ENSIGN GROUP, INC
Form 10-Q
May 10, 2016
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UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-Q

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

For the quarterly period ended March 31, 2016.

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

For the transition period from to .

Commission file number: 001-33757

THE ENSIGN GROUP, INC.

(Exact Name of Registrant as Specified in Its Charter)

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

27101 Puerta Real, Suite 450
Mission Viejo, CA 92691
(Address of Principal Executive Offices and Zip Code)

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

N/A
(Former Name, Former Address and Former Fiscal Year, If Changed Since Last Report)

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. x Yes o No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). x Yes o No

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

Large accelerated filer x	Accelerated filer o	Non-accelerated filer o	Smaller reporting company o

(Do not check if a smaller reporting
company)

Indicate by a check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). o Yes x No
As of May 6, 2016, 50,242,881 shares of the registrant’s common stock were outstanding.

THE ENSIGN GROUP, INC.
QUARTERLY REPORT ON FORM 10-Q
FOR THE THREE MONTHS ENDED MARCH 31, 2016
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Part I. Financial Information

Item 1. Financial Statements

THE ENSIGN GROUP, INC.

CONDENSED CONSOLIDATED BALANCE SHEETS

(In thousands, except par values)

(Unaudited)

	March 31, 2016	December 31, 2015
Assets		
Current assets:		
Cash and cash equivalents	$51,370	$ 41,569
Accounts receivable—less allowance for doubtful accounts of $32,098 and $30,308 at March 31, 2016 and December 31, 2015, respectively	217,171	209,026
Investments—current	2,003	2,004
Prepaid income taxes	3,254	8,141
Prepaid expenses and other current assets	19,441	18,827
Total current assets	293,239	279,567
Property and equipment, net	311,479	299,633
Insurance subsidiary deposits and investments	30,955	32,713
Escrow deposits	1,646	400
Deferred tax asset	20,823	20,852
Restricted and other assets	11,165	9,631
Intangible assets, net	44,444	45,431
Goodwill	41,034	40,886
Other indefinite-lived intangibles	18,896	18,646
Total assets	$773,681	$ 747,759
Liabilities and equity		
Current liabilities:		
Accounts payable	$35,695	$ 36,029
Accrued wages and related liabilities	67,567	78,890
Accrued self-insurance liabilities—current	18,204	18,122
Other accrued liabilities	46,018	46,205
Current maturities of long-term debt	627	620
Total current liabilities	168,111	179,866
Long-term debt—less current maturities	145,642	99,051
Accrued self-insurance liabilities—less current portion	39,872	37,881
Deferred rent and other long-term liabilities	9,860	3,976
Total liabilities	363,485	320,774
Commitments and contingencies (Notes 16, 18 and 19)		
Equity:		
Ensign Group, Inc. stockholders' equity:		
Common stock; $0.001 par value; 75,000 shares authorized; 52,207 and 50,205 shares issued and outstanding at March 31, 2016, respectively, and 51,918 and 51,370 shares issued and outstanding at December 31, 2015, respectively (Note 3)	52	51
Additional paid-in capital (Note 3)	241,022	235,076
Retained earnings	200,566	193,420
	(31,223)	(1,223)

Common stock in treasury, at cost, 1,575 and 123 shares at March 31, 2016 and December 31, 2015, respectively (Note 3)		
Total Ensign Group, Inc. stockholders' equity	410,417	427,324
Non-controlling interest	(221)	(339)
Total equity	410,196	426,985
Total liabilities and equity	$773,681	$ 747,759

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended March 31, 2016	2015
Revenue	$383,234	$306,529
Expense:		
Cost of services (exclusive of losses related to operational closure, rent, general and administrative and depreciation and amortization expenses shown separately below)	306,308	241,456
Losses related to operational closure	7,935	—
Rent—cost of services (Note 18)	26,991	18,966
General and administrative expense	17,387	14,416
Depreciation and amortization	8,298	6,517
Total expenses	366,919	281,355
Income from operations	16,315	25,174
Other income (expense):		
Interest expense	(1,370)	(667)
Interest income	234	166
Other expense, net	(1,136)	(501)
Income before provision for income taxes	15,179	24,673
Provision for income taxes	5,889	9,585
Net income	9,290	15,088
Less: net income (loss) attributable to noncontrolling interests	118	(82)
Net income attributable to The Ensign Group, Inc.	$9,172	$15,170
Net income per share attributable to The Ensign Group, Inc.:		
Basic	$0.18	$0.32
Diluted	$0.18	$0.31
Weighted average common shares outstanding:		
Basic	50,679	47,815
Diluted	52,334	49,652
Dividends per share	$0.0400	$0.0375

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended March 31, 2016			2015		
Cash flows from operating activities:						
Net income	$	9,290		$	15,088	
Adjustments to reconcile net income to net cash provided by operating activities:						
Depreciation and amortization	8,298			6,517		
Amortization of deferred financing fees	154			148		
Fixed assets impairment	137			—		
Write-off of deferred financing fee	197			—		
Deferred income taxes	21			22		
Provision for doubtful accounts	5,765			4,743		
Share-based compensation	1,885			1,493		
Excess tax benefit from share-based compensation	(685		)	(641		)
Change in operating assets and liabilities						
Accounts receivable	(13,910		)	(36,900		)
Prepaid income taxes	4,887			2,992		
Prepaid expenses and other assets	(615		)	(3,538		)
Insurance subsidiary deposits and investments	1,759			(205		)
Losses related to operational closure (Note 18)	7,798			—		
Accounts payable	(1,491		)	4,393		
Accrued wages and related liabilities	(11,323		)	(2,104		)
Income tax payable	13			5,914		
Other accrued liabilities	(1,473		)	6,557		
	1,906			1,355		

Accrued self-insurance liabilities		
Deferred rent liability	82	26
Net cash provided by operating activities	12,695	5,860
Cash flows from investing activities:		
Purchase of property and equipment	(18,231)	(12,719)
Cash payment for business acquisitions	(490)	(38,709)
Escrow deposits	(1,646)	(2,485)
Escrow deposits used to fund business acquisitions	400	16,153
Use of restricted cash	—	1,694
Cash proceeds from the sale of property and equipment and insurance proceeds	197	—
Restricted and other assets	(334)	(389)
Net cash used in investing activities	(20,104)	(36,455)
Cash flows from financing activities:		
Proceeds from revolving credit facility (Note 16)	156,750	29,000
Payments on revolving credit facility and other debt (Note 16 and Note 3)	(110,152)	(94,027)
Proceeds from common stock offering (Note 3)	—	112,078
Issuance costs in connection with common stock offering (Note 3)	—	(5,604)
Issuance of treasury stock upon exercise of options	—	6
Issuance of common stock upon exercise of options	3,377	2,410
Repurchase of shares of common stock	(30,000)	—
Dividends paid	(2,072)	(1,708)
Excess tax benefit from share-based	692	641

compensation					
Payments of deferred financing costs	(1,385		)	—	
Net cash provided by financing activities	17,210			42,796	
Net increase in cash and cash equivalents	9,801			12,201	
Cash and cash equivalents beginning of period	41,569			50,408	
Cash and cash equivalents end of period	$	51,370		$	62,609

See accompanying notes to condensed consolidated financial statements.

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

	Three Months Ended March 31,	
	2016	2015
Supplemental disclosures of cash flow information:		
Cash paid during the period for:		
Interest	$1,149	$745
Income taxes	$275	$15
Non-cash financing and investing activity:		
Accrued capital expenditures	$5,329	$4,048
Refundable deposits assumed as part of business acquisition	$—	$3,488
Issuance costs of common stock included in accounts payable	$—	$300

See accompanying notes to condensed consolidated financial statements.

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

1. DESCRIPTION OF BUSINESS

The Company - The Ensign Group, Inc. (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 well as, urgent care centers and other ancillary businesses. As of March 31, 2016, the Company operated 186 facilities, 34 home health, hospice and home care agencies, 17 urgent care centers and other ancillary operations located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oregon, 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, assisted living, home health, home care, hospice, urgent care and other ancillary services. The Company's operating subsidiaries have a collective capacity of approximately 19,600 operational skilled nursing, assisted living and independent living beds. As of March 31, 2016, the Company owned 32 of its 186 affiliated facilities and leased an additional 154 facilities through long-term lease arrangements, and had options to purchase 21 of those 154 facilities. As of December 31, 2015, the Company owned 32 of its 186 affiliated facilities and leased an additional 154 facilities through long-term lease arrangements, and had options to purchase 20 of those 154 facilities.
Certain of the Company’s wholly-owned independent subsidiaries, collectively referred to as the Service Center, provide certain 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 quarterly report is not meant to imply, nor should it be construed as meaning, that The Ensign Group, Inc. has direct operating assets, employees or revenue, or that any of the subsidiaries, are operated by The Ensign Group, Inc.
Other Information — The accompanying condensed consolidated financial statements as of March 31, 2016 and for the three months ended March 31, 2016 and 2015 (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, 2015 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 shareholder of various consolidated limited liability companies and corporations established to operate various acquired skilled nursing and assisted living operations, home health, hospice and home care operations, urgent care centers and related ancillary services. All intercompany transactions and balances have been eliminated in consolidation. The Company presents noncontrolling interest within the equity section of its consolidated balance sheets. The Company presents the amount of consolidated net income that is attributable to The Ensign Group, Inc. and the noncontrolling interest in its consolidated statements of income.

The consolidated financial statements include the accounts of all entities controlled by the Company through its ownership of a majority voting interest and the accounts of any variable interest entities (VIEs) where the Company is subject to a majority of the risk of loss from the VIE's activities, or entitled to receive a majority of the entity's residual returns, or both. The Company assesses the requirements related to the consolidation of VIEs, including a qualitative assessment of power and economics that considers which entity has the power to direct the activities that "most significantly impact" the VIE's economic performance and has the obligation to absorb losses of, or the right to receive benefits that could be potentially significant to, the VIE. The Company's relationship with variable interest entities was not material at March 31, 2016.

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On December 9, 2015, the Company announced a two-for-one stock split of its outstanding shares of common stock. The stock split was effected in the form of a stock dividend, paid on December 23, 2015 to shareholders of record at the close of business December 17, 2015. Common stock began trading at the split-adjusted price on December 24, 2015. All applicable share numbers and per share amounts presented in the notes to condensed consolidated financial statements and the condensed consolidated statements of income have been retroactively adjusted to reflect the stock split. The par value of the Company's common stock remained unchanged at $0.001 per share.

Reclassifications - Prior period results reflect reclassifications, for comparative purposes, related to the early adoption of authoritative guidance for the presentation of deferred taxes. Deferred tax assets have been presented on the balance sheet as a non-current asset for all periods presented. Historically, these assets were classified as either current or non-current assets, as applicable.

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 financial statements and the reported amounts of revenue and expenses during the reporting periods. The most significant estimates in the Company's Interim Financial Statements relate to revenue, allowance for doubtful accounts, intangible assets and goodwill, impairment of long-lived assets, 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.

Revenue Recognition — The Company recognizes revenue when the following four conditions have been met: (i) there is persuasive evidence that an arrangement exists; (ii) delivery has occurred or service has been rendered; (iii) the price is fixed or determinable; and (iv) collection is reasonably assured. The Company's revenue is derived primarily from providing healthcare services to patients and is recognized on the date services are provided at amounts billable to the individual. For reimbursement arrangements with third-party payors, including Medicaid, Medicare and private insurers, revenue is recorded based on contractually agreed-upon amounts on a per patient, daily basis.

Revenue from the Medicare and Medicaid programs accounted for 65.2% and 69.1% of the Company's revenue for the three months ended March 31, 2016 and 2015, respectively. The Company records revenue from these governmental and managed care programs as services are performed at their expected net realizable amounts under these programs. The Company's revenue from governmental and managed care programs is subject to audit and retroactive adjustment by governmental and third-party agencies. Consistent with healthcare industry accounting practices, any changes to these governmental revenue estimates are recorded in the period the change or adjustment becomes known based on final settlement. The Company recorded adjustments to revenue which were not material to the Company's consolidated revenue for the three months ended March 31, 2016 and 2015.

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

Skilled Nursing, Assisted and Independent Living Revenue

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

Home Health Revenue

Medicare Revenue

Net service revenue is recorded under the Medicare prospective payment system based on a 60-day episode payment rate that is subject to adjustment based on certain variables including, but not limited to: (a) an outlier payment if patient care was unusually costly; (b) a low utilization payment adjustment if the number of visits was fewer than five; (c) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required; (e) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (f) changes in the base episode payments established by the Medicare program; (g) adjustments to the base episode payments for case mix and geographic wages; and (h) recoveries of overpayments.

The Company makes adjustments to Medicare revenue on completed episodes to reflect differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Therefore, the Company believes that its reported net service revenue and patient accounts receivable will be the net amounts to be realized from Medicare for services rendered.

In addition to revenue recognized on completed episodes, the Company also recognizes a portion of revenue associated with episodes in progress. Episodes in progress are 60-day episodes of care that begin during the reporting period, but were not completed as of the end of the period. As such, the Company estimates revenue and recognizes it on a daily basis. The primary factors underlying this estimate are the number of episodes in progress at the end of the reporting period, expected Medicare revenue per episode and its estimate of the average percentage complete based on visits performed.

Non-Medicare Revenue

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

Non-episodic Based Revenue - Revenue is recorded on an accrual basis based upon the date of service at amounts equal to its established or estimated per-visit rates, as applicable.

Hospice Revenue

Revenue is recorded on an accrual basis based upon the date of service at amounts equal to the estimated payment rates. The estimated payment rates are daily rates for each of the levels of care the Company delivers. The Company makes adjustments to revenue for an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, the Company monitors its provider numbers and estimates amounts due back to Medicare if a cap has been exceeded. The Company records these adjustments as a reduction to revenue and increases other accrued liabilities.

