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 June 30, 2020.
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(g) 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**

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

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 July 31, 2020, 53,770,678 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 AND SIX MONTHS ENDED JUNE 30, 2020
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PART I.

Item 1. FINANCIAL STATEMENTS

THE ENSIGN GROUP, INC.
UNAUDITED CONDENSED CONSOLIDATED BALANCE SHEETS

	June 30, 2020	December 31, 2019
	(In thousands, except par values)	
Assets		
Current assets:		
Cash and cash equivalents	$ 201,738	$ 59,175
Accounts receivable—less allowance for doubtful accounts of $3,685 and $2,472 at June 30, 2020 and December 31, 2019, respectively	302,061	308,985
Investments—current	16,357	17,754
Prepaid income taxes	—	739
Prepaid expenses and other current assets	27,150	24,428
Total current assets	547,306	411,081
Property and equipment, net	780,439	767,565
Right-of-use assets	1,032,684	1,046,901
Insurance subsidiary deposits and investments	32,499	30,571
Escrow deposits	364	14,050
Deferred tax assets	3,612	4,615
Restricted and other assets	30,712	26,207
Intangible assets, net	3,004	3,382
Goodwill	54,469	54,469
Other indefinite-lived intangibles	3,068	3,068
Total assets	$ 2,488,157	$ 2,361,909
Liabilities and equity		
Current liabilities:		
Accounts payable	$ 42,694	$ 44,973
Accrued wages and related liabilities	155,013	151,009
Lease liabilities—current	46,983	44,964
Accrued self-insurance liabilities—current	29,493	29,252
CARES Act Provider Relief Fund and advance payments liabilities (Note 3)	207,642	—
Other accrued liabilities	95,921	70,273
Current maturities of long-term debt	3,292	2,702
Total current liabilities	581,038	343,173
Long-term debt—less current maturities	143,893	325,217
Long-term lease liabilities—less current portion	958,249	973,983
Accrued self-insurance liabilities—less current portion	61,324	58,114
Other long-term liabilities (Note 3)	25,877	5,278
Total liabilities	1,770,381	1,705,765
Commitments and contingencies (Notes 16, 18 and 19)		
Equity		
Ensign Group, Inc. stockholders' equity:		
Common stock: 0.001 par value; 100,000 shares authorized; 56,543 and 53,755 shares issued and outstanding at June 30, 2020, respectively, and 56,176 and 53,487 shares issued and outstanding at December 31, 2019, respectively (Note 20)	57	56
Additional paid-in capital	319,770	307,914
Retained earnings	467,219	391,523
Common stock in treasury, at cost, 2,788 and 2,079 shares at June 30, 2020 and December 31, 2019, respectively (Note 20)	(71,049)	(45,296)
Total Ensign Group, Inc. stockholders' equity	715,997	654,197
Non-controlling interest	1,779	1,947
Total equity	717,776	656,144
Total liabilities and equity	$ 2,488,157	$ 2,361,909

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
	(In thousands, except per share data)			
Revenue	$ 584,699	$ 492,916	$ 1,174,312	$ 964,224
Expense:				
Cost of services	451,749	394,741	906,270	766,730
Rent—cost of services	32,484	31,222	64,814	61,403
General and administrative expense	31,427	25,848	63,676	53,108
Depreciation and amortization	13,605	12,366	27,325	24,295
Total expenses	529,265	464,177	1,062,085	905,536
Income from operations	55,434	28,739	112,227	58,688
Other income (expense):				
Interest expense	(2,293)	(3,941)	(5,958)	(7,613)
Interest and other income	1,082	562	1,780	1,125
Other expense, net	(1,211)	(3,379)	(4,178)	(6,488)
Income before provision for income taxes	54,223	25,360	108,049	52,200
Provision for income taxes	13,535	4,576	26,159	9,851
Net income from continuing operations	40,688	20,784	81,890	42,349
Net income from discontinued operations, net of tax (Note 4)	—	8,141	—	14,183
Net income	40,688	28,925	81,890	56,532
Less:				
Net income attributable to noncontrolling interests in continuing operations	440	116	793	201
Net income attributable to noncontrolling interests in discontinued operations (Note 4)	—	200	—	350
Net income attributable to noncontrolling interests	440	316	793	551
Net income attributable to The Ensign Group, Inc.	$ 40,248	$ 28,609	$ 81,097	$ 55,981
Amounts attributable to The Ensign Group, Inc.:				
Income from continuing operations attributable to The Ensign Group, Inc.	$ 40,248	$ 20,668	$ 81,097	$ 42,148
Income from discontinued operations, net of income tax (Note 4)	—	7,941	—	13,833
Net income attributable to The Ensign Group, Inc.	$ 40,248	$ 28,609	$ 81,097	$ 55,981
Net income per share attributable to The Ensign Group, Inc.:				
Basic:				
Continuing operations	$ 0.76	$ 0.39	$ 1.52	$ 0.79
Discontinued operations	—	0.15	—	0.26
Basic income per share attributable to The Ensign Group, Inc.	$ 0.76	$ 0.54	$ 1.52	$ 1.05
Diluted:				
Continuing operations	$ 0.73	$ 0.37	$ 1.46	$ 0.75
Discontinued operations	—	0.14	—	0.25
Diluted income per share attributable to The Ensign Group, Inc.	$ 0.73	$ 0.51	$ 1.46	$ 1.00
Weighted average common shares outstanding:				
Basic	53,094	53,408	53,285	53,246
Diluted	55,181	56,078	55,489	55,896

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, 2020	53,487	$ 56	$ 307,914	$ 391,523	2,079	$ (45,296)	$ 1,947	$ 656,144
Issuance of common stock to employees and directors resulting from the exercise of stock options	148	—	1,552	—	—	—	—	1,552
Issuance of restricted stock	723	1	3,085	—	—	—	—	3,086
Dividends declared ($0.0500 per share)	—	—	—	(2,683)	—	—	—	(2,683)
Employee stock award compensation	—	—	3,235	—	—	—	—	3,235
Repurchase of common stock (Note 20)	(692)	—	—	—	692	(25,000)	—	(25,000)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	352	352
Distribution to noncontrolling interest holder	—	—	—	—	—	—	(720)	(720)
Net income attributable to the Ensign Group, Inc.	—	—	—	40,849	—	—	—	40,849
Balance - March 31, 2020	53,666	$ 57	$ 315,786	$ 429,689	2,771	$ (70,296)	$ 1,579	$ 676,815
Issuance of common stock to employees and directors resulting from the exercise of stock options	31	—	456	—	—	—	—	456
Issuance of restricted stock	75	—	—	—	—	—	—	—
Shares of common stock used to satisfy tax withholding obligations	(17)	—	—	—	17	(753)	—	(753)
Dividends declared ($0.0500 per share)	—	—	—	(2,718)	—	—	—	(2,718)
Employee stock award compensation	—	—	3,528	—	—	—	—	3,528
Net income attributable to noncontrolling interest	—	—	—	—	—	—	440	440
Distribution to noncontrolling interest holder	—	—	—	—	—	—	(240)	(240)
Net income attributable to the Ensign Group, Inc.	—	—	—	40,248	—	—	—	40,248
Balance - June 30, 2020	53,755	$ 57	$ 319,770	$ 467,219	2,788	$ (71,049)	$ 1,779	$ 717,776

(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, 2019	52,584	$ 55	$ 284,384	$ 344,901	1,932	$ (38,405)	$ 11,405	$ 602,340
Issuance of common stock to employees and directors resulting from the exercise of stock options and grant of stock awards	371	—	5,616	—	—	—	—	5,616
Dividends declared ($0.0475 per share)	—	—	—	(2,543)	—	—	—	(2,543)
Employee stock award compensation	—	—	2,612	—	—	—	—	2,612
Noncontrolling interest attributable to subsidiary equity plan (Note 17)	—	—	—	(317)	—	—	658	341
Cumulative effect of accounting change, net of tax	—	—	—	9,030	—	—	—	9,030
Net income attributable to noncontrolling interest	—	—	—	—	—	—	235	235
Net income attributable to the Ensign Group, Inc.	—	—	—	27,372	—	—	—	27,372
Balance - March 31, 2019	52,955	$ 55	$ 292,612	$ 378,443	1,932	$ (38,405)	$ 12,298	$ 645,003
Issuance of common stock to employees and directors resulting from the exercise of stock options and grant of stock awards	326	—	3,213	—	—	—	—	3,213
Shares of common stock used to satisfy tax withholding obligations	(9)	—	—	—	9	(485)	—	(485)
Dividends declared ($0.0475 per share)	—	—	—	(2,559)	—	—	—	(2,559)
Employee stock award compensation	—	—	3,066	—	—	—	—	3,066
Noncontrolling interest attributable to subsidiary equity plan (Note 17)	—	—	—	(2,497)	—	—	2,733	236
Distribution to noncontrolling interest holder	—	—	—	—	—	—	(92)	(92)
Net income attributable to noncontrolling interest	—	—	—	—	—	—	316	316
Net income attributable to the Ensign Group, Inc.	—	—	—	28,609	—	—	—	28,609
Balance - June 30, 2019	53,272	$ 55	$ 298,891	$ 401,996	1,941	$ (38,890)	$ 15,255	$ 677,307

See accompanying notes to condensed consolidated financial statements.

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

	Six Months Ended June 30,	
(In thousands)	**2020**	**2019**
Cash flows from operating activities:		
Net income	**$ 81,890**	$ 56,532
Net income from discontinued operations, net of tax	**—**	(14,183)
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation and amortization	**27,325**	24,295
Amortization of deferred financing fees	**420**	583
Non-cash leasing arrangement (Note 18)	**236**	(849)
Deferred income taxes	**1,003**	—
Provision for doubtful accounts	**1,559**	694
Stock-based compensation	**6,763**	5,385
Cash received from insurance proceeds related to replacement properties and business interruptions	**108**	638
Change in operating assets and liabilities		
Accounts receivable	**5,365**	(18,998)
Prepaid income taxes	**739**	343
Prepaid expenses and other assets	**(7,745)**	2,576
Operating lease obligations	**(378)**	(6,378)
Accounts payable	**(680)**	194
Accrued wages and related liabilities	**7,092**	(27)
Income taxes payable	**22,459**	—
Other accrued liabilities	**3,175**	(3,703)
Accrued self-insurance liabilities	**4,208**	3,717
Other long-term liabilities	**20,599**	2,006
Net cash provided by continuing operating activities	**174,138**	52,825
Net cash provided by discontinued operating activities (Note 4)	**—**	14,233
Net cash provided by operating activities	**174,138**	67,058
Cash flows from investing activities:		
Purchase of property and equipment	**(27,070)**	(32,099)
Cash payments for business acquisitions (Note 9)	**—**	(6,504)
Cash payments for asset acquisitions (Note 9)	**(14,054)**	(43,155)
Escrow deposits	**(364)**	—
Escrow deposits used to fund acquisitions	**14,050**	7,271
Cash proceeds from the sale of assets and insurance proceeds	**239**	2,575
Purchases of investments	**(5,984)**	(8,169)
Maturities of investments	**5,452**	6,088
Other restricted assets	**(595)**	(458)
Net cash used in continuing investing activities	**(28,326)**	(74,451)
Net cash used in discontinued investing activities (Note 4)	**—**	(18,585)
Net cash used in investing activities	**(28,326)**	(93,036)
Cash flows from financing activities:		
Proceeds from revolving credit facility and other debt (Note 16)	**380,600**	535,000
Payments on revolving credit facility and other debt (Note 16)	**(561,398)**	(500,965)
Issuance of common stock upon exercise of options	**2,008**	5,547
Repurchase of shares of common stock to satisfy tax withholding obligations	**(753)**	(485)
Repurchase of shares of common stock (Note 20)	**(25,000)**	—
Dividends paid	**(5,388)**	(5,068)
Non-controlling interest distribution	**(960)**	(92)
CARES Act Provider Relief Funds	**108,756**	—
Proceeds from Medicare Advance Payment Program (Note 3)	**98,886**	—
Net cash (used in)/provided by continuing financing activities	**(3,249)**	33,937
Net cash (used in)/provided by financing activities	**(3,249)**	33,937
Net increase in cash, cash equivalents, and restricted cash	**142,563**	7,959
Cash and cash equivalents beginning of period, including cash of discontinued operations	**59,175**	31,083
Cash and cash equivalents end of period, including cash of discontinued operations	**201,738**	39,042
Less cash of discontinued operations at end of period	**—**	43
Cash and cash equivalents end of period	**$ 201,738**	$ 38,999

See accompanying notes to condensed consolidated financial statements.

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

(In thousands)	Six Months Ended June 30,	
	2020	**2019**
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	**$ 6,917**	$ 7,500
Income taxes	**$ 1,935**	$ 12,375
Lease liabilities	**$ 65,109**	$ 73,748
Non-cash financing and investing activity:		
Accrued capital expenditures	**$ 2,500**	$ 3,600
Accrued dividends declared	**$ 2,718**	$ 2,559
Right-of-use assets obtained in exchange for new operating lease obligations	**$ 8,370**	$ 47,748

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. As of June 30, 2020, the Company operated 225 facilities and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Massachusetts, 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 22,900 operational skilled nursing beds and 2,100 senior living units. As of June 30, 2020, the Company operated 163 facilities under long-term lease arrangements, and had options to purchase 11 of those 163 facilities. The Company owned an additional 92 real estate properties, which included 62 operations the Company operated and managed, real estate properties of 31 senior living operations that were leased to The Pennant Group, Inc. as part of the Spin-Off (defined below), and the Service Center location. Of those 31 senior living operations, two are located on the same real estate properties as the skilled nursing facilities.

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 (the Captive) that provides some claims-made coverage to the Company’s operating subsidiaries for general and professional liability, as well as coverage for certain workers’ compensation insurance liabilities.

Each of the Company's affiliated operations are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. References herein to the consolidated “Company” and “its” assets and activities in this 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.

Spin-Off Transaction — On October 1, 2019, the Company completed the separation of its transitional and skilled nursing services, home health and hospice operations and substantially all of its senior living operations into two separate, publicly traded companies (the Spin-Off). Upon completion of the Spin-Off, the Company restructured its operations. The Company operates and reports only one reportable operating segment: transitional and skilled services. The Company believes that this structure reflects its current operational and financial management, and provides the best structure for the Company to focus on growth opportunities while maintaining financial discipline.

As a result of the Spin-Off, the condensed consolidated financial statements reflect the Spin-Off operations, assets and liabilities, and cash flows as discontinued operations for 2019 periods presented. Unless otherwise noted, amounts in the Notes to the Condensed Consolidated Financial Statements exclude amounts attributable to discontinued operations. Refer to Note 4, *Spin-Off of Subsidiaries*, for additional information regarding discontinued operations.

Other Information — The accompanying condensed consolidated financial statements as of June 30, 2020 and for the three and six months ended June 30, 2020 and 2019 (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, 2019 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 condensed consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest. 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, entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impact" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. The Company's relationship with variable interest entities was not material during the three and six months ended June 30, 2020 and 2019.

During the first quarter of 2019, the Company completed the sale of one of its senior living operations for a sale price of $1,838. The sale transaction did not meet the criteria of discontinued operations as it did not represent a strategic shift that had, or will have, a major effect on the Company's operations and financial results.

Estimates and Assumptions — The preparation of Interim Financial Statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the 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 liability, 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.

Revenue Recognition — The Company recognizes revenue in accordance with Accounting Standards Codification Topic 606, *Revenue from Contracts with Customers* (ASC 606). *See Note 5, Revenue and Accounts Receivable.*

Accounts Receivable and Allowance for Doubtful Accounts — Accounts receivable consist primarily of amounts due from Medicare and Medicaid programs, other government programs, managed care health plans and private payor sources, net of estimates for variable consideration. The allowance for doubtful accounts reflects the Company’s best estimate of probable losses inherent in the accounts receivable balance. The Company determines the allowance based on known troubled accounts and other currently available evidence.

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

Impairment of Long-Lived Assets — The Company reviews the carrying value of long-lived assets that are held and used in the Company’s operating subsidiaries for impairment whenever events or changes in circumstances indicate that the carrying amount of an asset may not be recoverable. Recoverability of these assets is determined based upon expected undiscounted future net cash flows from the operating subsidiaries to which the assets relate, utilizing management’s best estimate, appropriate assumptions, and projections at the time. If the carrying value is determined to be unrecoverable from future

operating cash flows, the asset is deemed impaired and an impairment loss would be recognized to the extent the carrying value exceeded the estimated fair value of the asset. The Company estimates the fair value of assets based on the estimated future discounted cash flows of the asset. Management has evaluated its long-lived assets and determined there was no impairment during the three and six months ended June 30, 2020 and 2019.

Leases and Leasehold Improvements - The Company leases skilled nursing facilities, senior living facilities and commercial office space. On January 1, 2019, the Company adopted Accounting Standards Codification Topic 842, *Leases* (ASC 842), electing the transition method that allows it to apply the standard as of the adoption date and record a cumulative adjustment in retained earnings. The Company determines if an arrangement is a lease at the inception of each lease. At the inception of each lease, the Company performs an evaluation to determine whether the lease should be classified as an operating or finance lease. As of June 30, 2020, the Company does not have any leases that are classified as finance leases. Operating leases are included in 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 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.

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 change that would reduce the fair value of a reporting unit below its carrying amount. 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 and six months ended June 30, 2020 and 2019.

Self-Insurance — The Company is partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. The combined self-insured retention is $500 per claim, subject to an additional one-time deductible of $750 for California affiliated operations and a separate, one-time, deductible of $1,000 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 self-insured retention and deductible limits for general and professional liability and workers' compensation for all states (except Texas and Washington for workers' compensation) are self-insured through the Captive, the related assets and liabilities of which are included in the accompanying condensed consolidated balance sheets. The Captive is subject to certain statutory requirements as an insurance provider.

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 $52,528 and $46,984 as of June 30, 2020 and December 31, 2019, respectively.

The Company's operating subsidiaries are self-insured for workers' compensation in California. To protect itself against loss exposure in California with this policy, the Company has purchased individual specific excess insurance coverage that insures individual claims that exceed $500 per occurrence. In Texas, the operating subsidiaries have elected non-subscriber status for workers' compensation claims and 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 Washington, the operating subsidiaries' coverage is financed through premiums paid by the employers and employees. The claims and benefit payments are managed through a state insurance pool. Outside of California, Texas and Washington, the Company has purchased insurance coverage that insures individual claims that exceed $350 per accident. In all states except Washington, the Company accrues amounts equal to the estimated costs to settle open claims, as well as an estimate of the cost of claims that have been incurred but not reported. The Company uses actuarial valuations to estimate the liability based on historical experience and industry information. Accrued workers' compensation liabilities are recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets and were $24,424 and $25,419 as of June 30, 2020 and December 31, 2019, respectively.

In addition, the Company has recorded an asset and equal liability of $7,242 and $7,999 at June 30, 2020 and December 31, 2019, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis.

The Company self-funds medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 for each covered person with an additional one-time aggregate individual stop loss deductible of $75. The Company's policy does not include the additional one-time aggregate individual stop loss deductible of $75. The Company's accrued liability under these plans recorded on an undiscounted basis in the accompanying condensed consolidated balance sheets was $6,623 and $6,964 as of June 30, 2020 and December 31, 2019, 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 liability exceeds its estimates of loss, its future earnings, cash flows and financial condition would be adversely affected.

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

In determining the need for a valuation allowance or the need for and magnitude of liabilities for uncertain tax positions, the Company makes certain estimates and assumptions. These estimates and assumptions are based on, among other things, knowledge of operations, markets, historical trends and likely future changes and, when appropriate, the opinions of advisors

with knowledge and expertise in certain fields. Due to certain risks associated with the Company’s estimates and assumptions, actual results could differ.

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

Stock-Based Compensation — The Company measures and recognizes compensation expense for all 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 Financial Accounting Standards Board (FASB) Accounting Standards Codification (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 August 2018, the FASB issued amended guidance to simplify fair value measurement disclosure requirements. The new provisions eliminate the requirements to disclose (1) transfers between Level 1 and Level 2 of the fair value hierarchy, (2) policies related to valuation processes and the timing of transfers between levels of the fair value hierarchy, and (3) net asset value disclosure of estimates of timing of future liquidity events. The FASB also modified disclosure requirements of Level 3 fair value measurements. The Company adopted this standard effective January 1, 2020 and determined there was no material impact on the Company's condensed consolidated financial statements.

In January 2017, the FASB issued amended authoritative guidance to simplify and reduce the cost and complexity of the goodwill impairment test. The new provisions eliminate step 2 from the goodwill impairment test and shifts the concept of impairment from a measure of loss when comparing the implied fair value of goodwill to its carrying amount to comparing the fair value of a reporting unit with its carrying amount. The FASB also eliminated the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment or step 2 of the goodwill impairment test. The new guidance does not amend the optional qualitative assessment of goodwill impairment. The Company adopted this standard effective January 1, 2020 and determined there was no material impact on the Company's condensed consolidated financial statements.

In June 2016, the FASB issued Accounting Standards Update (ASU) 2016-13 “*Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*”, which replaces the existing incurred loss impairment model with an expected credit loss model and requires a financial asset measured at amortized cost to be presented at the net amount expected to be collected. The Company adopted this standard effective January 1, 2020 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 December 2019, the FASB issued ASU 2019-12 *"Simplifying the Accounting for Income Taxes (Topic 740)"*, as part of its simplification initiative to reduce the cost and complexity in accounting for income taxes. ASU 2019-12 removes certain exceptions related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. ASU 2019-12 also amends other aspects of the guidance to help simplify and promote consistent application of GAAP. The guidance is effective for interim and annual periods beginning after December 15, 2020, with early adoption permitted. The Company is currently evaluating the impact of ASU 2019-12 on its financial position, results of operations and liquidity.

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 the new reference rates which will replace LIBOR and other reference rates expected to be discontinued. 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. 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 outbreak of the 2019 coronavirus disease (COVID-19), which was declared a global pandemic by the World Health Organization (WHO) on March 11, 2020, and the related responses by public health and governmental authorities to contain and combat its outbreak and spread, continues to spread and impact healthcare operations across the United States, including the markets in which the Company operates. The Centers for Disease Control and Prevention (CDC) has stated that older adults are at a higher risk for serious illness from the coronavirus. As the COVID-19 pandemic continues, the impact on the Company's financial and operational results remain subject to change. The Company continues to monitor the impacts of the pandemic on its operations and financial condition.

In response to the COVID-19 pandemic, Congress passed the Coronavirus Aid, Relief, and Economic Security Act of 2020 (the CARES Act), signed into law on March 27, 2020, which authorized the cash distribution of relief funds to healthcare providers. On April 10, 2020, the Company began to receive CARES Act provider relief fund payments (Provider Relief Fund) from the U.S. Department of Health and Human Services (HHS). As of June 30, 2020, the Company's affiliated operations have directly or indirectly received in the aggregate approximately $108,756 in Provider Relief Funds. In June 2020, the Company started to repay the Provider Relief Funds received and has subsequently returned the all of the funds received to an agent of HHS. As of June 30, 2020, the Company recorded the Provider Relief Funds as a short-term liability on the condensed consolidated balance sheet.

Additionally, the Company applied for and received $98,886 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. These funds are currently required to be repaid starting 120 days after the receipt of the cash. Any unpaid funds will begin accruing interest after the 120 day period. The Company has paid a portion of the funds back in July 2020 and, as of June 30, 2020, has classified the cash receipts as a short-term liability.

On March 18, 2020, the President signed into law The Family First Coronavirus Response Act, which provided a temporary 6.2% increase to the Federal Medical Assistance Percent (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 that the funds are to be used to reimburse the recipient for healthcare related expenses that are attributable to COVID-19 associated with providing patient care. As of June 30, 2020, eight of the fourteen states in which the Company operates have approved a state-specific FMAP Medicaid program. 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 FMAP-related revenue recognized is limited to the actual COVID-19 related expenses incurred. For the three months ended June 30, 2020, the Company received $14,388 in billable FMAP payments, of which, $12,404 was recognized as revenue. For the six months ended June 30, 2020, the Company received $15,118 in billable FMAP payments, of which, $13,134 was recognized 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 with the remaining 50% due by December 31, 2022. The Company recorded $16,434 of deferred payment of social security taxes as a long-term liability, which is included in Other Long-Term Liabilities in the condensed consolidated balance sheets as of June 30, 2020.

