repurchase program.

## Item 6. EXHIBITS

### EXHIBIT INDEX

| Exhibit | Description |
|---|---|
| 3.1 | Fifth Amended and Restated Certificate of Incorporation of The Ensign Group, Inc., filed with the Delaware Secretary of State on November 15, 2007 (attached as Exhibit 3.1 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on December 21, 2007) |
| 3.2 | Certificate of Amendment to the Fifth Amended and Restated Certificate of Incorporation of The Ensign Group, Inc., filed with the Delaware Secretary of State on February 4, 2020 (attached as Exhibit 3.2 to the Company's Annual Report on Form 10-K (File No. 001-33757) filed with the SEC on February 5, 2020) |
| 3.3 | Amendment to the Amended and Restated Bylaws, dated August 5, 2014 (attached as Exhibit 3.2 to the Company's Current Report on Form 8-K (File No. 001-33757) filed with the SEC on August 8, 2014) |
| 3.4 | Amended and Restated Bylaws of The Ensign Group, Inc. (attached as Exhibit 3.2 to the Company's Quarterly Report on Form 10-Q (File No. 001-33757) filed with the SEC on December 21, 2007) |
| 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 |
| 101.INS | XBRL Instance Document - the instance document does not appear in the Interactive Data File because its XBRL tags are embedded within the Inline XBRL document. |
| 101.SCH | Inline XBRL Taxonomy Extension Schema Document |
| 101.CAL | Inline XBRL Taxonomy Extension Calculation Linkbase Document |
| 101.DEF | Inline XBRL Taxonomy Extension Definition Linkbase Document |
| 101.LAB | Inline XBRL Taxonomy Extension Label Linkbase Document |
| 101.PRE | Inline XBRL Taxonomy Extension Presentation Linkbase Document |

## 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.

April 28, 2022 BY: /s/ SUZANNE D. SNAPPER

Suzanne D. Snapper

Chief Financial Officer, Executive Vice President and Director (Principal Financial Officer and Accounting Officer and Duly Authorized Officer)

**EXHIBIT 31.1**

I, Barry R. Port, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of The Ensign Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: April 28, 2022

/s/ Barry R. Port

| | |
|---|---|
| Name: | Barry R. Port |
| Title: | *Chief Executive Officer and Director (principal executive officer)* |

**EXHIBIT 31.2**

I, Suzanne D. Snapper, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of The Ensign Group, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer(s) and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal controls over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external reporting purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer(s) and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: April 28, 2022

/s/ Suzanne D. Snapper

| | |
|---|---|
| Name: | Suzanne D. Snapper |
| Title: | *Chief Financial Officer, Executive Vice President and Director (principal financial officer and accounting officer and duly authorized officer)* |

**EXHIBIT 32.1**

**CERTIFICATION PURSUANT TO**
**18 U.S.C. §1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Quarterly Report of The Ensign Group, Inc. (the Company) on Form 10-Q for the period ended March 31, 2022, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Barry R. Port, Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Barry R. Port

| | |
|---|---|
| Name: | Barry R. Port |
| Title: | *Chief Executive Officer and Director (principal executive officer)* |

April 28, 2022

*A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.*

**EXHIBIT 32.2**

**CERTIFICATION PURSUANT TO**
**18 U.S.C. §1350,**
**AS ADOPTED PURSUANT TO**
**SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the Quarterly Report of The Ensign Group, Inc. (the Company) on Form 10-Q for the period ended March 31, 2022, as filed with the Securities and Exchange Commission on the date hereof (the Report), I, Suzanne D. Snapper, Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. § 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that to my knowledge:

1 The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

2 The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Suzanne D. Snapper

| | |
|---|---|
| Name: | Suzanne D. Snapper |
| Title: | *Chief Financial Officer, Executive Vice President and Director (principal financial officer and accounting officer and duly authorized officer)* |

April 28, 2022

*A signed original of this written statement required by 18 U.S.C. Section 1350 has been provided to the Company and will be retained by the Company and furnished to the Securities and Exchange Commission or its staff upon request.*