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

In evaluating the collectability of accounts receivable, the Company considers a number of factors, including the age of the accounts, changes in collection patterns, the composition of patient accounts by payor type and the status of ongoing disputes with third-party payors. On an annual basis, the historical collection percentages are reviewed by payor and by state and are updated to reflect the recent collection experience of the Company. In order to determine the appropriate reserve rate percentages which ultimately establish the allowance, the Company analyzes historical cash collection patterns by payor and by state. The percentages applied to the aged receivable balances are based on the Company's historical experience and time limits, if any, for managed care, Medicare, Medicaid and other payors. The Company periodically refines its estimates of the allowance for doubtful accounts based on experience with the estimation process and changes in circumstances.

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 recorded an impairment charge of $137 related to the close of one

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facility during the three months ended March 31, 2016. The Company did not identified any asset impairment during the three months ended March 31, 2015.

Intangible Assets and Goodwill — Definite-lived intangible assets consist primarily of favorable leases, lease acquisition costs, patient base, facility trade names and customer relationships. Favorable leases and lease acquisition costs are amortized over the life of the lease of the facility. 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 up to 20 years.

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

Goodwill represents the excess of the purchase price over the fair value of identifiable net assets acquired in business combinations. Goodwill is subject to annual testing for impairment. In addition, goodwill is tested for impairment if events occur or circumstances change that would reduce the fair value of a reporting unit (operating segment) below its carrying amount. The Company performs its annual test for impairment during the fourth quarter of each year. See further discussion at Note 12, Goodwill and Other Indefinite-Lived Intangible Assets.

Self-Insurance — The Company is partially self-insured for general and professional liability up to a base amount per claim (the self-insured retention) with an aggregate, one-time deductible above this limit. Losses beyond these amounts are insured through third-party policies with coverage limits per claim, per location and on an aggregate basis for the Company. For claims made after January 1, 2013, the combined self-insured retention was $500 per claim, subject to an additional one-time deductible of $1,000 for California affiliated facilities and a separate, one-time, deductible of $750 for non-California facilities. For all California affiliated facilities, the third-party coverage above these limits was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate limit. For all facilities outside of California, except those located in Colorado, the third-party coverage above these limits was $1,000 per claim, $3,000 per facility, with a $5,000 blanket aggregate and an additional state-specific aggregate where required by state law. In Colorado, the third-party coverage above these limits was $1,000 per claim and $3,000 per facility for skilled nursing facilities, 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 consolidated balance sheets. The Captive is subject to certain statutory requirements as an insurance provider. These requirements include, but are not limited to, maintaining statutory capital. The Company’s policy is to accrue amounts equal to the actuarially estimated costs to settle open claims of insureds, as well as an estimate of the cost of insured claims that have been incurred but not reported. The Company develops information about the size of the ultimate claims based on historical experience, current industry information and actuarial analysis, and evaluates the estimates for claim loss exposure on a quarterly basis. Accrued general liability and professional malpractice liabilities on an undiscounted basis, net of anticipated insurance recoveries, were $31,035 and $29,772 as of March 31, 2016 and December 31, 2015, 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, effective February 1, 2011, the Company has purchased individual stop-loss coverage that insures individual claims that exceed $750 per occurrence. As of July 1, 2014, 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 pay benefits 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 $19,359 and $18,276 as of March 31, 2016 and December 31, 2015, respectively.

In addition, the Company has recorded an asset and equal liability of $3,048 and $2,881 at March 31, 2016 and December 31, 2015, respectively, in order to present the ultimate costs of malpractice and workers' compensation claims and the anticipated insurance recoveries on a gross basis. See Note 13, Restricted and Other Assets.

The Company self-funds medical (including prescription drugs) and dental healthcare benefits to the majority of its employees. The Company is fully liable for all financial and legal aspects of these benefit plans. To protect itself against loss exposure with this policy, the Company has purchased individual stop-loss insurance coverage that insures individual claims that exceed $300 for each covered person with an additional one-time aggregate individual stop loss deductible of $75. Beginning 2016, 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 $4,634 and $5,074 as of March 31, 2016 and December 31, 2015, 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 have been presented on the balance sheet as a non-current asset for all periods presented related to the early adoption of authoritative guidance for the presentation of deferred taxes. Historically, these assets were classified as either current or non-current assets, as applicable. There is no effect on the condensed consolidated statements of income or condensed consolidated statements of cash flow.

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

For interim reporting purposes, the provision for income taxes is determined based on the estimated annual effective income tax rate applied to pre-tax income, adjusted for certain discrete items occurring during the period. In determining the effective income tax rate for interim financial statements, the Company must consider expected annual income, permanent differences between financial reporting and tax recognition of income or expense and other factors. When the Company takes uncertain income tax positions that do not meet the recognition criteria, it records a liability for underpayment of income taxes and related interest and penalties, if any. In considering the need for and magnitude of a liability for such positions, the Company must consider the potential outcomes from a review of the positions by the taxing authorities.

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 consolidated statements of income and net income per share is calculated based on net income attributable to The Ensign Group, Inc.'s stockholders. The carrying amount of the noncontrolling interest is adjusted based on an allocation of subsidiary earnings based on ownership interest.

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

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Leases and Leasehold Improvements - At the inception of each lease, the Company performs an evaluation to determine whether the lease should be classified as an operating or capital lease. The Company records rent expense for operating leases that contain scheduled rent increases 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. The lease term used for this evaluation also provides the basis for establishing depreciable lives for buildings subject to lease and leasehold improvements, as well as the period over which the Company records straight-line rent expense.

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.

In April 2016, the FASB issued its standard to simplify several aspects the accounting for employee share-based payment transactions, which includes the accounting for income taxes, forfeitures, and statutory tax withholding requirements, as well as classification in the statement of cash flows. This guidance will be effective for annual periods beginning after December 15, 2016, which will be the Company's fiscal year 2017, with early adoption permitted. The Company is currently assessing whether the adoption of the guidance will have a material impact on its consolidated financial statements.

In March 2016, the FASB issued its standard to amend the principal-versus-agent implementation guidance and illustrations in the Board’s new revenue standard, which includes accounting implication related to (1) determining the appropriate unit of account under the revenue standard’s principal-versus-agent guidance and (2) applying the indicators of whether an entity is a principal or an agent in accordance with the revenue standard’s control principle. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be the Company's fiscal year 2018. The guidance has the same effective date as the new revenue standard and the Company is required to adopt the guidance by using the same transition method it would use to adopt the new revenue standard. The Company is currently assessing whether the adoption of the guidance will have a material impact on its consolidated financial statements.

In February 2016, the FASB issued amended authoritative guidance on accounting for leases. The new provisions require that a lessee of operating leases recognize in the statement of financial position a liability to make lease payments (the lease liability) and a right-of-use asset representing its right to use the underlying asset for the lease term. The lease liability will be equal to the present value of lease payments, with the right-of-use asset based upon the lease liability. The classification criteria for distinguishing between finance (or capital) leases and operating leases are substantially similar to the previous lease guidance, but with no explicit bright lines. As such, operating leases will result in straight-line rent expense similar to current practice. For short term leases (term of 12 months or less), a lessee is permitted to make an accounting election not to recognize lease assets and lease liabilities, which would generally result in lease expense being recognized on a straight-line basis over the lease term. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2018, which will be the Company's fiscal year 2019, with early adoption permitted. The adoption of this standard is expected to have a material impact on the Company's financial position. The Company is currently assessing the material impact of adopting the guidance on our consolidated financial statements.

In January 2016, the FASB issued amended authoritative guidance which makes targeted improvements for financial instruments. The new provisions impact certain aspects of recognition, measurement, presentation and disclosure requirements of financial instruments. Specifically, the guidance will (i) require equity investments to be measured at fair value with changes in fair value recognized in net income, (ii) simplify the impairment assessment of equity investments without readily determinable fair values, (iii) eliminate the requirement to disclose the method and assumptions used to estimate fair value for financial instruments measured at amortized cost, and (iv) require separate presentation of financial assets and financial liabilities by measurement category. This guidance applies to all entities and is effective for annual periods beginning after December 15, 2017, which will be the Company's fiscal year 2018, with early adoption not permitted. The Company does not expect the adoption of the guidance will have a material impact on its consolidated financial statements.

In May 2014, the FASB and International Accounting Standards Board issued their final standard on revenue from contracts with customers that outlines a single comprehensive model for entities to use in accounting for revenue arising from contracts with customers. The new standard supersedes most current revenue recognition guidance, including industry-specific guidance. In July 2015, the FASB formally deferred for one year the effective date of the new revenue standard and decided to permit entities to early adopt the standard. The guidance will be effective for fiscal years beginning after December 15, 2017, which will be the

Company's fiscal year 2018. The Company is currently assessing whether the adoption of the guidance will have a material impact on the Company's consolidated financial statements.

3. COMMON STOCK

Common Stock Repurchase Program

On November 4, 2015 and February 9, 2016, the Company announced that its Board of Directors authorized two stock repurchase programs, under which the Company may repurchase up to $15,000 of its common stock under each program for a period of 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. As of March 31, 2016, the Company repurchased 1,452 shares of its common stock for a total of $30,000. The Company did not have stock repurchase programs in place during the three months ended March 31, 2015.

Common Stock Offering

In February 2015, the Company completed a common stock offering, issuing 5,467 shares at approximately $20.50 per share. After deducting underwriting discounts and commissions of $5,604, excluding other issuance costs of $357, the Company received net proceeds of $106,474. The Company then used $94,000 of the net proceeds to pay off outstanding amounts under its credit facility.

4. COMPUTATION OF NET INCOME PER COMMON SHARE

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

As discussed in Note 2, Summary of Significant Accounting Policies, all per share amounts and number of shares outstanding presented below reflect the two-for-one stock split that was effected in the fourth quarter of 2015.

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

	Three Months Ended March 31,	
	2016	2015
Numerator:		
Net Income	$9,290	$15,088
Less: net income (loss) attributable to noncontrolling interests	118	(82)
Net income attributable to The Ensign Group, Inc.	$9,172	$15,170
Denominator:		
Weighted average shares outstanding for basic net income per share	50,679	47,815
Basic net income per common share attributable to The Ensign Group, Inc.	$0.18	$0.32

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

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	Three Months Ended March 31,				
	2016		2015		
Numerator:					
Net Income	$	9,290	$	15,088	
Less: net income (loss) attributable to noncontrolling interests	118		(82		)
Net income attributable to The Ensign Group, Inc.	$	9,172	$	15,170	
Denominator:					
Weighted average common shares outstanding	50,679		47,815		
Plus: incremental shares from assumed conversion [(1)]	1,655		1,837		
Adjusted weighted average common shares outstanding	52,334		49,652		
Diluted net income per common share attributable to The Ensign Group, Inc.	$	0.18	$	0.31	

(1) Options outstanding which are anti-dilutive and therefore not factored into the weighted average common shares amount above were 725 and 248 for the three months ended March 31, 2016 and 2015, respectively.

5. 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 following table summarizes the financial assets and liabilities measured at fair value on a recurring basis as of March 31, 2016 and December 31, 2015:

	March 31, 2016			December 31, 2015		
	Level 1	Level 2	Level 3	Level 1	Level 2	Level 3
Cash and cash equivalents	$51,370	$ —	$ —	$41,569	$ —	$ —

Our non-financial assets, which include long-lived assets, including goodwill, intangible assets and property and equipment, are not required to be measured at fair value on a recurring basis. However, on a periodic basis, or whenever events or changes in circumstances indicate that their carrying value may not be recoverable, we assess our long-lived assets for impairment. When impairment has occurred, such long-lived assets are written down to fair value. See Note 2, Summary of Significant Accounting Policies for further discussion of the Company's significant accounting policies.

Debt Security Investments - Held to Maturity

At March 31, 2016 and December 31, 2015, the Company had approximately $32,958 and $34,717, respectively, in debt security investments which were classified as held to maturity and carried at amortized cost. The carrying value of the debt securities approximates fair value. The Company has the intent and ability to hold these debt securities to maturity. Further, as of March 31, 2016, the debt security investments are held in AA, A and BBB+ rated debt securities.

6. REVENUE AND ACCOUNTS RECEIVABLE

Revenue for the three months ended March 31, 2016 and 2015 is summarized in the following tables:

	Three Months Ended March 31,			
	2016		2015	
	Revenue	% of Revenue	Revenue	% of Revenue
Medicaid	$117,575	30.7 %	$101,628	33.2 %
Medicare	110,278	28.8	94,356	30.8
Medicaid — skilled	21,665	5.7	15,537	5.1
Total Medicaid and Medicare	249,518	65.2	211,521	69.1
Managed care	64,543	16.8	46,330	15.1
Private and other payors[1]	69,173	18.0	48,678	15.8
Revenue	$383,234	100.0 %	$306,529	100.0 %

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

Accounts receivable as of March 31, 2016 and December 31, 2015 is summarized in the following table:

	March 31, 2016	December 31, 2015
Medicaid	$90,994	$ 90,677
Managed care	61,346	56,411
Medicare	51,487	49,970
Private and other payors	45,442	42,276
	249,269	239,334
Less: allowance for doubtful accounts	(32,098)	(30,308)
Accounts receivable	$217,171	$ 209,026

7. BUSINESS SEGMENTS

The Company has two reportable operating segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of the Company's business and (2) home health and hospice services, which includes the Company's home health, home care and hospice businesses. The Company's Chief Executive Officer, who is the 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 urgent care centers and other ancillary operations. The urgent care centers and other ancillary operations are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. The reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations. The "all other" category also includes operating expenses that the Company does not allocate to operating segments as these expenses are not included in the segment operating performance measures evaluated by the CODM. See also Note 12, Goodwill and Other Indefinite-Lived Intangible Assets for comparative information on changes in the carrying amount of goodwill by segment.