The U.S. Treasury Department and Internal Revenue Service also allows corporate taxpayers to defer their estimated federal income taxes for the first and second quarters of 2020. Total income tax payable as of June 30, 2020 of $22,459 is included in Other Accrued Liabilities in the condensed consolidated balance sheets. The Company subsequently paid the payable in July 2020.

4. SPIN-OFF OF SUBSIDIARIES

On October 1, 2019, the Company completed the separation of its transitional and skilled nursing services, ancillary businesses, home health and hospice operations and substantially all of its senior living operations into two separate, publicly traded companies:

- Ensign, which includes skilled nursing and senior living services, physical, occupational and speech therapies and other rehabilitative and healthcare services at 225 healthcare facilities and campuses, post-acute-related ancillary operations and real estate investments; and
- The Pennant Group, Inc. (Pennant), which is a holding company of operating subsidiaries that provide home health, hospice and senior living services.

The Company completed the separation through a tax-free distribution of substantially all of the outstanding shares of common stock of Pennant to Ensign stockholders on a pro rata basis. Ensign stockholders received one share of Pennant common stock for every two shares of Ensign common stock held at the close of business on September 20, 2019, the record date for the Spin-Off. The number of shares of Ensign common stock each stockholder owns and the related proportionate interest in Ensign did not change as a result of the Spin-Off. Each Ensign stockholder received only whole shares of Pennant common stock in the distribution, as well as cash in lieu of any fractional shares. The Spin-Off was effective October 1, 2019, with shares of Pennant common stock distributed on October 1, 2019. Pennant is listed on the NASDAQ Global Select Market (NASDAQ) and trades under the ticker symbol “PNTG”.

Ensign and Pennant entered into several agreements in connection with the Spin-Off, including a transition services agreement (TSA), separation and distribution agreement, tax matters agreement and an employee matters agreement. Pursuant to the TSA, Ensign, Pennant and their respective subsidiaries are providing various services to each other on an interim, transitional basis. Services being provided by Ensign include, among others, certain finance, information technology, human resources, employee benefits and other administrative services. The TSA will terminate on or before September 30, 2021. Billings by Ensign under the TSA were not material during the three and six months ended June 30, 2020.

Immediately after the Spin-Off, Ensign no longer consolidated the results of Pennant operations into its financial results. Pennant's operating results and cash flows for the three and six months ended June 30, 2019 presented have been classified as discontinued operations within the Condensed Consolidated Financial Statements.

The following table presents the financial results of Pennant for the indicated period and does not include corporate overhead allocations:

	Three Months Ended June 30, 2019	Six Months Ended June 30, 2019
	(In thousands)	
Revenue	$ 82,734	$ 160,641
Expense:		
Cost of services	62,258	120,272
Rent—cost of services	5,839	11,443
General and administrative expense	4,712	10,477
Depreciation and amortization	818	1,487
Total expenses	73,627	143,679
Income from discontinued operations	9,107	16,962
Interest income	10	22
Provision for income taxes	976	2,801
Income from discontinued operations, net of tax	8,141	14,183
Net income attributable to discontinued noncontrolling interests	200	350
Net income attributable to The Ensign Group, Inc.	$ 7,941	$ 13,833

The Company incurred transaction costs of $9,119 related to the Spin-Off since commencing in 2018, of which $1,658 and $4,648 is reflected in the Company's condensed consolidated statement of operations as discontinued operations for the three and six months ended June 30, 2019, respectively. Transaction costs primarily consist of third-party advisory, consulting, legal and professional services, as well as other items that are incremental and one-time in nature that are related to the separation.

5. REVENUE AND ACCOUNTS RECEIVABLE

The Company's revenue is derived primarily from providing healthcare services to its patients. Revenues are 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 transitional and 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 74.8% and 72.7% for the three and six months ended June 30, 2020, respectively and 70.3% for both the three and six months ended June 30, 2019. 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 consolidated revenue or Interim Financial Statements for the three and six months ended June 30, 2020 and 2019.

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 rate, adjusted for estimates for variable consideration, on a per patient, daily basis or as services are performed.

Revenue for the three and six months ended June 30, 2020 and 2019 is summarized in the following tables:

	Three Months Ended June 30,			
	2020		2019	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	**$ 226,118**	**38.7 %**	$ 195,778	39.7 %
Medicare	**175,044**	**29.9**	118,807	24.1
Medicaid — skilled	**36,385**	**6.2**	31,792	6.5
Total Medicaid and Medicare	**437,547**	**74.8**	346,377	70.3
Managed care	**82,316**	**14.1**	86,491	17.5
Private and other[1]	**64,836**	**11.1**	60,048	12.2
Revenue	**$ 584,699**	**100.0 %**	$ 492,916	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the three months ended June 30, 2020 and 2019. During the three months ended June 30, 2020 and 2019, private and other payors includes $3,927 and $668 of rental income, respectively.

	Six Months Ended June 30,			
	2020		2019	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	**$ 450,314**	**38.3 %**	$ 380,277	39.4 %
Medicare	**330,628**	**28.2**	235,508	24.4
Medicaid — skilled	**72,394**	**6.2**	62,243	6.5
Total Medicaid and Medicare	**853,336**	**72.7**	678,028	70.3
Managed care	**184,345**	**15.7**	169,663	17.6
Private and other[(1)]	**136,631**	**11.6**	116,533	12.1
Revenue	**$ 1,174,312**	**100.0 %**	$ 964,224	100.0 %

(1) Private and other payors also includes revenue from all payors generated in other ancillary services for the six months ended June 30, 2020 and 2019. During the six months ended June 30, 2020 and 2019, private and other payors includes $8,230 and $1,425 of rental income, respectively

Balance Sheet Impact

Included in the Company's condensed consolidated balance sheets are contract assets, 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 as of June 30, 2020 and December 31, 2019, or activity during the three and six months ended June 30, 2020 and 2019.

Accounts receivable as of June 30, 2020 and December 31, 2019, is summarized in the following table:

	June 30, 2020	December 31, 2019
Medicaid	$ 117,451	$ 125,443
Managed care	57,906	70,015
Medicare	66,017	53,163
Private and other payors	64,372	62,836
	305,746	311,457
Less: allowance for doubtful accounts	(3,685)	(2,472)
Accounts receivable, net	**$ 302,061**	$ 308,985

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.

6. COMPUTATION OF NET INCOME PER COMMON SHARE

Basic net income per share is computed by dividing income from continuing 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 June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Numerator:				
Net income from continuing operations	$ 40,688	$ 20,784	$ 81,890	$ 42,349
Less: net income attributable to noncontrolling interests in continuing operations	440	116	793	201
Net income from continuing operations attributable to The Ensign Group, Inc.	40,248	20,668	81,097	42,148
Net income from discontinued operations, net of tax	—	8,141	—	14,183
Less: net income attributable to noncontrolling interests in discontinued operations	—	200	—	350
Net income from discontinued operations, net of tax	—	7,941	—	13,833
Net income attributable to The Ensign Group, Inc.	$ 40,248	$ 28,609	$ 81,097	$ 55,981
Denominator:				
Weighted average shares outstanding for basic net income per share	53,094	53,408	53,285	53,246
Basic net income per common share:				
Income from continuing operations	$ 0.76	$ 0.39	$ 1.52	$ 0.79
Income from discontinued operations	—	0.15	—	0.26
Net income attributable to The Ensign Group, Inc.	$ 0.76	$ 0.54	$ 1.52	$ 1.05

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

	Three Months Ended June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Numerator:				
Net income from continuing operations	$ 40,688	$ 20,784	$ 81,890	$ 42,349
Less: net income attributable to noncontrolling interests in continuing operations	440	116	793	201
Net income from continuing operations attributable to The Ensign Group, Inc.	40,248	20,668	81,097	42,148
Net income from discontinued operations, net of tax	—	8,141	—	14,183
Less: net income attributable to noncontrolling interests in discontinued operations	—	200	—	350
Net income from discontinued operations, net of tax	—	7,941	—	13,833
Net income attributable to The Ensign Group, Inc.	$ 40,248	$ 28,609	$ 81,097	$ 55,981
Denominator:				
Weighted average common shares outstanding	53,094	53,408	53,285	53,246
Plus: incremental shares from assumed conversion (1)	2,087	2,670	2,204	2,650
Adjusted weighted average common shares outstanding	55,181	56,078	55,489	55,896
Diluted net income per common share:				
Income from continuing operations	$ 0.73	$ 0.37	$ 1.46	$ 0.75
Income from discontinued operations	—	0.14	—	0.25
Net income attributable to The Ensign Group, Inc.	$ 0.73	$ 0.51	$ 1.46	$ 1.00

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 1,199 and 852 for the three and six months ended June 30, 2020, respectively and 173 and 322 for the three and six months ended June 30, 2019, respectively.

7. 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 $201,738 and $59,175 as of June 30, 2020 and December 31, 2019, 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 June 30, 2020, the fair value of the pooled investment funds of $4,610 is derived using Level 2 inputs.

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

At June 30, 2020 and December 31, 2019, the Company had approximately $48,856 and $48,325, 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 June 30, 2020, 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 June 30, 2020 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date, including the recent developments related to Coronavirus (COVID-19), that would indicate any other-than-temporary impairment.

8. BUSINESS SEGMENTS

Prior to the Spin-Off, the Company had three reportable segments: (1) transitional and skilled services, (2) home health and hospice services and (3) senior living services. Upon completion of the Spin-Off, the Company has one reportable operating segment: transitional and skilled services, which includes the operation of skilled nursing facilities. The Company's Chief Executive Officer, who is its chief operating decision maker, or CODM, reviews financial information at the operating segment level. The Company also reports an “all other” category that includes results from its senior living operations, real estate properties leased to third-parties, mobile diagnostics, medical transportation and other ancillary operations. These operations are neither significant individually nor in the aggregate, and therefore do not constitute a reportable segment. The Company believes that this structure reflects its current operational and financial management, and provides the best structure for the Company to maximize the quality of care provided while maintaining financial discipline.

As of June 30, 2020, transitional and skilled services included 193 wholly-owned affiliated skilled nursing operations and 23 campuses that provide skilled nursing and rehabilitative care services and senior living services. Included in the "all other" category are ancillary services the Company provided through ancillary operations and room and board and social services through nine wholly-owned affiliated senior living operations and 23 campuses. The Company evaluates performance and allocates capital resources to its operations based on an operating model that is designed to maximize the quality of care provided and profitability. General and administrative expenses are not allocated to the Company's reportable segment for purposes of determining segment profit or loss, and are included in the "all other" category in the selected segment financial data that follows. The accounting policies of the reporting segment are the same as those described in Note 2, *Summary of Significant Accounting Policies.* The Company's CODM does not review assets by segment in his resource allocation and therefore assets by segment are not disclosed below.

Segment revenues by major payor source were as follows:

	Three Months Ended June 30, 2020				
	Transitional and Skilled Services	All Other		Total Revenue	Revenue %
Medicaid	$ 222,924	$ 3,194	(1)	$ 226,118	38.7 %
Medicare	175,044	—		175,044	29.9
Medicaid-skilled	36,385	—		36,385	6.2
Subtotal	434,353	3,194		437,547	74.8
Managed care	82,316	—		82,316	14.1
Private and other	40,110	24,726	(2)	64,836	11.1
Total revenue	$ 556,779	$ 27,920		$ 584,699	100.0 %

(1) Medicaid payor includes revenue generated from senior living operations for the three months ended June 30, 2020.
(2) Private and other payors also includes revenue from rental income, senior living operations and all payors generated in other ancillary services for the three months ended June 30, 2020.

	Three Months Ended June 30, 2019				
	Transitional and Skilled Services	All Other		Total Revenue	Revenue %
Medicaid	$ 192,545	$ 3,233	(1)	$ 195,778	39.7 %
Medicare	118,807	—		118,807	24.1
Medicaid-skilled	31,792	—		31,792	6.5
Subtotal	343,144	3,233		346,377	70.3
Managed care	86,491	—		86,491	17.5
Private and other	39,603	20,445	(2)	60,048	12.2
Total revenue	$ 469,238	$ 23,678		$ 492,916	100.0 %

(1) Medicaid payor includes revenue generated from senior living operations for the three months ended June 30, 2019.
(2) Private and other payors also includes revenue from rental income, senior living operations and all payors generated in other ancillary services for the three months ended June 30, 2019.

	Six Months Ended June 30, 2020				
	Transitional and Skilled Services	All Other		Total Revenue	Revenue %
Medicaid	$ 443,893	$ 6,421	(1)	$ 450,314	38.3 %
Medicare	330,628	—		330,628	28.2
Medicaid-skilled	72,394	—		72,394	6.2
Subtotal	846,915	6,421		853,336	72.7
Managed care	184,345	—		184,345	15.7
Private and other	83,924	52,707	(2)	136,631	11.6
Total revenue	$ 1,115,184	$ 59,128		$ 1,174,312	100.0 %

(1) Medicaid payor includes revenue generated from senior living operations for the six months ended June 30, 2020.
(2) Private and other payors also includes revenue from rental income, senior living operations and all payors generated in other ancillary services for the six months ended June 30, 2020.

	Six Months Ended June 30, 2019				
	Transitional and Skilled Services	All Other		Total Revenue	Revenue %
Medicaid	$ 373,839	$ 6,438	(1)	$ 380,277	39.4 %
Medicare	235,508	—		235,508	24.4
Medicaid-skilled	62,243	—		62,243	6.5
Subtotal	671,590	6,438		678,028	70.3
Managed care	169,663	—		169,663	17.6
Private and other	77,243	39,290	(2)	116,533	12.1
Total revenue	$ 918,496	$ 45,728		$ 964,224	100.0 %

(1) Medicaid payor includes revenue generated from senior living operations for the six months ended June 30, 2019.
(2) Private and other payors also includes revenue from rental income, senior living operations and all payors generated in other ancillary services for the six months ended June 30, 2019.

The following tables set forth selected financial data consolidated by business segment:

	Three Months Ended June 30, 2020		
	Transitional and Skilled Services	All Other(1)	Total
Revenue	$ 556,779	$ 27,920	$ 584,699
Segment income (loss)	84,904	(29,470)	55,434
Interest expense, net of interest and other income			(1,211)
Income before provision for income taxes			$ 54,223
Depreciation and amortization	$ 10,197	$ 3,408	$ 13,605

(1) General and administrative expense are included in the "all other" category.

	Three Months Ended June 30, 2019		
	Transitional and Skilled Services	All Other(1)	Total
Revenue	$ 469,238	$ 23,678	$ 492,916
Segment income (loss)	56,652	(27,913)	28,739
Interest expense, net of interest and other income			(3,379)
Income before provision for income taxes			$ 25,360
Depreciation and amortization	$ 8,938	$ 3,428	$ 12,366

(1) General and administrative expense is included in the "all other" category.

	Six Months Ended June 30, 2020		
	Transitional and Skilled Services	All Other(1)	Total
Revenue	$ 1,115,184	$ 59,128	$ 1,174,312
Segment income (loss)	172,082	(59,855)	112,227
Interest expense, net of interest and other income			(4,178)
Income before provision for income taxes			$ 108,049
Depreciation and amortization	$ 20,457	$ 6,868	$ 27,325

(1) General and administrative expense are included in the "all other" category.

	Six Months Ended June 30, 2019		
	Transitional and Skilled Services	All Other(1)	Total
Revenue	$ 918,496	$ 45,728	$ 964,224
Segment income (loss)	115,416	(56,728)	58,688
Interest expense, net of interest and other income			(6,488)
Income before provision for income taxes			$ 52,200
Depreciation and amortization	$ 17,552	$ 6,743	$ 24,295

(1) General and administrative expense is included in the "all other" category

9. ACQUISITIONS

The Company's subsidiaries acquisition 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 accompanying 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, the affiliated operations will acquire the real estate of facilities that have been operating under third-party leases.

2020 Acquisitions

During the six months ended June 30, 2020, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of three stand-alone skilled nursing operations and one stand-alone independent living operation. The addition of these operations added a total of 247 operational skilled nursing beds and 162 operational senior living units to be operated by the Company's affiliated operating subsidiaries. The aggregate purchase price for these acquisitions during the six months ended June 30, 2020 was $14,054.

For the acquisitions 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 fair value of assets for all four of the acquisitions was concentrated in property and equipment and as such, these transactions were classified as asset acquisitions. The purchase price for the asset acquisitions was $14,054.

During the first quarter of 2020, the Company entered into a long-term lease agreement to transfer two senior living operations to Pennant. Ensign affiliates retained ownership of the real estate for these two senior living communities.

Subsequent to June 30, 2020, the Company expanded its operations through the acquisition of one campus operation for a purchase price of approximately $8 million, which added 62 operational skilled nursing beds and 162 operational senior living units to be operated by its operating subsidiary.

2019 Acquisitions

During the six months ended June 30, 2019, the Company expanded its operations through a combination of long-term leases and real estate purchases, with the addition of seven stand-alone skilled nursing operations, one stand-alone senior living operation and three campus operations. For the acquisitions 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 addition of these operations added a total of 1,088 operational skilled nursing beds and 312 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. The Company entered into a separate operations transfer agreement with the prior operator as part of each transaction. The aggregate purchase price for these acquisitions during the six months ended June 30, 2019 was $50,583.

The fair value of assets for the eleven acquisitions was concentrated in property and equipment and as such, these transactions were classified as asset acquisitions. The purchase price for the eleven asset acquisitions was $43,155. The fair value of assets for the one acquisition was concentrated in goodwill and as such, the transaction was classified as a business combination in accordance with ASC 805. The purchase price for the business combination was $7,428. The Company also entered into a note payable with the seller of $924, which was subsequently paid off in the second quarter of 2019 and included as payments of debt in the condensed consolidated statement of cash flow.

In connection with the Spin-Off, the Company transferred the assets of two home health agencies, four hospice agencies, two home care agencies and the operations of one stand-alone senior living that were purchased for an aggregate price of $14,779.

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 operating subsidiaries acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming operating subsidiaries, 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 businesses acquired during the six months ended June 30, 2020 were not material acquisitions to the Company individually or in the aggregate. Accordingly, pro forma financial information is not presented. These acquisitions have been included in the June 30, 2020 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 dates the Company gained effective control.

The table below presents the allocation of the purchase price for the operations acquired during the six months ended June 30, 2020 and 2019, excluding assets that were contributed to Pennant that occurred during the Spin-Off.

	Six Months Ended June 30,	
	2020	2019
Land	$ 4,080	$ 7,660
Building and improvements	9,669	33,900
Equipment, furniture, and fixtures	236	2,758
Assembled occupancy	69	224
Definite-lived intangible assets	—	440
Goodwill	—	5,431
Other indefinite-lived intangible assets	—	170
Total acquisitions	$ 14,054	$ 50,583

10. PROPERTY AND EQUIPMENT— NET

Property and equipment, net consists of the following:

	June 30, 2020	December 31, 2019
Land	$ 95,820	$ 91,740
Buildings and improvements	547,859	531,538
Equipment	225,763	212,808
Furniture and fixtures	4,524	4,453
Leasehold improvements	132,993	127,983
Construction in progress	3,193	3,409
	1,010,152	971,931
Less: accumulated depreciation	(229,713)	(204,366)
Property and equipment, net	$ 780,439	$ 767,565

See also Note 9, *Acquisitions* for information on acquisitions during the six months ended June 30, 2020 and 2019.

11. INTANGIBLE ASSETS — NET

		June 30, 2020			December 31, 2019		
Intangible Assets	Weighted Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	1.7	$ 360	$ (360)	$ —	$ 360	$ (349)	$ 11
Favorable leases	2.1	534	(534)	—	534	(448)	86
Assembled occupancy	0.4	3,051	(3,051)	—	2,982	(2,818)	164
Facility trade name	30.0	733	(354)	379	733	(342)	391
Customer relationships	18.2	4,640	(2,015)	2,625	4,640	(1,910)	2,730
Total		$ 9,318	$ (6,314)	$ 3,004	$ 9,249	$ (5,867)	$ 3,382

During the three and six months ended June 30, 2020, amortization expense was $417 and $1,091 and of which $290 and $644, respectively, was related to the amortization of right-of-use assets. Amortization expense was $990 and $1,869 and of which $495 and $990, respectively, was related to the amortization of right-of-use assets for the three and six months ended June 30, 2019, respectively.

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

Year	Amount
2020 (remainder)	$ 117
2021	234
2022	234
2023	234
2024	234
2025	234
Thereafter	1,717
	$ 3,004

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 Accounting Standards Codification 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, a "Step 0" analysis. 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 "Step 1" of the traditional two-step goodwill impairment test by comparing the net assets of each reporting unit to their respective fair values. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. In the event a unit's net assets exceed its fair value, an implied fair value of goodwill must be determined by assigning the unit's fair value to each asset and liability of the unit. The excess of the fair value of the reporting unit over the amounts assigned to its assets and liabilities is the implied fair value of goodwill. An impairment loss is measured by the difference between the goodwill carrying value and the implied fair value.

The Company anticipates that the majority of total goodwill recognized will be fully deductible for tax purposes as of June 30, 2020. See further discussion of goodwill acquired at Note 9, *Acquisitions*.

The following table represents activity in goodwill by transitional and skilled service segment and "all other" category as of and for the six months ended June 30, 2020:

	Goodwill		
	Transitional and Skilled Services	All Other	Total
January 1, 2020	**$ 45,486**	**$ 8,983**	**$ 54,469**
Additions	**—**	**—**	**—**
June 30, 2020	**$ 45,486**	**$ 8,983**	**$ 54,469**

Other indefinite-lived intangible assets consists of the following:

	June 30, 2020	December 31, 2019
Trade name	**$ 889**	$ 889
Medicare and Medicaid licenses	**2,179**	2,179
	$ 3,068	$ 3,068

13. RESTRICTED AND OTHER ASSETS

Restricted and other assets consists of the following:

	June 30, 2020	December 31, 2019
Debt issuance costs, net	$ 3,019	$ 3,374
Long-term insurance losses recoverable asset	7,242	7,999
Deposits with landlords	12,141	11,765
Capital improvement reserves with landlords and lenders	3,700	3,024
Cash surrender value of life insurance related to deferred compensation plan	4,610	—
Other	—	45
Restricted and other assets	$ 30,712	$ 26,207

Included in restricted and other assets as of June 30, 2020 and December 31, 2019 are anticipated insurance recoveries related to the Company's workers' compensation, general and professional liability claims that are recorded on a gross rather than net basis in accordance with an Accounting Standards Update issued by the FASB.

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 gain on the deferral investment, which is included in interest and other income, and an offsetting expense, which is included in cost of services, of $458 in the accompanying condensed consolidated statements of income for both the three and six months ended June 30, 2020.

14. OTHER ACCRUED LIABILITIES

Other accrued liabilities consists of the following:

	June 30, 2020	December 31, 2019
Quality assurance fee	$ 6,096	$ 6,461
Refunds payable	34,149	29,412
Resident advances	4,707	8,870
Cash held in trust for patients	6,093	3,038
Resident deposits	1,630	1,818
Dividends payable	2,718	2,705
Property taxes	7,311	8,055
Income tax payable	22,459	—
Other	10,758	9,914
Other accrued liabilities	$ 95,921	$ 70,273

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 accompanying condensed consolidated balance sheets.

15. INCOME TAXES

The Company recorded income tax expense of $26,159 and $9,851 during the six months ended June 30, 2020 and 2019, respectively, or 24.2% of earnings before income taxes for the six months ended June 30, 2020, compared to 18.9% for the six months ended June 30, 2019. The effective tax rate for both six month periods includes excess tax benefits from stock-based compensation, which were higher in 2019, offset by non-deductible expenses including non-deductible compensation.

In February 2020, the IRS sent notification to the Company that its 2017 tax return will be examined. It is anticipated the audit will begin during the third quarter of 2020. The Company is not currently under examination by any other major income tax jurisdiction. During 2020, the statutes of limitations will lapse on the Company's 2016 Federal tax year and certain 2015 and 2016 state tax years. The Company does not believe the Federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the six months ended June 30, 2020 and 2019.

16. DEBT

Debt consists of the following:

	June 30, 2020	December 31, 2019
Revolving credit facility with Truist	**$ 30,000**	$ 210,000
Mortgage loans and promissory notes	**119,552**	120,350
	149,552	330,350
Less: current maturities	**(3,292)**	(2,702)
Less: debt issuance costs	**(2,367)**	(2,431)
	$ 143,893	$ 325,217

Credit Facility with a Lending Consortium Arranged by Truist

The Company maintains a revolving credit facility under the Third Amended and Restated Credit Agreements, dated as of October 1, 2019, between the Company and Truist Financial Corporation (Truist) (formerly known as SunTrust Bank, Inc.) (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 pays 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 than1.50:1.00). As of June 30, 2020, the Company's operating subsidiaries had $30,000 outstanding under the Credit Facility. The Company was in compliance with all loan covenants as of June 30, 2020.