As of March 31, 2016, TSA services included 186 wholly-owned skilled nursing affiliated facilities that skilled nursing, assisted living and rehabilitative care services, as well as wholly-owned assisted and independent living affiliated facilities that provide room and board and social services. Home health, home care and hospice services were provided to patients through the Company's 34 agencies. The Company's urgent care services, which is included in "all other" category, were provided to patients by the Company's wholly owned urgent care operating subsidiaries. As of March 31, 2016, the Company held majority membership interests in other ancillary operations, which operating results are included in the "all other" category.

The Company evaluates performance and allocates capital resources to each segment 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 any 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 segments 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 March 31, 2016				
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$115,001	$2,574	$—	$117,575	30.7 %
Medicare	91,644	18,634	—	110,278	28.8
Medicaid-skilled	21,665	—	—	21,665	5.7
Subtotal	228,310	21,208	—	249,518	65.2
Managed care	60,538	4,005	—	64,543	16.8
Private and other	56,535	1,453	11,185	69,173	18.0
Total revenue	$345,383	$26,666	$11,185	$383,234	100.0 %

	Three Months Ended March 31, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Total Revenue	Revenue %
Medicaid	$99,706	$1,922	$—	$101,628	33.2 %
Medicare	81,690	12,666	—	94,356	30.8
Medicaid-skilled	15,537	—	—	15,537	5.1
Subtotal	196,933	14,588	—	211,521	69.1
Managed care	44,107	2,223	—	46,330	15.1
Private and other	37,734	1,504	9,440	48,678	15.8
Total revenue	$278,774	$18,315	$9,440	$306,529	100.0 %

The following table sets forth selected financial data consolidated by business segment:

	Three Months Ended March 31, 2016				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$345,383	$26,666	$11,185		$383,234
Intersegment revenue (1)	710	—	271	(981)	—
Total revenue	$346,093	$26,666	$11,456	$ (981)	$383,234
Segment income (loss) (2)	$30,856	$3,176	$(17,717)	$ —	$16,315
Interest expense, net of interest income					$(1,136)
Income before provision for income taxes					$15,179

Depreciation and amortization	$6,302	$268	$1,728	$ —	$8,298

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.
(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services.

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	Three Months Ended March 31, 2015				
	TSA Services	Home Health and Hospice Services	All Other	Elimination	Total
Revenue from external customers	$278,774	$18,315	$9,440		$306,529
Intersegment revenue (1)	474	—	203	(677)	—
Total revenue	$279,248	$18,315	$9,643	$ (677)	$306,529
Segment income (loss) (2)	$37,298	$2,675	$(14,799)	$ —	$25,174
Interest expense, net of interest income					$(501)
Income before provision for income taxes					$24,673
Depreciation and amortization	$4,949	$221	$1,347	$ —	$6,517

(1) Intersegment revenue represents services provided at the Company's skilled nursing facilities, urgent care centers and other ancillary operations to the Company's other operating subsidiaries.
(2) Segment income excludes general and administrative expense for TSA services and home health and hospice services.

8. ACQUISITIONS

The Company’s acquisition strategy is to purchase or lease operating subsidiaries that are complementary to the Company’s current affiliated facilities, accretive to the Company's business or otherwise advance the Company's strategy. The results of all the Company’s 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 also enters into long-term leases that may include options to purchase the affiliated facilities. As a result, from time to time, the Company will acquire affiliated facilities that the Company has been operating under third-party leases.

During the three months ended March 31, 2016, the Company expanded its operations with the addition of one home health agency and one hospice agency through purchases. The aggregate purchase price for these acquisitions was $490. In addition, the Company entered into a long-term lease agreement for a newly constructed post-acute care campus, which added 70 operational skilled nursing beds and 30 operational assisted living units, operated by the Company's operating subsidiaries.

The table below presents the allocation of the purchase price for the operations acquired in business combinations during the three months ended March 31, 2016 and 2015:

	March 31,	
	2016	2015
Land	$—	$3,608
Building and improvements	—	29,390
Equipment, furniture, and fixtures	—	1,429
Assembled occupancy	—	639
Definite-lived intangible assets	100	360
Goodwill	140	2,512
Favorable leases	—	2,069
Other indefinite-lived intangible assets	250	2,190
Total acquisitions	$490	$42,197

Subsequent to March 31, 2016, the Company expanded its operations with the addition of one hospice agency and eighteen stand-alone skilled nursing operations and through purchases and a long-term master lease agreement. As part of this acquisition, the Company acquired the real estate at two of the skilled nursing operations and entered into a long term lease for sixteen skilled nursing operations. 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 aggregate purchase price for the acquisitions was $52,095, including $24,600 related to purchases of real estate. The expansion of skilled nursing operations added 2,177 operational skilled nursing beds operated by the Company's operating subsidiaries. The Company also entered into a separate operations transfer

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agreement with the prior operator as part of each transaction. In addition, the Company has invested in new ancillary services that are complementary to its existing TSA services and home health and hospice businesses.

9. ACQUISITIONS - PRO FORMA FINANCIAL INFORMATION

The Company has established an acquisition strategy that is focused on identifying acquisitions within its target markets that offer the greatest opportunity for investment return at attractive prices. The facilities acquired by the Company are frequently underperforming financially and can have regulatory and clinical challenges to overcome. Financial information, especially with underperforming facilities, is often inadequate, inaccurate or unavailable. As a result, the Company has developed an acquisition assessment program that is based on existing and potential resident mix, the local available market, referral sources and operating expectations based on the Company's experience with its existing facilities. Following an acquisition, the Company implements a well-developed integration program to provide a plan for transition and generation of profits from facilities that have a history of significant operating losses. Consequently, the Company believes that prior operating results are not meaningful as the information is not generally representative of the Company's current operating results or indicative of the integration potential of its newly acquired facilities.

The following table represents pro forma results of consolidated operations as if the acquisitions acquired from January 1, 2016 through the issuance date of the financial statements had occurred at the beginning of 2015, after giving effect to certain adjustments.

	March 31,	
	2016	2015
Revenue	$421,468	$344,967
Net income attributable to The Ensign Group, Inc.	9,567	15,899
Diluted net income per common share	$0.18	$0.32

Our pro forma assumptions are as follows:

- Revenues and operating costs were based on actual results from the prior operator or from regulatory filings where available. If actual results were not available, revenues and operating costs were estimated based on available partial operating results of the prior operator of the facility, or if no information was available, estimates were derived from the Company’s post-acquisition operating results for that particular facility. Prior year results for the 2016 acquisitions were obtained from available financial information provided by prior operators or available cost reports filed by the prior operators.

- Interest expense is based upon the purchase price and average cost of debt borrowed during each respective year when applicable and depreciation is calculated using the purchase price allocated to the related assets through acquisition accounting.

The foregoing unaudited pro forma information is not indicative of what the results of operations would have been if the acquisitions had actually occurred at the beginning of the periods presented, and is not intended as a projection of future results or trends. Included in the table above are pro forma revenue and income generated during the three months ended March 31, 2016, by individually immaterial business acquisitions completed through the issuance date of the financial statements of $38,234 and $395, respectively. Included in the table above are pro forma revenue and income generated during the three months ended March 31, 2015, by individually immaterial business acquisitions completed through the issuance date of the financial statements of $38,438 and $729, respectively.

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10. PROPERTY AND EQUIPMENT— Net
Property and equipment, net consist of the following:

	March 31, 2016	December 31, 2015
Land	$42,021	$ 41,451
Buildings and improvements	153,647	151,434
Equipment	124,943	114,752
Furniture and fixtures	5,529	5,504
Leasehold improvements	73,216	68,405
Construction in progress	1,869	781
	401,225	382,327
Less: accumulated depreciation	(89,746)	(82,694)
Property and equipment, net	$311,479	$ 299,633

See Note 8, Acquisitions for information on acquisitions during the three months ended March 31, 2016.

11. INTANGIBLE ASSETS — Net

		March 31, 2016			December 31, 2015		
Intangible Assets	Weighted Average Life (Years)	Gross Carrying Amount	Accumulated Amortization	Net	Gross Carrying Amount	Accumulated Amortization	Net
Lease acquisition costs	19.9	$90	$ (64)	$26	$604	$ (577)	$27
Favorable leases	27.6	43,248	(3,590)	39,658	43,248	(2,923)	40,325
Assembled occupancy	0.3	598	(571)	27	4,779	(4,476)	303
Facility trade name	30.0	733	(250)	483	733	(244)	489
Customer relationships	18.3	5,390	(1,140)	4,250	5,300	(1,013)	4,287
Total		$50,059	$ (5,615)	$44,444	$54,664	$ (9,233)	$45,431

Amortization expense was $1,087, and $1,153 for the three months ended March 31, 2016 and 2015, respectively. Of the $1,087 in amortization expense incurred during the three months ended March 31, 2016, approximately $276 related to the amortization of patient base intangible assets at recently acquired facilities, which is typically amortized over a period of four to eight months, depending on the classification of the patients and the level of occupancy in a new acquisition on the acquisition date. In addition, the Company identified intangible assets that have become fully amortized as of March 31, 2016 and removed the fully amortized balances from the gross asset and accumulated amortization amounts.
Estimated amortization expense for each of the years ending December 31 is as follows:

Year	Amount
2016 (remainder)	$2,293
2017	2,992
2018	2,992
2019	2,992
2020	2,283
2021	2,218

Thereafter	28,674
	$44,444

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THE ENSIGN GROUP, INC.
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12. GOODWILL AND OTHER INDEFINITE-LIVED INTANGIBLE ASSETS

The Company performs its annual goodwill impairment analysis during the fourth quarter of each year for each reporting unit that constitutes a business for which discrete financial information is produced and reviewed by operating segment management and provides services that are distinct from the other components of the operating segment. The Company tests for impairment by comparing the net assets of each reporting unit to their respective fair values. The Company determines the estimated fair value of each reporting unit using a discounted cash flow analysis. In the event a unit's net assets exceed its fair value, an implied fair value of goodwill must be determined by assigning the unit's fair value to each asset and liability of the unit. The excess of the fair value of the reporting unit over the amounts assigned to its assets and liabilities is the implied fair value of goodwill. An impairment loss is measured by the difference between the goodwill carrying value and the implied fair value.

The following table represents activity in goodwill by segment as of and for the three months ended March 31, 2016:

	Goodwill			
	TSA Services	Home Health and Hospice Services	All Other	Total
January 1, 2016	$17,759	$16,102	$7,025	$40,886
Impairments	—	—	—	—
Purchase price adjustment	—	—	8	8
Additions	—	140	—	140
March 31, 2016	$17,759	$16,242	$7,033	$41,034

As of March 31, 2016, the Company anticipates that total goodwill recognized will be fully deductible for tax purposes. See further discussion of goodwill acquired at Note 8, Acquisitions.

Other indefinite-lived intangible assets consists of the following:

	March 31, 2016	December 31, 2015
Trade name	$ 1,915	$ 1,915
Home health and hospice Medicare license	16,981	16,731
	$ 18,896	$ 18,646

13. RESTRICTED AND OTHER ASSETS

Restricted and other assets consist of the following:

	March 31, 2016	December 31, 2015
Debt issuance costs, net	$ 3,054	$ 2,021
Long-term insurance losses recoverable asset	3,048	2,881
Deposits with landlords	4,224	3,969
Capital improvement reserves with landlords and lenders	839	760
Restricted and other assets	$ 11,165	$ 9,631

Included in restricted and other assets as of March 31, 2016, are anticipated insurance recoveries related to the Company's general and professional liability claims that are recorded on a gross rather than net basis in accordance with an Accounting Standards Update issued by the FASB.

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14. OTHER ACCRUED LIABILITIES

Other accrued liabilities consist of the following:

	March 31, 2016	December 31, 2015
Quality assurance fee	$ 4,133	$ 6,120
Refunds payable	14,784	13,252
Deferred revenue	5,862	6,696
Cash held in trust for patients	2,121	3,016
Resident deposits	5,976	5,884
Dividends payable	2,026	2,072
Property taxes	4,680	4,230
Charges related to operational closure	1,994	—
Other	4,442	4,935
Other accrued liabilities	$ 46,018	$ 46,205

Quality assurance fee represents amounts payable to Arizona, California, Colorado, Idaho, Iowa, Nebraska, Utah, Washington and Wisconsin as a result of a mandated fee based on patient days. Refunds payable includes payables related to overpayments and duplicate payments from various payor sources. Deferred revenue occurs 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 is not currently under examination by any major income tax jurisdiction. During 2016, the statutes of limitations will lapse on the Company's 2012 Federal tax year and certain 2011 and 2012 state tax years. The Company does not believe the Federal or state statute lapses or any other event will significantly impact the balance of unrecognized tax benefits in the next twelve months. The net balance of unrecognized tax benefits was not material to the Interim Financial Statements for the three months ended March 31, 2016 or 2015.

The Company recorded total pre-tax charges and expenses related to the closure of one facility during the three months ended March 31, 2016 for a total charge of $7,935. The Company recorded estimated tax benefits of $3,065 for the three months ended March 31, 2016. Similar charges did not occurred during the three months ended March 31, 2015. See Note 18, Leases.

16. DEBT

Long-term debt consists of the following:

	March 31, 2016	December 31, 2015
Credit facility with SunTrust, interest payable monthly and quarterly	$ 131,750	$ 85,000
Mortgage loans and promissory note, principal and interest payable monthly, interest at fixed rate	14,519	14,671
	146,269	99,671
Less current maturities	(627)	(620)
	$ 145,642	$ 99,051

Amended Credit Facility with a Lending Consortium Arranged by SunTrust (the Amended Credit Facility)
In February 2016, the Company amended its existing revolving credit facility with a lending consortium arranged by SunTrust to increase its aggregate principal amount available to $250,000 (the Amended Credit Facility). Under the Amended Credit Facility, the Company may seek to obtain incremental revolving or term loans in an aggregate amount not to exceed $150,000. The interest

rates applicable to loans under the Amended Credit Facility are, at the Company's option, equal to either a base rate plus a margin ranging from 0.75% to 1.75% per annum or LIBOR plus a margin ranging from 1.75% to 2.75% per annum, based on the Consolidated Total Net Debt to Consolidated EBITDA ratio (as defined in the agreement). In addition, the Company will pay a commitment fee on the unused portion of the commitments under the Amended Credit Facility that will range from 0.30% to 0.50% per annum, depending on the Consolidated Total Net Debt to Consolidated EBITDA ratio of the Company and our subsidiaries. Loans made under the Amended Credit Facility are not subject to interim amortization. The Company is not required to repay any loans under the Amended Credit Facility prior to maturity, other than to the extent the outstanding borrowings exceed the aggregate commitments under the Amended Credit Facility. The Company is permitted to prepay all or any portion of the loans under the Amended Credit Facility prior to maturity without premium or penalty, subject to reimbursement of any LIBOR breakage costs of the lenders. As of March 31, 2016, the Company's operating subsidiaries had $131,750 outstanding under the Amended Credit Facility.
The Amended Credit Facility 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 Amended 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 Amended Credit Facility, the Company must comply with financial maintenance covenants to be tested quarterly, consisting of a maximum Consolidated Total Net Debt to consolidated EBITDA ratio (which shall be increased to 3.50:1.00 for the current fiscal quarter and the immediate following three fiscal quarters), and a minimum interest/rent coverage ratio (which cannot be below 1.50:1.00). The majority of lenders can require that the Company and its operating subsidiaries mortgage certain of its real property assets to secure the Amended Credit Facility if an event of default occurs, the Consolidated Total Net Debt to consolidated EBITDA ratio is above 2.75:1.00 for two consecutive fiscal quarters, or its liquidity is equal or less than 10% of the Aggregate Revolving Commitment Amount (as defined in the agreement) for ten consecutive business days, provided that such mortgages will no longer be required if the event of default is cured, the Consolidated Total Net Debt to consolidated EBITDA ratio is below 2.75:1.00 for two consecutive fiscal quarters, or its liquidity is above 10% of the Aggregate Revolving Commitment Amount (as defined in the agreement) or ninety consecutive days, as applicable. As of March 31, 2016, the Company was in compliance with all loan covenants.

As of May 9, 2016, there was approximately $196,750 outstanding under the Amended Credit Facility.

Mortgage Loans and Promissory Note

The Company had outstanding indebtedness under mortgage loans and promissory note issued in connection with various acquisitions. The mortgage loans are insured with the U.S. Department of Housing and Urban Development (HUD), which subjects the Company's operating subsidiaries to HUD oversight and periodic inspections. The mortgage loans and note bear fixed interest rates between 2.6% and 5.3% per annum. Amounts borrowed under the mortgage loans may be prepaid starting after the second anniversary of the notes subject to prepayment fees of the principal balance on the date of prepayment. These prepayment fees are reduced by 1.0% per year for years three through eleven of the loan. There is no prepayment penalty after year eleven. The term of the mortgage loans and note is between 12 and 33 years. The mortgage loans and note are secured by the real property comprising the facilities and the rents, issues and profits thereof, as well as all personal property used in the operation of the facilities. As of March 31, 2016, the Company's operating subsidiaries had $14,519 outstanding under the mortgage loans and note, of which $627 is classified as short-term and the remaining $13,892 is classified as long-term. As of March 31, 2016, the Company is in compliance with all loan covenants.

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

Off-Balance Sheet Arrangements

As of March 31, 2016, the Company had approximately $1,860 on the Amended Credit Facility of borrowing capacity pledged as collateral to secure outstanding letters of credit.

17. OPTIONS AND AWARDS

All per share amounts and numbers of common shares outstanding presented below reflect the two-for-one stock split that was effected in the fourth quarter of 2015. See further details in Note 2, Summary of Significant Accounting Policies.

Stock-based compensation expense consists of share-based payment awards made to employees and directors, including employee stock options and restricted stock awards, based on estimated fair values. As stock-based compensation expense recognized in the Company's consolidated condensed statements of income for the three months ended March 31, 2016 and 2015 was based on awards ultimately expected to vest, it has been reduced for estimated forfeitures. The Company estimates forfeitures at the time of grant and, if necessary, revises the estimate in subsequent periods if actual forfeitures differ.
The Company has three option plans, the 2001 Stock Option, Deferred Stock and Restricted Stock Plan (2001 Plan), the 2005 Stock Incentive Plan (2005 Plan) and the 2007 Omnibus Incentive Plan (2007 Plan), all of which have been approved by the Company's stockholders. The total number of shares available under all of the Company's stock incentive plans was 3,386 as of March 31, 2016.

The Company uses the Black-Scholes option-pricing model to recognize the value of stock-based compensation expense for all share-based payment awards. Determining the appropriate fair-value model and calculating the fair value of stock-based awards at the grant date requires considerable judgment, including estimating stock price volatility, expected option life and forfeiture rates. The Company develops estimates based on historical data and market information, which can change significantly over time. The Company granted 167 options and 161 restricted stock awards from the 2007 Plan during the three months ended March 31, 2016.

The Company used the following assumptions for stock options granted during the three months ended March 31, 2016 and 2015:

Grant Year	Options Granted	Weighted Average Risk-Free Rate	Expected Life	Weighted Average Volatility	Weighted Average Dividend Yield
2016	167	1.34%	6.5 years	46%	0.77%
2015	144	1.45%	6.5 years	44%	0.65%

For the three months ended March 31, 2016 and 2015, the following represents the exercise price and fair value displayed at grant date for stock option grants:

Grant Year	Granted	Weighted Average Exercise Price	Weighted Average Fair Value of Options
2016	167	$ 19.89	$ 8.55
2015	144	$ 21.79	$ 9.20

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 March 31, 2016 and 2015 and therefore, the intrinsic value was $0 at date of grant.

The following table represents the employee stock option activity during the three months ended March 31, 2016:

	Number of Options Outstanding	Weighted Average Exercise Price	Number of Options Vested	Weighted Average Exercise Price of Options

				Vested
January 1, 2016	5,448	$ 10.36	2,526	$ 6.35
Granted	167	19.89		
Forfeited	(14)	10.80		
Exercised	(129)	6.65		
March 31, 2016	5,472	$ 10.74	2,611	$ 6.70

The following summary information reflects stock options outstanding, vested and related details as of March 31, 2016:

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

	Stock Options Outstanding				Stock Options Vested
Year of Grant	Exercise Price	Number Outstanding	Black-Scholes Fair Value	Remaining Contractual Life (Years)	Vested and Exercisable
2006	1.93 - 2.05	102	269	1	102
2008	2.56 - 4.06	465	687	2	465
2009	4.06 - 4.56	641	1,373	3	641
2010	4.77 - 4.96	162	392	4	162
2011	5.90 - 7.99	200	675	5	151
2012	6.56 - 7.96	611	2,251	6	349
2013	7.98 - 11.49	681	3,326	7	289
2014	10.55 - 18.94	1,822	10,290	8	425
2015	21.47 - 25.24	621	5,632	9	27
2016	19.89	167	1,428	10	—
Total		5,472	$ 26,323		2,611

The Company granted 161 and 130 restricted stock awards during the three months ended March 31, 2016 and 2015, respectively. All awards were granted at an exercise price of $0 and generally vest over five years. The fair value per share of restricted awards granted during the three months ended March 31, 2016 and 2015 ranged from $19.89 to $21.84 and $21.30 to $21.79, respectively.
A summary of the status of the Company's non-vested restricted stock awards as of March 31, 2016 and changes during the three months ended March 31, 2016 is presented below:

	Non-Vested Restricted Awards	Weighted Average Grant Date Fair Value
Nonvested at January 1, 2016	425	$ 19.79
Granted	161	21.35
Vested	(158)	20.34
Forfeited	(1)	17.97
Nonvested at March 31, 2016	427	$ 20.18

During the three months ended March 31, 2016, the Company granted 8 automatic quarterly stock awards to non-employee directors for their service on the Company's board of directors. The fair value per share of these stock awards was $21.26 based on the market price on the grant date.

Total share-based compensation expense recognized for the three months ended March 31, 2016 and 2015 was as follows:

	Three Months Ended March 31,	
	2016	2015
Share-based compensation expense related to stock options	$1,184	$956
Share-based compensation expense related to restricted stock awards	548	416

Share-based compensation expense related to stock awards	153	121
Total	$1,885	$1,493

For the three months ended March 31, 2016 and 2015, the Company expensed $153 and $121, respectively, in share-based compensation related to the quarterly stock awards to non-employee directors. In future periods, the Company expects to recognize approximately $15,556 and $7,499 in share-based compensation expense for unvested options and unvested restricted stock awards, respectively, that were outstanding as of March 31, 2016. Future share-based compensation expense will be recognized over 3.4 and 3.6 weighted average years for unvested options and restricted stock awards, respectively. There were 2,861 unvested and outstanding options at March 31, 2016, of which 2,668 are expected to vest. The weighted average contractual life for options outstanding, vested and expected to vest at March 31, 2016 was 4.8 years.

The aggregate intrinsic value of options outstanding, vested, expected to vest and exercised as of March 31, 2016 and 2015 is as follows:

Options	March 31, 2016	December 31, 2015
Outstanding	$ 65,791	$ 67,508
Vested	41,618	41,128
Expected to vest	21,628	23,508
Exercisable	1,822	8,709

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

18. LEASES

The Company leases from CareTrust REIT, Inc. (CareTrust) real property associated with 93 affiliated skilled nursing, assisted living and independent living facilities used in the Company's operations under eight "triple-net" master lease agreements (collectively, the Master Leases), which ranges from 12 to 19 years. At the Company's option, the Master Leases may be extended for two or three five-year renewal terms beyond the initial term, on the same terms and conditions. The extension of the term of any of the Master Leases is subject to the following conditions: (1) no event of default under any of the Master Leases having occurred and being continuing; and (2) the tenants providing timely notice of their intent to renew. The term of the Master Leases is subject to termination prior to the expiration of the then current term upon default by the tenants in their obligations, if not cured within any applicable cure periods set forth in the Master Leases.

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 and 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 $14.0 million for the three months ended March 31, 2016 and 2015.

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 March 31, 2016.

During the three months ended March 31, 2016, the Company voluntarily discontinued operations in one of its skilled nursing facilities in order to preserve the overall ability to serve the residents in surrounding counties after careful consideration and some clinical survey challenges. As part of this closure, the Company entered into an agreement with its landlord allowing for the closure of the property as well as other provisions to allow its landlord to transfer the property and the licenses free and clear of the applicable master lease. This arrangement will not impact the rent expense to be paid in 2016 or expected to be paid in future periods and will have no material impact on the Company's lease coverage ratios under the Master Leases. The Company recorded continued obligation under the lease and related closing expenses of $7,935, including the present value of rental payments of approximately $6,512. Residents of the affected facility were transferred to other local skilled nursing facilities.

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 upon completion of construction.

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The term of each lease is 15 years with two five-year renewal options and is subject to annual escalation equal to the percentage change in the Consumer Price Index with a stated cap percentage. In addition, the Company leases certain of its equipment under non-cancelable operating leases with initial terms ranging from three to five years. Most of these leases contain renewal options, certain of which involve rent increases. Total rent expense, inclusive of straight-line rent adjustments and rent associated with the Master Leases noted above, was $27,135 and $19,081 for the three months ended March 31, 2016 and 2015, respectively.

Future minimum lease payments for all leases as of March 31, 2016 are as follows:

Year	Amount
2016 (remainder)	97,862
2017	135,539
2018	142,514
2019	142,045
2020	141,188
2021	140,522
Thereafter	1,301,533
	$2,101,203

Inclusive of the sixteen facilities expansion subsequent to March 31, 2016 that are under a master lease agreement, thirty-eight of the Company's affiliated facilities, excluding the facilities that are operated under the Master Leases with CareTrust, are operated under five 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.

In addition, a number of the Company's individual facility leases are held by the same or related landlords, and some of these leases include cross-default provisions that could cause a default at one facility to trigger a technical default with respect to others, potentially subjecting certain leases and facilities to the various remedies available to the landlords under separate but cross-defaulted leases. The Company is not aware of any defaults as of March 31, 2016.

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. The Company believes that it is in compliance in all material respects with all applicable laws and regulations.

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

Income Tax Examinations — The Company is not currently under examination by any major income tax jurisdiction. See Note 15, Income Taxes.

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

Litigation — The skilled nursing business involves a significant risk of liability given the age and health of the patients and residents served by the Company's operating subsidiaries. The Company, its 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.

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

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

Healthcare litigation (including class action litigation) is common and is filed based upon a wide variety of claims and theories, and we are routinely subjected to varying types of claims. One particular type of suit arises from alleged violations of state-established minimum staffing requirements for skilled nursing facilities. Failure to meet these requirements can, among other things, jeopardize a facility's compliance with conditions of participation under certain state and federal healthcare programs; it may also subject the facility to a notice of deficiency, a citation, civil monetary penalty, or litigation. These class-action "staffing" suits have the potential to result in large jury verdicts and settlements, and have become more prevalent in the wake of a previous substantial jury award against one of the Company's competitors. The Company expects the plaintiff's bar to continue to be aggressive in their pursuit of these staffing and similar claims.

The Company has 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 a material ongoing 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 us and other companies in our industry. If there were a significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, this could materially adversely affect the Company's business, financial condition, results of operations and cash flows.

The Company and its 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 as well as employment related claims. The Company does not believe that the ultimate resolution of these actions will have a material adverse effect on the Company’s business, cash flows, financial condition or results of operations. A significant increase in the number of these claims or an increase in amounts owing should plaintiffs be successful in their prosecution of these claims, could materially adversely affect the Company’s business, financial condition, results of operations and cash flows.