As of July 31, 2020, there was approximately $30,000 of outstanding borrowings under the Credit Facility.

Mortgage Loans and Promissory Notes

As of June 30, 2020, 19 of the Company's subsidiaries are under mortgage loans insured with the Department of Housing and Urban Development (HUD) in the aggregate amount of $114,983, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear fixed interest rates ranging from 2.6% to 3.5% 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, during the first three years, the prepayment fee is 10% and is reduced by 3% 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. Loan proceeds were used to pay down previously drawn amounts on Ensign's revolving line of credit. In addition to refinancing existing borrowings, the proceeds of the HUD-insured debt helped fund acquisitions, to renovate and upgrade existing and future facilities, to cover working capital needs and for other business purposes.

In addition to the HUD mortgage loans above, the Company has two promissory notes. The notes bear fixed interest rates of 5.3% and 4.3% per annum and the term of the notes are 12 years and 10 months, respectively. The 12 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.

As of June 30, 2020, the Company's operating subsidiaries had $119,552 outstanding under the mortgage loans and notes, of which $3,292 is classified as short-term and the remaining $116,260 is classified as long-term. The Company was in compliance with all loan covenants as of June 30, 2020.

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

Off-Balance Sheet Arrangements

As of June 30, 2020, the Company had approximately $5,792 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 and six months ended June 30, 2020 and 2019 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. In connection with the Spin-Off, the number of shares available to be issued under the 2017 Plan were adjusted in the current year in order to reflect the proportional adjustments. The adjustment provides for a total issuance of 8,118 shares of common stock (the Spin-Off Conversion). 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 5 years at 20% per year on the anniversary of the grant date. Options expire 10 years from the date of grant. At June 30, 2020, there were approximately 3,585 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 all stock-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time.

Modifications of Equity Awards

Effective at the time of the consummation of the Spin-Off, all holders of the Company's restricted stock awards on the date of record for the Spin-Off, received Pennant restricted stock awards consistent with the distribution ratio, with terms and conditions substantially similar to the terms and conditions applicable to the Company's restricted stock awards. For purposes of the vesting of these equity awards, continued employment or service with Ensign or with Pennant is treated as continued employment for purposes of both Ensign's and Pennant's equity awards and the vesting terms of each converted grant remained unchanged. Also, effective with the Spin-Off, the holders of the Company's stock options on the date of record received stock options consistent with a conversion ratio that was necessary to maintain the pre Spin-Off intrinsic value of the options. The stock options terms and conditions are based on the preexisting terms in the 2017 Plan, including nondiscretionary antidilution provisions. In order to preserve the aggregate intrinsic value of the Company's stock options held by such persons, the exercise prices of such awards were adjusted by using the proportion of the Pennant closing stock price to the total Company closing stock prices on the distribution date. All of these adjustments were designed to equalize the fair value of each award before and after Spin-Off. These adjustments were accounted for as modifications to the original awards. Due to the modification of the equity options as a result of the Spin-Off, the Company compared the fair value of the original equity awards immediately before and after the Spin-Off and no incremental fair value was recognized as a result of the above adjustments due to immateriality. Accordingly, the Company did not record any incremental compensation expense as a result of the modifications to the awards on the date of the Spin-Off.

The Company's stock-based compensation expense was not significantly impacted by the equity award adjustments that occurred as a result of the Spin-Off. Deferred compensation costs as of the date of the Spin-Off reflected the unamortized balance of the original grant date fair value of the equity awards held by the employees of the Company's operating subsidiaries (regardless of whether those awards are linked to the Company's stock or Pennant's stock).

Stock Options

The Company granted 235 and 380 stock options during the three and six months ended June 30, 2020, respectively.

The Company used the following assumptions for stock options granted during the three months ended June 30, 2020 and 2019:

Grant Year	Options Granted(1)	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2020	**235**	**0.4%**	**6.2 years**	**40.9%**	**0.4%**
2019	258	2.1%	6.3 years	34.0%	0.4%

(1) Options granted represents historical grant values prior to the Spin-Off for the three months ended June 30, 2019.

The Company used the following assumptions for stock options granted during the six months ended June 30, 2020 and 2019:

Grant Year	Options Granted(1)	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2020	**380**	**0.8%**	**6.2 years**	**37.6%**	**0.4%**
2019	399	2.2%	6.3 years	33.9%	0.3%

1) Options granted represents historical grant values prior to the Spin-Off for the six months ended June 30, 2019.

For the six months ended June 30, 2020 and 2019, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted[1]	Weighted Average Exercise Price[2]	Weighted Average Fair Value of Options[3]
2020	**380**	**$ 47.26**	**$ 16.87**
2019	399	$ 45.49	$ 16.40

(1) Options granted from January 1, 2019 through June 30, 2019 represent historical grant values prior to the impact of the Spin-Off. Options granted subsequent to October 1, 2019 represent grant values reflective of the Spin-Off.
(2) Weighted average exercise price was calculated using exercise prices reflective of the Spin-Off Conversion for all periods presented.
(3) Weighted average fair value of options was calculated using the fair values reflective of the Spin-Off Conversion for all periods presented.

The weighted average exercise price equaled the weighted average fair value of common stock on the grant date for all options granted during the periods ended June 30, 2020 and 2019 and therefore, the intrinsic value was $0 at the date of grant.

The following table represents the employee stock option activity during the six months ended June 30, 2020:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options Vested
January 1, 2020	**4,428**	**$ 20.85**	**2,557**	**$ 12.82**
Granted	**380**	**47.26**		
Forfeited	**(34)**	**30.39**		
Exercised	**(179)**	**11.20**		
June 30, 2020	**4,595**	**$ 23.34**	**2,697**	**$ 14.70**

The following summary information reflects stock options outstanding, vested and related details as of June 30, 2020:

	Stock Options Outstanding				Stock Options Vested
Year of Grant	**Exercise Price**	**Number Outstanding**	**Black-Scholes Fair Value**	**Remaining Contractual Life (Years)**	**Vested and Exercisable**
2010	$4.04 - $4.20	4	$ 9	0	4
2011	5.00 - 6.77	73	180	1	73
2012	5.56 - 6.75	191	596	2	191
2013	6.76 - 9.74	340	1,390	3	340
2014	8.94 - 16.05	971	4,650	4	971
2015	18.20 - 21.39	436	3,374	5	373
2016	15.93 - 16.86	362	2,137	6	246
2017	15.80 - 19.41	436	2,571	7	210
2018	22.49 - 32.71	651	6,669	8	199
2019	41.07 - 45.76	752	11,805	9	90
2020	$44.84 - $51.20	379	6,392	10	—
Total		4,595	$ 39,773		2,697

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of June 30, 2020 and December 31, 2019 is as follows:

Options	**June 30, 2020**	**December 31, 2019**
Outstanding	**$ 89,021**	$ 108,623
Vested	**73,559**	83,243
Expected to vest	**13,889**	22,399
Exercisable	**6,532**	29,032

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 intrinsic values as of June 30, 2020 decreased compared to the intrinsic values as of December 31, 2019 due to a decrease in the Company's stock price.

Restricted Stock Awards

The Company granted 81 and 194 restricted stock awards during the three and six months ended June 30, 2020, respectively. The Company granted 89 and 194 restricted stock awards during the three and six months ended June 30, 2019, 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 six months ended June 30, 2020 and 2019 ranged from $35.47 to $51.20 and $41.68 to $53.99, respectively. The fair value per share during the six months ended June 30, 2019 is reflective of values prior to the Spin-Off, while the fair value per share during six months ended June 30, 2020 is reflective of values subsequent to the Spin-Off. 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 June 30, 2020 and changes during the six months ended June 30, 2020 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2020	**610**	**$ 31.35**
Granted	**194**	**44.71**
Vested	**(193)**	**34.31**
Forfeited	**(8)**	**27.63**
Nonvested at June 30, 2020	**603**	**$ 34.76**

During the three and six months ended June 30, 2020, the Company granted 5 and 10 automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards ranged from $35.47 to $47.09 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 and Pennant who assisted in the consummation of the Spin-Off 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 $389 for the three and six months ended June 30, 2020, respectively.

Stock-based compensation expense recognized for the Company's equity incentive plans and long-term incentive plan for the three and six months ended June 30, 2020 and 2019 was as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2020	2019[(1)]	2020	2019[(1)]
Stock-based compensation expense related to stock options	**$ 1,545**	$ 1,403	**$ 2,965**	$ 2,657
Stock-based compensation expense related to restricted stock awards	**1,777**	1,138	**3,374**	2,069
Stock-based compensation expense related to stock options and restricted stock awards to non-employee directors	**206**	388	**424**	659
Total	**$ 3,528**	$ 2,929	**$ 6,763**	$ 5,385

(1) The amount of stock-based compensation expense that was classified as discontinued operations was $137 and $293, respectively for the three and six months ended June 30, 2019.

In future periods, the Company expects to recognize approximately $21,826 and $25,078 in stock-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of June 30, 2020. Future stock-based compensation expense will be recognized over 3.8 weighted average years for both unvested options and restricted stock awards, respectively. There were 1,898 unvested and outstanding options at June 30, 2020, of which 1,780 shares are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at June 30, 2020 was 6.0 years.

Equity Instrument Denominated in the Shares of a Subsidiary

On May 26, 2016, the Company granted stock options and restricted stock awards under the Subsidiary Equity Plan to employees and management of the subsidiary. During 2019, the Company contributed the net assets of the subsidiary to Pennant prior to the consummation of the Spin-Off on October 1, 2019. Effective upon the Spin-Off, all shares under the Plan were converted to Pennant shares and Pennant's Board of Directors hold full administrative authority of the Cornerstone Plan.

The Company did not grant any new restricted shares nor did the Company grant any options during the six months ended June 30, 2019. The awards granted generally vested over a period of three to five years, or upon the occurrence of certain prescribed events. During the six months ended June 30, 2019, there were 976 restricted stock awards that vested.

Prior to the Spin-Off, the grant-date fair value of the awards was recognized as compensation expense over the relevant vesting periods, with a corresponding adjustment to noncontrolling interests. As a result of the conversion of the Subsidiary Equity Plan, the Company's noncontrolling interest in the subsidiary was eliminated. The grant values were determined based on an independent valuation of the subsidiary shares. For the three and six months ended June 30, 2019, the Company expensed $236 and $577, respectively, in stock-based compensation related to the Subsidiary Equity Plan. Further, during the second quarter of 2019, the Company repurchased 469 shares of common stock under the Subsidiary Equity Plan for $2,293. The Company subsequently sold the shares and received net proceeds of $2,293. Stock-based compensation expense related to the Subsidiary Equity Plan, payments from the repurchase of shares and the proceeds from the sale of the repurchased shares related to the Subsidiary Equity Plan are all included within the Company's condensed consolidated financial statements as discontinued operations.

18. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 85 affiliated skilled nursing, senior living facilities used in the Company's operations under eight "triple-net" master lease agreements (collectively, the Master Leases), which range in terms from 12 to 20 years. In connection with the Spin-Off, 11 of the original 94 properties under the CareTrust lease were transferred to Pennant. Of the 11 properties, two of the senior living operations are located on the same real estate properties as the skilled nursing facilities. 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.

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.

Commencing the third year, the rent structure under the Master Leases includes a fixed component, subject to annual escalation equal to the lesser of (1) the percentage change in the Consumer Price Index (but not less than zero) or (2) 2.5%. In addition to rent, the Company is required to pay the following: (1) all impositions and taxes levied on or with respect to the leased properties (other than taxes on the income of the lessor); (2) all utilities and other services necessary or appropriate for the leased properties and the business conducted on the leased properties; (3) all insurance required in connection with the leased properties and the business conducted on the leased properties; (4) all facility maintenance and repair costs; and (5) all fees in connection with any licenses or authorizations necessary or appropriate for the leased properties and the business conducted on the leased properties. Total rent expense under the Master Leases was approximately $13,130 and $26,255 for the three and six months ended June 30, 2020, respectively, and $13,566 and $26,924 for the three and six months ended June 30, 2019, 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 not aware of any defaults as of June 30, 2020.

In connection with the Spin-Off, the Company amended the Master Leases with CareTrust and other third-party lease agreements. These amendments terminated the leases related to Pennant and modified the rental payments and lease terms of the operations that remained with Ensign. In accordance with ASC 842, the amended lease agreements are considered to be modified and subject to lease modification guidance. The amended lease agreements are considered to be modified and subject to lease modification guidance. The right-of-use (ROU) asset and lease liabilities related to these agreements were remeasured based on the change in the lease conditions such as rent payment and lease terms. The incremental borrowing rate was adjusted to reflect the revised lease terms which became effective at the date of the modification, which is the date of the Spin-Off. The net impact of the lease termination, for the 23 leases that transferred to Pennant and modification of lease agreements, is a reduction in ROU asset and lease liabilities of approximately $35,000. The annual rent expense transferred to Pennant was approximately $23,000.

In connection with the Spin-Off, the Company also guaranteed certain leases of Pennant based on the underlying terms of the leases. The Company does not consider these guarantees to be probable, and cannot estimate the maximum exposure.

The Company also leases certain affiliated operations and its administrative offices under non-cancelable operating leases, most of which have initial lease terms ranging from five to 20 years. The Company has entered into multiple lease agreements with 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 for continuing operations inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $32,499 and $64,846 for the three and six months ended June 30, 2020, respectively, and $31,372 and $61,708 for the three and six months ended June 30, 2019, respectively.

Forty 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. 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 June 30,		Six Months Ended June 30,	
	2020	**2019**	**2020**	**2019**
Rent - cost of services[(1)]	**$ 32,484**	$ 31,222	**$ 64,814**	$ 61,403
General and administrative expense	**15**	150	**32**	305
Depreciation and amortization[(2)]	**290**	495	**644**	990
Variable lease costs[(3)]	**3,252**	3,248	**6,463**	6,063
	$ 36,041	$ 35,115	**$ 71,953**	$ 68,761

(1) Rent- cost of services includes deferred rent adjustments of $111 and $236 for the three and six months ended June 30, 2020, respectively and $595 and $849 for the three and six months ended June 30, 2019, respectively. Additionally, rent- cost of services includes other variable lease costs such as CPI increases and short-term leases of $620 and $1,214 three and six months ended June 30, 2020, respectively and $339 and $428 for the three and six months ended June 30, 2019, 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 June 30, 2020 are as follows:

Year	**Amount**
2020 (remainder)	$ 63,875
2021	127,375
2022	126,153
2023	124,417
2024	123,436
2025	123,288
Thereafter	1,020,202
Total lease payments	1,708,746
Less: present value adjustment	(703,514)
Present value of total lease liabilities	1,005,232
Less: current lease liabilities	(46,983)
Long-term operating lease liabilities	$ 958,249

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 June 30, 2020, the weighted average remaining lease term is 14.2 and the weighted average discount rate used to determine the operating lease liability is 8.3%.

Subsequent to June 30, 2020, the Company exercised options to extend the leases at two of its facilities for an additional 10 years each. These extensions resulted in an aggregate increase to the Company's operating lease liabilities of approximately $6.3 million. Each of the modified leases now extend through November 31, 2031.

Lessor Activities

In connection with the Spin-Off, Ensign affiliates retained ownership of the real estate at 29 senior living operations that were contributed to Pennant. During the first quarter of 2020, the Company transferred the operations of an additional two senior living operations to Pennant. Ensign affiliates retained ownership of the real estate for these 31 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 annual rental income generated from the leases with Pennant is approximately $14,000, which includes variable rent such as property taxes, insurance and other items.

Total rental income from all third-party sources for the three and six months ended June 30, 2020 and 2019 is as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Pennant[(1)]	$ 3,262	$ —	$ 6,829	$ —
Other third-party	665	668	1,401	1,425
	$ 3,927	$ 668	$ 8,230	$ 1,425

(1) Pennant rental income includes variable rent such as property taxes, insurance and other items of $131 and $597 during the three and six months ended June 30, 2020, respectively.

Future minimum lease payments receivable for all leases as of June 30, 2020 were as follows:

Year	Amount
2020 (remainder)	$ 8,328
2021	15,583
2022	15,099
2023	14,913
2024	14,516
2025	14,333
Thereafter	102,220
Total lease payments receivable	$ 184,992

19. COMMITMENTS AND CONTINGENCIES

Regulatory Matters — Laws and regulations governing Medicare and Medicaid programs are complex and subject to interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires healthcare providers (among other things) to safeguard the privacy and security of certain 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 employees, under which the Company may be required to indemnify such persons for liabilities arising out of their employment relationship or 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 consolidated balance sheets for any of the periods presented.

U.S. Department of Justice Civil Investigative Demand - On May 31, 2018, the Company received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating whether there has been a violation of the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of the Company’s independently operated skilled nursing facilities and persons who serve or have served as medical directors, advisory board participants or other potential referral sources. The CID covered the period from October 3, 2013 to the present, and was limited in scope to ten of the Company’s Southern California independent operating entities. In October 2018, the Department of Justice made an additional request for information covering the period of January 1, 2011 to the present, relating to the same topic. As a general matter, the Company’s independent operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. The Company has fully cooperated with the U.S. Department of Justice to promptly respond to the requests for information, and has been advised that the U.S. Department of Justice declined to intervene in any subsequent action based on or related to the subject matter of this investigation.

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. 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.

Further, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis has launched an investigation into the coronavirus crisis in nursing homes. In June 2020, the Company received a document request from the House Select Subcommittee. The Company is cooperating with this inquiry; however, it is not possible to predict the ultimate outcome of any such investigation or what other investigations or regulatory responses may result from the investigation and 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, the Company is also subject to potential lawsuits under the Federal False Claims Act and comparable state laws alleging submission of fraudulent claims for services to any healthcare program (such as Medicare) or payor. A violation may provide the basis for exclusion from Federally-funded healthcare programs. Such exclusions could have a correlative negative impact on the Company's financial performance. Under the *qui tam* or "whistleblower" provisions of the False Claims Act, 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. For example, and despite the decision of the U.S. Department of Justice to decline participation in litigation based on the subject matter of its previously issued Civil Investigative Demand, the *qui tam* relator may continue on with the lawsuit and pursue claims that the Company has 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. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. As such, the Company could face increased scrutiny, potential liability and legal expenses and costs based on claims under state false claims acts in markets in which 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 (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 it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, 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. One particular type of suit arises from alleged violations of minimum staffing requirements for skilled nursing facilities in those states which have enacted such requirements. The alleged failure to meet these requirements can, among other things, jeopardize a facility's compliance with the requirements of participation under certain state and federal healthcare programs; it may also subject the facility to a deficiency, a citation, a civil money penalty, or litigation. These class-action "staffing" suits have the potential to result in large jury verdicts and settlements. The Company expects the plaintiffs' bar to continue to be aggressive in their pursuit of these staffing and similar claims.

The Company and its independent operating subsidiaries have in the past been subject to class action litigation involving claims of alleged violations of regulatory requirements related to staffing. 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 has been subjected to, and is 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 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 and legal actions that arise in the ordinary course of business, including potential claims filed by residents and responsible parties related to patient care and treatment (professional negligence claims), as well as 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.

The Company cannot predict or provide any assurance as to the possible outcome of any inquiry, investigation or litigation. If any such 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, the Company's business, financial condition and results of operations and cash flows could be materially and adversely affected and its stock price could be adversely impacted. Among other things, any settlement or litigation could involve the payment of substantial sums to settle any alleged civil violations, and may also include the assumption of specific procedural and financial obligations by the Company or its operating subsidiaries going forward under a corporate integrity agreement and/or other such arrangements.

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 (PSC), and Medicaid Integrity Contractors (MIC) programs (collectively referred to as Reviews). Centers for Medicare and Medicaid Services (CMS) has suspended all Targeted Probe and Educate program activity due to the public health emergency declared as a result of COVID-19. Accordingly, as of June 30, 2020, none of the Company's independent operating subsidiaries had Reviews scheduled, on appeal, or are in a dispute resolution process, both pre- and post-payment. Once the suspension period is lifted, the previously in-progress reviews could start again. The Company anticipates that these Reviews will reconvene and could increase in frequency in the future.

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

In connection with the settlement and effective as of October 1, 2013, the Company and its independent operating entities entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. CMS acknowledged the existence of the Company’s current compliance program, which is in accord with the Office of the Inspector General (OIG)’s guidance related to an effective compliance program, and required that the Company and its independent operating entities continue during the term of the CIA to maintain a program designed to promote compliance with the statutes, regulations, and written directives of Medicare, Medicaid, 5and all other Federal health care programs.

In the first quarter of 2019, the Company received notice from the OIG that the Company’s five-year CIA with the OIG had been completed. Upon receipt of the Company’s fifth and final annual report, the OIG confirmed that the term of the CIA is concluded.

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 60.0% and 57.3% of its total accounts receivable as of June 30, 2020 and December 31, 2019, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 74.8% and 72.7% of the Company's revenue for the three and six months ended June 30, 2020, respectively, and 70.3% for both the three and six months ended June 30, 2019.

Cash in Excess of FDIC Limits — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of July 31, 2020, the Company had approximately $468 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

20. COMMON STOCK REPURCHASE PROGRAM

As approved by the Board of Directors on March 4, 2020 and March 13, 2020, the Company entered into two stock repurchase programs pursuant to which the Company may repurchase up to $20,000 and $5,000, respectively, of its common stock under the programs for a period of approximately 12 months. Under these programs, 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 first quarter of 2020, the Company repurchased 503 shares of its common stock for a total of $20,000 and 189 shares of its common stock for a total of $5,000, respectively. These repurchase programs expired upon the repurchase of the full authorized amount under the two plans.

As approved by the Board of Directors on August 26, 2019, 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. 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. The Company repurchased 138 shares of its common stock for a total of $6,406 in fiscal year 2019 before the repurchase program was cancelled in the first quarter of 2020.

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 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, 2019 (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 Report, and similar discussions in our other SEC filings, also describe some of the important risk factors that may affect our business, financial condition, results of operations and/or liquidity. You should carefully consider those risks, in addition to the other information in this Report and in our other filings with the SEC, before deciding to purchase, hold or sell our common stock.

This Report contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to the Company's expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, plans and objectives of management. Forward-looking statements can often be identified by words such as "anticipates," "expects," "intends," "plans," "predicts," "believes," "seeks," "estimates," "may," "will," "should," "would," "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, many of these risks and uncertainties are currently amplified by and in the future may be amplified by, the COVID-19 outbreak. The developments with respect to the spread of COVID-19 and its impacts have been occurring rapidly and because of the unprecedented nature of the pandemic, we are unable to predict the full extent and duration of the adverse financial impact of COVID-19 on our business, financial condition and results of operations. While we are not able to estimate the full impact of the COVID-19 outbreak on our financial condition and future results of operations, we expect that this situation will have an adverse effect on our reported results in the future. Our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section "Risk Factors" contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management's beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law.

As used in this Management's Discussion and Analysis of Financial Condition and Results of Operations, the words, "we," "our" and "us" refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our affiliated operations, the Service Center and the Captive are operated by separate, wholly-owned, independent subsidiaries that have their own management, employees and assets. The use of "we," "us," "our" and similar verbiage in this Quarterly Report on Form 10-Q is not meant to imply that any of our affiliated operations, the Service Center or the Captive are operated by the same entity. This Management's Discussion and Analysis of Financial Condition and Results of Operations should be read in conjunction with our consolidated financial statements and related notes included the Annual Report.

Overview

We are a provider of health care services across the post-acute care continuum, as well as other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Massachusetts, Nebraska, Nevada, South Carolina, Texas, Utah, Washington and Wisconsin. Our operating subsidiaries, each of which strives to be the service of choice in the community it serves, provide a broad spectrum of skilled nursing, senior living and other ancillary services. As of June 30, 2020, we offered skilled nursing, senior living and rehabilitative care services through 225 skilled nursing and senior living facilities. Of the 225 facilities, we operated 163 facilities under long-term lease arrangements, and have options to purchase 11 of those 163 facilities. We owned an additional 92 real estate properties, which included 62 operations we operated and managed, real estate properties of 31 senior living operations that were leased to The Pennant Group, Inc. as part of the Spin-Off (defined below), and the Service Center location. Of those 31 senior living operations, two are located on the same real estate properties as the skilled nursing facilities.