The Company cannot predict or provide any assurance as to the possible outcome of any litigation. If any litigation were to proceed, and the Company and its operating subsidiaries are subjected to, alleged to be liable for, or agrees to a settlement of, claims or obligations under Federal Medicare statutes, the Federal False Claims Act, or similar State and Federal statutes and related regulations, 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 subsidiaries going forward under a corporate integrity agreement and/or other arrangement with the government.
Medicare Revenue Recoupments — The Company is subject to reviews relating to Medicare services, billings and potential overpayments. The Company had seven operating subsidiaries subject to probe review during the three months ended March 31, 2016. In addition, one of our operating subsidiaries not previously included in the probe process has been recently selected for a Review and Educate (also known as pre-payment) review. The Company anticipates that these probe reviews will increase in frequency in the future. If a facility fails prepayment review, the facility could then be subject to undergo targeted review, which is a review that targets perceived claims deficiencies.

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

In connection with the settlement and effective as of October 1, 2013, the Company entered into a five-year corporate integrity agreement (the CIA) with the Office of Inspector General-HHS. The CIA acknowledges 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 requires that the Company 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, and all other Federal health care programs. The Company is also required to notify the Office of Inspector General-HHS in writing, of, among other things: (i) any ongoing government investigation or legal proceeding involving an allegation that the Company has committed a crime or has engaged in fraudulent activities; (ii) any other matter that a reasonable person would consider a probable violation of applicable criminal, civil, or administrative laws related to compliance with federal healthcare programs; and (iii) any change in location, sale, closing, purchase, or establishment of a new business unit or location related to items or services that may be reimbursed by federal health care programs. The Company is also required to retain an Independent Review Organization (IRO) to review certain clinical documentation annually for the term of the CIA.

The Company has met the requirements of its second year under the Settlement Agreement and passed its IRO audits. Participation in federal healthcare programs by the Company is not affected by the Settlement Agreement or the CIA. In the event of an uncured material breach of the CIA, the Company could be excluded from participation in federal healthcare programs and/or subject to prosecution.

Concentrations
Credit Risk — The Company has significant accounts receivable balances, the collectability of which is dependent on the availability of funds from certain governmental programs, primarily Medicare and Medicaid. These receivables represent the only significant concentration of credit risk for the Company. The Company does not believe there are significant credit risks associated with these governmental programs. The Company believes that an appropriate allowance has been recorded for the possibility of these receivables proving uncollectible, and continually monitors and adjusts these allowances as necessary. The Company’s receivables from Medicare and Medicaid payor programs accounted for approximately 57.2% and 58.8% of its total accounts receivable as of March 31, 2016 and December 31, 2015, respectively. Revenue from reimbursement under the Medicare and Medicaid programs accounted for 65.2%, and 69.1% of the Company's revenue for the three months ended March 31, 2016 and 2015, respectively

Cash in Excess of FDIC Limits — The Company currently has bank deposits with financial institutions in the U.S. that exceed FDIC insurance limits. FDIC insurance provides protection for bank deposits up to $250. In addition, the Company has uninsured bank deposits with a financial institution outside the U.S. As of May 9, 2016, the Company had approximately $2,100 in uninsured cash deposits. All uninsured bank deposits are held at high quality credit institutions.

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

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

This Report contains "forward-looking statements," within the meaning of the Private Securities Litigation Reform Act of 1995, which include, but are not limited to the Company’s expected future financial position, results of operations, cash flows, financing plans, business strategy, budgets, capital expenditures, competitive positions, growth opportunities, plans and objectives of management. Forward-looking statements can often be identified by words such as “anticipates,” “expects,” “intends,” “plans,” “predicts,” “believes,” “seeks,” “estimates,” “may,” “will,” “should,” “would,” “continue,” “ongoing,” similar expressions, and variations or negatives of these words. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions that are difficult to predict. Therefore, our actual results could differ materially and adversely from those expressed in any forward-looking statements as a result of various factors, some of which are listed under the section “Risk Factors” contained in Part II, Item 1A of this Report. These forward-looking statements speak only as of the date of this Report, and are based on our current expectations, estimates and projections about our industry and business, management’s beliefs, and certain assumptions made by us, all of which are subject to change. We undertake no obligation to revise or update publicly any forward-looking statement for any reason, except as otherwise required by law. As used in this Management’s Discussion and Analysis of Financial Condition and Results of Operations, the words, “we,” “our” and “us” refer to The Ensign Group, Inc. and its consolidated subsidiaries. All of our 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 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 in the Annual Report.

Overview

We are a provider of health care services across the post-acute care continuum, as well as urgent care centers and other ancillary businesses located in Arizona, California, Colorado, Idaho, Iowa, Kansas, Nebraska, Nevada, Oregon, 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, assisted living, home health and hospice, urgent care and other ancillary services. As of March 31, 2016, we offered skilled nursing, assisted living and rehabilitative care services through 186 skilled nursing and assisted living facilities across 13 states. Of the 186 facilities, we owned 32 and operated an additional 154 facilities under long-term lease arrangements, and had options to purchase 21 of those 154 facilities. Our home health and hospice business provides home health, hospice and home care services from 34 agencies across nine states. Our 17 urgent care centers and mobile ancillary operations are located in Arizona, Colorado, Utah and Washington.

The following table summarizes our affiliated facilities and operational skilled nursing, assisted living and independent living beds by ownership status as of March 31, 2016:

	Owned	Leased (with a	Leased (without	Total

		Purchase Option)	a Purchase Option)	
Number of facilities	32	21	133	186
Percentage of total	17.2 %	11.3 %	71.5 %	100.0 %
Operational skilled nursing, assisted living and independent living beds	3,402	1,502	14,682	19,586
Percentage of total	17.4 %	7.6 %	75.0 %	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

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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, 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

Common Stock Repurchase Program - During the three months ended March 31, 2016, we repurchased 1.5 million shares of our common stock for a total of $30.0 million.

Close of one facility - After careful consideration and some clinical survey challenges, we voluntarily discontinued operations in one of our skilled nursing facilities in order to preserve the overall ability to serve the residents in surrounding counties. The operation represented approximately 0.5% of our revenue and adjusted EBITDAR in 2015. As part of this closure, we entered into an agreement with our landlord allowing for the closure of the property as well as other provisions to allow our landlord to transfer the property and the licenses free and clear of the applicable master lease. This arrangement will not impact the rent expense to be paid in 2016 or expected to be paid in future periods and will have no material impact on our lease coverage ratios under the Master Leases. We recorded continued obligation under the lease and related closing expenses of $7.9 million, including the present value of rental payments of approximately $6.5 million. Residents of the affected facility were transferred to other local skilled nursing facilities in an orderly fashion and in accordance with their individual clinical needs.

Acquisition History

The following table sets forth the location of our facilities and the number of operational beds located at our facilities as of March 31, 2016:

	CA	AZ	TX	WI	UT	CO	WA	ID	NE	IA	SC	KS	NV	Total
Cumulative number of skilled nursing, assisted and independent living operations	48	28	27	17	15	10	10	9	7	5	4	3	3	186
Cumulative number of operational skilled nursing, assisted living and independent living beds/units	4,989	4,288	3,307	899	1,613	745	943	719	662	356	426	335	304	19,586

As of March 31, 2016, we provided home health and hospice services through our 34 agencies in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington.

During the three months ended March 31, 2016, we expanded our operations with the addition of one home health agency and one hospice agency through purchases. The aggregate purchase price for these acquisitions was $0.5 million. In addition, we entered into a long-term lease agreement for a newly constructed post-acute care campus, which added 70 operational skilled nursing beds and 30 operational assisted living units, operated by our operating subsidiaries.

Subsequent to March 31, 2016, we completed transactions to expand our operations with the addition of one hospice agency and eighteen stand-alone skilled nursing operations through purchases and a long-term master lease agreement. As part of this acquisition, we acquired the real estate at two of the skilled nursing operations and entered into a long term lease for sixteen skilled nursing operations. We 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 aggregate purchase price for the acquisitions was $52.1 million, including $24.6 million related to purchases of real estate. The expansion of skilled nursing operations added 2,177 operational skilled nursing beds operated by our operating subsidiaries. We also entered into a separate operations transfer agreement with the prior operator as part of each transaction.

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In addition, we invested in new ancillary services that are complementary to our existing transitional, skilled and assisted living services (TSA services) and home health and hospice businesses. For further discussion of our acquisitions, see Note 8, Acquisitions in the Notes to Condensed Consolidated Financial Statements.

Key Performance Indicators

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

Transitional, Skilled and Assisted Living 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 that 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 assisted living services.
- Skilled mix. The amount of our skilled revenue as a percentage of our total routine revenue. Skilled mix (in days) represents the number of days our Medicare, managed care, or other skilled patients are receiving services at the skilled nursing facilities divided by the total number of days patients (less days from assisted living services) from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Quality mix. The amount of routine non-Medicaid revenue as a percentage of our total routine revenue. Quality mix (in days) represents the number of days our non-Medicaid patients are receiving services at the skilled nursing facilities divided by the total number of days patients from all payor sources are receiving services at the skilled nursing facilities for any given period (less days from assisted living services).
- Average daily rates. The routine revenue by payor source for a period at the skilled nursing facilities divided by actual patient days for that revenue source for that given period.
- Occupancy percentage (operational beds). The total number of patients occupying a bed in a skilled nursing, assisted living or independent living facility as a percentage of the beds in a facility which are available for occupancy during the measurement period.
- Number of facilities and operational beds. The total number of skilled nursing, assisted living and independent living facilities that we own or operate and the total number of operational beds associated with these facilities.

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

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

	Three Months Ended March 31,	
	2016	2015
Skilled Mix:		
Days	32.5%	30.3%
Revenue	54.6%	52.9%
Quality Mix:		

Days	43.9%	42.8%
Revenue	62.6%	61.4%

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

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

	Three Months Ended March 31,	
	2016	2015
Occupancy:		
Operational beds at end of period	19,586	15,483
Available patient days	1,786,513	1,367,829
Actual patient days	1,376,879	1,077,238
Occupancy percentage (based on operational beds)	77.1 %	78.8 %

Home Health and Hospice

- Medicare episodic admissions. The total number of episodic admissions derived from patients who are receiving care under Medicare reimbursement programs.
- Average Medicare revenue per completed episode. The average amount of revenue for each completed 60-day episode generated from patients who are receiving care under Medicare reimbursement programs.
- Average daily census. The average number of patients who are receiving hospice care as a percentage of total number of patient days.

The following table summarizes our overall home health and hospice statistics for the periods indicated:

	Three Months Ended March 31,	
	2016	2015
Home health services:		
Medicare Episodic Admissions	2,157	1,384
Average Medicare Revenue per Completed Episode	$2,923	$2,861
Hospice services:		
Average Daily Census	843	536

Segments

We have two reportable segments: (1) transitional, skilled and assisted living services (TSA services), which includes the operation of skilled nursing facilities and assisted and independent living facilities and is the largest portion of our business; and (2) home health and hospice services, which includes our home health, home care and hospice businesses. Our Chief Executive Officer, who is our chief operating decision maker (CODM), reviews financial information at the operating segment level.

We also report an “all other” category that includes results from our urgent care centers and other ancillary operations. Our urgent care centers and other ancillary businesses are neither significant individually nor in aggregate and therefore do not constitute a reportable segment. Our reporting segments are business units that offer different services and that are managed separately to provide greater visibility into those operations.

Revenue Sources

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

	Three Months Ended March 31, 2016						
	TSA Services		Home Health and Hospice Services		All Other		
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %
Medicaid	$112,781	$ 2,220	$1,042	$1,532	$—	$117,575	30.7 %
Medicare	91,644	—	7,653	10,981	—	110,278	28.8
Medicaid-skilled	21,665	—	—	—	—	21,665	5.7
Subtotal	226,090	2,220	8,695	12,513	—	249,518	65.2
Managed care	60,538	—	3,803	202	—	64,543	16.8
Private and other	28,584	27,951	1,410	43	11,185 (1)	69,173	18.0
Total revenue	$315,212	$ 30,171	$13,908	$12,758	$11,185	$383,234	100.0 %

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers and other ancillary operations.

	Three Months Ended March 31, 2015						
	TSA Services		Home Health and Hospice Services		All Other		
	Skilled Nursing Facilities	Assisted and Independent Living Facilities	Home Health Services	Hospice Services	Other Services	Total Revenue	Revenue %
Medicaid	$98,626	$ 1,080	$814	$ 1,108	$ —	$101,628	33.2 %
Medicare	81,690	—	5,942	6,724	—	94,356	30.8
Medicaid-skilled	15,537	—	—	—	—	15,537	5.1
Subtotal	195,853	1,080	6,756	7,832	—	211,521	69.1
Managed care	44,107	—	2,142	81	—	46,330	15.1
Private and other	24,511	13,223	1,465	39	9,440 (1)	48,678	15.8
Total revenue	$264,471	$ 14,303	$10,363	$ 7,952	$ 9,440	$306,529	100.0 %

(1) Private and other payors in our "All Other" category includes revenue from urgent care centers and other ancillary operations.

Transitional, Skilled and Assisted Living Services

Skilled Nursing Operations. Within our skilled nursing operations, we generate our revenue from Medicaid, private pay, managed care and Medicare payors. We believe that our skilled mix, which we define as the number of days our 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 assisted living and independent 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 the established supplemental payment program in the state of Texas that provides supplemental Medicaid payments for skilled nursing facilities that are licensed to non-state government-owned entities such as county hospital districts. Our operating subsidiaries, previously operating ten company-owned Texas skilled nursing facilities, 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.

Assisted and Independent Living Operations. Within our assisted and independent living operations, we generate revenue primarily from private pay sources, with a small portion earned from Medicaid or other state-specific programs.

Home Health and Hospice Services

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Home Health. We provided home health care in Arizona, California, Colorado, Idaho, Iowa, Oregon, Texas, Utah and Washington as of March 31, 2016. We derive the majority of our revenue from our home health business from Medicare and managed care. The payment is adjusted for differences between estimated and actual payment amounts, an inability to obtain appropriate billing documentation or authorizations acceptable to the payor and other reasons unrelated to credit risk. The home health prospective payment system (PPS) provides home health agencies with payments for each 60-day episode of care for each beneficiary. If a beneficiary is still eligible for care after the end of the first episode, a second episode can begin. There are no limits to the number of episodes a beneficiary who remains eligible for the home health benefit can receive. While payment for each episode is adjusted to reflect the beneficiary's health condition and needs, a special outlier provision exists to ensure appropriate payment for those beneficiaries that have the most expensive care needs. The payment under the Medicare program is also adjusted for certain variables including, but not limited to: (a) a low utilization payment adjustment if the number of visits was fewer than five; (b) a partial payment if the patient transferred to another provider or the Company received a patient from another provider before completing the episode; (c) a payment adjustment based upon the level of therapy services required; (d) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (e) changes in the base episode payments established by the Medicare program; (f) adjustments to the base episode payments for case mix and geographic wages; and (g) recoveries of overpayments.

Hospice. As of March 31, 2016, we provided hospice care in Arizona, California, Colorado, Idaho, Texas, Utah and Washington. We derive substantially all of the revenue from our hospice business from Medicare reimbursement. The estimated payment rates are daily rates for each of the levels of care we deliver. 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. Additionally, as Medicare hospice revenue is subject to an inpatient cap limit and an overall payment cap, we monitor our provider numbers and estimate amounts due back to Medicare if a cap has been exceeded.

Beginning January 1, 2016, the Centers for Medicare & Medicaid Services (CMS) has provided for two separate payment rates for routine care: payments for the first 60 days of care and care beyond 60 days. In addition to the two routine rates, beginning January 1, 2016, Medicare is also reimbursing for a service intensity add-on (SIA). The SIA is based on visits made in the last seven days of life by a registered nurse (RN) or medical social worker (MSW) for patients in a routine level of care.

Other

As of March 31, 2016, we operated seventeen urgent care clinics in Colorado and Washington. Our urgent care centers provide daily access to healthcare for minor injuries and illnesses, including x-ray and lab services, all from convenient neighborhood locations with no appointments. As of March 31, 2016, we held majority membership interests in our mobile 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 Update

There have been no significant changes during the three months ended March 31, 2016 to the items that we disclosed as our critical accounting policies and estimates in our discussion and analysis of financial condition and results of operations in our Annual Report on Form 10-K for the year ended December 31, 2015, filed with the SEC.

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 United States continues to increase healthcare costs, often faster than the available funding from government-sponsored healthcare programs. In response, federal and state governments have adopted cost-containment measures that encourage the treatment of patients in more cost-effective settings such as skilled nursing facilities, for which the staffing requirements and associated costs are often significantly lower than acute care hospitals, inpatient rehabilitation facilities and other post-acute care settings. As a result, skilled nursing facilities are generally serving a larger population of higher-acuity patients than in the past.
- Significant Acquisition and Consolidation Opportunities. The skilled nursing industry is large and highly fragmented, characterized predominantly by numerous local and regional providers. We believe this fragmentation provides significant acquisition and consolidation opportunities for us.

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- Improving Supply and Demand Balance. The number of skilled nursing facilities has declined modestly over the past several years. We expect that the supply and demand balance in the skilled nursing industry will continue to improve due to the shift of patient care to lower cost settings, an aging population and increasing life expectancies.
- Increased Demand Driven by Aging Populations and Increased Life Expectancy. As life expectancy continues to increase in the United States and seniors account for a higher percentage of the total U.S. population, we believe the overall demand for skilled nursing services will increase. At present, the primary market demographic for skilled nursing services is primarily individuals age 75 and older. According to the 2010 U.S. Census, there were over 40 million people in the United States in 2010 that are over 65 years old. The 2010 U.S. Census estimates this group is one of the fastest growing segments of the United States population and is expected to more than double between 2000 and 2030.
- Accountable Care Organizations and Reimbursement Reform. A significant goal of federal health care reform is to transform the delivery of health care by changing reimbursement for health care services to hold providers accountable for the cost and quality of care provided. Medicare and many commercial third party payors are implementing Accountable Care Organization (ACO) models in which groups of providers share in the benefit and risk of providing care to an assigned group of individuals. Other reimbursement methodology reforms include value-based purchasing, in which a portion of provider reimbursement is redistributed based on relative performance on designated economic, clinical quality, and patient satisfaction metrics. In addition, CMS is implementing demonstration and mandatory programs to bundle acute care and post-acute care reimbursement to hold providers accountable for costs across a broader continuum of care. These reimbursement methodologies and similar programs are likely to continue and expand, both in public and commercial health plans. On April 26, 2015, CMS announced its goal to have 30% of Medicare payments for quality and value through alternative payment models such as ACOs or bundled payments by 2016 and up to 50% by the end of 2018. In March 2016, CMS announced that its 30% target for 2016 was reached in January 2016. Providers who respond successfully to these trends are able to deliver quality care at lower cost are likely to benefit financially.

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 seniors are looking for alternatives outside the family for their care.

Effects of Changing Prices

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

Our Medicare reimbursement rates and procedures for our home health and hospice operations are based on the severity of the patient's condition, his or her service needs and other factors relating to the cost of providing services and supplies. Our home health rates and services are bundled into 60-day episodes of care. Payments can be adjusted for: (a) an outlier payment if our patient's care was unusually costly (capped at 10% of total reimbursement per provider number); (b) a low utilization payment adjustment (LUPA) if the number of visits during the episode was fewer than five; (c) a partial payment if our patient transferred to another provider or we received a patient from another provider before completing the episode; (d) a payment adjustment based upon the level of therapy services required (with various incremental adjustments made for additional visits, and larger payment increases associated with the sixth, fourteenth and twentieth visit thresholds); (e) a payment adjustment if we are unable to perform periodic therapy assessments; (f) the number of episodes of care provided to a patient, regardless of whether the same home health provider provided care for the entire series of episodes; (g) changes in the base episode payments established by the Medicare program; (h) adjustments to the base episode payments for case mix and geographic wages; and (i) recoveries of overpayments.

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 the possible 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.

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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, independently worsened and antianxiety or hypnotic medication among nursing home residents. Beginning in July 2016, CMS will incorporate all of these measures, except for the antianxiety/hypnotic medication measure, into the calculation of the Nursing Home Five-Star Quality Ratings.

On February 2, 2016, CMS issued its final rule concerning face-to-face requirements for Medicaid home health services. Under the rule, the Medicaid home health service definition was revised consistent with applicable sections of the PPACA and H.R. 2 Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The rule also requires that for the initial ordering of home health services, the physician must document that a face-to-face encounter that is related to the primary reason the beneficiary requires home health services occurred no more than 90 days before or 30 days after the start of services. The final rule also requires that for the initial ordering of certain medical equipment, the physician or authorized non-physician provider (NPP) must document that a face-to-face encounter that is related to the primary reason the beneficiary requires medical equipment occurred no more than six months prior to the start of services.

On November 16, 2015, CMS issued the final rule for a new mandatory Comprehensive Care for Joint Replacement (CJR) model focusing on coordinated, patient-centered care. Under this model, the hospital in which the hip or knee replacement takes place is accountable for the costs and quality of care from the time of the surgery through 90 days after, or an “episode” of care. Depending on the hospital’s quality and cost performance during the episode, the hospital either earns a financial reward or is required to repay Medicare for a portion of the costs. This payment is intended to give hospitals an incentive to work with physicians, home health agencies and nursing facilities to make sure beneficiaries receive the coordinated care they need with the goal of reducing avoidable hospitalizations and complications. This model initially covers 67 geographic areas throughout the country and most hospitals in those regions are required to participate. Following the implementation of the CJR program on April 1, 2016, our Medicare revenues derived from our affiliated skilled nursing facilities and other post-acute services related to lower extremity joint replacement hospital discharges could be increased or decreased in those geographic areas identified by CMS for mandatory participation in the bundled payment program.

On July 13, 2015, CMS released a proposed rule that would reform requirements for long-term care (LTC) facilities, specifically skilled nursing facilities (SNFs) and nursing facilities (NFs), to participate in Medicare and Medicaid. The rule would reorder, clarify, and update regulations that the agency has not reviewed comprehensively since 1991. Under the proposed rule, facilities are required to 1) create interim care plans within 48 hours of admission, notify a resident’s physician after a change in status, engage in interdisciplinary care planning, have a practitioner assess the patient in-person prior to a transfer to the hospital, and improve clinical records to ensure providers have the necessary information to decide on hospitalization; 2) conduct comprehensive assessments of their staff and patient needs, apply current requirements for antipsychotic drugs to all psychotropic drugs, and require physicians to document their response to irregularities identified by consultant pharmacists; 3) conduct assessments of their resident population, implement and update periodically an infection prevention and control program, and establish an antibiotic stewardship program; 4) address requirements related to behavioral health services, ensuring facilities have adequate staffing to meet the needs of residents with mental illness and cognitive impairment; and 5) conduct assessments of their patient populations and related care needs to determine adequate staffing levels (i.e., number and skillsets) for nursing, behavioral health, and nutritional services. CMS estimates that these proposed regulations would cost facilities nearly $46.5 million in the first year and over $40.6 million in subsequent years. However, these amounts would vary considerably among organizations. In addition to the monetary costs, these regulations may create compliance issues, as state regulators and surveyors interpret requirements that are less explicit.

Skilled Nursing

CMS Payment Rules. On April 21, 2016, CMS issued a proposed rule outlining fiscal year 2016 Medicare payment rates and quality programs for skilled nursing facilities. The policies in the proposed rule continue to shift Medicare payments from volume to value. CMS estimates that aggregate payments to skilled nursing facilities will increase by

2.1% for fiscal year 2017. This estimate increase reflected a 2.6% market basket increase, reduced by a 0.5% multi-factor productivity (MFP) adjustment required by the Patient Protection and Affordable Care Act (PPACA). This proposed rule also further defines the skilled nursing facilities Quality Reporting Program and clarifies the Value-Based Purchasing Program to establish performance standards, baseline and performance periods, performance scoring methodology and feedback reports.

On July 30, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by 1.2% for fiscal year 2016. This estimate increase reflected a 2.3% market basket increase, reduced by a 0.6% point forecast error adjustment and further reduced by 0.5% MFP adjustment required by the Patient Protection and Affordable Care Act (PPACA). This final rule also identified a new skilled nursing facility value-based purchasing program and all-cause all-condition hospital readmission measure.

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On July 31, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates for skilled nursing facilities. CMS estimates that aggregate payments to skilled nursing facilities will increase by $750 million, or 2.0% for fiscal year 2015, relative to payments in 2014. The estimated increase reflects a 2.5% market basket increase, reduced by the 0.5% MFP adjustment required by PPACA.

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

Home Health

On November 5, 2015, CMS issued final payment changes to the Medicare home health prospective payment system (HH PPS) for calendar year 2016. Under this rule, CMS projects that Medicare payments will be reduced by 1.4%. This decrease reflects a 1.9% home health payment update percentage; a 0.9% decrease in payments due to the 0.97% payment reduction to the national, standardized 60-day episode payment rate to account for nominal case-mix growth from 2012 through 2014; and a 2.4% decrease in payments due to the third year of the four-year phase-in of the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the non-routine medical supplies (NRS) conversion factor. Along with the payment update, CMS is revising the ICD-10-CM translation list and adding certain initial encounter codes to the HH PPS Grouper based upon revised ICD-10-CM coding guidance.

Pursuant to the rule, CMS is also implementing a Home Health Value-Based Purchasing model effective for calendar year 2016, in which all Medicare-certified home health agencies (HHAs) in selected states will be required to participate. The model would apply a payment reduction or increase to current Medicare-certified HHA payments, depending on quality performance, for all agencies delivering services within nine randomly-selected states. Payment adjustments would be applied on an annual basis, beginning at 3.0% in the first payment adjustment year, 5.0% in the second payment adjustment year, 6.0% in the third payment adjustment year and 8.0% in the final two payment adjustment years. CMS estimates that implementing a home health value-based model will result in a 1.4% decrease in Medicare payments to home health agencies across the industry.

Lastly, CMS implemented a standardized cross-setting measure for calendar year 2016. The Home Health Conditions of Participation (CoPs) require home health agencies to submit OASIS assessments as a condition of payment and also for quality measurement purposes. Home health agencies that do not submit quality measure data to CMS will see a 2.0% reduction in their annual home health payment update percentage. Under the rule, all home health agencies are required to submit both admission and discharge OASIS assessments for a minimum of 70.0% of all patients with episodes of care occurring during the reporting period starting July 1, 2015. The rule will incrementally increase this compliance threshold by 10.0% in each of the subsequent periods (July 1, 2016 and July 1, 2017) to reach 90.0%.

On October 30, 2014, CMS announced payment changes to the Medicare HH PPS for calendar year 2015. Under this rule, CMS projects that Medicare payments to home health agencies in calendar year 2015 will be reduced by 0.3%, or $60 million. The decrease reflects the 2.1% home health payment update percentage and the rebasing adjustments to the national, standardized 60-day episode payment rate, the national per-visit payment rates, and the NRS conversion factor. CMS is also finalizing three changes to the face-to-face encounter requirements under the ACA. These changes include: a) eliminating the narrative requirement currently in regulation, b) establishing that if each HHA claim is denied, the corresponding physician claim for certifying/re-certifying patient eligibility for Medicare-covered home health services is considered non-covered as well because there is no longer a corresponding claim for Medicare-covered home health services and c) clarifying that a face-to-face encounter is required for certifications, rather than initial episodes; and that a certification (versus a re-certification) is generally considered to be any time a new start of care assessment is completed to initiate care. This rule also established a minimum submission threshold for the number of OASIS assessments that each HHA must submit under the Home Health Quality Reporting Program and the Home Health Conditions of Participant for speech language pathologist personnel.