The following table summarizes our affiliated facilities and operational skilled nursing beds and senior living units by ownership status as of June 30, 2020:

	Owned and Operated	Leased (with a Purchase Option)	Leased (without a Purchase Option)	Total for Facilities Operated
Number of facilities	62	11	152	225
Percentage of total	27.6 %	4.9 %	67.5 %	100.0 %
Operational skilled nursing beds	6,156	1,145	15,606	22,907
Percentage of total	26.9 %	5.0 %	68.1 %	100.0 %
Senior living units	1,334	178	606	2,118
Percentage of total	63.0 %	8.4 %	28.6 %	100.0 %

The Ensign Group, Inc. (collectively, Ensign or the Company) is a holding company with no direct operating assets, employees or revenues. Our operating subsidiaries are operated by separate, independent entities, each of which has its own management, employees and assets. In addition, certain of our wholly owned subsidiaries, referred to collectively as the Service Center, provide centralized accounting, payroll, human resources, information technology, legal, risk management and other centralized services to the other operating subsidiaries through contractual relationships with such subsidiaries. We also have a wholly owned captive insurance subsidiary (the Captive) that provides some claims-made coverage to our operating subsidiaries for general and professional liability, as well as coverage for certain workers' compensation insurance liabilities. References herein to the consolidated "Company" and "its" assets and activities, as well as the use of the terms "we," "us," "our" and similar terms in this Quarterly Report on Form 10-Q, 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

Coronavirus - The outbreak of the 2019 coronavirus disease (COVID-19), which was declared a global pandemic by the World Health Organization (WHO) on March 11, 2020, and the related responses by public health and governmental authorities to contain and combat its outbreak and spread, continues to spread and disrupt healthcare operations across the United States, including the markets in which we operate. The rapid spread of the virus has led to the implementation of various responses, including federal, state and local government-imposed quarantines, shelter-in-place mandates, sweeping restrictions on travel, and substantial changes to selected protocol within the healthcare system across the United States. Additionally, the Centers for Disease Control and Prevention (CDC) has stated that older adults are at a higher risk for serious illness and death from COVID-19. The extent to which COVID-19 impacts our operations will depend on future developments which continue to remain highly uncertain and cannot be predicted with confidence, including the duration of the outbreak, additional or modified government actions, new information which may emerge concerning the severity of COVID-19 and the actions taken to contain COVID-19 or treat its impact, among others. In response to the pandemic, federal and state agencies have been evolving and in some cases, relaxing enforcement requirements, trending toward granting healthcare providers with flexibility to prioritize resident care over stringent adherence to regulatory compliance.

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. The CDC has stated that older adults, such as our patients, are at a higher risk for serious illness and death from COVID-19 due to the prevalence of chronic medical conditions. In addition, our employees are at higher risk of contracting or spreading the disease due to the nature of the work environment when caring for patients. Consistent with CDC guidelines and recommendations applicable to nursing facilities, we implemented new infection control policies and practices to prevent the introduction of COVID-19 into our facilities and to control the spread of COVID-19 within communities. These changed include restricting visitors at all of our facilities except for essential healthcare personnel and certain end-of-life situations, screening employees and others permitted to enter the building, restricted communal dining, and reducing or restricting activities programming and optional therapies. Upon confirmation of a positive COVID-19 exposure at a facility, we follow CDC guidance to minimize further exposure, including implementing personal protection protocols, restricting new admissions, and cohorting and isolating patients. Due to the vulnerable nature of our patients, we expect many of these protections will continue at our facilities, even as federal, state, and local stay-at-home and social distancing orders and recommendations are relaxed. Notwithstanding these protocols and our other response efforts, the virus will likely continue to be introduced to and transmitted within certain facilities due to the transmissible nature of COVID-19.

The full financial impact of COVID-19 will continue to be dependent upon numerous factors, including the nature of the COVID-19 pandemic (such as geographic concentration of virus, rate of spread, and duration), as well as access and costs of staffing, testing and supplies), legal and regulatory matters and federal and state stimulus and other measures intended to mitigate the clinical and financial harm of the pandemic. While the operating environment for healthcare providers is continuously changing during this pandemic, the safety and well-being of our patients and employees remains our top priority.

Although the ultimate impact of the COVID-19 pandemic remains uncertain, we can offer the following observations regarding the impact of COVID-19 on our operations, as well as significant regulatory and legislative relief initiatives.

Occupancy

Prior to COVID-19, we were exhibiting consistent growth in our occupancy and skilled mix. However, following the introduction of COVID-19 into the U.S., our operations have experienced declines in occupancy as a result of local government-imposed quarantines, including shelter-in-place mandates, sweeping restrictions on travel, and substantial restrictions and changes to protocol within the healthcare system across the U.S., including temporary limitations on certain medical procedures, which limited the number of patients visiting the hospital and needing skilled nursing services.

The introduction of the virus into our operations is typically contemporaneous with the virus' impact in each community in which we operate. Our operations are located in 14 states and range from metropolitan, suburban and rural communities. The prevalence of the virus varies dramatically by state, within the same state or within the same county. Accordingly, the impact on each of our operations has also varied widely.

Our first location to have a confirmed positive COVID-19 patient and staff member was in the state of Washington, which was one of the first states to have confirmed COVID-19 cases in the United States. Accordingly, our Washington locations were impacted beginning in mid-February. As the weeks continued, and as reported and confirmed cases of COVID-19 infections in the United States increased, we also began experiencing an impact on our revenues and expenses throughout the organization. As of June 30, 2020, we have 138 operations that have positive cases of COVID-19 amongst patients or staff. Most of these operations have seen only a few cases amongst patients, staff or both and a small number of operations have had multiple positive cases amongst the patients, staff or both. We expect to continue to see new positive cases in some of our operations as the virus continues to impact each community and as testing is more readily available and mandated in certain circumstances. Approximately 80% of the patient and resident positive COVID-19 cases that we experienced in our facilities have occurred in the states of Arizona, California and Texas. These are states which have experienced significant community outbreaks.

Beginning in mid-February and continuing throughout the second quarter, we experienced decreased volumes which we believe resulted from a number of factors related to the spread of COVID-19, including lower census at acute-care hospitals. Many-acute care hospitals took affirmative steps to prepare for an increase of COVID-19 and critical care patients, and imposed admission restrictions due to the need to preserve personal protective equipment and a heightened anxiety among patients and caregivers regarding the risk of exposure to COVID-19. Occupancy was also initially impacted by decisions of our operating subsidiaries to limit new admissions into their operations due to the risks and uncertainties surrounding the potential spread of the virus by individuals that had either tested positive for COVID-19, were symptomatic of COVID-19 but had not yet been tested positive due to a shortage of tests, or that were asymptomatic of COVID-19 but had an unknown status and were potentially positive and contagious.

On March 13, 2020, President Trump issued a national emergency declaration in connection with the COVID-19 situation. Following the State of Emergency declarations, California was the first state to have a shelter-in-place order, which was subsequently followed by similar orders in 42 other states. As COVID-19 cases began to decline in late May and June, we saw an increase in occupancy and a slight decrease of skilled mix as the needs of high acuity patients were fewer. Between mid-May to mid-June, Same Facilities and Transitioning Facilities occupancy increased by 0.4% and skilled mix decreased by 1.1%. However, the recent influx of COVID-19 cases in several key states, occupancy again began to decrease slightly while skilled mix improved as the number of high acuity patients increased. Between mid-June and mid-July, combined Same Facilities and Transitioning Facilities occupancy was down by approximately 2.3% and skilled mix increased by 8.1%. Although census trends declined significantly during the second quarter, the rate of decline in occupancy has continued to slow. Beginning in June and continued into July, occupancy has remained stable.

As COVID-19 has progressed and spread throughout the community we serve, our local operations and caregivers have been serving higher acuity patients who have or have been suspected of having COVID-19. The surge of COVID-19 positive patients, or patients suspected to have been exposed to COVID-19, has resulted in an increase in the number of patients requiring skilled services, which we are able to serve through skilled-in-place (SIP) precautions and procedures. In addition, patients that are not COVID-19 positive or suspected to be COVID-19 positive but require skilled services and qualify to be cared for under the SIP precautions and procedures, have remained in our facilities instead of moving to the hospitals first. This not only allows hospitals to maintain open acute care beds for COVID-19 patients and other highly acute patients, but it also limits the risks involved with moving patients back and forth from one care setting to another. Accordingly, our skilled mix days have substantially recovered to rates similar to those prior to the COVID-19 impact.

Legislative and Regulatory Relief

In March 2020, the federal government began to undertake numerous legislative and regulatory initiatives designed to provide relief to the healthcare industry during the COVID-19 pandemic. These initiatives include:

- **Temporary suspension of Medicare sequestration** - The Coronavirus Aid, Relief, and Economic Security Act of 2020 (the CARES Act) temporarily suspends the automatic 2% reduction of Medicare claim reimbursements for the period of May 1, 2020 through December 31, 2020. The suspension of the Medicare sequestration increased our revenue by approximately $2.5 million in the second quarter. The magnitude of the positive impact will depend on the continued impact of the virus on our census and skilled mix through the remainder of the year.
- **Relief funds for healthcare providers** - The CARES Act also authorized the distribution of relief fund grants from the Department of Health and Human Services (HHS) to healthcare providers "to support healthcare-related expenses or lost revenue attributable to COVID-19…" Distributions were automatically paid to each provider by HHS based upon the provider's patient revenue, number of facilities and operational beds, as well as various other factors. To keep the funds, HHS requires providers to submit an attestation accepting certain terms and conditions within 90 days of receipt of each distribution of funds. Providers could also apply for additional funding. Our operations began automatically receiving relief fund payments in April 2020. We received approximately $108.8 million in relief distributions. We have elected not to accept any of the CARES Act relief funds received to date and have returned all funds to an agent of HHS. For further discussion, see *Note 3, COVID-19 Update* in the Notes to Condensed Consolidated Financial Statements.
- **Increase in Federal Medical Assistance Percent (FMAP)** - The Family First Coronavirus Response Act provides a 6.2% increase to FMAP. The Act permits states to retroactively increase the Medicaid rates to January 1, 2020. The FMAP funding will terminate at the end of the quarter when the national emergency status is lifted. To date, we have recognized $13.1 million of FMAP reimbursement relief. The temporary increase on FMAP and the timing of payments has and will continue to vary substantially dependent on the state.

- **Temporary suspension of certain patient coverage criteria and documentation and care requirements** - The CARES Act and a series of temporary waivers and guidance issued by the Centers for Medicare and Medicaid Services (CMS) suspend various Medicare patient coverage criteria, as well as, certain documentation and care requirements. These accommodations are intended to ensure patients have adequate access to care notwithstanding the burdens placed on healthcare providers due to the COVID-19 pandemic. These regulatory actions have and will continue to contribute to an increase in census volumes and skilled mix, that may not otherwise occur.
- **Medicare Accelerated and Advance Payment Program** - The CARES Act expands the Medicare Accelerated and Advance Payment Program to ensure providers and suppliers have the resources needed to combat the pandemic. Our operations began to receive advances in April 2020. Year to date, we have received $98.9 million through the Medicare Accelerated and Advance Payment Program. The payment acceleration from Medicare is to be repaid starting 120 days after the receipt of cash. We have paid a portion of the fund back in July 2020.
- **Deferral of Taxes** - 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 U.S. Treasury Department and Internal Revenue Service, also allows corporate taxpayers to defer their estimated federal income taxes for the first and second quarters of 2020 to July 15, 2020.

Net revenue

Our net revenues for the three months ended June 30, 2020 were impacted by COVID-19 as we experienced revenue lost from a decline in occupancy, which was partially offset by our skilled mix changes. As part of the healthcare community, we have been actively participating in ensuring our patients receive necessary services. CMS has authorized these services through skilled in place (SIP) programs. These programs are designed to allow skilled nursing providers to provide skilled services to higher acuity patients, while allowing hospitals to have increased capacity to care for critical care patients (including COVID-19 positive patients) and limiting the risks related to moving patients between care settings in the midst of a pandemic. In addition, the FMAP program has been designed to enhance the reimbursements to provide additional funding to cover COVID related expenses in selected states. In the second quarter, we recorded FMAP revenue of $12.4 million, which correlate directly to the additional COVID-19 related expenses we incurred.

Operating Expenses

We have and continued to experience increased operating expenses during the period impacted by COVID-19 due to the higher utilization, cost and type of personal protective equipment, testing for COVID-19 as well as increased purchasing of other medical supplies and cleaning and sanitization materials. In addition, we have and expect to continue to have increases in labor costs on a per patient basis. In response, we have reduced spending on non-essential supplies, travel costs and all other discretionary items, ceased all non-essential capital expenditure projects and temporarily instituted wage reductions and hiring freezes for non-clinical staff which were both reinstated in June 2020.

Overall

The exact timing and pace of the recovery is uncertain given the impact of the pandemic on the overall U.S. and global economy. While we are uncertain as to the duration of the lower census volumes we are experiencing due to the COVID-19 pandemic, we expect the adverse impact to continue through the end of the third quarter. We also expect to experience a modest recovery in the fourth quarter of 2020 as the volumes in the hospitals increase and as the spread of the virus continues to slow in addition to our typical fourth quarter seasonality in our business. Our forecasted measures may be modified as the pace of the recovery in our volumes becomes more clear over the coming months.

We are focused on navigating the challenges presented by COVID-19 through utilizing the infrastructure of our local operational approach. Each location is partnering with its local leaders and community outreach to ensure the operations are well equipped to deliver quality care. Consistent with previous hurdles, our local leaders are adjusting their operation to meet the clinical and financial challenges, including utilizing the expertise of our Service Center resources to implement best practices.

Common Stock Repurchase Program - As approved by the Board of Directors on March 4, 2020 and March 13, 2020, we entered into two separate stock repurchase programs pursuant to which we may repurchase up to $20.0 million and $5.0 million, respectively, of our common stock under the programs for a period of approximately 12 months each. During the three months ended March 31, 2020, we repurchased 0.5 million and 0.2 million shares of our common stock for a total of $20.0 million and $5.0 million under the March 4, 2020 and March 13, 2020 repurchase programs, respectively. These repurchase programs expired upon the repurchase of the full authorized amount under the two plans. The stock repurchases were supported with funds from our ordinary operations and took place prior to the passage of The CARES Act, which was passed by Congress and signed into law by President Trump on March 27, 2020. Currently we have no active repurchase plans and do not intend to approve another repurchase plan at this time. As we enter a period of economic uncertainty, we are taking steps to manage our expenses and preserve our cash. We believe our current cash management strategy is appropriate at this time and will consider approving stock repurchase programs in the future after we gain additional visibility into our cash flows and how to best utilize those funds.

Spin-Off of Subsidiaries

On October 1, 2019, we completed the separation of our transitional and skilled nursing services, home health and hospice operations and substantially all of our senior living operations into two separate, publicly traded companies:

- Ensign, which includes skilled nursing and senior living services, physical, occupational and speech therapies and other rehabilitative and healthcare services, post-acute-related new business ventures and real estate investments; and

- The Pennant Group, Inc. (Pennant), which is a holding company of operating subsidiaries that provide home health, hospice and senior living services.

We completed the separation through a tax-free distribution of substantially all of the outstanding shares of common stock of Pennant to Ensign stockholders on a pro rata basis (the Spin-Off). We transferred to Pennant net assets of 63 home health, hospice and home care agencies and 52 senior living communities. We retained ownership of all the real estate, which includes 29 of the 52 senior living operations that were contributed to Pennant. These assets are leased to Pennant on a triple-net basis. Pennant affiliates are responsible for all costs at the properties, including property taxes, insurance and maintenance and repair costs. Annual rental income generated from the leases with Pennant is $14.0 million. Pennant's remaining 23 senior living operations are leasing the underlying real estate from unrelated third parties.

As part of the Spin-Off, we amended the Master Leases with CareTrust and other third-party lease agreements. These amendments terminate the leases related to the operations that transferred to Pennant and modified the rental payments and lease terms of the operations that remained with Ensign. The net impact of the lease termination and modification of the senior living properties is a reduction in annual rent expense of approximately $23.0 million.

We entered into several agreements with Pennant in connection with the Spin-off, including a transition services agreement (TSA), separation and distribution agreement, tax matters agreement and employee matters agreement. Pursuant to the TSA, Ensign and Pennant and our respective subsidiaries agreed to provide various services to each other on an interim, transitional basis. Services being provided by us include, among others, certain finance, information technology human resources, employee benefits and other administrative services. The services generally commenced on October 1, 2019 and will terminate on or before September 30, 2021. Revenue to Ensign under the TSA was not material during the quarter ended March 31, 2020.

Immediately after the Spin-Off, we no longer consolidated our home health and hospice operations and the senior living operations that were contributed to Pennant into our financial results. As a result, the consolidated financial statements included in this Quarterly Report on Form 10-Q and related financial information reflect the Pennant operations, assets and liabilities, and cash flows as discontinued operations for 2019 financial periods presented. In the fourth quarter of 2019 and subsequent to the Spin-Off, we have one reportable segment, transitional and skilled services, which includes the operation of skilled nursing facilities. Prior to the separation of Pennant, we had three reportable segments. See Note 4, *Spin-Off of Subsidiaries*, in the notes to condensed consolidated financial statements for further detail.

On October 1, 2019, in connection with the Spin-Off, we entered into the Credit Facility, with 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. Borrowings are supported by a lending consortium arranged by Truist. In connection with the amendment, we also terminated the term loan under the prior credit facility.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds and units located at our facilities as of June 30, 2020:

	TX	CA	AZ	UT	CO	WA	ID	NE	IA	SC	WI	NV	KS	Total
Number of facilities														
Skilled nursing operations	55	47	29	18	11	9	9	4	4	4	2	1	—	193
Senior living communities	1	—	—	2	5	—	—	1	—	—	—	—	—	9
Campuses(1)	5	1	2	1	1	—	2	2	2	—	—	—	7	23
Number of operational beds/units														
Operational skilled nursing beds	7,301	4,781	4,097	2,015	970	841	904	413	368	424	100	92	601	22,907
Senior living units	514	65	179	165	620	—	37	301	31	—	—	—	206	2,118

(1) Campus represents a facility that offers both skilled nursing and senior living services.

During the six months ended June 30, 2020, we expanded our operations through a combination of long-term leases and real estate purchases, with the addition of three stand-alone skilled nursing operations and one stand-alone independent living operation. The addition of these operations added a total of 247 operational skilled nursing beds and 162 operational senior living units to be operated by our affiliated operating subsidiaries. The purchase price for the acquisitions during the six months ended June 30, 2020 was $14.1 million. During the first quarter of 2020, the Company entered into a long-term lease agreement to transfer two senior living operations to Pennant. Our affiliated operations retained ownership of the real estate for these two senior living communities. For further discussion of our acquisitions, see *Note 9, Acquisitions* in the Notes to Condensed Consolidated Financial Statements.

Subsequent to June 30, 2020, we expanded our operations through the acquisition of one campus operation for a purchase price of $8 million, which added 62 operational skilled nursing beds and 162 operational senior living units to be operated by our operating subsidiary.

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:

Transitional and 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 FMAP 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 June 30,		Six Months Ended June 30,	
Skilled Mix:	**2020**	**2019**	**2020**	**2019**
Days	**29.7 %**	29.0 %	**29.5 %**	29.5 %
Revenue	**51.4 %**	48.7 %	**50.8 %**	49.2 %

Occupancy. We define occupancy derived from our transitional and 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 June 30,		Six Months Ended June 30,	
Occupancy for transitional and skilled services:	**2020**	**2019**	**2020**	**2019**
Operational beds at end of period	**22,907**	20,656	**22,907**	20,656
Available patient days	**2,084,261**	1,855,909	**4,154,993**	3,627,614
Actual patient days	**1,530,286**	1,472,798	**3,173,676**	2,879,167
Occupancy percentage (based on operational beds)	**73.4 %**	79.4 %	**76.4 %**	79.4 %

Segments

We have one reportable segment, transitional and skilled services, which includes the operation of skilled nursing facilities. Our Chief Executive Officer, who is our chief operating decision maker, or CODM, reviews financial information at the operating segment level.

We also report an “all other” category that includes revenue from our senior living operations, real estate properties, mobile diagnostics and other ancillary operations. These operations are neither significant individually nor in aggregate and therefore do not constitute a reportable segment.

Revenue Sources

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

	Three Months Ended June 30,					
	Transitional and Skilled Services		Other[(1)]		Total	
	2020	2019	2020	2019	2020	2019
Medicaid	$ 222,924	$ 192,545	$ 3,194	$ 3,233	$ 226,118	$ 195,778
Medicare	175,044	118,807	—	—	175,044	118,807
Medicaid-skilled	36,385	31,792	—	—	36,385	31,792
Subtotal	434,353	343,144	3,194	3,233	437,547	346,377
Managed care	82,316	86,491	—	—	82,316	86,491
Private and other	40,110	39,603	24,726	20,445	64,836	60,048
Total revenue	$ 556,779	$ 469,238	$ 27,920	$ 23,678	$ 584,699	$ 492,916
Medicaid	40.0 %	41.0 %	11.4 %	13.7 %	38.7 %	39.7 %
Medicare	31.4	25.3	—	— %	29.9	24.1
Medicaid-skilled	6.6	6.8	—	— %	6.2	6.5
Subtotal	78.0	73.1	11.4	13.7 %	74.8	70.3
Managed care	14.8	18.4	—	— %	14.1	17.5
Private and other	7.2	8.5	88.6	86.3 %	11.1	12.2
Total revenue	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

(1) Private and other payors in our "all other" category includes revenue from rental income, senior living operations and all payors generated in our other ancillary operations.

	Six Months Ended June 30,					
	Transitional and Skilled Services		Other[(1)]		Total	
	2020	2019	2020	2019	2020	2019
Medicaid	$ 443,893	$ 373,839	$ 6,421	$ 6,438	$ 450,314	$ 380,277
Medicare	330,628	235,508	—	—	330,628	235,508
Medicaid-skilled	72,394	62,243	—	—	72,394	62,243
Subtotal	846,915	671,590	6,421	6,438	853,336	678,028
Managed care	184,345	169,663	—	—	184,345	169,663
Private and other	83,924	77,243	52,707	39,290	136,631	116,533
Total revenue	$ 1,115,184	$ 918,496	$ 59,128	$ 45,728	$ 1,174,312	$ 964,224
Medicaid	39.8 %	40.7 %	10.9 %	14.1 %	38.3 %	39.4 %
Medicare	29.6	25.6	—	—	28.2	24.4
Medicaid-skilled	6.6	6.8	—	—	6.2	6.5
Subtotal	76.0	73.1	10.9	14.1	72.7	70.3
Managed care	16.5	18.5	—	—	15.7	17.6
Private and other	7.5	8.4	89.1	85.9	11.6	12.1
Total revenue	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %	100.0 %

(1) Private and other payors in our "all other" category includes revenue from rental income, senior living operations and all payors generated in our other ancillary operations.

Transitional and 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.

Other

Within our senior living operations, we generate revenue primarily from private pay sources, with a portion earned from Medicaid or other state-specific programs. As part of, and subsequent to, the Spin-Off, we lease 31 of the 92 real estate properties owned by us to Pennant on a triple-net basis. Annual rental income generated from the leases with Pennant is approximately $14.0 million. In addition, we held 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 Policies

Our discussion and analysis of our financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with U.S. Generally Accepted Accounting Principles (GAAP). The preparation of these financial statements and related disclosures requires us to make judgments, estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenue and expenses during the reporting period. On an ongoing basis, we review our judgments and estimates, including but not limited to those related to the variable considerations to arrive at the transaction price for revenue recognition, income taxes, intangible assets and loss contingencies. We base our estimates and judgments upon our historical experience, knowledge of current conditions and our belief of what could occur in the future considering available information, including assumptions that we believe to be reasonable under the circumstances. By their nature, these estimates and judgments are subject to an inherent degree of uncertainty, and actual results could differ materially from the amounts reported. While we believe that our estimates, assumptions, and judgments are reasonable, they are based on information available when the estimate was made. Refer to Note 2, *Summary of Significant Accounting Policies*, within the Condensed Consolidated Financial Statements for further information on our critical accounting estimates and policies, which are as follows:

- ***Revenue recognition*** - the estimate of variable considerations to arrive at the transaction price, including methods and assumptions used to determine settlements with Medicare and Medicaid payors or retroactive adjustments due to audits and reviews;
- ***Self-insurance*** - the valuation methods and assumptions used in estimating 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;
- ***Lease***s - the incremental borrowing rate determination;
- ***Acquisition accounting*** - the assumptions used to allocate the purchase price paid for assets acquired and liabilities assumed in connection with our acquisitions; and
- ***Income taxes*** - the estimation of valuation allowance or the need for and magnitude of liabilities for uncertain tax position.

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 of 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 significant acquisition and consolidation opportunities for us.

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

- ***Increased Demand Driven by Aging Populations.*** 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 2018, between 2010 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 13% to 21%. The Bureau expects this segment to increase nearly 90% to 73 million, as compared to the total U.S. population which is projected to increase by 17% 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, 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 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 our revenues, costs and the way we operate our business. Our subsidiaries that provide healthcare services are subject to federal, state and local laws relating to, among other things, licensure, delivery, quality and adequacy of care, physical plant requirements, life safety, personnel and operating policies. In addition, our provider subsidiaries are subject to federal and state laws that govern billing and reimbursement, relationships with vendors and business relationships with physicians. Such laws include the Anti-Kickback Statue, the federal False Claims Act (FCA), the Stark Law and state corporate practice of medicine statutes.

Governmental and other authorities periodically inspect our skilled nursing facilities, senior living facilities and outpatient rehabilitation agencies to verify that we continue to comply with the applicable regulations and standards. We must pass these inspections to remain licensed under state laws and to comply with our Medicare and Medicaid provider agreements. We can only participate in these third-party payment programs if inspections by regulatory authorities reveal that our operations are in substantial compliance with applicable requirements. In the ordinary course of business, we may receive notices from federal or state regulatory authorities alleging deficiencies in certain regulatory practices. These statements of deficiency may require us to take corrective action to regain and maintain compliance. In some cases, federal or state regulators may impose other remedies including imposition of CMPs, temporary payment bans, loss of certification as a provider in the Medicare and/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 HHS Office of the Inspector General (OIG) audits, state Medicaid agencies, local and state ombudsman offices and CMS Recovery Audit Contractors, among other agencies. In response to the inquiries, investigations and audits, the federal and state governments continue to impose citations for regulatory deficiencies and other regulatory penalties, including demands for refund of overpayments, expanded Civil Money Penalties (CMPs) that extend over long periods of time and date back to incidents long before surveyor visits, Medicare and Medicaid payment bans and terminations from the Medicare and Medicaid programs. We vigorously contest these matters where 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 our operations.

COVID-19

Temporary suspension of certain patient coverage criteria and documentation and care requirements - The CARES Act and a series of temporary waivers and guidance issued by the CMS suspend various Medicare patient coverage criteria as well as documentation and care requirements to provide regulatory relief to ensure patients continue to have adequate access to care notwithstanding the burdens placed on healthcare providers due to the COVID-19 pandemic. Examples include 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 for physicians, nurses, and other clinicians to be readily hired from the community or from other states to allow healthcare systems to rapidly expands their workforce; (3) increasing access to telehealth and corresponding reimbursement through Medicare to ensure patients have access to healthcare while keeping patients safe at home; (4) expanding in-place COVID-19 testing to allow for more testing at home or in community based settings; and (5) temporarily waiving certain documentation, reporting and audit requirements to allow providers, health care facilities, Medicare Advantage 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 are waived or otherwise not being enforced during the public health emergency due to the exercise of enforcement discretion. We believe these regulatory actions could contribute to an increase in skilled mix that may not otherwise occur.

CMS also authorized temporary waivers on medical review requirements, effective March 1, 2020, for the duration of the public health emergency. CMS is also pausing standard medical review activities, including prior authorization and other reviews that require providers to provide documentation. 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 will allow providers, CMS and the organizations to focus on patient care.

CMS recently updated their COVID-19 Provider Burden Relief Frequently Asked Questions (FAQs) related to claim audit waivers for multiple services. On March 30, 2020, CMS suspended most Medicare Fee-For-Service (FFS) medical review 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 Contractor (SMRC) reviews and Recovery Audit Contractor (RAC). CMS expects to resume these audit activities beginning on August 3, 2020, regardless of the status of the public health emergency. All reviews will be conducted in accordance with statutory and regulatory provisions, as well as related billing and coding requirements. Waivers and flexibility in place at the time of the dates of service of any claims potentially selected for review will also be applied.

The COVID 1135 Waiver also allows the SNF to provide a “skill-in-place” program for Medicare beneficiaries who are residents of the SNF and who meet the skill in place criteria, foregoing the usual 3-day qualifying hospital stay, as outlined in the waiver. As patients qualify for SIP for Medicare Part A stays, we could see a decrease in long-term care Medicare Part B PT, OT, SLP program.

Testing requirements

Beginning in April 2020, authorities in several states in which we operate began to mandate widespread COVID-19 testing at all nursing home and long-term care facilities. This came after the CDC stated that older adults are at a higher risk for serious illness from the coronavirus and issued updated testing guidelines for nursing homes. On June 19, 2020, CMS instructed Medicare Administrative Contractors and Medicare Advantage plans to cover COVID-19 testing for nursing home residents consistent with CDC testing guidelines and recommendations. Subsequently, 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.

In response to CDC guidelines recommending COVID-19 testing guidelines, mandated Medicare coverage of such tests, and mandates for staff testing in specific situations, in addition to recommended infection prevention control measures, we anticipate that the number of states mandating COVID-19 testing of patients and staff may increase. Testing mandates can vary by state and may require testing for 1) residents, 2) staff, or 3) both residents and staff. The responsibility for performing testing varies by payor and state. In addition, CMS may also implement federal testing requirements. Non-compliance with these state or federal mandates may result in imposition of fines or other administrative action, including license revocation. Additionally, the responsibility for payment of such tests will vary based on the patient's payor.

Reporting requirements

On April 19, 2020, CMS announced new regulatory requirements requiring skilled nursing homes to report cases of COVID-19 directly to the CDC. This information must be reported in accordance with existing privacy regulations and statues. In addition, skilled nursing homes are required to inform residents, their families and representatives of COVID-19 cases in their facilities. This 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. CMS is making COVID-19 nursing home data collected under this mandate publicly available on a dedicated website. There could be civil monetary penalties for not meeting these reporting requirements. We believe these reporting requirements will not have a material impact on our Condensed Consolidated Financial Statements.

On April 30, 2020, CMS announced that it would be convening an independent commission to conduct comprehensive assessments of nursing home responses to the COVID-19 pandemic. On June 19, 2020 CMS announced the initial membership of the Coronavirus Commission on Safety and Quality in Nursing Homes (Commission on Safety and Quality). The Commission on Safety and Quality consists of resident advocates, infectious disease experts, directors and administrators of nursing homes, academics, state authorities, clinicians, a medical ethicist and a nursing home resident. In addition to the official Commission on Safety and Quality members, there may also be new members added to help bring additional viewpoints and insights. The Commission on Safety and Quality will conduct a comprehensive assessment of the overall response to the COVID-19 pandemic in nursing homes. Based on its assessment, the Commission on Safety and Quality will make recommendations on actions and best practices for immediate and future actions. The Commission on Safety and Quality's key areas of focus include: (1) protecting residents from COVID-19 and improving the responsiveness of care delivery; (2) strengthening regulations to enable rapid and effective identification and mitigation of COVID-19 transmissions in nursing homes; and (3) enhancing enforcement strategies to improve compliance with infection control policies.

Medicare

Medicare presently accounts for approximately 29.6% of our transitional and skilled nursing services year-to-date revenue, 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 was effective October 1, 2019. The SNF PPS Rule includes a new case-mix model that focuses on the patient's condition and resulting care needs (clinically relevant factors), rather than on the volume of care provided, to determine reimbursement from Medicare. The case mix-model is called the Patient-Driven Payment Model (PDPM), which utilizes clinically relevant factors for determining Medicare payment by using ICD-10 diagnosis codes and other patient characteristics as the basis for patient classification. PDPM utilizes five case-mix adjusted payment components: physician therapy (PT), occupational therapy (OT), speech language pathology (SLP), nursing and social services (nursing) and non-therapy ancillary services (NTA). It also uses a sixth non-case mix component to cover utilization of SNF resources that do not vary depending on resident characteristics.

PDPM replaces the existing case-mix classification methodology, Resource Utilization Groups, Version IV (RUG-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 SNF per diem payments to reflect varying costs throughout the stay, through the PT, OT and NTA components.

In addition, PDPM is intended to reduce paperwork requirements for performing patient assessments. Under the new 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.

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 for the year are reduced by 2.0% for that 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 will receive a notification letter from its Medicare administrator contractor if it was non-compliant with the Quality Reporting Program reporting requirements and is subject to the payment reduction.

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 (FY 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. Under the SNF QRP, a skilled nursing facility's annual market basket percentage is reduced by 2.0% if the skilled nursing facility does not submit quality measure data in accordance with thresholds set by the IMPACT Act. Skilled nursing facilities that do not meet the SNF QRP requirements for a program year will receive a notice of non-compliance.

Medicare Annual Market Basket

Current law requires CMS 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 increase 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 with a 0.0% point reduction for multifactor productivity adjustment.

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

The SNF-VBP Program rewards SNFs 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 SNFs using the SNF-VBP Program. Effective October 1, 2018, CMS began withholding 2.0% to fund the SNF-VBP incentive payment pool and will redistribute 60% of the withheld payments back to SNFs through the program. The FY 2020 SNF PPS Rules estimate an economic impact of the SNF-VBP Program to be a reduction of $213.6 million in aggregate payments to SNFs 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.

Decisions Regarding Skilled Nursing Facility Payment

In addition to setting the payment rules for skilled nursing facility services using the SNF-VBP Program, CMS annually adjusts its payment rules for other acute and post-acute service providers including hospitals and home health agencies using a similar SNF-VBP Program. It is important to understand the Medicare program and that its 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 II, Item 1A Risk Factors under the headings Risks Related to Our Business and Industry - "O*ur revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare," "Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending,"* "*We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations*" and "*Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements.*"

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 OT services. These caps were implemented under the authority of the Balanced Budget Amendments of 1997. For PT and SLP combined, the limit on incurred expenses is $2,080 for 2020 compared to $2,040 in 2019. The cap limit is the same for occupational therapy (OT) services.

On multiple occasions during the past two decades, Congress has interceded to suspend the "therapy caps" offering an "exceptions process" so claims in excess of the annualized cap can be processed. The Deficit Reduction Act of 2005 (DRA) added Section 1833(g)(5) of the Social Security Act and directed CMS to develop a process that allows exceptions for Medicare beneficiaries to therapy caps when continued therapy is deemed medically necessary.

Specifically, the Middle Class Tax Relief and Job Creation Act of 2012 extended the therapy exceptions process but added a second tier cap mandating manual medical review (MMR) for claims submitted that exceeded $3,700 for PT and SLP services combined and another threshold of $3,700 for OT services. On April 16, 2015, President Obama signed MACRA into law. MACRA authorized payment reforms for physicians and other professional services, including the three rehabilitative therapies, included provisions not only stabilizing the professional fee schedules, but also extending the therapy cap exceptions process through December 31, 2017. On February 9, 2018, the Bipartisan Budget Act of 2018 was signed into law, which provides for the repeal of all therapy caps retroactively to January 1, 2018. The law retained the MMR process for claims over the threshold, but reduced the claim threshold to $3,000.

Consistent with CMS' "Patients over Paperwork" initiative, the agency has also been moving toward eliminating burdensome claims-based functional reporting requirements for Part B therapy services. For example, beginning in January 2019, SNFs are no longer required to append selected G-codes or the severity modifiers on outpatient therapy claims. This reduces the reporting burden on therapists providing outpatient services and increase the amount of time that therapists can spend with their patients.

On November 1, 2019, CMS issued the calendar year 2020 Physician Fee Schedule Final Rule establishing that therapy assistant claim modifiers will be required starting in calendar year 2020. This rule is consistent with the requirement of the Balanced Budget Act (BBA) of 2018, which requires a 15% payment reduction when a physical therapist assistant (PTA) or occupational therapy assistant (OTA) provides services "in whole or in part" on a given day. While the modifiers are required to be applied to the claims beginning in calendar year 2020, the 15% therapist assistant payment reduction will not be applied until calendar year 2022. The final rule clarified the meaning of "in whole or in part" to mean when 10% or more of the services are provided by a PTA or OTA.

The FY 2020 Physician Fee Schedule (PFS), indicates that there will be no decrease in physical and occupational therapy code payments in 2020. However, in the proposed and final FY 2020 PFS, CMS also indicated its intent to make changes to reimbursement rates that would become effective January 1, 2021. These changes, if finalized in the fiscal year 2021 PFS Rule, will effectively lower the reimbursement rate for therapy Medicare Part B specialty providers; specific to our industry, by 8%.

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, 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 as a part of the COVID-19 1135 waiver provisions. This waiver allows the reimbursement of certain HCPCS codes delivered by PT, OT, SLP through telehealth. The reimbursement follows the existing physician fee screen reimbursement through the duration of the public health emergency. These services have been used to provide some services to community based outpatients from our SNFs that are eligible through local rules to provide community-based outpatient services. Eligible PT, OT, SLP services delivered through telehealth to long-term care residents, when the local COVID-19 quarantine requirements suggest provision of PT, OT, SLP services through alternative means, are also reimbursed per the waiver.

The COVID-19 1135 waiver provisions also allow 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 through the end of the public health emergency. Our facilities are utilizing this waiver as physicians elect to provide telehealth visits to Medicare Part B beneficiaries residing in the SNF.

Sequestration of Medicare Rates

The Budget Control Act of 2011 requires a mandatory, across the board reduction in federal spending, called a sequestration. Medicare Fee-For-Service (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% reduction of Medicare claim reimbursements for the period of May 1, 2020 through December 31, 2020.

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.

Medicaid Fiscal Accountability Regulation (MFAR)

On November 18, 2019, CMS published a proposed rule, the Medicaid Fiscal Accountability Regulation (MFAR) that could impact our federal Medicaid revenue in some of our facilities. Specifically, some states' Medicaid programs allow for upper payment limit (UPL) payments to be made to SNFs that are owned or operated by a non-state government (NSG) provider, such as a city or county hospital. These supplemental UPL payments are paid through federal Medicaid funds, but administered through the state. In 2012, the Utah Medicaid Program was amended to allow for such UPL payments. In 2015, the Texas Medicaid Program was amended to also allow for such UPL payments (the program in Texas is currently called the Quality Incentive Payment Program or "QIPP). Ensign has 17 Utah facilities and 52 Texas facilities that have entered into agreements with NSG hospitals in which operations have been transferred to the NSG hospitals, but Ensign-related entities manage these facilities. This has allowed the 69 facilities to obtain supplemental UPL funds from the federal Medicaid program.

The proposed MFAR rule, if enacted as currently written, would institute sweeping changes to the UPL program, including changes to: (i) the calculations related to the UPL payments; (ii) the definition of "public funds" that can be used for intergovernmental transfers (IGTs) (which would negatively impact the available revenue for UPL payments); and (iii) the definition of a "non-state government" provider (making fewer entities eligible to participate). Additionally, the proposed MFAR rule requires additional and detailed reporting by states related to UPL payments and suggests that CMS will increase scrutiny of hospitals/facilities that are part of such arrangements.

Preadmission Screening and Resident Review (PASRR)

On February 20, 2020, CMS published a proposed rule which would modernize requirements for the Preadmission Screening and Resident Review (PASRR) 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.

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 recent congressional elections in the United States and policies implemented by the current administration have resulted in significant changes in legislation, regulation, implementation of Medicare and/or Medicaid, and government policy, but the upcoming 2020 presidential and congressional elections could 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 long-term care (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, in 2016 CMS instituted new requirements, to be met in three phases. The first phase was effective November 28, 2016, the second phase was effective November 28, 2017 and the third phase became effective November 28, 2019 (despite recent proposals to delay implementation of specific portions of the rule). Additionally, beginning in 2016, SNFs 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 explicitly inform the resident or his or her representative of the right not to sign the agreement as a condition of admission.

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 (BBA) 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 False Claims Act (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. CMPs under the FCA range from approximately $11,665 to $23,331 and are adjusted each January 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 tracks the federal FCA. Federal law also provides that 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. And, CMS can recover overpayments from health care providers up to five years following the year in which payment was made.

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 SNFs, but claimed the higher reimbursements associated with discharges to homes. A similar OIG audit report, released in February 2019, focused on improper payments for SNF services when the Medicare 3-day inpatient hospital stay requirement was not met. These investigatory actions by OIG demonstrate their increased scrutiny into post-hospital SNF 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 Health Care Reform

On October 30, 2015, CMS released a final rule addressing, among other things, implementation of certain provisions of MACRA, which changes the way physicians are paid who participate in Medicare through implementation of the Quality Payment Program (QPP). QPP creates two tracks for physician payment: (1) the Merit-Based Incentive Payment System (MIPS) that streamlines multiple quality programs; and (2) Alternative Payment Models (APMs) that give bonus payments for participation in eligible APMs. The current Value-Based Payment Modifier program expired at the end of 2018 (CY 2018 will be the final payment adjustment period under the Value-Based Payment Modifier), with the first MIPS adjustments began in 2019. The October 30, 2015 final rule added measures where gaps exist in the current Physician Quality Reporting System (PQRS), which is used by CMS to track the quality of care provided to Medicare beneficiaries. The final rule also excludes services furnished in SNFs from the definition of primary care services for purposes of the Shared Savings Program. The rule may have an impact on our revenue in the future.

Additionally, in 2015, CMS began implementing a series of changes to the Five-Star Quality Rating system that have made it more difficult for facilities to achieve the highest ratings. These changes have included, among other things:

- In 2015, changes include the use of antipsychotics in calculating the star ratings, modified calculations for staffing levels and reflect higher standards for nursing homes to achieve a high rating on the quality measure dimension.

- In 2016, the addition of six new quality measures to the Nursing Home Five-Star Quality Ratings, including the rate of hospitalization, emergency room use, community discharge, improvements in function, independently worsened and anxiety or hypnotic medication among nursing home residents.

- In 2018, (i) a freeze of the Health Inspection Five Star Ratings; (ii) the addition of Payroll Based Journals (PBJ) data to calculate the staffing ratings in the Nursing Home Five Star Quality Rating System; and (iii) the addition of two claims data measures: Medicare spending per beneficiary and rate of successful return to home or community from a skilled nursing facility for quality measures.

- In 2019, (i) the addition of separate ratings for short stay and long stay care; (ii) changes in staffing thresholds; and (iii) modifications to put more emphasis on registered nurse (RN) staffing, including a set rating for nursing homes that report four or more days in the quarter with no RN on site.

CMS predicted that the 2019 changes would result in 47 percent of all nursing centers to lose stars in their "Quality" ratings, 33 percent to lose stars in their "Staffing" ratings and some 36 percent to lose stars in their "Overall" ratings. Unsurprisingly, these changes resulted in a reduction in Ensign's number of facilities with 4 or 5-star ratings in 2019. Additionally, on October 7, 2019, CMS announced it will begin increasing quality measure thresholds by 50% of the average rate of improvement of QM scores every six months, beginning in April 2020. This means if there is an average rate of improvement of 2%, the quality measure threshold will be raised 1%. This frequent adjustment is intended to avoid larger adjustments to thresholds in the future. However, 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.

On April 27, 2016, CMS added six new quality measures to its consumer-based Nursing Home Compare website. These quality measures include the rate of rehospitalization, emergency room use, community discharge, improvements in function, independent worsening of ability to move, and use antianxiety or hypnotic medication among nursing home residents. Beginning in July 2016, CMS incorporated all these measures, except for the antianxiety/hypnotic medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings. In 2018, CMS added PBJ data to be used to calculate the staffing ratings in the Nursing Home Five Star Quality Rating System. In 2019, CMS updated thresholds for assigning stars for both the staffing and quality components of the system and added measures of long-stay hospitalizations and long-stay ED visits were added to the quality measure rating. Since the standards for performance are more difficult to achieve, the number of our 4 and 5 facilities could be reduced.

Additionally, in April of 2019, CMS announced a new framework for informing CMS's work related to the safety and quality in America's nursing homes. The approach includes the following pillars: Strengthening Oversight, Enhancing Enforcement, Increasing Transparency, Improving Quality, and Putting Patients over Paperwork. As part of the Transparency Pillar, beginning on October 23, 2019 on the Nursing Home Compare website, CMS began displaying a consumer alert icon next to nursing homes that have been cited for incidents of abuse, neglect, or exploitation. The icon will be updated monthly, at the same time CMS inspection results are updated. 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 responding to the COVID-19 pandemic, CMS announced a new, targeted inspection plan to focus inspections on urgent patient safety threats and infection control, therefore causing a shift in the number of nursing homes inspected and how the inspections are conducted. As this change would disrupt the inspection domain of the Nursing Home Five Star Quality Rating System, results of inspections conducted on or after March 4, 2020 will not be used to calculate a nursing home's health inspection star ratings. In addition, on June 25, 2020, CMS announced that beginning July 29, 2020, data used to calculate measures in the Five Star Quality ratings system will be based on the data collection period ending December 31, 2019 so as to exclude data from resident assessments that are impacted by the waiver associated with the public health emergency.

Monitoring Compliance in Our Facilities

Governmental agencies and other authorities periodically inspect our facilities to assess our 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. We must pass these inspections to maintain our licensure under state law, to obtain or maintain certification under the Medicare and Medicaid programs, to continue participation in the Veterans Administration (VA) program at some facilities, and to comply with our provider contracts with managed care clients at many facilities. From time to time, we, like others in the healthcare industry, may receive notices from federal and state regulatory agencies alleging that we failed to substantially comply with applicable standards, rules or regulations. These notices may require us to take 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 facilities fail to comply with these directives or otherwise fail to comply substantially with licensure and certification laws, rules and regulations, we could lose our certification as a Medicare or Medicaid provider, or lose our state licenses to operate the facilities.

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, although where denial of payment remedies are asserted, such interim remedies go into effect much sooner. Facilities with deficiencies that immediately jeopardize patient health and safety and those that are classified as poor performing facilities, however, are not generally given an opportunity to correct their deficiencies prior to the imposition of remedies and other enforcement actions. Moreover, facilities with poor regulatory histories continue to be classified by CMS as poor performing facilities notwithstanding any intervening change in ownership, unless the new owner obtains a new Medicare provider agreement instead of assuming the facility's existing agreement. However, new owners (including us, historically) nearly always assume the existing Medicare provider agreement due to the difficulty and time delays generally associated with obtaining new Medicare certifications, especially in previously certified locations with sub-par operating histories. Accordingly, facilities that have poor regulatory histories before we acquire them and that develop new deficiencies after we acquire them are more likely to have sanctions imposed upon them by CMS or state regulators.

In addition, CMS has increased its focus on facilities with a history of serious quality of care problems through the special focus facility initiative. A facility's administrators and owners are notified when it is identified as a special focus facility. This information is also provided to the general public. The special focus facility designation is based in part on the facility's compliance history typically dating before our acquisition of the facility. Local state survey agencies recommend to CMS that facilities be placed on special focus status. A special focus facility receives heightened scrutiny and more frequent regulatory surveys. Failure to improve the quality of care can result in fines and termination from participation in Medicare and Medicaid. A facility "graduates" from the program once it demonstrates significant improvements in quality of care that are continued over time.

Moreover, sanctions such as denial of payment for new admissions often are scheduled to go into effect before surveyors return to verify compliance. Generally, if the surveyors confirm that the facility is in compliance upon their return, the sanctions never take effect. However, if they determine that the facility is not in compliance, the denial of payment goes into effect retroactive to the date given in the original notice. This possibility sometimes leaves affected operators, including us, with the difficult task of deciding whether to continue accepting patients after the potential denial of payment date, thus risking the retroactive denial of revenue associated with those patients' care if the operators are later found to be out of compliance, or simply refusing admissions from the potential denial of payment date until the facility is actually found to be in compliance. In the past and from time to time, some of our affiliated facilities 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, these sanctions, entailing 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.