Hospice

On April 21, 2016, CMS issued a proposed rule that would update the payment rates, wage index and cap amount for hospices serving Medicare beneficiaries for fiscal year 2017. Under the proposed rule, hospices will see an estimated 2.0% increase in their payments effective October 1, 2016. The hospice payment increase would be the net result of 2.8% inpatient hospital market basket update, reduced by a 0.5% productivity adjustment and by a 0.3% adjustment set by the Affordable Care Act. The hospice cap amount for fiscal year 2017 will be increased by 2% to $28,377.17, which is equal to the 2016 cap amount ($27,820.75)

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updated by the FY 2017 hospice payment update percentage of 2.0%. In addition, this rule would propose changes to the hospice quality reporting program, including proposing new quality measures.

On July 31, 2015, CMS issued its final rule outlining fiscal year 2016 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.1% increase in their payments effective October 1, 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a "hospital market basket" increase of 2.4% minus 0.3% for reductions required by law) and 1.2% decrease in payments to hospices due to updated wage data and the phase-out of its wage index budget neutrality adjustment factor (BNAF), offset by the newly announced Core Based Statistical Areas (CBSA) delineation impact of 0.2%. The rule also created two different payment rates for routine home care (RHC) that would result in a higher base payment rate for the first 60 days of hospice care and a reduced base payment rate for 61 or more days of hospice care and a Service Intensity Add-On (SIA) Payment for fiscal year 2016 and beyond in conjunction with the proposed RHC rates.

On August 1, 2014, CMS issued its final rule outlining fiscal year 2015 Medicare payment rates and the wage index for hospices serving Medicare beneficiaries. Under the final rule, hospices will see an estimated 1.4% increase in their payments for fiscal year 2015. The hospice payment increase would be the net result of a hospice payment update to the hospice per diem rates of 2.1% (a "hospital market basket" increase of 2.9% minus 0.8% for reductions required by law) and a 0.7% decrease in payments to hospices due to updated wage data and the sixth year of CMS' seven-year phase-out of its wage index BNAF. The final rule also states that CMS will begin national implementation of the CAHPS Hospice Survey starting January 1, 2015. In the final rule, CMS requires providers to complete their hospice cap determination within 150 days after the cap period and remit any overpayments. If a hospice does not complete its cap determination in a timely fashion, its Medicare payments would be suspended until the cap determination is complete and received by the contractor. This is similar to the current practice for all other provider types that file cost reports with Medicare.

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

Annual limitations on beneficiary incurred expenses for outpatient therapy services under Medicare Part B are commonly referred to as "therapy caps." All beneficiaries began a new cap year on January 1, 2015 since the therapy caps are determined on a calendar year basis. For physical therapy (PT) and speech-language pathology services (SLP) combined, the limit on incurred expenses is $1,960 in 2016 compared to $1,940 in 2015. For occupational therapy (OT) services, the limit is $1,960 in 2016 compared to $1,960 in 2015. Deductible and coinsurance amounts paid by the beneficiary for therapy services count toward the amount applied to the limit.

An "exceptions process" to the therapy caps exists; however, manual policies relevant to the exceptions process apply only when exceptions to the therapy caps are in effect. The therapy exception process, which under previous legislation was due to expire, was extended and the expected SGR of 21% to the Physician Fee Screen for outpatient therapy services was repealed through the MACRA. Under the legislation, the therapy cap exception extends through December 31, 2017. The application of the therapy caps, and related provisions, to outpatient hospitals is also extended until January 1, 2018.

A manual medical review process, as part of the therapy exceptions process, applies to therapy claims when a beneficiary's incurred expenses exceed a threshold amount of $3,700 annually. Specifically, combined PT and SLP services that exceed $3,700 are subject to manual medical review, as well as OT services that exceed $3,700. A beneficiary's incurred expenses apply towards the manual medical review thresholds in the same manner as it applies to the therapy caps. Manual medical review was in effect through a post-payment review system until March 31, 2015. On February 9, 2016, MACRA modified the requirement for manual medical review for services over the $3,700 therapy thresholds to eliminate the requirement for manual medical review of all claims exceeding the thresholds and instead allows a targeted review process.

Medicare Coverage Settlement Agreement. A proposed federal class action settlement was filed in federal district court on October 16, 2012 that would end the Medicare coverage standard for skilled nursing, home health and outpatient therapy services that a beneficiary's condition must be expected to improve. The settlement was approved on January 24, 2013, which tasked CMS with revising its Medicare Benefit Manual and numerous other policies, guidelines and instructions to ensure that Medicare coverage is available for skilled maintenance services in the home health, skilled nursing and outpatient settings. CMS was also required to develop and implement a nationwide education campaign for all who make Medicare determinations to ensure that beneficiaries with chronic conditions are not denied coverage for critical services because their underlying conditions will not improve, after which the members of the class were given the opportunity for re-review of their claims. The major provisions of this settlement agreement have been implemented by CMS, which could favorably impact Medicare coverage reimbursement for our services. However, health care providers may be subject to liability in the event they fail to appropriately adapt to the newly clarified reimbursement rules and consequently overbill state Medicaid programs in connection with services rendered to dual-eligible Medicare patients (i.e., by not maximizing Medicare coverage before billing Medicaid).

Historically, adjustments to reimbursement under Medicare have had a significant effect on our revenue. For a discussion of historic adjustments and recent changes to the Medicare program and related reimbursement rates, see Part II, Item 1A Risk Factors under the headings Risks Related to Our Business and Industry - “Our revenue could be impacted by federal and state changes to reimbursement and other aspects of Medicaid and Medicare,” “Our future revenue, financial condition and results of operations could be impacted by continued cost containment pressures on Medicaid spending,” “We may not be fully reimbursed for all services for which each facility bills through consolidated billing, which could adversely affect our revenue, financial condition and results of operations” and “Reforms to the U.S. healthcare system will impose new requirements upon us and may lower our reimbursements.” The federal government and state governments continue to focus on efforts to curb spending on healthcare programs such as Medicare and Medicaid. We are not able to predict the outcome of the legislative process. We also cannot predict the extent to which proposals will be adopted or, if adopted and implemented, what effect, if any, such proposals and existing new legislation will have on us. Efforts to impose reduced allowances, greater discounts and more stringent cost controls by government and other payors are expected to continue and could adversely affect our business, financial condition and results of operations.

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Results of Operations

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

	Three Months Ended March 31, 2016	2015
Revenue	100.0 %	100.0 %
Expenses:		
Cost of services (exclusive of losses related to operational closure, rent, general and administrative expense and depreciation and amortization shown separately below)	79.9	78.8
Losses related to operational closure	2.1	—
Rent—cost of services	7.0	6.2
General and administrative expense	4.5	4.7
Depreciation and amortization	2.2	2.1
Total expenses	95.7	91.8
Income from operations	4.3	8.2
Other income (expense):		
Interest expense	(0.4)	(0.2)
Interest income	0.1	—
Other expense, net	(0.3)	(0.2)
Income before provision for income taxes	4.0	8.0
Provision for income taxes	1.5	3.1
Net income	2.5	4.9
Less: net income (loss) attributable to the noncontrolling interests	—	—
Net income attributable to The Ensign Group, Inc.	2.5 %	4.9 %

	Three Months Ended March 31, 2016	2015
	(In thousands)	
Other Non-GAAP Financial Data:		
EBITDA[1]	$24,495	$31,773
Adjusted EBITDA[1][2]	37,574	32,407
EBITDAR[1]	51,486	50,739
Adjusted EBITDAR[1][2]	62,625	50,884

(1) EBITDA, EBITDAR, Adjusted EBITDA and Adjusted EBITDAR are supplemental non-GAAP financial measures. Regulation G, Conditions for Use of Non-GAAP Financial Measures, and other provisions of the Exchange Act define and prescribe the conditions for use of certain non-GAAP financial information. We calculate EBITDA as net income from continuing operations, adjusted for net losses attributable to noncontrolling interest, before (a) interest expense, net, (b) provision for income taxes, and (c) depreciation and amortization. We calculate EBITDAR by adjusting EBITDA to exclude rent—cost of services. These non-GAAP financial measures are used in addition to and in conjunction with results presented in accordance with GAAP. These non-GAAP financial measures should not be relied upon to the exclusion of GAAP financial measures. These non-GAAP financial measures reflect an additional way of viewing aspects of our operations that, when viewed with our GAAP results and the accompanying reconciliations to corresponding GAAP financial measures, provide a more complete understanding of factors and trends affecting our business.

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

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

We use EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR:

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

We typically use EBITDA, Adjusted EBITDA, EBITDAR and Adjusted EBITDAR to compare the operating performance of each operation. EBITDA and EBITDAR are useful in this regard because they do not include such costs as net interest expense, income taxes, depreciation and amortization expense, and, with respect to EBITDAR, rent — cost of services, 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. As a result, we believe that the use of EBITDA and EBITDAR provide a meaningful and consistent comparison of our business between periods by eliminating certain items required by GAAP.

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

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

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

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

Management strongly encourages investors to review our consolidated financial statements in their entirety and to not rely on any single financial measure. Because these non-GAAP financial measures are not standardized, it may not be possible to compare these financial measures with other companies' non-GAAP financial measures having the same or similar names. For information about our financial results as reported in accordance with GAAP, see our consolidated financial statements and related notes included elsewhere in this document.

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

- results at our urgent care centers (including the portion related to non-controlling interest);

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- breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder;
- acquisition-related costs;
- stock-based compensation expense;
- costs incurred for facilities currently being constructed and other start-up operations;
- costs incurred related to new systems implementation;
- professional service fees including costs incurred to recognize income tax credits;
- results at one closed facility, including continued obligation under the lease and related closing expenses; and
- rent related to our urgent care centers, facilities currently being constructed and other start-up operations.

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

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

	Three Months Ended March 31,	
	2016	2015
	(In thousands)	
Consolidated statements of income data:		
Net income	$9,290	$15,088
Less: net income (loss) attributable to noncontrolling interests	118	(82)
Interest expense, net	1,136	501
Provision for income taxes	5,889	9,585
Depreciation and amortization	8,298	6,517
EBITDA	$24,495	$31,773
Facility rent—cost of services	26,991	18,966
EBITDAR	$51,486	$50,739
EBITDA	$24,495	$31,773
Urgent care center earnings(a)	(1,057)	(940)
Breakup fee, net of costs, received in connection with a public auction(b)	—	(1,019)
Acquisition related costs(c)	145	152
Stock-based compensation expense(d)	1,885	1,493
Costs incurred for facilities currently being constructed and other start-up operations(e)	1,363	146
Costs incurred related to new systems implementation(f)	678	287
Professional service fees(g)	—	26
Results at closed facility, including continued obligations and closing expenses(h)	8,125	—
Rent related to items(a),(e) and (h) above	1,940	489
Adjusted EBITDA	$37,574	$32,407
Facility rent—cost of services	26,991	18,966
Less: rent related to items(a),(e) and (h) above	(1,940)	(489)
Adjusted EBITDAR	$62,625	$50,884

(a) Operating results at urgent care centers. This amount excluded rent, depreciation and interest of $0.8 million for the three months ended March 31, 2016 and 2015. The results also excluded the net loss attributable to the variable interest entity associated with our urgent care business.
(b) Breakup fee, net of costs, received in connection with a public auction in which we were the priority bidder.
(c) Costs incurred to acquire an operation which are not capitalizable.
(d) Stock-based compensation expense incurred during the three months ended March 31, 2016 and 2015.
(e)

Costs incurred for facilities currently being constructed and other start-up operations. This amount excluded rent, depreciation and interest of $1.4 million for the three months ended March 31, 2016.

(f) Costs incurred related to new systems implementation.

(g) Professional service fees include costs incurred to recognize income tax credits which contributed to a decrease in effective tax rate.

(h) Results at closed facility during three months ended March 31, 2016, including fair value of continued obligation under lease agreement and related closing expenses of $7.9 million and operating loss of $0.2 million. This amount excluded rent, depreciation and interest of $0.1 million.

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Three Months Ended March 31, 2016 Compared to the Three Months Ended March 31, 2015

Revenue

	Three Months Ended March 31,					
	2016			2015		
	Revenue Dollars	Revenue Percentage		Revenue Dollars	Revenue Percentage	
	(Dollars in thousands)					
TSA services:						
Skilled nursing facilities	$315,212	82.3	%	$264,471	86.3	%
Assisted and independent living facilities	30,171	7.9		14,303	4.6	
Total TSA services	345,383	90.2		278,774	90.9	
Home health and hospice services:						
Home health	13,908	3.6		10,363	3.4	
Hospice	12,758	3.3		7,952	2.6	
Total home health and hospice services	26,666	6.9		18,315	6.0	
All other (1)	11,185	2.9		9,440	3.1	
Total revenue	$383,234	100.0	%	$306,529	100.0	%

(1) Includes revenue from services provided at our urgent care clinics and other ancillary operations.

Consolidated revenue increased $76.7 million, or 25.0%, compared to the same quarter in the prior year. TSA services revenue increased by $66.6 million, or 23.9%, mainly attributable to the increase in patient days, revenue per patient day skilled mix and the impacts of acquisitions. Home health and hospice services revenue increased by $8.4 million, or 45.6%, mainly due to an increase in volume in existing agencies, revenue per episode and census combined with acquisitions. Revenue from acquisitions increased consolidated revenue by $62.6 million in the first quarter of 2016 when comparing to the same quarter of 2015.