Regulations Regarding Financial Arrangements

We are also subject to federal and state laws that regulate financial arrangement by 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 (the Anti-Kickback Statute or AKS) 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 federal anti-kickback laws can result in criminal penalties of up to $100,000 and ten years' imprisonment. Violations of the anti-kickback laws can also result in civil monetary penalties of up to $100,000 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 laws may also result in an individual's or organization's exclusion from future participation in Medicare, Medicaid and other state and federal healthcare programs. State Medicaid programs are required to enact an anti-kickback statute. Many states in which we 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.

In addition to these regulations, we may face adverse consequences if we violate the federal Stark laws related to certain Medicare physician referrals. 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, home health services, and clinical laboratory 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 must be repaid to Medicare or Medicaid, any other third-party payor, and the patient. In addition, CMPs, which are adjusted for annual inflation, and treble damages may be imposed for presenting or causing to be presented, a claim for a service rendered in violation of the Stark Law. 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.

Any services furnished pursuant to a prohibited referral are not eligible for payment by the Medicare programs, and the provider is prohibited from billing any third party for such services. The Stark laws provide for the imposition of a civil monetary penalty of $15,000 per prohibited claim, and up to $100,000 for knowingly entering into certain prohibited cross-referral schemes, and potential exclusion from Medicare for any person who presents or causes to be presented a bill or claim the person knows or should know is submitted in violation of the Stark laws.

Regulations Regarding Patient Record Confidentiality

We 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, which relate to the privacy of certain patient information. These rules govern our use and disclosure of protected health information. We have established policies and procedures to comply with HIPAA privacy and security requirements at our affiliated facilities and operating subsidiaries. We maintain a company-wide HIPAA compliance plan, which we believe complies with the HIPAA privacy and security regulations. The HIPAA privacy regulations and security regulations have and will continue to impose significant costs on our facilities 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 operations 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.

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.

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 11% of total other 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 SNF 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 SNFs. 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 assisted 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 for through Medicaid waiver programs. CMS is encouraging state Medicaid programs to expand their use of home and community-based services as alternatives to institutional services, pursuant to provisions of the ACA, and other authorities, through the use of several programs.

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, and safety and health standards set by the Occupational Safety and Health Administration (OSHA). Changes in the law or new interpretations of existing laws may have an adverse impact on our methods and costs of doing business.

Our 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 our services and facilities 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 experienced healthy census growth during the first two months of 2020, achieving record revenue and net income. However, we experienced sharp declines in census beginning in late March 2020, which was attributable to concerns relating to the COVID-19 pandemic.

Our net revenues for the three months ended June 30, 2020 continued to be impacted by COVID-19 as we experience revenue lost from a decline in occupancy which was partially offset by our skilled mix changes. To respond to the COVID-19 pandemic and ease the healthcare system burdens, a series of temporary waivers and guidance 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 SNF coverage without having to start a new benefit period for certain beneficiaries who recently exhausted their SNF benefits. As our communities experience surges of COVID-19 cases, our patients needs have required the use of skilled care, resulting in an increase in Medicare Part A days. In addition, the FMAP program have been designed to enhance the reimbursements to provide additional funding to cover COVID related expenses in selected states. In the second quarter, we recorded FMAP revenue of $12.4 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 $91.8 million, or 18.6% while our diluted continuing operations GAAP earning per share grew more than 97.3%, from $0.37 to $0.73, compared to the second quarter in 2019. Over the past four quarters, we have continued to make progress on initiatives which we established more than two years ago. 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 transitional and skilled services collectively increased by more than 7%. We have also strengthened our collection process as well as identified non-clinical areas where we can manage spending. These operational fundamentals coupled with the reduction of interest expense due to the deferral of tax payments and proceeds from Medicare Accelerated and Advance Payment Program resulted in strong second quarter performance.

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 June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Service revenue	**100.0 %**	100.0 %	**100.0 %**	100.0 %
Expense:				
Cost of services	**77.3**	80.1	**77.2**	79.5
Rent—cost of services	**5.6**	6.3	**5.5**	6.4
General and administrative expense	**5.4**	5.2	**5.4**	5.5
Depreciation and amortization	**2.3**	2.5	**2.3**	2.5
Total expenses	**90.6**	94.1	**90.4**	93.9
Income from operations	**9.4**	5.9	**9.6**	6.1
Other income (expense):				
Interest expense	**(0.4)**	(0.8)	**(0.5)**	(0.8)
Interest and other income	**0.2**	0.1	**0.2**	0.1
Other expense, net	**(0.2)**	(0.7)	**(0.3)**	(0.7)
Income before provision for income taxes	**9.2**	5.2	**9.3**	5.4
Provision for income taxes	**2.3**	0.9	**2.2**	1.0
Net income from continuing operations	**6.9**	4.3	**7.1**	4.4
Net income from discontinued operations, net of tax	**—**	1.7	**—**	1.5
Net income	**6.9**	6.0	**7.1**	5.9
Less: net income attributable to noncontrolling interests in continuing operations	**0.1**	—	**0.1**	—
Net income attributable to noncontrolling interests in discontinued operations	**—**	—	**—**	—
Net income attributable to The Ensign Group, Inc.	**6.8 %**	6.0 %	**7.0 %**	5.9 %

	Three Months Ended June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Non-GAAP Financial Measures:	**(In thousands)**			
Performance Metrics				
EBITDA from continuing operations[1]	**$ 68,599**	$ 40,989	**$ 138,759**	$ 82,782
EBITDA total[2]	**$ 68,599**	$ 50,714	**$ 138,759**	$ 100,881
Adjusted EBITDA from continuing operations[1]	**$ 72,383**	$ 44,440	**$ 146,191**	$ 89,055
Adjusted EBITDA total[2]	**$ 72,383**	$ 56,776	**$ 146,191**	$ 113,532
Valuation Metric				
Adjusted EBITDAR[3]	**$ 104,842**		**$ 210,958**	

(1) EBITDA and Adjusted EBITDA represents results without discontinued operations of the Spin-Off, which occurred on October 1, 2019.
(2) EBITDA and Adjusted EBITDA total for 2019 represents results inclusive of discontinued operations.
(3) Presented for current year only.

The following discussion includes references to EBITDA, Adjusted EBITDA and Adjusted EBITDAR which are non-GAAP financial measures (collectively, Non-GAAP Financial Measures). Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the 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 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 interest expense, net and depreciation and amortization, which can vary substantially from company to company depending on the book value of assets, capital structure and the method by which assets were acquired; and

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

We use 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 typically use 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 net interest 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, Non-GAAP Financial Measures have no standardized meaning defined by GAAP. Therefore, 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 net 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 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) interest 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:

- results related to operations not at full capacity;
- stock-based compensation expense; and
- acquisition related costs.

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 June 30,		Six Months Ended June 30,	
	2020	2019	2020	2019
Consolidated statements of income data:		(In thousands)		
Net income	$ 40,688	$ 28,925	$ 81,890	$ 56,532
Less: net income attributable to noncontrolling interests in continuing operations	440	116	793	201
Less: net income from discontinued operations	—	8,141	—	14,183
Add: Interest expense, net	1,211	3,379	4,178	6,488
Provision for income taxes	13,535	4,576	26,159	9,851
Depreciation and amortization	13,605	12,366	27,325	24,295
EBITDA from continuing operations	68,599	40,989	138,759	82,782
EBITDA from discontinued operations(c)	—	9,725	—	18,099
EBITDA	$ 68,599	$ 50,714	$ 138,759	$ 100,881
Results related to operations not at full capacity(a)	197	365	539	629
Stock-based compensation expense	3,528	2,930	6,763	5,385
Acquisition related costs(b)	34	49	83	76
Rent related to items above	25	107	47	183
Adjusted EBITDA from continuing operations	72,383	44,440	146,191	89,055
Adjusted EBITDA from discontinued operations(c)	—	12,336	—	24,477
Adjusted EBITDA	$ 72,383	$ 56,776	$ 146,191	$ 113,532
Rent—cost of services	32,484	31,222	64,814	61,403
Less: rent related to items above	(25)	(107)	(47)	(183)
Adjusted rent from continuing operations	32,459	31,115	64,767	61,220
Adjusted rent included in discontinued operations	—	5,836	—	11,434
Adjusted EBITDAR from continuing operations	$ 104,842		$ 210,958	

(a) Represents results of operations not at full capacity during the period presented.
(b) Costs incurred to acquire operations which are not capitalizable.
(c) All adjustments included in the table below are presented within net income from discontinued operations, net of tax.

	Three Months Ended June 30, 2019	Six Months Ended June 30, 2019
Net income from discontinued operations, net of tax	$ 8,141	$ 14,183
Less: net income attributable to noncontrolling interests in discontinued operations	200	350
Add: Interest and other income, net	(10)	(22)
Provision for income taxes	976	2,801
Depreciation and amortization	818	1,487
EBITDA from discontinued operations	$ 9,725	$ 18,099
Losses related to operations in the start-up phase	82	318
Stock-based compensation expense	372	869
Spin-Off transaction costs	1,658	4,648
Acquisition related costs	497	533
Rent related to items above	2	10
Adjusted EBITDA from discontinued operations	$ 12,336	$ 24,477

Three Months Ended June 30, 2020 Compared to the Three Months Ended June 30, 2019

Revenue

	Three Months Ended June 30,			
	2020		2019	
	$	%	$	%
	(Dollars in thousands)			
Transitional and skilled services	$ 556,779	95.2 %	$ 469,238	95.2 %
All other [(1)]	27,920	4.8	23,678	4.8
Total revenue	$ 584,699	100.0 %	$ 492,916	100.0 %

(1) Includes revenue from rental income and services generated from our senior living services, rental income and other ancillary services.

Our total revenue increased $91.8 million, or 18.6%, compared to the three months ended June 30, 2019. The increase in revenue was primarily driven by an increase in our skilled mix days and revenue per patient day from Same Facilities and Transitioning Facilities in our transitional and skilled services operations, along with the impact of acquisitions. Total revenue from operations acquired on or subsequent to July 1, 2019 increased our consolidated revenue by $48.2 million during the three months ended June 30, 2020, when compared to the same period in 2019. In addition, we recorded $12.4 million of FMAP revenue, which correlate directly to the additional COVID-19 expenses incurred. All FMAP revenue is included in Medicaid revenue.

Transitional and Skilled Services

The following table presents the transitional and skilled services revenue and key performance metrics by category during the three months ended June 30, 2020 and 2019:

	Three Months Ended June 30,			
	2020	2019	Change	% Change
Total Facility Results:	(Dollars in thousands)			
Transitional and skilled revenue	556,779	$ 469,238	$ 87,541	18.7 %
Number of facilities at period end	193	171	22	12.9 %
Number of campuses at period end*	23	22	1	4.5 %
Actual patient days	1,530,286	1,472,798	57,488	3.9 %
Occupancy percentage — Operational beds	73.4 %	79.4 %		(6.0) %
Skilled mix by nursing days	29.7 %	29.0 %		0.7 %
Skilled mix by nursing revenue	51.4 %	48.7 %		2.7 %

	Three Months Ended June 30,			
	2020	2019	Change	% Change
Same Facility Results(1):	(Dollars in thousands)			
Transitional and skilled revenue	$ 433,889	$ 405,095	$ 28,794	7.1 %
Number of facilities at period end	152	152	—	— %
Number of campuses at period end*	15	15	—	— %
Actual patient days	1,165,243	1,253,908	(88,665)	(7.1) %
Occupancy percentage — Operational beds	73.7 %	79.6 %		(5.9) %
Skilled mix by nursing days	31.4 %	30.4 %		1.0 %
Skilled mix by nursing revenue	53.4 %	50.5 %		2.9 %

Transitioning Facility Results(2):	Three Months Ended June 30, 2020	Three Months Ended June 30, 2019	Change	% Change
	(Dollars in thousands)			
Transitional and skilled revenue	$ 51,092	$ 45,604	$ 5,488	12.0 %
Number of facilities at period end	16	16	—	— %
Number of campuses at period end*	4	4	—	— %
Actual patient days	147,658	154,072	(6,414)	(4.2)%
Occupancy percentage — Operational beds	76.1 %	79.9 %		(3.8)%
Skilled mix by nursing days	25.5 %	21.9 %		3.6 %
Skilled mix by nursing revenue	43.2 %	36.9 %		6.3 %

Recently Acquired Facility Results(3):	Three Months Ended June 30, 2020	Three Months Ended June 30, 2019	Change	% Change
	(Dollars in thousands)			
Transitional and skilled revenue	$ 71,798	$ 15,689	$ 56,109	NM
Number of facilities at period end	25	2	23	NM
Number of campuses at period end*	4	3	1	NM
Actual patient days	217,385	55,850	161,535	NM
Occupancy percentage — Operational beds	70.1 %	74.5 %		NM
Skilled mix by nursing days	23.5 %	21.1 %		NM
Skilled mix by nursing revenue	45.0 %	37.6 %		NM

Facility Closed Results(4):	Three Months Ended June 30, 2020	Three Months Ended June 30, 2019	Change	% Change
	(Dollars in thousands)			
Skilled nursing revenue	$ —	$ 2,850	$ (2,850)	NM
Actual patient days	—	8,968	(8,968)	NM
Occupancy percentage — Operational beds	— %	66.1 %		NM
Skilled mix by nursing days	— %	16.9 %		NM
Skilled mix by nursing revenue	— %	34.6 %		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, 2017.
(2) Transitioning Facility results represent all facilities purchased from January 1, 2017 to December 31, 2018.
(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2019.
(4) Facility Closed results represents closed operations during the three months ended June 30, 2019, which were excluded from Same Facilities results for the three months ended June 30, 2019 and 2020 for comparison purposes.

Transitional and skilled services revenue increased $87.5 million, or 18.7%, compared to the three months ended June 30, 2019. Of the $87.5 million increase, Medicare revenue increased $56.2 million, or 47.3%, Medicaid custodial revenue increased $30.4 million, or 15.8%, Medicaid skilled revenue increased $4.6 million, or 14.4% and private and other revenue increased $0.5 million, or 1.3%. These increases are partially offset by the decrease in managed care revenue of $4.2 million or 4.8%.

Revenue in our Same Facilities increased $28.8 million, or 7.1%. The impact of COVID-19 resulted in a decrease of occupancy of 5.9%. The decline in our occupancy is mainly in our non-skilled patient days, which is being offset by a shift to higher Medicare days. Our skilled mix days increased by 1.0% coupled with an increase from our revenue daily rate of 13.0%, including the impact of 2% sequestration reversal, resulting in an increase in skilled mix revenue of $17.2 million. In addition, included in total revenue for Same Facilities is $9.7 million of Medicaid revenue related to FMAP program.

We began experiencing a significant decline our Medicaid custodial and private patient days related to COVID-19 during the second quarter of 2020. Our Medicaid census decreased by 7.7%, but is offset by an increase in our Medicaid daily rate of 5.9% as a result of our successful participation in the quality improvement programs and the supplemental programs in various states.

Revenue generated by our Transitioning Facilities increased $5.5 million, or 12.0%, primarily due to an increase in Medicare patient days of 19.1% coupled with the increase in revenue daily rate of 12.5% offset by the decrease of 6.2% in non-skilled patient days. We experienced and continued to see a shift in higher patient acuity, resulting in an increase in skilled mix revenue of $4.2 million, or 25.7%, compared to the three months ended June 30, 2019.

Transitional and skilled services revenue generated by Recently Acquired Facilities increased by approximately $56.1 million compared to the three months ended June 30, 2019. We acquired 24 operations between July 1, 2019 and June 30, 2020 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 June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Skilled Nursing Average Daily Revenue Rates:								
Medicare	**$ 670.86**	$ 600.18	**$ 598.49**	$ 533.45	**$ 646.18**	$ 613.79	**$ 661.05**	$ 594.59
Managed care	**497.79**	458.01	**466.67**	423.61	**481.16**	420.45	**493.10**	454.37
Other skilled	**537.06**	492.87	**521.15**	443.91	**348.72**	341.70	**530.57**	488.04
Total skilled revenue	**589.05**	521.14	**542.50**	480.74	**579.18**	498.63	**584.08**	517.71
Medicaid	**235.96**	222.87	**244.76**	233.09	**217.95**	223.66	**234.02**	224.27
Private and other payors	**231.70**	230.30	**241.66**	218.00	**210.49**	207.80	**229.76**	227.22
Total skilled nursing revenue	**$ 346.41**	$ 314.68	**$ 320.26**	$ 284.72	**$ 301.88**	$ 280.00	**$ 337.55**	$ 310.16

(1) These rates exclude additional FMAP revenue we recognized as part of The Family First Coronavirus Response Act and include sequestration reversal of 2%.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 11.8% and 12.2%, respectively, compared to the three months ended June 30, 2019. The increase is attributable to the 2.4% net market basket increase that became effective in October 2019 coupled with our continued shift towards higher acuity patients. Included in revenue for the three months ended June 30, 2019 is the results of two months of the temporary suspension of the 2% Medicare sequestration, which started on May 1, 2020 and will go through December 31, 2020. In addition, our new payment model, PDPM, became effective on October 1, 2019.

Our average Medicaid rates increased 4.3% 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 FMAP 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 June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Percentage of Skilled Nursing Revenue:								
Medicare	**29.6 %**	23.4 %	**25.7 %**	20.6 %	**31.6 %**	20.7 %	**29.5 %**	23.1 %
Managed care	**15.0**	19.0	**13.8**	13.2	**12.3**	14.2	**14.6**	18.2
Other skilled	**8.8**	8.1	**3.7**	3.1	**1.1**	2.7	**7.3**	7.4
Skilled mix	**53.4**	50.5	**43.2**	36.9	**45.0**	37.6	**51.4**	48.7
Private and other payors	**7.2**	8.1	**10.6**	12.7	**8.2**	7.8	**7.7**	8.5
Medicaid	**39.4**	41.4	**46.2**	50.4	**46.8**	54.6	**40.9**	42.8
Total skilled nursing	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %

	Three Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Percentage of Skilled Nursing Days:								
Medicare	**15.3 %**	12.2 %	**13.7 %**	11.1 %	**14.8 %**	9.5 %	**15.1 %**	12.0 %
Managed care	**10.5**	13.0	**9.5**	8.9	**7.7**	9.5	**10.0**	12.4
Other skilled	**5.6**	5.2	**2.3**	1.9	**1.0**	2.1	**4.6**	4.6
Skilled mix	**31.4**	30.4	**25.5**	21.9	**23.5**	21.1	**29.7**	29.0
Private and other payors	**10.8**	11.4	**14.1**	16.3	**11.7**	10.5	**11.3**	12.0
Medicaid	**57.8**	58.2	**60.4**	61.8	**64.8**	68.4	**59.0**	59.0
Total skilled nursing	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %

Other

Our other revenue increased by $4.2 million, or 17.9% to $27.9 million, compared to the three months ended June 30, 2019. Other revenue for the second quarter in 2020 includes senior living revenue of $14.9 million; mobile diagnostics revenue of $6.5 million, medical transportation revenue of $4.4 million and rental and other ancillary operations revenue of $2.1 million. The increase in other revenue is due to acquisitions and rental income from Pennant.

Cost of Services

The following table sets forth total cost of services for continuing operations of our transitional and skilled services and "All Other" category for the periods indicated (dollars in thousands):

	Three Months Ended June 30,				Change	
	2020		2019			
	$	%[1]	$	%[1]	$	%
Transitional and skilled services	**$ 431,080**	**77.4 %**	$ 373,992	79.7 %	$ 57,088	15.3 %
All other	**20,669**	**74.0**	20,750	87.6	(81)	(0.4)
Total cost of services	**$ 451,749**	**77.3 %**	$ 394,742	80.1 %	$ 57,007	14.4 %

(1) This represents cost of services as a percentage of revenue.

Consolidated cost of services increased $57.0 million, or 14.4% compared to the three months ended June 30, 2019. Consolidated cost of services as a percentage of revenue decreased by 2.8%.

Transitional and Skilled Services

Cost of services related to our transitional and skilled services segment increased $57.1 million, or 15.3%, due primarily to additional costs for COVID-19 related expenses and at Recently Acquired Facilities. Cost of services as a percentage of revenue decreased to 77.4% from 79.7%, a decrease of 2.3%. We experienced an increase in expenses related to COVID-19, including wages, supplies and additional therapy costs. These increases were offset with better collections and lower costs of insurance expenses.

Rent — cost of services. Our rent — cost of services as a percentage of total revenue decreased by 0.7% to 5.6%, primarily due to our recent acquisitions including real estate assets, coupled with the growth in revenue outpacing the increase in rent expense.

General and administrative expense. *G*eneral and administrative expense increased $5.6 million or 21.6%, to $31.4 million.This increase was primarily due to increases in wages to support growth. In addition, general and administrative expense as a percentage of revenue increased by 0.3% to 5.4%.

Depreciation and amortization. Depreciation and amortization expense increased $1.2 million, or 10.0%, to $13.6 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 0.2%, to 2.3%, as a percentage of revenue.

Other expense, net. Other expense, net as a percentage of revenue decreased by 0.5%, to 0.2%. Other expense primarily includes interest expense related to borrowings under our credit facility. During the quarter, we were able to utilize the proceeds from Medicare Accelerated and Advance Payment Program and deferral tax programs to reduce the amount outstanding on our revolving credit facility. Most of these deferral programs expired in July 2020.

Provision for income taxes. Our effective tax rate was 25.0% for the three months ended June 30, 2020, compared to 18.0% for the same period in 2019. 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 Condensed Consolidated Financial Statements for further discussion.

Six Months Ended June 30, 2020 Compared to the Six Months Ended June 30, 2019

Revenue

	Six Months Ended June 30,			
	2020		2019	
	$	%	$	%
	(Dollars in thousands)			
Transitional and skilled services	**1,115,184**	**95.0 %**	918,496	95.3 %
All other [(1)]	**59,128**	**5.0**	45,728	4.7
Total revenue	**$ 1,174,312**	**100.0 %**	$ 964,224	100.0 %

(1) Includes revenue from rental income and services generated from our senior living services, rental income and other ancillary services.

Our total revenue increased $210.1 million, or 21.8%, compared to the six months ended June 30, 2019. The increase in revenue was primarily driven by an increase in our skilled mix days and revenue per patient day from Same Facilities and Transitioning Facilities in our transitional and skilled services operations, along with the impact of acquisitions. Total revenue from operations acquired on or subsequent to July 1, 2019 increased our consolidated revenue by $88.8 million during the six months ended June 30, 2020, when compared to the same period in 2019. In addition, we recorded $13.1 million of FMAP payments received.

Transitional and Skilled Services

The following table presents the transitional and skilled services revenue and key performance metrics by category during the six months ended June 30, 2020 and 2019:

	Six Months Ended June 30,			
	2020	2019	Change	% Change
Total Facility Results:	**(Dollars in thousands)**			
Transitional and skilled revenue	**1,115,184**	918,496	$ 196,688	21.4 %
Number of facilities at period end	**193**	171	22	12.9 %
Number of campuses at period end*	**23**	22	1	4.5 %
Actual patient days	**3,173,676**	2,879,167	294,509	10.2 %
Occupancy percentage — Operational beds	**76.4 %**	79.4 %		(3.0) %
Skilled mix by nursing days	**29.5 %**	29.5 %		— %
Skilled mix by nursing revenue	**50.8 %**	49.2 %		1.6 %

	Six Months Ended June 30,			
	2020	2019	Change	% Change
Same Facility Results(1):	**(Dollars in thousands)**			
Transitional and skilled revenue	**$ 876,403**	$ 805,535	$ 70,868	8.8 %
Number of facilities at period end	**152**	152	—	— %
Number of campuses at period end*	**15**	15	—	— %
Actual patient days	**2,431,203**	2,494,206	(63,003)	(2.5) %
Occupancy percentage — Operational beds	**76.9 %**	79.8 %		(2.9) %
Skilled mix by nursing days	**31.5 %**	30.7 %		0.8 %
Skilled mix by nursing revenue	**53.1 %**	50.8 %		2.3 %

	Six Months Ended June 30,			
	2020	2019	Change	% Change
Transitioning Facility Results(2):	**(Dollars in thousands)**			
Transitional and skilled revenue	**$ 102,568**	$ 89,805	$ 12,763	14.2 %
Number of facilities at period end	**16**	16	—	— %
Number of campuses at period end*	**4**	4	—	— %
Actual patient days	**307,982**	303,266	4,716	1.6 %
Occupancy percentage — Operational beds	**79.4 %**	78.8 %		0.6 %
Skilled mix by nursing days	**24.7 %**	22.3 %		2.4 %
Skilled mix by nursing revenue	**41.8 %**	37.4 %		4.4 %

	Six Months Ended June 30,			
	2020	2019	Change	% Change
Recently Acquired Facility Results(3):	(Dollars in thousands)			
Transitional and skilled revenue	$ 136,213	$ 17,764	$ 118,449	NM
Number of facilities at period end	25	2	23	NM
Number of campuses at period end*	4	3	1	NM
Actual patient days	434,491	63,831	370,660	NM
Occupancy percentage — Operational beds	71.6 %	71.9 %		NM
Skilled mix by nursing days	21.8 %	20.4 %		NM
Skilled mix by nursing revenue	42.3 %	36.5 %		NM

	Six Months Ended June 30,			
	2020	2019	Change	% Change
	(Dollars in thousands)			
Facility Closed Results(4):				
Skilled nursing revenue	$ —	$ 5,392	$ (5,392)	NM
Actual patient days	—	17,864	(17,864)	NM
Occupancy percentage — Operational beds	— %	66.2 %		NM
Skilled mix by nursing days	— %	16.9 %		NM
Skilled mix by nursing revenue	— %	34.6 %		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, 2017.
(2) Transitioning Facility results represent all facilities purchased from January 1, 2017 to December 31, 2018.
(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2019.
(4) Facility Closed results represents closed operations during the three months ended June 30, 2019, which were excluded from Same Facilities results for the six months ended June 30, 2019 and 2020 for comparison purposes.

Transitional and skilled services revenue increased $196.7 million, or 21.4%, compared to the six months ended June 30, 2019. Of the $196.7 million increase, Medicare and managed care revenue increased $109.8 million, or 27.1%, Medicaid custodial revenue increased $70.1 million, or 18.7% Medicaid skilled revenue increased $10.2 million, or 16.3% and private and other revenue increased $6.6 million, or 8.6%.

The increase in revenue was primarily driven by strong performance across our transitional and skilled services operations during the first quarter of 2020, which grew first quarter revenue by $109.1 million. We began experiencing the impact of COVID-19 during our second quarter, which negatively impacted our census by 6.0%. This was offset by our strong census in the first quarter, resulting in a net occupancy decline of 3.0% for the six months ended June 30, 2020. The occupancy decline was offset by the increase in skilled mix days due to a continuous shift toward high acuity patients. Total revenue from all operations acquired on or subsequent to January 1, 2019 increased our consolidated revenue by $88.8 million during the six months ended June 30, 2020, when compared to the same period in 2019.

Revenue in our Same Facilities increased $70.9 million, or 8.8%. The impact of COVID-19 resulted in a decrease in occupancy of 2.9%. The decline in our occupancy is mainly in our non-skilled patient days, which is being offset by the shift toward high acuity patients. Our skilled days increased by 0.8%, coupled with an increase in our skilled revenue daily rate of 10.6%, resulting in an increase in skilled mix revenue of $42.4 million, or 10.7%. In addition, included in total revenue for Same Facilities is $10.4 million of Medicaid revenue related to FMAP program.

We began experiencing a significant decline our Medicaid custodial and private patient days related to COVID-19 during the second quarter of 2020. Our Medicaid census decreased by 2.9% but is offset by an increase in our Medicaid daily rate of 4.9% as a result of our successful participation in the quality improvement programs and the supplemental programs in various states.

Revenue generated by our Transitioning Facilities increased $12.8 million, or 14.2%, primarily due to increases in our daily rate and patient days compared to the six months ended June 30, 2019, demonstrating our ability to transition these healthcare operations that were acquired two and three years ago. In addition, we continued to see a shift toward higher acuity patients. Our skilled days increased by 2.4%, coupled with an increase from our skilled mix revenue daily rate of 9.6%.

Transitional and skilled services revenue generated by Recently Acquired Facilities increased by approximately $118.4 million compared to the six months ended June 30, 2019. We acquired 24 operations between July 1, 2019 and June 30, 2020 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)]:

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Skilled Nursing Average Daily Revenue Rates:								
Medicare	**$ 670.19**	$ 598.59	**$ 591.98**	$ 532.66	**$ 640.72**	$ 606.06	**$ 659.51**	$ 592.89
Managed care	**486.12**	455.96	**459.72**	425.46	**460.35**	426.54	**481.46**	453.16
Other skilled	**530.41**	492.22	**500.48**	462.71	**334.43**	346.66	**522.09**	489.47
Total skilled revenue	**575.38**	520.26	**528.81**	482.30	**563.00**	498.84	**570.34**	517.29
Medicaid	**233.45**	222.62	**241.58**	231.61	**215.45**	225.11	**231.54**	223.83
Private and other payors	**232.89**	229.92	**239.48**	222.35	**211.29**	198.65	**230.38**	227.54
Total skilled nursing revenue	**$ 341.02**	$ 315.07	**$ 312.17**	$ 285.85	**$ 290.78**	$ 277.35	**$ 331.33**	$ 311.00

(1) These rates exclude additional FMAP revenue we recognized as part of The Family First Coronavirus Response Act.

Our Medicare daily rates at Same Facilities and Transitioning Facilities increased by 12.0% and 11.1%, respectively, compared to the six months ended June 30, 2019. Included in revenue for the six months ended June 30, 2020 is the results of two months of the temporary suspension of the 2% Medicare sequestration, which started on May 1, 2020 and will go through December 31, 2020. In addition, our new payment model, PDPM, became effective on October 1, 2019.

Our average Medicaid rates increased 3.4% due to state reimbursement increases and our participation in supplemental Medicaid payment programs and quality improvement programs in various states.

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:

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Percentage of Skilled Nursing Revenue:								
Medicare	**27.4 %**	23.9 %	**23.1 %**	20.6 %	**29.2 %**	19.8 %	**27.2 %**	23.5 %
Managed care	**17.2**	18.9	**15.0**	13.6	**11.7**	14.1	**16.3**	18.2
Other skilled	**8.5**	8.0	**3.7**	3.2	**1.4**	2.6	**7.3**	7.5
Skilled mix	**53.1**	50.8	**41.8**	37.4	**42.3**	36.5	**50.8**	49.2
Private and other payors	**7.4**	8.1	**11.0**	12.2	**9.2**	8.9	**7.9**	8.4
Medicaid	**39.5**	41.1	**47.2**	50.4	**48.5**	54.6	**41.3**	42.4
Total skilled nursing	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %

	Six Months Ended June 30,							
	Same Facility		Transitioning		Acquisitions		Total	
	2020	2019	2020	2019	2020	2019	2020	2019
Percentage of Skilled Nursing Days:								
Medicare	**13.9 %**	12.5 %	**12.2 %**	11.1 %	**13.2 %**	9.1 %	**13.7 %**	12.3 %
Managed care	**12.0**	13.0	**10.2**	9.1	**7.4**	9.2	**11.2**	12.5
Other skilled	**5.6**	5.2	**2.3**	2.1	**1.2**	2.1	**4.6**	4.7
Skilled mix	**31.5**	30.7	**24.7**	22.3	**21.8**	20.4	**29.5**	29.5
Private and other payors	**10.7**	11.4	**14.3**	15.4	**12.8**	12.0	**11.4**	11.8
Medicaid	**57.8**	57.9	**61.0**	62.3	**65.4**	67.6	**59.1**	58.7
Total skilled nursing	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %	**100.0 %**	100.0 %

Other

Our other revenue increased by $13.4 million, or 29.3% to $59.1 million, compared to the six months ended June 30, 2019. Other revenue for the first half of 2020 includes senior living revenue of $30.1 million; mobile diagnostics revenue of $14.4 million, medical transportation revenue of $10.7 million and rental and other ancillary operations revenue of $3.9 million. The increase in other revenue is due to acquisitions and rental income from Pennant.

Cost of Services

The following table sets forth total cost of services for continuing operations of our transitional and skilled services and "All Other" category for the periods indicated (dollars in thousands):

	Six Months Ended June 30,					
	2020		2019		Change	
	$	%(1)	$	%(1)	$	%
Transitional and skilled services	**$ 861,667**	**77.3 %**	$ 727,309	79.2 %	$ 134,358	18.5 %
All other	**44,603**	**75.4**	39,422	86.2	5,181	13.1
Total cost of services	**$ 906,270**	**77.2 %**	$ 766,731	79.5 %	$ 139,539	18.2 %

(1) This represents cost of services as a percentage of revenue.

Consolidated cost of services increased $139.5 million, or 18.2% compared to the six months ended June 30, 2019. Consolidated cost of services as a percentage of revenue decreased by 2.3% to 77.2%.

Transitional and Skilled Services

Cost of services related to our transitional and skilled services segment increased $134.4 million, or 18.5%, due primarily to additional costs at Recently Acquired Facilities, which accounted for 85.7 million of the increase. Cost of services as a percentage of revenue decreased to 77.3% from 79.2%, a decrease of 1.9%.

Rent — cost of services. Our rent — cost of services as a percentage of total revenue decreased by 0.9% to 5.5%, primarily due to our recent acquisitions including real estate assets, coupled with the growth in revenue outpacing the increase in rent expense.

General and administrative expense. General and administrative expense increased $10.6 million or 19.9%, to $63.7 million. This increase was primarily due to increases in wages to support growth. In addition, general and administrative expense as a percentage of revenue decreased by 0.1% to 5.4%.

Depreciation and amortization. Depreciation and amortization expense increased $3.0 million, or 12.5%, to $27.3 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 0.2%, to 2.3%, as a percentage of revenue.

Other expense, net. Other expense, net as a percentage of revenue decreased by 0.4%, to 0.3%. Other expense primarily includes interest expense related to borrowings under our credit facility. Interest expense during the second quarter of 2020 decreased as we were able to utilize the proceeds from Medicare Accelerated and Advance Payment Program and deferral tax programs to reduce the amount outstanding on our revolving credit facility.

Provision for income taxes. Our effective tax rate was 24.2% for the six months ended June 30, 2020, compared to 18.9% for the same period in 2019. 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 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 revolving credit facilities. Our liquidity as of June 30, 2020 is impacted by cash receipt from Provider Relief Fund and Medicare Accelerated and Advance Payment Program, and deferral social security taxes and estimated federal income taxes for the first and second quarters of 2020 under the CARES Act.

Historically, we have primarily financed the majority of our acquisitions through the financing of our operating subsidiaries through mortgages, our revolving credit facility, and cash generated from operations. Cash paid to fund acquisitions was $0.4 million, and $42.4 million for the six months ended June 30, 2020 and 2019, respectively. Total capital expenditures for property and equipment were $27.1 million and $32.1 million for the six months ended June 30, 2020 and 2019, respectively. We currently have approximately $42.0 million budgeted for renovation projects for 2020, which incorporates the temporary suspension of non-essential capital expenditure projects. 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 June 30, 2020 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2020, we held debt security investments of approximately $48.9 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 June 30, 2020 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date, including the recent developments related to COVID-19, that would indicate any other-than-temporary impairment.

As mentioned above, one primary source of cash is generated 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 June 30, 2020, along with projected operating cash flows and available financing, will support our normal business operations for the foreseeable future. Given the uncertainty in the rapidly changing market and economic conditions related to the COVID-19 outbreak, we will continue to evaluate the nature and extent of the impact to our business and financial position.

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

	Six Months Ended June 30,	
	2020	**2019**
	(In thousands)	
Net cash provided by/(used in):		
Continuing operating activities	**$ 174,138**	$ 52,825
Continuing investing activities	**(28,326)**	(74,451)
Continuing financing activities	**(3,249)**	33,937
Net increase in cash and cash equivalents from discontinued operations	**—**	(4,352)
Net increase in cash and cash equivalents	**142,563**	7,959
Cash and cash equivalents beginning of period, including cash of discontinued operations	**59,175**	31,083
Cash and cash equivalents end of period, including cash of discontinued operations	**$ 201,738**	$ 39,042
Less cash of discontinued operations at end of period	**—**	43
Cash and cash equivalents at end of period	**$ 201,738**	$ 38,999

Operating Activities

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

The $121.3 million increase in cash provided by continuing operating activities for the six months ended June 30, 2020 compared to the same period in 2019 was primarily due to higher net income and changes in working capital in the first two quarters of 2020. Changes in working capital was driven by deferred payment of the employer portion of social security taxes, strong accounts receivable collections, deferred payments of income taxes, timing of accrued expenses and accrued wages and related liabilities.

Investing Activities

Investing cash flows consist primarily of capital expenditures, investment purchases and cash used for acquisitions.

The decrease in cash used in continuing investing activities for the six months ended June 30, 2020 compared to the same period in 2019 of $46.1 million was primarily due to a decrease in cash used for acquisitions, net of escrow deposits, of $42.0 million coupled with a decrease in capital expenditures of $5.0 million.

Financing Activities

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

The decrease in cash provided by continuing financing activities for the six months ended June 30, 2020 compared to the same period in 2019 of $37.1 million was primarily due to a net repayment of $180.8 million in the first two quarters of 2020 compared to a net borrowing of $34.0 million in the same period in 2019. Additionally, during the first two quarters of 2020 we repurchased $25.0 million of common stock under our authorized common stock repurchase programs. We did not have any repurchases of common stock in the first two quarters of 2019. The decreases are offset by proceeds received under the Medicare Accelerated and Advance Payment Program of $98.9 million, as well as proceeds received under the Provider Relief Funds of $108.8 million.

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 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.

Mortgage Loans and Promissory Note

As of June 30, 2020, 19 of our subsidiaries are under mortgage loans insured with Department of Housing and Urban Development (HUD) for an aggregate amount of $115.0 million, which subjects these subsidiaries to HUD oversight and periodic inspections. The mortgage loans bear fixed interest rates range of 2.6% to 3.5% 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 two promissory notes. The notes bear fixed interest rates of 5.3% and 4.3% per annum and the term of the notes are 12 years and 10 months, respectively. The 12 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

During the second quarter of 2020, 163 of our facilities are under long-term lease arrangements, of which 85 of the operations are under the triple-net Master Leases with CareTrust REIT, Inc. (CareTrust). In connection with the Spin-Off, 11 of the original 94 properties were transferred to Pennant. Of the 11 properties, two of the senior living operations are located on the same real estate properties as the skilled nursing facilities. 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.

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 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.

U.S. Department of Justice Civil Investigative Demand

On May 31, 2018, we received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating to determine whether we have violated the False Claims Act and/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. The CID covered the period from October 3, 2013 to the present, and was limited in scope to ten of our Southern California skilled nursing facilities. In October 2018, the Department of Justice made an additional request for information covering the period of January 1, 2011 to the present, relating to the same topic. As a general matter, our operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. We have fully cooperated with the U.S. Department of Justice to promptly respond to the requests for information and have recently been advised that the U.S. Department of Justice has declined to intervene in any subsequent action based on or related to the subject matter of this investigation.

Inflation

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

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

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 August 2018, the FASB issued amended guidance to simplify fair value measurement disclosure requirements. The new provisions eliminate the requirements to disclose (1) transfers between Level 1 and Level 2 of the fair value hierarchy, (2) policies related to valuation processes and the timing of transfers between levels of the fair value hierarchy, and (3) net asset value disclosure of estimates of timing of future liquidity events. The FASB also modified disclosure requirements of Level 3 fair value measurements. We adopted this standard effective January 1, 2020 and determined there was no material impact on our consolidated financial statements.

In January 2017, the FASB issued amended authoritative guidance to simplify and reduce the cost and complexity of the goodwill impairment test. The new provisions eliminate step 2 from the goodwill impairment test and shifts the concept of impairment from a measure of loss when comparing the implied fair value of goodwill to its carrying amount to comparing the fair value of a reporting unit with its carrying amount. The FASB also eliminated the requirements for any reporting unit with a zero or negative carrying amount to perform a qualitative assessment or step 2 of the goodwill impairment test. The new guidance does not amend the optional qualitative assessment of goodwill impairment. We adopted this standard effective January 1, 2020 and determined there was no material impact on our consolidated financial statements.

In June 2016, the FASB issued Accounting Standards Update (ASU) 2016-13 "*Financial Instruments – Credit Losses (Topic 326): Measurement of Credit Losses on Financial Instruments*", which replaces the existing incurred loss impairment model with an expected credit loss model and requires a financial asset measured at amortized cost to be presented at the net amount expected to be collected. We adopted this standard effective January 1, 2020 and determined there was no material impact on our consolidated financial statements.

Accounting Standards Recently Issued but Not Yet Adopted by the Company

In December 2019, the FASB issued ASU 2019-12 *"Simplifying the Accounting for Income Taxes (Topic 740)"*, as part of its simplification initiative to reduce the cost and complexity in accounting for income taxes. ASU 2019-12 removes certain exceptions related to the approach for intraperiod tax allocation, the methodology for calculating income taxes in an interim period and the recognition of deferred tax liabilities for outside basis differences. ASU 2019-12 also amends other aspects of the guidance to help simplify and promote consistent application of GAAP. The guidance is effective for interim and annual periods beginning after December 15, 2020, with early adoption permitted. We are currently evaluating the impact of ASU 2019-12 on our financial position, results of operations and liquidity.

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 the new reference rates which will replace LIBOR and other reference rates expected to be discontinued. 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. We are currently evaluating the impact of ASU. 2020-04 on our financial position, results of operations and liquidity.

Off-Balance Sheet Arrangements

As of June 30, 2020, we had approximately $5.8 million on our Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

Item 3. QUANTITATIVE AND QUALITATIVE DISCLOSURES ABOUT MARKET RISK

Interest Rate Risk. We are exposed to risks associated with market changes in interest rates. 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.

At June 30, 2020, our subsidiaries had $30.0 million outstanding under our revolving credit facility. We have outstanding indebtedness under mortgage loans insured with Department of Housing and Urban Development (HUD) and two promissory notes to third parties of $119.6 million.

Our cash and cash equivalents as of June 30, 2020 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of June 30, 2020, we held debt security investments of approximately $48.9 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 June 30, 2020 were not other-than-temporarily impaired, nor has any event occurred subsequent to that date, including the recent developments related to COVID-19, 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% 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 June 30, 2020 and does not consider those exposures or positions which could arise after that date. If we diversify our investment portfolio into securities and other investment alternatives, we may face increased risk and exposures as a result of interest risk and the securities markets in general.

Item 4. CONTROLS AND PROCEDURES

Disclosure Controls and Procedures

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

There were no changes in our internal control over financial reporting (as such term is defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) that occurred during the three months ended June 30, 2020, 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 interpretation. Compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as significant regulatory action including fines, penalties, and exclusion from certain governmental programs. Included in these laws and regulations is the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which requires healthcare providers (among other things) to safeguard the privacy and security of certain 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 employees, under which we may be required to indemnify such persons for liabilities arising out of their employment relationships or 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.

U.S. Department of Justice Civil Investigative Demand - On May 31, 2018, we received a Civil Investigative Demand (CID) from the U.S. Department of Justice stating that it is investigating to determine whether there has been a violation of the False Claims Act and/or the Anti-Kickback Statute with respect to the relationships between certain of our independently operated skilled nursing facilities and persons who serve or have served as medical directors, advisory board participants or other potential referral sources. The CID covered the period from October 3, 2013 to the present, and was limited in scope to ten of our Southern California independent operating entities. In October 2018, the Department of Justice made an additional request for information covering the period of January 1, 2011 to the present, relating to the same topic. As a general matter, our independent operating entities maintain policies and procedures to promote compliance with the False Claims Act, the Anti-Kickback Statute, and other applicable regulatory requirements. We have fully cooperated with the U.S. Department of Justice to promptly respond to the requests for information, and have recently been advised that the U.S. Department of Justice has declined to intervene in any subsequent action based on or related to the subject matter of this investigation.

Litigation — We are party to various legal actions and administrative proceedings, and are subject to various claims arising in the ordinary course of business, including claims that 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, in the ordinary course of business, we are continuously subject to State and Federal regulatory scrutiny, supervision and control. Such regulatory scrutiny often includes inquiries, investigations, examinations, audits, site visits and surveys, some of which are non-routine. In addition to being subject to direct regulatory oversight of State and Federal regulatory agencies, the skilled nursing and post-acute care industry is also subject to regulatory requirements which could subject us to civil, administrative or criminal fines, penalties or restitutionary relief, and reimbursement; authorities could also seek the suspension or exclusion of the provider or individual from participation in their programs. We believe that there has been, and will continue to be, an increase in governmental investigations of long-term care providers, particularly in the area of Medicare/Medicaid false claims, as well as an increase in enforcement actions resulting from these investigations. Adverse 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, the U.S. House of Representatives Select Subcommittee on the Coronavirus Crisis has launched an investigation into the coronavirus crisis in nursing homes. In June 2020, the Company received a document request from the House Select Subcommittee. The Company is cooperating with this inquiry; however, it is not possible to predict the ultimate outcome of any such investigation or what other investigations or regulatory responses may result from the investigation and 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 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 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 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. For example, and despite the decision of the U.S. Department of Justice to decline participation in litigation based on the subject matter of its previously issued Civil Investigative Demand, the *qui tam* relator may continue on with the lawsuit and pursue claims that one or more of the Company' 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. In addition, the Deficit Reduction Act of 2005 created incentives for states to enact anti-fraud legislation modeled on the Federal False Claims Act. As such, we could face increased scrutiny, potential liability, and legal expenses and costs based on claims under state false claims acts in markets in which our 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 (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 it is knowingly improper. In addition, FERA extended protections against retaliation for whistleblowers, including protections not only for employees, but also contractors and agents. Thus, 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. One particular type of suit arises from alleged violations of minimum staffing requirements for skilled nursing facilities in those states which have enacted such requirements. The alleged failure to meet these requirements can, among other things, jeopardize a facility's compliance with requirements of participation under certain State and Federal healthcare programs; it may also subject the facility to a notice of deficiency, a citation, a civil money penalty, or litigation. 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 and legal actions that arise in the ordinary course of business, including potential claims related to patient care and treatment (professional negligence claims) as well as employment related claims. While we have been able to settle 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.

Claims and suits, including class actions, continue to be filed against us and other companies in the post-acute care industry. We and our independent operating entities 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 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, PSC and MIC (collectively referred to as Reviews). CMS has suspended all Targeted Probe and Educate program activity due to the State of Emergency. Accordingly, as of June 30, 2020, none of our independent operating subsidiaries had Reviews scheduled, on appeal, or are in a dispute resolution process, both pre- and post-payment. Once the suspension period has been lifted our previously in-progress reviews could begin again. We anticipate that these Reviews will reconvene and could increase in frequency in the future.

Item 1A. RISK FACTORS

Risks Related to Our Business and Industry

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

The COVID-19 pandemic has spread across the globe and disrupted economies around the world, including the markets in which we operate. The rapid spread of the virus has led to the implementation of various responses, including federal, state and local government-imposed quarantines, shelter-in-place mandates, sweeping restrictions on travel, and other public health safety measures, as well as reported adverse impacts on healthcare resources, facilities and providers. In March, the outbreak was declared a pandemic by the World Health Organization, and the Health and Human Services Secretary declared a public health emergency in the United States in response to the outbreak. Additionally, the CDC has stated that older adults are at a higher risk for serious illness from the coronavirus. The extent to which COVID-19 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, additional or modified government actions, new information which may emerge concerning the severity of the virus and the actions taken to contain the virus or treat its impact, among others.

In response to COVID-19, federal, state and local regulators have both implemented new regulations and waived existing regulations in an effort to promote efficient care delivery to decrease the spread of COVID-19. 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 with changes and monitoring for future changes. Additionally, most of the accommodations are limited in duration to the COVID-19 public health emergency, thus there may be significant operational change requirements on short notice. Also, the reinstatement of waived state and federal regulations may not occur simultaneously, requiring heightened monitoring to ensure compliance.

To date, regulatory changes have impacted a number of operational areas in our business, including the following: patient privacy and patient rights; use of telehealth; employment, including benefits, leave, credentialing, worker’s compensation, workplace safety; tax rates and deadlines; Medicare and Medicaid conditions of participation and conditions of payment; quality reporting; and insurance premiums.