TSA Services

	Three Months Ended March 31,						
	2016		2015				
	(Dollars in thousands)				Change	% Change	
Total Facility Results:							
Skilled nursing revenue	$315,212		$264,471		$50,741	19.2	%
Assisted and independent living revenue	30,171		14,303		15,868	110.9	%
Total TSA services revenue	$345,383		$278,774		$66,609	23.9	%
Number of facilities at period end	186		143		43	30.1	%
Actual patient days	1,376,879		1,077,238		299,641	27.8	%
Occupancy percentage — Operational beds	77.1	%	78.8	%		(1.7	)%
Skilled mix by nursing days	32.5	%	30.3	%		2.2	%
Skilled mix by nursing revenue	54.6	%	52.9	%		1.7	%

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	Three Months Ended March 31, 2016	2015	Change	% Change
	(Dollars in thousands)			
Same Facility Results(1):				
Skilled nursing revenue	$223,757	$215,556	$8,201	3.8 %
Assisted and independent living revenue	9,107	9,063	44	0.5 %
Total TSA services revenue	$232,864	$224,619	$8,245	3.7 %
Number of facilities at period end	106	106	—	— %
Actual patient days	856,247	845,502	10,745	1.3 %
Occupancy percentage — Operational beds	80.1 %	80.5 %		(0.4)%
Skilled mix by nursing days	31.3 %	30.6 %		0.7 %
Skilled mix by nursing revenue	53.6 %	53.3 %		0.3 %

	Three Months Ended March 31, 2016	2015	Change	% Change
	(Dollars in thousands)			
Transitioning Facility Results(2):				
Skilled nursing revenue	$43,938	$40,571	$3,367	8.3 %
Assisted and independent living revenue	4,588	4,367	221	5.1 %
Total TSA services revenue	$48,526	$44,938	$3,588	8.0 %
Number of facilities at period end	29	29	—	— %
Actual patient days	188,249	181,847	6,402	3.5 %
Occupancy percentage — Operational beds	74.1 %	71.8 %		2.3 %
Skilled mix by nursing days	34.9 %	31.1 %		3.8 %
Skilled mix by nursing revenue	56.8 %	53.8 %		3.0 %

	Three Months Ended March 31, 2016	2015	Change	% Change
	(Dollars in thousands)			
Recently Acquired Facility Results(3):				
Skilled nursing revenue	$46,897	$6,447	$40,450	NM
Assisted and independent living revenue	16,476	873	15,603	NM
Total TSA services revenue	$63,373	$7,320	$56,053	NM
Number of facilities at period end	51	7	44	NM
Actual patient days	329,138	40,696	288,442	NM
Occupancy percentage — Operational beds	71.8 %	77.6 %		NM
Skilled mix by nursing days	36.7 %	20.8 %		NM
Skilled mix by nursing revenue	57.8 %	39.8 %		NM

	Three Months Ended March 31, 2016	2015	Change	% Change
	(Dollars in thousands)			
Facility Closed(4):				
Skilled nursing revenue	$620	$1,897	$(1,277)	NM

Assisted and independent living revenue	—	—	—	NM
Total TSA services revenue	$620	$1,897	$(1,277)	NM
Actual patient days	3,245	9,193	(5,948)	NM
Occupancy percentage — Operational beds	70.7 %	74.6 %		NM
Skilled mix by nursing days	9.6 %	15.4 %		NM
Skilled mix by nursing revenue	14.0 %	36.0 %		NM

(1) Same Facility results represent all facilities purchased prior to January 1, 2013.

(2) Transitioning Facility results represents all facilities purchased from January 1, 2013 to December 31, 2014.

(3) Recently Acquired Facility (Acquisitions) results represent all facilities purchased on or subsequent to January 1, 2015.

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(4) Facility Closed represent the result of one facility closed during the three months ended March 31, 2016. These results were excluded from Same Facility results for three months ended March 31, 2016 and 2015 for comparison purposes.

TSA services revenue increased $66.6 million, or 23.9%, compared to the same quarter in the prior year. Of the $66.6 million increase, Medicare and managed care revenue increased $26.4 million, or 21.0%, Medicaid custodial revenue increased $15.3 million, or 15.3%, private and other revenue increased $18.8 million, or 49.8%, and Medicaid skilled revenue increased $6.1 million, or 39.4%.

TSA services revenue generated by Same Facilities increased $8.2 million, or 3.7%, compared to the same quarter in the prior year. This increase reflects the following:

- Managed care revenue increased by $6.7 million, or 20.6%, which was driven by a 15.7% increase in managed care days as well as a 2.4% increase in managed care revenue per patient day.
- Medicaid revenue, including medicaid skilled revenue) increased by $5.0 million, or 5.3%, which was driven by a 2.9% increase in Medicaid days, as well as a 1.4% increase in Medicaid revenue per patient day.
- Medicare revenue decreased by $4.0 million, or 5.8%, which was driven by a 10.0% decrease in Medicare days offset by a 2.2% increase in Medicare revenue per patient day.

TSA services revenue generated by Transitioning Facilities increased $3.6 million, or 8.0%, compared to the same quarter in the prior year. This increase is due to increases in total patient days and revenue per patient day of 3.5% and 4.9%, respectively.

TSA services revenue generated by Recently Acquired Facilities increased by approximately $56.1 million compared to the same quarter in the prior year, which was driven by an increase by patient days due to newly acquired facilities. Since January 1, 2015, we have acquired 51 facilities in ten states.

Historically, we have generally experienced lower occupancy rates, lower skilled mix and quality mix at Recently Acquired Facilities and therefore, we anticipate generally lower overall occupancy during years of growth. In the future, if we acquire additional facilities into our overall portfolio, we expect this trend to continue. Accordingly, we anticipate our overall occupancy will vary from quarter to quarter based upon the maturity of the facilities within our portfolio. Included in our metrics at Recently Acquired Facilities are facilities we acquired that are matured and have higher occupancy rates, higher skilled mix days and skilled mix revenue.

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

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Skilled Nursing Average Daily Revenue Rates:								
Medicare	$578.81	$566.27	$557.05	$557.14	$488.89	$447.71	$558.04	$561.71
Managed care	421.54	411.53	465.94	464.09	410.77	370.04	427.87	422.79
Other skilled	466.22	479.49	349.83	325.21	394.25	672.04	438.70	464.13
Total skilled revenue	500.30	501.46	478.46	484.83	449.86	464.48	488.13	497.92
Medicaid	196.98	194.31	188.19	183.51	187.25	182.39	194.12	191.69
Private and other payors	199.63	190.40	234.49	210.98	208.45	186.80	206.05	193.42
Total skilled nursing revenue	292.15	287.85	294.41	280.61	285.97	242.06	291.17	$284.54

Medicare daily rates at Same Facilities increased by 2.2% compared to the same quarter in the prior year. The increase was impacted by a 1.2% net market basket increase, which went into effect in October 2015, compared to a net market basket increase of 2.0%, which went into effect in October 2014. The increase in Medicare daily rates also was impacted by the continuous shift towards higher acuity patients. In addition, the average Medicaid rates increased 1.3% primarily due to increases in rates in various states.

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

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Revenue:								
Medicare	28.3 %	31.5 %	22.7 %	23.1 %	32.9 %	24.8 %	28.2 %	30.0 %
Managed care	17.4	15.1	27.4	27.0	19.3	6.6	19.1	16.6
Other skilled	7.9	6.7	6.7	3.7	5.6	8.4	7.3	6.3
Skilled mix	53.6	53.3	56.8	53.8	57.8	39.8	54.6	52.9
Private and other payors	7.9	8.0	8.3	9.1	7.7	19.5	8.0	8.5
Quality mix	61.5	61.3	65.1	62.9	65.5	59.3	62.6	61.4
Medicaid	38.5	38.7	34.9	37.1	34.5	40.7	37.4	38.6
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	Three Months Ended March 31,							
	Same Facility		Transitioning		Acquisitions		Total	
	2016	2015	2016	2015	2016	2015	2016	2015
Percentage of Skilled Nursing Days:								
Medicare	14.2 %	16.0 %	12.0 %	11.6 %	19.2 %	13.4 %	14.7 %	15.2 %
Managed care	12.0	10.5	17.3	16.3	13.5	4.3	13.0	11.2
Other skilled	5.1	4.1	5.6	3.2	4.0	3.1	4.8	3.9
Skilled mix	31.3	30.6	34.9	31.1	36.7	20.8	32.5	30.3
Private and other payors	11.6	12.1	10.4	12.2	10.6	25.1	11.4	12.5
Quality mix	42.9	42.7	45.3	43.3	47.3	45.9	43.9	42.8
Medicaid	57.1	57.3	54.7	56.7	52.7	54.1	56.1	57.2
Total skilled nursing	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Home Health and Hospice Services

	Three Months Ended March 31,			
	2016	2015	Change	% Change
	(Dollars in thousands)			
Results:				
Home health and hospice revenue				
Home health services	$13,908	$10,363	$3,545	34.2 %
Hospice services	12,758	7,952	4,806	60.4
Total home health and hospice revenue	$26,666	$18,315	$8,351	45.6 %
Home health services:				
Medicare Episodic Admissions	2,157	1,384	773	55.9 %
Average Medicare Revenue per Completed Episode	$2,923	$2,861	$62	2.2 %
Hospice services:				
Average Daily Census	843	536	307	57.3 %

Home health and hospice revenue increased $8.4 million, or 45.6%, compared to the same quarter in the prior year. Of the $8.4 million increase, Medicare and managed care revenue increased $7.8 million, or 52.1%. The increase in revenue is primarily

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due to the increase in volume, census and revenue per episode in existing agencies, coupled with the addition of eight home health, hospice and home care operations in five states between January 1, 2015 and March 31, 2016.

Cost of Services (exclusive of losses related to operational closure, rent and depreciation and amortization shown separately)

The following table sets forth our total cost of services by each of our reportable segments and our "All Other" category for the periods indicated (dollars in thousands):

	Three Months Ended March 31,							
	2016				2015			
	TSA Services	Home Health and Hospice	All Other	Total	TSA Services	Home Health and Hospice	All Other	Total
Cost of service dollars	$274,303	$22,843	$9,162	$306,308	$218,363	$15,161	$7,932	$241,456

Consolidated cost of services increased $64.9 million, or 26.9%, compared to the same quarter in the prior year primarily due to acquisitions for all segments, including the All Other category. Cost of services for all acquisitions accounted for 18.1% of consolidated costs of services during the first quarter of 2015 compared to 2.7% in the same period in 2015.

TSA Services

	Three Months Ended March 31,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$274,303	$218,363	$55,940	25.6 %
Revenue percentage	79.4 %	78.3 %		1.1 %

Cost of services related to our TSA services segment increased $55.9 million, or 25.6%, compared to the same quarter in the prior year due to additional costs at Recently Acquired Facilities of $44.0 million and organic operational growth. Cost of service increased as a percentage of revenue to 79.4%. The main component of the increase is due to start-up costs related newly constructed post-acute care campuses and increase in insurance expenses.

Home Health and Hospice Services

	Three Months Ended March 31,			%
	2016	2015	Change	Change
	(dollars in thousands)			
Cost of service dollars	$22,843	$15,161	$7,682	50.7 %
Revenue percentage	85.7 %	82.8 %		2.9 %

Cost of services related to our home health and hospice services segment increased $7.7 million, or 50.7%, compared to the same quarter in the prior year due to additional costs at agencies acquired during 2016 of $4.1 million and organic operational growth. Cost of services as a percentage of total revenue increased by 2.9% primarily due to costs related to start-up and transitioning operations. We have generally experienced higher costs due to the addition of resources at our newly acquired and start-up agencies.

Rent — Cost of Services. Rent — cost of services increased $8.0 million, or 42.3%, to $27.0 million. Rent - cost of service as a percentage of total revenue increased by 0.8% to 7.0%. The additional increase in rent was primarily due to new leases for newly opened and acquired operations.

Losses on operational closure - We recorded charges of $7.9 million related to the close of one facility in February 2016, which represents the present value of rental payments of $6.5 million related to continued obligation under the lease and related closing expenses. These charges did not occurred in 2015.

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General and Administrative Expense. General and administrative expense increased $3.0 million, or 20.6%, to $17.4 million. The increase was primarily due to the operational growth during 2016 and the addition of resources in our post acute continuum team working on bundled payments, value-based programs for care improvement initiatives, managed care providers and other initiatives. In addition, general and administrative expense decreased slightly as a percentage of revenue by 0.2% to 4.5%.

Depreciation and Amortization. Depreciation and amortization expense increased $1.8 million, or 27.3%, to $8.3 million. Depreciation and amortization expense increased slightly as a percentage of total revenue by 0.1% to 2.2%. This increase was primarily related to the additional depreciation incurred as a result of our newly acquired and newly built operations of $1.0 million.

Other Expense, net. Other expense, net increased $0.6 million to $1.1 million. Other expense as a percentage of revenue increased slightly by 0.1% to 0.3%. The increase is due the additional borrowings under the Amended Credit Facility.

Provision for Income Taxes. The provision for income taxes is based upon our projected income for each respective accounting period and includes the effect of certain non-taxable and non-deductible items. Our effective tax rate was 38.8% for the three months ended March 31, 2016 compared to 38.9% for the same period in 2015. The effective income tax rate in 2016 included charges related to operational closure at one of our operating facilities.

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.

Historically, we have financed the majority of our acquisitions primarily through financing of our operating subsidiaries through mortgages, our revolving credit facility, and cash generated from operations. Cash paid for business acquisitions was $0.5 million and $38.7 million for the three months ended March 31, 2016 and 2015, respectively. Total capital expenditures for property and equipment were $18.2 million and $12.7 million for the three months ended March 31, 2016 and 2015, respectively. We currently have approximately $60.0 million budgeted for renovation projects for 2016.

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.

In February 2015, we completed a common stock offering, issuing 5.5 million shares at approximately $20.50 per share. After deducting underwriting discounts and commissions of $5.6 million, excluding other issuance costs of $0.4 million, we received net proceeds of $106.5 million. We then used $94.0 million of the net proceeds to pay off outstanding amounts under our credit facility.

We may in the future seek to raise additional capital to fund growth, capital renovations, operations and other business activities, but such additional capital may not be available on acceptable terms, on a timely basis, or at all.

Our cash and cash equivalents as of March 31, 2016 consisted of bank term deposits, money market funds and U.S. Treasury bill related investments. In addition, as of March 31, 2016, we held debt security investments of approximately $33.0 million, which were split between AA, A and BBB+ rated securities. 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.