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

- significantly reduced occupancy as a result of local government-imposed quarantines, including shelter-in-place mandates, sweeping restrictions on travel, and substantial changes to selected protocol within the healthcare system across the United States, including temporary limitations on certain medical procedures that limited the number of patients visiting the hospital and needing skilled nursing services;
- general decline in all hospital procedures, including temporary cessation of elective procedures at acute-care hospitals to prepare for an increase of COVID-19 cases and critical care life threatening patients affecting lower census;
- increased costs and staffing requirements related to additional protocols implemented in connection with CDC and related isolation procedures, including obligations to test patients and staff for COVID-19;
- departure of nurses and other skilled personnel, such as Certified Nurse Assistants, social workers and speech, physical and occupational therapists due to their own COVID-19-related illness or concern regarding their exposure to illness at our facilities, which could lead to staffing shortages or reliance on less experienced personnel, including in states where standard licensing credentials may be amended or waived to assist with staffing shortages;
- disruptions to supply chains which could negatively impact consistent and reliable delivery of personal protective equipment (PPE), sanitizing supplies, food, pharmaceuticals, utilities and other goods to our affiliated facilities, resulting in our inability to obtain on reasonable terms, or at all, PPE, sanitizing supplies, food, pharmaceuticals, utilities and other goods;

- incurrence of additional expenditures in connection with our response to COVID-19, including additional temporary facilities to separate patients (e.g., house suspected or confirmed COVID-19 patients in one facility and others in different facility), additional equipment or temporary construction, and implementation of new protocols related to isolation procedures;

- 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;

- determination by one or more states in which we operate to not waive state-level regulatory requirements applicable to long-term care facilities commensurate with blanket waivers and flexibilities granted by CMS pursuant to sections 1135 and 1812(f) of the Social Security Act;

- increased risk of litigation and related liabilities arising in connection with patient or staff illness, hospitalization and/or death;

- increased legal and operational costs related to compliance with changes in federal and state laws and regulations;

- potential repayments of relief funds received as changes in federal guidelines are published; and

- negative impacts on our patients' ability or willingness to pay for healthcare services and our third parties' ability or willingness to pay rents.

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 29.9% and 28.2% of our revenue from the Medicare programs for the three and six months ended June 30, 2020, respectively and 24.1% and 24.4% for the three and six months ended June 30, 2019, 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 1., *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;
- the reduction or elimination of annual rate increases (See also, Item 1., *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, IRFs, 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. 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 revenues, 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 44.9% and 44.5% of our revenue for the three and six months ended June 30, 2020, respectively and 46.2% and 45.9% for the three and six months ended June 30, 2019, 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. This 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.

Additionally, as discussed in greater detail in Item 1.A, under the Government Regulation heading, CMS recently published a proposed rule, titled Medicaid Fiscal Accountability Regulation (MFAR). If the proposed MFAR rule goes into effect, without change, the number of our facilities participating in the UPL program (presently 69 facilities), and/or the amount of reimbursement we receive through the UPL program, could dramatically decrease or even cease. Such would have a significant and adverse effect on our Utah Medicaid revenue, 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, such as PDPM.

As discussed in more detail in Item 1, Government Regulation, CMS implemented a final rule in October 2019 to replace the existing case-mix classification system, RUG-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. The following represent examples of potential risks associated with PDPM:

- Transition to a new reimbursement model. There is a short-term risk related to decreased accuracy due to the inherent learning curve associated with the implementation of a new reimbursement system and the corresponding process changes required to ensure that all the clinical conditions affecting the patient are accurately captured. During the initial transition from RUG IV to PDPM, it is possible that providers may not capture all aspects of a patient's condition, resulting in lower reimbursement under PDPM. However, this risk should subside over time as providers gain experience with the new system.
- Future reimbursement levels. The final rule indicates that payments under PDPM will be budget neutral. CMS has made assumptions in the final rule as to the comparison of payments under RUG-IV to PDPM in fiscal year 2020. This estimate determined that a parity adjustment would be required to increase PDPM payments to bring them equal to what they would have been under RUG-IV payments. This increase, for fiscal year 2020, would achieve budget neutrality. However, the risk to providers is that going forward from fiscal year 2020 a lower parity adjustment could be applied to recapture any exceptional overpayments to providers caused by overestimating the parity adjustment. With the increased focus on therapy utilization under RUGs IV, there is concern as to the accuracy of the parity adjustment and how closely it will reflect the data that will be captured under PDPM where the focus is on the clinical condition of the patient in lieu of resource utilization. In addition, the entire parity adjustment could be removed by CMS and this would cause a drastic reduction in payments.

- Medicare Managed Care Programs and Rates. The introduction of PDPM could pose an indirect risk on existing Medicare Managed Care Plans. For example, many of the Medicare Managed Care Plans have relied upon the existing RUG-IV rates to set their own rates. Medicare Managed Care Plan contracts with providers may even make reference to RUG-IV rates. With the implementation of PDPM, CMS will no longer support the RUG-IV system after fiscal year 2020. This will leave providers to negotiate individual Medicare Managed Care reimbursement rates not based on the traditional Medicare Part A program. The risk is that the Medicare Managed Care Plans could negotiate much lower reimbursement rates and or leave providers without a contract for their Medicare Managed Care patients because the reimbursement rates would be too low to cover the cost of care.

- Impact on Medicaid Reimbursement. Various state Medicaid programs have used data collected using the MDS based on RUG-IV. With the shift to PDPM, some or all of that data will no longer be collected by CMS and made available to the states. In addition, CMS has notified state Medicaid programs that they will no longer support the RUG-IV system after fiscal year 2020 and recommended that states make changes to their Medicaid reimbursement programs to accommodate the upcoming changes. Consequently, there is a risk to providers that states may not have sufficient time to address the changes required to transition to a different Medicaid reimbursement methodology. We may be adversely affected by the rates at which our services are reimbursed by state Medicaid plans.

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

The Patient Protection and Affordable Care Act and the Healthcare Education and Reconciliation Act (collectively, 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 1., under *Government Regulation*, the ACA included the following:

- Imposed new reporting obligations on SNFs, requiring them to (i) disclose information regarding ownership, expenditures and certain other information, and (ii) electronically submit verifiable data on direct care staffing.

- Sought to address potential fraud and abuse in federal healthcare programs by, among other things, (i) implementing screenings and enhanced oversight periods for new providers and suppliers, (ii) providing enhanced penalties for submitting false claims, (iii) providing funding for enhanced anti-fraud activities, and (iv) providing the federal government with expanded authority to suspend payment if a provider is investigated for allegations or issues of fraud.

- Gave authority to U.S. Department of Health and Human Services (HHS) to establish, test and evaluate alternative payment methodologies for Medicare services, many of which have been developed, focusing on incentives for providers to coordinate patient care across the continuum and to be jointly accountable for an entire episode of care centered around a hospitalization.

- Working to improve the healthcare delivery system through incentives to enhance quality, improve beneficiary outcomes and increase value of care, with one of these key delivery system reforms being the encouragement of ACOs to facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. Participating ACOs that meet specified quality performance standards are eligible to receive a share of any savings if the actual per capita expenditures of their assigned Medicare beneficiaries are a sufficient percentage below their specified benchmark amount.

- Required HHS to develop a plan to implement a value-based purchasing program for Medicare payments to skilled nursing facilities, including measures and performance standards regarding preventable hospital readmissions. As part of this program, the skilled nursing facility value-based purchasing (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 withholds 2% of skilled nursing facilities' fee-for-service Part A Medicare payments to fund the program, referred to as the "withhold." CMS then redistributes 60% of the withhold to skilled nursing facilities as incentive payments.

CMS will continue to issue rules to implement the ACA. Courts will continue to interpret and apply the ACA's provisions. We cannot predict what effect these changes will have on our business, including the demand for our services or the amount of reimbursement available for those services. However, it is possible these new laws may lower reimbursement or increase the cost of doing business and adversely affect our business.

Additionally, as discussed below under the heading "*Our business may be materially impacted if certain aspects of the ACA are amended, repealed, or successfully challenged,*" any further amendments or revisions to the ACA or its implementing regulations could materially impact our business. Moreover, the upcoming presidential and congressional elections in the United States 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. This includes Democratic proposals for Medicare for All or significant expansion of Medicare, which could significantly impact our business and the healthcare industry. We continually monitor these developments in order to respond to the changing regulatory environment impacting our business.

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. On December 14, 2018, the U.S. District Court for the Northern District of Texas held the individual mandate provision, and therefore the entirety of ACA, unconstitutional. This ruling was appealed to the Fifth Circuit Court of Appeals, which issued its decision on December 18, 2019, partially affirming the district court's decision, finding the individual mandate to be unconstitutional and remanding the case to the district court for additional analysis on whether the individual mandate provision was severable from the remainder of the ACA. The case has been appealed to the U.S. Supreme Court. Other unrelated 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 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. Private pay sources also reserve the right to conduct audits. We believe that billing and reimbursement errors and disagreements are common in our industry. We are regularly engaged in reviews, audits and appeals of our claims for reimbursement due to the subjectivities inherent in the process related to patient diagnosis and care, record keeping, claims processing and other aspects of the patient service and reimbursement processes, and the errors and disagreements those subjectivities can produce. An adverse review, audit or investigation could result in:

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

In 2004, our Medicare fiscal intermediaries 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. CMS has suspended all Targeted Probe and Educate program activity due to the State of Emergency. Accordingly, as of June 30, 2020, none of our independent operating subsidiaries had Reviews scheduled, on appeal, or are in a dispute resolution process, both pre- and post-payment. Once the suspension period is lifted, the previously in-progress reviews could start again. We anticipate that these Reviews will reconvene and 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.

On May 31, 2018, we received a Civil Investigative Demand (CID) from the DOJ stating that it is investigating the Company to determine whether we have violated the FCA and/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. The CID covered the period from October 3, 2013 to the present and was limited in scope to ten of our Southern California skilled nursing facilities. In October 2018, the Department of Justice made an additional request for information covering the period of January 1, 2011 to the present, relating to the same topic. As a general matter, our operating entities maintain policies and procedures to promote compliance with the FCA, the Anti-Kickback Statute, and other applicable regulatory requirements. We are fully cooperating with the U.S. Department of Justice to promptly respond to the requests for information. However, we cannot predict when the investigation will be resolved, the outcome of the investigation or its potential impact on the Company.

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 and/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/or civil claims, administrative sanctions and penalties for amounts that could be material to our business, results of operations and financial condition. In addition, we and/or some of 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 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. 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 1., *Government Regulation*, we are subject to federal and state laws intended to prevent healthcare fraud and abuse, including the federal False Claims Act (FCA), state false claims acts, the illegal remuneration provisions of the Social Security Act, the federal Anti-Kickback Statute (AKS), 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. For example, in April 2013, we reached a settlement with the Department of Justice (DOJ) regarding their investigation related to claims submitted to the Medicare program for rehabilitation services provided at skilled nursing facilities in Southern California. As part of the settlement, we agreed to pay $48.0 Million and we entered into a Corporate Integrity Agreement (the CIA) with the Office of Inspector General-HHS. Failure to comply with the terms of a Corporate Integrity Agreement can result in substantial civil or criminal penalties and being excluded from government health care programs, which could adversely affect our financial condition and results of operations. In March 2019, we were notified by the OIG that the five-year term of the CIA has been concluded and effectively released from the CIA.

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. As already mentioned herein, the Company is currently aware of another investigation by the DOJ related to allegations some of our California facilities may have violated the FCA and/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 the 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 long-term care facilities 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 long-term care facilities, as discussed in Item 1, *Government Regulation*, state survey agencies will have more accountability for their survey and enforcement efforts. As discussed in Item 1, under the heading *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 results of operations as a whole.

For example, in 2016, we elected to voluntarily close one operating subsidiary as a result of multiple regulatory deficiencies in order to avoid continued strain on our staff and other resources and to avoid restrictions on our ability to acquire new facilities or expand or operate existing facilities. In addition, 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 one facility placed on special focus facility status. Other operating subsidiaries may be identified for such status in the future.

Future cost containment initiatives undertaken by private third-party payors may limit our future 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 1., *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 Bipartisan Budget Act of 2018 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.

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

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. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Clinical Health Act of 2009 (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.

Additionally, healthcare businesses are increasingly targets of cyberattacks whereby hackers disrupt business operations and/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 security 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 security 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 security 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. At present, this provision applies to a limited number of DRGs, but already is apparently having a negative effect on skilled nursing facility utilization and payments, either because hospitals are finding it difficult to place patients in skilled nursing facilities which will not be paid as before or because hospitals are reluctant to discharge the patients to skilled nursing facilities and lose part of their payment. This bundling requirement could be extended to more DRGs in the future, which would accentuate the negative impact on skilled nursing facility utilization and payments. We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations.

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/or the termination of Medicaid participation, or the suspension, revocation or nonrenewal of the skilled nursing facility's license. If the federal or state governments were to issue regulations which materially change the way compliance with the minimum staffing standard is calculated or enforced, our labor costs could increase and the current shortage of healthcare workers could impact us more significantly.

Increased competition for, or a shortage of, nurses or other trained personnel, or general inflationary pressures may require that we enhance our pay and benefits packages to compete effectively for such personnel. We may not be able to offset such added costs by increasing the rates we charge to 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 1.A, under the heading *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 Multiple Procedure Payment Reduction (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 expressed intent to effectively lower Medicare Part B reimbursement rates for outpatient therapy services by 8%, 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 1, *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, the OIG publishes these reports, in part, to educate involved stakeholders and signal future enforcement focus. A 2019 report and pending 2020 report demonstrate the OIG’s increased scrutiny on post-hospital SNF care and billing. This may impact the SNF industry by motivating additional reviews and stricter compliance in the areas outlined in the recent reports, expending material time and resources.

Additionally, OIG reports published in 2010 and 2015 show the OIG’s concerns related to the billing practices of SNFs based on Medicare Part A claims and financial incentives for facilities to bill for higher levels of therapies, even when not needed by patients. Also, 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.

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 (ADL) services in order to, 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 the acquisition of a facility being operated by a non-profit organization requires the approval of the state Attorney General.

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, 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 in 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 Americans with Disabilities Act (ADA) and similar state laws that provide civil rights protections to individuals with disabilities in the context of employment, public accommodations and other areas, the National Labor Relations Act, regulations of the Equal Employment Opportunity Commission (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. Because labor represents such a large portion of our operating costs, changes in federal and state employment-related laws and regulations could increase our cost of doing business.

The compliance costs associated with these laws and evolving regulations could be substantial. For example, all of our 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 experience damages that are not covered by our insurance policies or that exceed our insurance limits, and we may be required to pay such damages directly, which would negatively impact our cash flow from operations.

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, including in connection with the Spin-Off, our operations must receive change of ownership (CHOW) approvals from state licensing agencies, Medicare and Medicaid as well as third party payors. 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 and six months ended June 30, 2020, 74.8% and 72.7% of our revenue was provided by government payors that reimburse us at predetermined rates, respectively. 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.

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 and/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 an 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 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.

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

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

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. 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, (1) 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, (2) 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 (3) 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, the purchase price of the facilities, prevailing market conditions, the availability of leadership to manage new facilities and our own willingness to take on new operations, the rate at which we have historically acquired facilities has fluctuated significantly. In the future, we anticipate the rate at which we may acquire facilities will continue to fluctuate, which may affect our revenue.

We have also historically acquired a few facilities, either because they were included in larger, indivisible groups of facilities or under other circumstances, which were or have proven to be non-strategic or less desirable, and we may consider disposing of such facilities or exchanging them for facilities which are more desirable. To the extent we dispose of such a facility without simultaneously acquiring a facility in exchange, our revenues might decrease.

We may not be able to successfully integrate acquired facilities 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 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 six months ended June 30, 2020, we expanded our operations through a combination of long-term leases and real estate purchases, with the addition of three stand-alone skilled nursing operations and one stand-alone senior living operation. 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. 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 and maintain competitive quality of care ratings from CMS and 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. See Item 1., *Government Regulation*. The 2019 changes included (i) the addition of separate ratings for short stay and long stay care; (ii) changes in staffing thresholds; and (iii) modifications to put more emphasis on RN staffing, including a set rating for nursing homes that report four or more days in the quarter with no RN on site.

CMS estimated the April 24, 2019 changes would cause 47 percent of all nursing centers to lose stars in their "Quality" ratings, with 33 percent to lose stars in their "Staffing" ratings, and some 36 percent to lose stars in their "Overall" ratings.

In responding to the COVID-19 pandemics, CMS announced a new, targeted inspection plan to focus inspections on urgent patient safety threats and infection control, therefore causing a great shift in the number of nursing homes inspected and how the inspections are conducted. As this change would disrupt the inspection domain of the Nursing Home Five Star Quality Rating System, results of inspection conducted on or after March 4, 2020 will not be used to calculate a nursing home’s health inspection star ratings. In addition, on June 25, 2020, CMS announced that beginning July 29, 2020, data used to calculate measures in the Five Star Quality rating system will be based on the data collection period ending December 31, 2019 so as to exclude data from resident assessments that are impacted by the waiver associated with the public health emergency.

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 1., *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 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 (SIR) 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. 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 subsidiary insurance company, Standardbearer Insurance Company, Ltd. (Standardbearer), to insure our self-insurance reimbursements (SIR) 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 SIR under our general and professional liability and workers compensation programs applies on a per claim basis, there is no limit to the maximum number of claims or the total amount for which we could incur liability in any policy period.

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 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. 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 could experience risks associated with leased property, including risks relating to lease termination, lease extensions and special charges, which could adversely affect our business, financial position or results of operations.

As of June 30, 2020, we leased 163 of our 225 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 number of reasons, including, subject to applicable cure periods, 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.

In 2017, we voluntarily discontinued operations at one of our skilled nursing facilities after determining that the facility could not competitively operate in the marketplace without substantial investment renovating the building. After careful consideration, we determined that the costs to renovate the facility would outweigh the future returns from the operation. As part of the arrangement, we remain obligated for lease payments and other obligations under the lease agreement. We have in the past, and may in the future, continued to be obligated for lease payments and other obligations under the leases even if we decided to no longer operate those locations. We could incur special charges relating to the closing of such facilities including lease termination costs, impairment charges and other special charges that would reduce our net income and could adversely affect our business, financial condition and 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.

We maintain the Credit Facility with a lending consortium arranged by Truist with a revolving line of credit of up to $350.0 million in aggregate principal amount. As of June 30, 2020, our operating subsidiaries had $30.0 million outstanding under our Credit Facility. Nineteen of our subsidiaries are under mortgage loans insured with Department of Housing and Urban Development (HUD) for an aggregate amount of $115.0 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 had outstanding promissory notes of approximately $4.6 million as of June 30, 2020. The term of the note is 12 years and 10 months. Because these mortgage loans are insured with HUD, our borrower subsidiaries under these loans are subject to HUD oversight and periodic inspections.

In addition, we had $1.7 billion of future operating lease obligations as of June 30, 2020. 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 facilities and mortgage loans contain restrictive covenants and require us to maintain or satisfy specified coverage tests on a consolidated basis and on a facility or facilities basis. These restrictions and operating covenants include, among other things, requirements with respect to occupancy, debt service coverage, 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 existing credit facilities or to obtain new financing or to engage in other business activities, which may inhibit our ability to grow our business and increase revenue.

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.

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 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 service, 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, 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, unless and until the current U.S. and global political, credit and financial market crisis has been sufficiently resolved, it may be 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 favorable to us. If capital is not available, we may not be able to fund internal or external business expansion or respond to competitive pressures or other market conditions.

Delays in reimbursement may cause liquidity problems.

If we experience problems with our 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.

Nineteen 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 revenues. 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 transitional 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 two Spin-Offs fail to qualify as generally tax-free for U.S. federal income tax purposes, we and our stockholders could be subject to significant tax liabilities.

In addition to the Spin-Off, in June 2014, we completed the separation of our healthcare business and our real estate business into two separate and independent publicly traded companies through the distribution of all of the outstanding shares of common stock of CareTrust REIT, Inc. (CareTrust) to Ensign stockholders on a pro rata basis (the CareTrust Spin-Off). Both of these transactions were intended to qualify for tax-free treatment to us and our stockholders for U.S. federal income tax purposes. Accordingly, completion of the transactions were 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 either the Spin-Off or the CareTrust 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 these two transactions. Any indemnity obligations for tax issues or other liabilities related to the spin off, could be significant and could adversely impact our business.

We may not achieve some or all of the anticipated benefits of the Spin-Off, which may adversely affect our business.

The Spin-Off was completed in 2019. We may not be able to achieve the full strategic, financial or other benefits expected to result from the Spin-Off, or such benefits may be delayed or not occur at all. If we fail to achieve some or all of the expected benefits of the separation, or if such benefits are delayed, our business, financial condition, results of operations and the value of our stock could be adversely impacted. The combined value of the common stock of the two publicly traded companies may not be equal to or greater than what the value of our common stock would have been had the separation not occurred. The common stock price of each company may experience periods of extreme volatility. The separation also presents a number of significant risks to our internal processes, including the failure to maintain an adequate control environment due to changes to our infrastructure technology systems and financial reporting processes.

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.

The Spin-Off could be challenged under various state and federal fraudulent conveyance laws. An unpaid creditor could claim that we did not receive fair consideration or reasonably equivalent value in the Spin-Off, and that the Spin-Off left us insolvent, or with unreasonably small capital, or that we intended or believed it would incur debts beyond its ability to pay such debts as they mature. If a court were to agree with such a plaintiff, then such court could void the Spin-Off as a fraudulent transfer and could impose a number of different remedies, including without limitation, returning the assets or the shares in Pennant to us or providing us with a claim for money damages against the spun-off business in an amount equal to the difference between the consideration received by us and the fair market value of the spun-off business at the time of the Spin-Off.

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.

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 31 of our properties to Pennant's senior living operations. In the future, we might expand our leasing property portfolio to additional Pennant operations or 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 other 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. 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. 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.

Changes in the method of determining LIBOR, or the replacement of LIBOR with an alternative reference rate, may adversely affect interest rates on our current or future indebtedness and may otherwise adversely affect our financial condition and results of operations.

Certain of our indebtedness is made at variable interest rates that use the London Interbank Offered Rate, or LIBOR (or metrics derived from or related to LIBOR), as a benchmark for establishing the interest rate. On July 27, 2017, the United Kingdom's Financial Conduct Authority announced that it intends to stop persuading or compelling banks to submit LIBOR rates after 2021. These reforms may cause LIBOR to cease to exist, new methods of calculating LIBOR to be established, or alternative reference rates to be established. The potential consequences cannot be fully predicted and could have an adverse impact on the market value for or value of LIBOR-linked securities, loans, and other financial obligations or extensions of credit held by or due to us. Changes in market interest rates may influence our financing costs, returns on financial investments and the valuation of derivative contracts and could reduce our earnings and cash flows. In addition, any transition process may involve, among other things, increased volatility or illiquidity in markets for instruments that rely on LIBOR, reductions in the value of certain instruments or the effectiveness of related transactions such as hedges, increased borrowing costs, uncertainty under applicable documentation, or difficult and costly consent processes. This could materially and adversely affect our results of operations, cash flows, and liquidity. We cannot predict the effect of the potential changes to LIBOR or the establishment and use of alternative rates or benchmarks.

Risks Related to Ownership of our Common Stock

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

Our ability to pay and maintain cash dividends is based on many factors, including our ability to make and finance acquisitions, our ability to negotiate favorable lease and other contractual terms, anticipated operating cost levels, the level of demand for our beds, the rates we charge and actual results that may vary substantially from estimates. Some of the factors are beyond our control and a change in any such factor could affect our ability to pay or maintain dividends. In addition, the revolving credit facility portion of 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

None.

Item 3. DEFAULTS UPON SENIOR SECURITIES

None.

Item 4. MINE SAFETY DISCLOSURES

None.

Item 5. OTHER INFORMATION

None.

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)
3.5	Certificate of Designation, Preferences and Rights of Series A Junior Participating Preferred Stock, as filed with the Secretary of State of the State of Delaware on November 7, 2013 (attached as Exhibit 3.1 to the Company's Current Report on Form 8-K (File No. 001-33757) filed with the SEC on November 7, 2013)
3.6	Certificate of Elimination of Series A Junior Participating Preferred Stock (attached as Exhibit 3.1 to the Company's Current Report on Form 8-K (File No. 001-33757) filed with the SEC on June 5, 2014)
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.	
August 5, 2020	BY:	/s/ SUZANNE D. SNAPPER
		Suzanne D. Snapper
		Chief Financial Officer and Executive Vice President (Principal Financial 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: August 5, 2020

/s/ Barry R. Port

Name: Barry R. Port

Title: *Chief 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: August 5, 2020

/s/ Suzanne D. Snapper

Name:	Suzanne D. Snapper
Title:	*Chief Financial Officer and Executive Vice President*

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 June 30, 2020, 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*

August 5, 2020

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 June 30, 2020, 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 and Executive Vice President*

August 5, 2020

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.